Akari Care Limited

Church House Care Home

Inspection report

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Date of inspection visit:
21 August 2018
23 August 2018

Date of publication:
15 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 21 and 23 August 2018 and was unannounced.

During our last comprehensive inspection in July 2017, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to person centred care, need for consent, safe care and treatment and governance.

Following the last inspection, we asked the provider to complete an action plan and we also met with the management team. This was to confirm what they would do and by when, to improve the key questions of safe, effective, responsive and well-led to at least a rating of good.

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

Church House accommodates 44 people in one adapted building. The accommodation is based over two floors. At the time of our inspection there were 32 people living at the home.

At this inspection in August 2018 we identified continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 9 (Person centred Care)). One new breach was found relating to Regulation 18 (staffing). The provider was no longer in breach of Regulation 11 (consent).

We found the service 'Inadequate' and the service is therefore in 'special measures.'

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An interim manager had been in post since the departure of the previous registered manager in April 2018 but had subsequently resigned. A new home manager was about to start at the service and we were advised they would be applying to register as the manager.

Risks to people's health and safety were not always suitably assessed and managed. Timely action had not been taken to act on recommendations made by health professionals.

There was not always enough staff deployed to meet people's needs in a safe and timely way. Feedback demonstrated that people and relatives were concerned about staffing levels and changes to the staff team. The recruitment of staff was a priority and we saw that staff were recruited using safe procedures.

Suitable arrangements were in place for the safe administration of medicines.

Safety checks were carried out on the premises. Following our inspection, the local fire service undertook a fire safety audit of the home and we were advised that some actions needed to be carried out within certain timescales.

Records did not demonstrate that staff were trained to provide safe and effective care. Staff had received some supervision meetings with managers, however the provider could not evidence the frequency of these.

People had choices of food and drinks, they were complimentary about the food on offer. However, people's nutritional risks were not always managed safely.

Improvements had been made to ensure compliance with the MCA. Staff sought consent before providing care to people.

People's bedrooms were decorated and personalised according to their preferences.

There were some members of staff who had worked at the service for some time and had good knowledge of people's backgrounds and preferences. Where possible staff supported people to be as independent as they wanted to be.

People told us that staff treated in a kind and caring manner, respecting their dignity. However, the service did not always give the staff the time they needed to provide care in a caring and personal way.

Whilst some people were positive about the support they received, we found that people did not always receive care that was responsive to their needs.

People and their relatives told us they had been involved in care planning and reviews of their care. We saw that care plans contained information about people's likes, dislikes and interests.

There were gaps in people's records and the provider could not always evidence that care had been provided as required in people's care plans.

There was an activities coordinator and people were complimentary about the activities on offer, which included trips out.

The provider had a complaints procedure in place which was on display within the reception area. People told us that they felt able to raise any concerns with the staff.

During this inspection we found that whilst the provider had addressed one of the breaches they had not addressed all the concerns identified at the last inspection. In addition we found a further breach of regulation. We concluded the service was not well-led. The registered provider had not responded appropriately to ensure people received safe care and treatment.

The quality assurance systems in place had failed to identify the significant concerns in the home to keep people safe.

Following this inspection, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken

immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe, and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. 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 is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Risks associated with people's needs were not sufficiently assessed, monitored and managed. Professional guidance had not been acted upon in a timely manner.

There were not always enough staff available to provide people with the assistance they needed in a timely way.

The recruitment of new staff was a priority. Agency staff were being used to cover gaps in the rota.

Suitable arrangements were in place for the safe administration of medicines.

Environmental checks were undertaken. An action plan had been implemented by the fire service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records did not demonstrate that staff were trained to provide safe and effective care. Staff had received some supervision meetings with managers although the frequency of this was unclear.

People had a choice of food and drinks and were complimentary about the food on offer. However, people's nutritional risks were not always managed safely.

Improvements had been made to ensure compliance with the MCA. Staff sought consent before providing care to people.

People's bedrooms were decorated and personalised to reflect their preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they were treated in a kind and caring manner. Certain staff were knowledgeable and had built positive relationships with people.

