Care Quality Commission

Coate Water Care Company (Church View Nursing Home) Limited

Chapel House Care Centre

Inspection report

Chapel House Care Centre
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Ratings

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

Overall summary

This was an unannounced inspection which was carried out over two days on 8 and 11 November 2014. Chapel House Care Centre provides care and support for people with physical and mental health needs and people who live with dementia. It can accommodate 41 people and at the time of this inspection 19 people were living in the home. Accommodation was across three floors each with its own dining room, lounge and bedrooms with personal bathrooms. A passenger lift was available to help people get to the first and second floors. The top floor was dedicated to caring for those who live with a dementia.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches related to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, the care and welfare of people, suitably qualified staff, staff

Summary of findings

recruitment, management of medicines, assessment and monitoring the quality of service provision, record keeping and formal notifications. You can see what action we told the provider to take at the back of the full version of the report.

Although a new home manager had started in post on 23 October 2014, at the time of this inspection, the home did not have a registered manager. 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 and associated Regulations about how the service is run.

Managers who were responsible for providing leadership since the home opened in May 2014 had failed to provide this effectively. The quality of the service provided and the standard of care had not been monitored. The provider's own systems for checking shortfalls had not been effective enough to identify specific risks and poor care.

Arrangements to ensure people received the care they required had failed some people. Health care professionals had reported their concerns about this to the County Council's safeguarding team. They subsequently found two people had come to actual harm because their needs had not been appropriately met. Others were at risk of not having their needs met. Some people's health and care needs, including associated risks, had not been appropriately assessed or identified. The care required to meet these needs had not been suitably planned and reviewed.

People had not been protected against risks associated with poor medicines management. Although some improvements had been made to how people received their medicines, the medicines system still required improvement in order to fully protect people from medicine errors.

A lack of accurate record keeping put people at risk of receiving inappropriate care or treatment because there was insufficient information about them. This also meant staff lacked guidance on how to meet people's needs and manage their risks. People's choices, wishes and preferences were not always recorded. Visits from health care professionals and their instructions had not always been recorded.

People who did not have mental capacity had not been protected under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Two people had been deprived of their liberty. One had been deprived of their liberty unlawfully. There was no guidance for staff in either case on how to do this in the least restrictive way. Equipment such as bed rails, which can deprive people of their liberty, were in use without people's consent. People who live with a dementia had not had their mental capacity assessed and best interests decisions for the use of this equipment were not in place.

People were at risk of being cared for by staff who maybe unsuitable. It was not possible for the home manager to demonstrate that robust staff recruitment practices had been followed prior to staff starting work. An audit of the staff recruitment files had found certain required documents missing.

Notifications (a specific way that the Care Quality Commission must be notified about significant events) had not always been completed and forwarded to us. This meant we were not aware of incidents or situations that we are responsible for following up in order to ensure the provider had managed these correctly.

Staff had not been provided with adequate supervision or support. They had not received feedback on their performance and had not had their training needs reviewed.

People were protected from acts of abuse because staff knew how to recognise abuse and how to report incidents or allegations of abuse.

Despite these shortfalls people were looked after in a caring way. Staff were patient and showed kindness. People were treated with dignity, respect and compassion. Some people were supported to live their lives the way they wanted to and to make their own decisions. People were able to receive visitors without restrictions. Where appropriate staff communicated with visitors about their relative's health and welfare. People were provided with the privacy they wanted and required.

Summary of findings

Information was provided to people about how to make a complaint. It was not possible to assess whether the provider's complaints