However, the service did not always give the staff the time they needed to provide care in a caring and personal way. People's dignity was sometimes compromised.

People were supported to be as independent as they wanted to be and to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and treatment that was responsive to their needs or provided in a person centred way.

There was a continued failure to maintain an accurate and complete record in respect of each person.

People were complimentary about the activities on offer.

The provider had a complaints procedure and people said they felt able to raise any concerns.

Is the service well-led?

Inadequate

The service was not well-led.

The service has a poor record and history of not meeting legal requirements.

The registered provider had not responded appropriately to ensure people received safe care and treatment. However they had started to take action at the time of the inspection.

Systems in place to monitor the quality and safety of the service were ineffective.

Church House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 21 and 23 August 2018 and was unannounced. The inspection was carried out by one adult social care inspector, a specialist nurse advisor and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted in part by concerns raised by members of the public about the standard of care provided. Some of these were being investigated under safeguarding procedures at the time of the inspection and the local authority was also monitoring the service. Some of the concerns related to the care provision during the night time. Therefore, the second day of the inspection was also unannounced and commenced at 5.00am, which enabled us to meet with night staff.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. 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. We did however review the information we held about the service, including statutory notifications received from the provider. Notifications are incidents which the provider is legally obliged to send the Commission. We contacted the local authority commissioners and safeguarding teams, who informed us that the service was subject to an improvement plan.

During the inspection we spoke with 17 people who lived at the service and five relatives and/or visitors, to seek their views. We spoke with 14 members of staff including, two nurses, eight care staff including agency staff, the housekeeper, cook, domestic, maintenance person and temporary administrator. We also spoke with a temporary regional manager and quality assurance manager. Telephone contact was made with social and health care professionals who were involved with the home.

We looked at the care plans of four people who lived at the home and inspected other care records such as

daily charts. We reviewed further documentation which related to the day to day management of the service, including, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We looked around the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people and observed the lunch-time meal.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection in July 2017, we rated this key question as 'requires improvement'. We found the provider was in breach of regulations relating to safe care and treatment. At this inspection, we found ongoing concerns relating to the safe management of risks. We also found a further breach relating to staffing.

Prior to the inspection we were made aware of whistle blowing concerns which had been received by the local authority and the Commission about the care provision. Some of these were being investigated under safeguarding procedure at the time of the inspection and the local authority were also monitoring the service

At this inspection we found the provider had not taken responsive action to keep people safe. Individual risks to people were not always managed safely. There were significant shortfalls in this area and the registered provider remained in breach of this regulation.

We reviewed people's records and were concerned people were not always protected from risks. Staff had not always followed professional guidance relating to the safer management of falls. One person living at the home was at high risk of falling. During the first morning of the inspection we saw they were seated in an armchair in the lounge and when passing the lounge staff were rarely present. There were two staff available on the ground floor who were very busy providing personal care to people throughout the morning. We reviewed the person's care plan and saw they had been identified at high risk of falls. We spoke with an occupational therapist who told us they had undertaken an assessment early in August 2018 but that recommendations made had not been actioned when they returned on 22 August. This included recommendations that the person should be supervised whilst in the lounge and installing a chair sensor alert. We found that these recommendations were not included in the person's care plan and had not been actioned in a timely way to ensure the risk of the person falling and sustaining an injury was mitigated.

Staff did not have access to appropriate equipment to assist with safe moving and handling. Whistle blowing concerns had alleged that staff were not using safe techniques to move and handle people. Again, an occupational therapist provided guidance that people needed to be assessed for individual hoist slings. However, during the inspection staff told us they used one hoist sling for all people but were aware that people should have individual slings; staff told us that, "the office" were dealing with this. The regional manager told us on the second day of the inspection that some hoist slings had been ordered. The issue had not been identified in a "manager's walk around report" completed on 23 July 2018 which noted that "correct slings" were used.

We found further examples where risk assessments had not been undertaken and action considered to mitigate future risks. For example, we saw two incidents recorded in people's records. One involved a person being found outside the fire exit doors. No harm had occurred and we were advised that this was probably when the person was unwell. However, we were unable to evidence that any further consideration had been given to managing any future risk. Neither of the concerns had not been reported as safeguarding. The

quality manager referred both incidents to the local authority under safeguarding following the inspection. We found further examples where risk assessments had identified actions to reduce the risk but that staff had not always ensured these were followed.

We were concerned that lessons had not always been learnt where things had gone wrong, to ensure people received safe care. There had been a safeguarding enquiry relating to a person who was given a meal of the wrong consistency for their needs. The former interim manager dealt with this as a complaint and identified there had been a communication issue between staff. Meeting notes indicated that this had been raised with staff. We were told that action had been taken to ensure that there was clear information for all staff about each person living at the home and their dietary needs, including a board in the kitchen which highlighted people's individual requirements. However, during the inspection, we found two further examples where staff were not following guidance recommended by a speech and language therapist and the records were unclear and contradictory.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not done all that was reasonably practicable to mitigate risks.

We saw that accidents and incidents were recorded. There was a folder in place where staff logged any accidents and incidents monthly. These were also analysed to identified whether there were any trends or frequent falls. However, issues identified during the inspection evidenced that the system, had not ensured that all incidents had been followed up effectively.

We asked people whether they felt safe living at Church House and whether there were sufficient staff to meet their needs. Overwhelming feedback was that people were concerned about staffing levels. They told us, "I do worry when I call the bell how long it will take them to come"; "Can't fault the carers but there are just not enough" and" They take ages to come when I press the bell." Relatives commented, "A stable team is what is needed" and "It would help if the staff stayed."

Feedback received and observations made indicated there were times when there were not enough care staff available to provide people with the assistance they needed in a timely way. During the inspection we sometimes found it hard to find care staff and at times saw people in the lounge unsupervised.

There were 32 people living at Church House, spread across two floors of the home. The temporary regional manager told us staffing levels were based on an assessment of people's dependency needs. Staffing levels were, six care staff and one nurse during the day, which reduced to five after 2pm. Plus one nurse and three care staff at night time. We were particularly concerned about the ground floor where two carer staff were supporting 13 people and the lounge area. 11 of these people needed support from two members of staff with their care needs. People raised concerns that when they used their call bell staff would often come and turn it off and say they would be back but left them waiting. We observed this happening during the inspection. One person was particularly anxious because their relative was due to take them out and they were waiting for support to get out of bed and prepare for the day ahead. Two people gave us examples of waiting for excessive time for support. Staff comments included "Call bells cannot be answered in a timely way. We never stop."

A review of the rotas indicated that staffing had sometimes dropped below these numbers and we were told this was due to sickness. Some staff had left the service and the management team said they always tried to cover last minute absences. We noted on the first day of the inspection that the medication round was late to start because a member of staff had not arrived and a member of staff was called in to cover the medication round. The impact of this was that a person was given medication at 10.30am after they had

eaten, however the directions were to administer the medication at an earlier time and prior to food. The staff member stated that this was not usual practice and was due to staff sickness.

The above issues were a breach of Regulation 18 [staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not always deployed sufficient experienced staff to make sure that they could meet people's personal care and treatment needs.

The home was using agency staff to cover gaps in the rota and told us they tried to use consistent staff and some agency staff were very familiar with the home. However, we were told of occasions when all staff on the night shift were agency with no regular staff available. Staff told us this could make it more difficult if they were unsure of anything. Rotas confirmed this had occasionally been the case. Some permanent staff had been asked to cover some of the night shifts to try to address this. We were advised that recruitment was a priority. This was particularly the case for nursing staff. As a short-term measure two agency nurses, familiar with the home had been booked for a longer period to ensure there was adequate cover. We were advised that a recruitment day had been organised. Three care staff were awaiting final recruitment checks.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people.The DBS check helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable people.

Staff spoken with had an understanding of safeguarding and how to report any concerns. One person commented, "I would have no hesitation in whistleblowing, if I saw or heard anything that wasn't right for the resident." Overall, we saw that safeguarding concerns when identified by the staff and former managers had been reported through local procedures. However, as noted above there had been two occasions when they had not been reported. There was a register in place which recorded any safeguarding referrals and the action taken in response.

Whistleblowing allegations had been made about some staff sleeping during the night shift. This was being investigated by the provider and local authority. The provider told us that appropriate action would be taken to address any substantiated concerns. We saw that night checks had subsequently been undertaken by the acting regional manager and we were advised that these would continue randomly on a regular basis. Our inspection commenced at 5am on the second day. Staff were active and knowledgeable and we saw from the records that people had been checked on a regular basis throughout the night.

We checked the arrangements for the management of medicines. There was an up to date medication policy in place. We observed medicines being administered safely. We saw that qualified nurses and senior staff responsible for administering medication, undertook competency assessments. The previous electronic system used to record medication administering had recently been discontinued because of problems with the internet connection. The home was moving back to paper Medication Administration Records (MARs) and a new pharmacy was to supply all medicines.

The arrangements for the storage, recording and administration of medication was satisfactory. Medication was stored in trolleys which were usually secured to the wall or in locked rooms when not in use. MARs were correctly completed following the administration of any medication. The individual MARs contained information about people's allergies and a photograph of the person, helping to reduce the risk of potentially giving the medication to the wrong person. Records of the daily room and fridge temperatures had been maintained Protocols were in place for when medicines were prescribed to be taken 'when

required, 'often referred to as PRN medication. These additional instructions were needed to guide staff how and when this medication should be given. We raised one concern with the acting manager because we saw a gap on the MAR for one medication earlier that morning. The staff member had noticed the gap and had made necessary checks to ensure that the medication had been administered. However, the recording error had not been reported to the manager. They told us they intended to report this but acknowledged this should have been reported as soon as they were aware.

We looked around the home and saw that the environment was generally clean and odour free. Staff were wearing appropriate gloves and aprons to reduce the risk and help the prevention of infections. We noted that some areas of the home looked tired and worn. For example, paint work was chipped and carpets stained in certain areas. The temporary regional manager told us that a budget meeting was planned and following that a schedule of works would be developed with regards to ongoing improvements.

The provider employed a maintenance person. We spoke with them and reviewed their records.These demonstrated that checks were conducted on the facilities and equipment, to ensure they were safe. This included fire safety systems, call bells, water temperatures and electrical equipment. Gas, water and other appliances were also regularly serviced. We had been made aware of an ongoing concern relating to the home's boiler, which had previously impacted on the heating and hot water in the home. We discussed this with the maintenance person who confirmed that one of the boilers had been repaired and was now functioning correctly. This however, would need replacement in the near future. During the inspection we saw that one person's bedroom did not have hot water available. We were told that this had not been reported and was addressed by the maintenance person on the day of the inspection, this related to the tap rather than the boiler.

During the inspection we also found that there were a significant number of wasps in an area of the building, early in the morning. The provider arranged for a pest control company to address the situation on the same day.

A few days following our inspection the local fire service undertook a fire safety audit of the home and we were advised that some actions needed to be carried out within certain timescales. The acting manager confirmed that the home had devised their own action plan and had started to act to ensure compliance.

There was a business continuity plan for any unforeseen emergencies, which had been reviewed and updated on the day of the inspection.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in July 2017, we rated this key question as' requires improvement'. This we because we found a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always act in accordance with the Mental Capacity Act (2005). At this inspection we found that the provider had made some improvements and were no longer in breach of this regulation. However, we found further breaches of regulations relating to the safe management of nutritional risks and staffing.

People's weights were regularly monitored and we saw that where people had lost weight action had been taken in response. However, we had concerns about how other nutritional risks were being managed. During the inspection, we found two examples where staff were not following guidance recommended by a speech and language therapist (SALT). One person's eating and drinking care plan identified they required a pureed diet. Different information was recorded on records in their bedroom and diet notification sheet. The cook told us the person's swallowing had improved and they were now able to tolerate a soft diet. However, there was no written information about the person's needs being reviewed and the original guidance from SALT was unavailable. A choking risk assessment was also not in place. The records were contradictory and confusing. This meant that the person was at risk of unsafe care because staff did not have access to accurate records. There was a further example where guidance was not being followed because staff felt it wasn't suitable for the person, however this had not been formally reviewed or referred back to SALT. We asked the management team to ensure that a review was sought from the SALT team as soon as possible and to update the records.

This was a further breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not done all that was reasonably practicable to mitigate risks.

People told us, "I'm always asked what I would like to eat or drink"; "We have meal choices the night before and there is always a choice" and "The food is good." We observed the lunchtime meal and saw that tables were nicely presented. The food looked appetizing and assistance was provided to people where necessary. We observed drinks were available to people throughout the day. The cook regularly sought feedback from people about the menu and took people's preferences into account. If people did not like the choices available then alternative options were always provided.

Staff told us they received training. Comments included "We get training all the time" and "Yes we get training." A relative commented, "Training seems consistent as the staff are good." However, training records were not well maintained or up to date. There was an in-house trainer for moving and handling and an outside training company provided other training and maintained the training records. The management team told us that some training had been undertaken but was not yet included in the matrix, as they were awaiting certificates. New staff were not all included on the matrix and we found it difficult to establish whether staff had undertaken training in areas deemed mandatory by the provider, including safeguarding and moving and handling. A recent fire service inspection also identified that sufficient fire evacuation training had not been undertaken.

We were advised that new staff undertook a period of induction, which was currently being revised. The provider expected staff to complete The Care Certificate. The Care Certificate is a recognised set of standards that health and social care workers must adhere to in their daily work. The quality manager explained they had asked the previous interim manager to ensure staff completed questionnaires to establish whether they needed to undertake the Care Certificate, but these had not yet been completed. Records to demonstrate training already undertaken by new starters was not readily available and some were awaiting induction packs to be implemented. Therefore, the registered provider was unable to provide satisfactory evidence to show that staff were suitably training for their roles.

This was a further breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The registered provider had not ensured that staff received appropriate support, training, development and supervision.

We spoke with agency staff who advised us they had undertaken an initial induction when they started at Church House. One person told us that they had completed an induction sheet which included information about the fire safety policy and were also shown around the building. They were aware of information about people's specific needs including those at risk of falling and where the necessary information could be found.

The provider had a policy that staff should receive supervision sessions six times per year. Staff spoken with varied in their response about the frequency of supervision, one staff member told us they had regular supervision whilst another said that it had been a while. A matrix had been implemented from July 2018 and we saw that several supervision sessions had taken place in that month. The incoming manager and regional manager told us they planned for all staff to receive a supervision session within the next two of weeks and a plan would be in place following this.

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.

At the last inspection we found the provider was not consistently working within the principles of the MCA and we were unable to ascertain from the records which people were subject to a DoLS authorisation. At this inspection we saw that a new matrix had been implemented which provided clearer information about DoLS applications made and authorisations in place. The provider had focused on ensuring that where necessary applications were made to the supervisory body (local authority) where it was deemed that people were being deprived of their liberty. A system had now been implemented to ensure that any renewals were made in a timely manner, although this needed to be embedded.

Further improvements were required to ensure that the MCA was always followed where necessary. We found mental capacity assessments along with best interest decisions had been made appropriately where people lacked the capacity to make the decision themselves. However, further work was required to ensure that all assessments were decision specific. The quality assurance manager had already started to work on this and demonstrated that a decision specific best interest decision had been recorded around the decision for a person to use a senor mat. We saw that staff sought people's consent to provide care and a relative confirmed that they were involved by staff in decisions about their relative's care.

There was access to health and social care professionals and this was recorded in people's care records

about GP visits, optician and chiropody appointments. We saw that referrals were also made to other health professionals such as dieticians and speech and language therapists. However, we found on some occasions that referrals to other professionals had not always been made in a timely manner, such as a referral to SALT.

People's bedrooms were decorated and personalised to reflect their preferences. Each bedroom had a picture frame, which contained "All about me" information and a photograph of the person. This acted as a useful prompt for meaningful conversations. There was an attractive outside garden and seating area, which enabled people to spend time outside in the warmer weather.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in July 2017, this key question was rated as 'good'.

We asked people whether the service was caring, they told us "Staff respect me"; "The staff are caring and they do a good job even when they are short staffed" and "The staff encourage me to make decisions." Visiting relatives commented, "They treat my husband with respect" and "There are caring staff, just need more."

Prior to the inspection we had received concerns suggesting that staff approach was not always caring or compassionate. These issues were being investigated by the local authority under safeguarding with support from the provider of the service.

During the inspection, we observed staff communicating in a kind manner. For example, one member of staff was very reassuring with a person and supported them to walk saying, "I'll be with you, you won't be on your own." Another member of staff asked in a caring way about how a person was feeling and asked their permission to wipe their face. Whist we found staff were caring in their approach, we also found that the service did not always give the staff the time they needed to provide care in a caring and personal way. For example, one person was calling for assistance, we saw that a carer went and turned the call bell off telling the person they'd be back in a minute, they were in the middle of supporting another person. Several minutes later the carer returned and said that they need to go and get the person "off the loo". Another person commented "It can take a long time for toileting."

Certain members of staff had worked at the service for some time and had good knowledge of people's backgrounds and preferences and had developed positive relationships with people. However, people told us that there were lots of staff changes which meant that there wasn't always familiarity. For example, one person said, "The staff they bring in (agency staff), they are alright but it's not the same as the ordinary staff."

At times people were supported to make individual choices about their care. For example, people could decide where they preferred to spend their time or whether they would like to take part in activities. People spoken with told us that overall staff respected their dignity and privacy. We saw that staff knocked on people's doors and staff could tell us about the sort of actions they would take to maintain people's dignity. We saw that care plans included details to guide staff to ensure people's dignity was maintained. One member of staff said, "We try and respect people's choices" and that all the staff were kind with people. During the inspection a person suffered a fall, we saw that staff provided cushions to ensure the person was kept comfortable whilst waiting for paramedics, they also ensured that a member of staff escorted the person to the hospital.

However, we also found staff were not always able to respond to people's discomfort or distress in a timely way. A person who remained in bed told us they needed assistance with their continence needs. They were waiting for staff but said that it was "too late". When we informed a member of care staff that a person

required support with their continence needs, we were advised they were aware but that the other carer was on a break and the person would have to wait until they returned. This compromised the person's dignity. When we discussed this with the management team, they were concerned about this and raised it as a safeguarding concern with the local authority. We saw further examples where staff were unable to respond to people in a timely way.

These issues were a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences.

Where possible staff supported people to be as independent as they wanted to be. One person told us that they would like to return to living in the community and that the staff had been very supportive and were encouraging them to be as independent as possible. They commented, "Having the care staff encouraging me to do as much as I can is a good thing, to keep me active."

Equality and diversity training was available to staff, although according to the records, not all the staff were up to date with the training. The provider had a policy relating to equality and diversity. Initial assessments undertaken when a person moved to the service included information about people's specific requirements, such as considering religious or cultural needs.

People were supported to maintain relationships which were important to them. The service had enabled a married couple to occupy a shared room and visitors were able to visit the home without any restrictions in place. During the inspection we saw that people had visitors throughout the day. People's care records were kept securely and were kept in a locked cupboard.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2017, this key question was rated as 'requires improvement' and we found a continued breach of Regulations relating to 'person centred' care. This was because people did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. At this inspection we found that the provider remained in breach of this regulation. We also found a further breach relating to record keeping.

At this inspection we found that the support provided did not always meet people's personal preferences. We spoke to one person who told us they had requested a shower the previous afternoon but hadn't received one because there hadn't been time. They explained how they needed to request a shower and were never certain when they would have one. It had been necessary for a relative to leave a note to ask staff to ensure their relative received a shower. Another relative told us it had previously been necessary to ask staff to clean their relative's nails. We noted that people's oral hygiene needs were not always be attended to. Some tooth brushes were dry and charts did not always record that people had been supported with oral hygiene.

On the first day of the inspection we found that staff followed a routine when providing care, which was not personalised. Staff advised us that, where possible people were given choices around when they would like to get up and we saw a few more independent people in the dining room for breakfast. However, we observed and staff described a general routine in place whereby staff were focused on tasks. We saw that several people were brought down to the lounge just prior to lunchtime and waited in wheelchairs before lunch. A member of staff brought a person into the lounge in a wheelchair, they did not ask they person where they would like to sit or whether they would like to be transferred into an arm chair.

These issues were a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences.

We discussed this task focused approach with the acting management team, who told us they were already aware of this and agreed that support needed to be provided in a more personalised way. On the second day of the inspection we saw that more people were up in the dining room for breakfast and some people spent time in the lounge during the morning. One relative told us that they were pleased to see their relative up and in the lounge, as this was quite a nice change.

Some people were positive about the support they received. Comments varied and included, "They have been brilliant here,"; "They are responsive yes, but would work better if they had a stable team"; "Staff ask if I need anything else" and "Very caring staff, they can't do enough for me."

People and their relatives told us they had been involved in care planning and reviews of their care. We saw that care plans contained information about people's likes, dislikes and interests. There was a "This is me" document, which was completed with people and provided a good picture of the person and their

preferences. One person told us, "My views and likes and dislikes are taken into to account." We saw that one person preferred to eat alone and were supported to dine in a separate room.

Charts were kept demonstrating people had received support, for example with personal care, positional turns or food and fluid intake. However, we found that these were not fully completed. There were gaps in the charts reviewed and we could not always evidence that care had been provided as required in people's care plans. We saw some charts relating to fluid intake, which were not fully completed or the amount taken totalled. This meant that staff could not easily identify whether people had taken enough fluid and act upon this information if not. There was a record of a person having had a drink but we saw that this remained on their bedside for at least two hours. We later saw that the amount had been crossed out but were concerned that records were completed prior to the fluid being taken and therefore may be inaccurate.

In addition, we saw gaps in bowel charts. Where there were gaps we were not provided with information to demonstrate that consideration had be made as to whether any further action was required. In one example we checked handover charts and the person's care plan and there was no record that any further action had been taken or whether this was a recording omission.

These issues were a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure an accurate and contemporaneous record was maintained.

Care plans reviewed contained some person-centred information about people's support needs and had generally been reviewed on a regular basis. There was a "resident of the day" system in place which meant that on each day in the month a person would be reviewed along with their care plans and medications. However, some care plans had limited information or had not been updated to fully reflect changes to people's needs. We saw examples where staff had written "check regularly" or "plenty of fluids" and "changes made to pad size" without any further details. Therefore, this did not provide sufficient detail to guide staff to know how to support the person effectively.

Care plans contained information in relation to supporting effective communication with individuals. This included information on any communication aids such as glasses or hearing aids that the person might require. Care records also showed people had been offered the opportunity to discuss their end of life wishes. Where people did not want to be resuscitated in the event of a decline in their health, a signed form completed by a health professional was displayed at the front of their care record. This helped ensure staff had access to important information. The GP also supported the home to develop care plans which considered priorities for end of life care.

The home employed an activities coordinator who supported people to be able to follow their interests. They were on leave during the inspection but people were complimentary about the activities on offer. They told us, "Activities are great,"; "Days out are good" and "I love it when the singer comes in." We saw that a weekly activities planner was in place and included activities such as, bingo, quizzes, keep fit, and outings. There were also regular visits from entertainers. There was a notice board in the reception area which advertised the activities on offer. The activities coordinator was involved in seeking people's views about the service and facilitated a residents and relatives' meeting.

The provider had a complaints procedure in place which was on display within the reception area. People told us that they felt able to raise any concerns with the staff. One person said, "Any issues I would tell my carer." There was a complaints folder which logged complaints and we were advised that this had recently been implemented by the interim manager, to ensure any complaints were appropriately recorded. The

folder contained one recorded complaint. We saw that a response had been provided.

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2017, we identified breaches of regulation in relation to the well-led domain and this domain was rated as, 'Requires improvement.' Following the last inspection, the provider sent us an action plan which outlined what they intended to do to make improvements within the service to ensure it met the regulations. We also met with the management team.

At this inspection we have found breaches of regulations in respect of person centred care, safe care and treatment; good governance and staffing. This meant the provider had failed to improve the overall rating of the home from 'requires improvement'. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case as we found the quality of care was not continuously improving over time. The previous two inspections had also rated the service as 'requires improvement'. During this inspection we found that whilst the provider had addressed one of the breaches they had not addressed all the concerns identified at the last inspection and we found a further breach. We concluded the service was not well-led. The registered provider had not responded appropriately to ensure people received safe service.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.The registered provider had not adequately assessed, monitored and improved the quality of the service.

At the time of the inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last registered manager left the home in April 2018. An interim manager had been appointed. At the time of the inspection the interim manager was absent and we were advised they had resigned from the position of home manager. The interim deputy manager was also absent from the service. There had been a period of inconsistent management at the home. Due to the current concerns a temporary regional manager was covering the home along with a quality assurance manager. We were told that a new peripatetic manager was due to start at the home shortly and planned to stay at the home for the foreseeable future. We met with them on the first day of the inspection, as they were undertaking a handover. We found the new manager was keen and motivated to make the necessary improvements.

Feedback received from people, staff and visiting professionals indicated that concerns had become apparent following the departure of the previous registered manager. One person told us that the home, "had gone down" since the previous registered manager had left. Whilst some staff told us that they felt supported by the management team others raised concerns that since the previous registered manager had left, the interim management had not always been approachable and had not always listened to staff concerns. There had been a recent number of staff who had left the service. However, there were some comments which indicated staff enjoyed working at the home and worked well as a team.

The provider's quality assurance systems in place had failed to identify the significant concerns in the service to keep people safe. We found the culture had been reactive rather than proactive in ensuring that people received a good standard of care. Whilst the provider had started to take some action at the time of the inspection, this was mainly as result of numerous whistle blowing and safeguarding concerns which had been raised. We were concerned that during the period where there had been no manager there had been a number of management staff covering the service. Feedback from the local authority indicated that some recommendations made had not been acted upon in a timely manner.

Whilst some audits had been undertaken these had not proved effective in identifying all the concerns raised at this inspection, such as the safe management of risk, lack of accurate record keeping and staffing issues. Care plans and risk assessments had not been robustly audited. We had identified a number of issues in one person's care plan which had not been identified in the audit. The interim manager had undertaken a number of audits including health and safe, dining experience, medication and infection control. An audit completed by the provider's quality assurance team was last undertaken in December 2017. There had been two regional manager audits in February and May 2018. However, the May audit found the service to be 87 % complaint. Systems in place to monitor were not always effective, for example the mattress checks were inaccurate and there were significant gaps in daily monitoring.

The service had not always provided a 'person centred' culture that centred on people's needs and valued them as individuals. The quality assurance manager told us they were tackling the culture and said that recently staff had felt more comfortable about raising issues of concern. The acting management team had put some systems in place to ensure more effective recording such as for complaints and DoLS. A home development plan had also been implemented with a view to making the necessary improvements.

Residents and relative's meetings had occasionally taken place to seek people's feedback about the service. However, the latest minutes available were from February 2018 but we were advised that one had been held more recently and another one was booked for the following week. The provider had an annual survey which went out to people and relatives to gather their views on the service. However, we were unable to clarify whether this had been undertaken for Church House.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. This is called a notification. We checked our records and found that we had received appropriate notifications to CQC as required. The current CQC rating was displayed as legally required on the registered provider's web site and within the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not done all that was reasonably practicable to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not adequately assessed, monitored and improved the quality of the service. The provider had failed to ensure an accurate and contemporaneous record was maintained.

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 The registered provider had not always deployed sufficient experienced and skilled staff to make sure that they could meet people's personal care and treatment needs. The registered provider had not ensured that staff received appropriate support, training, development and supervision.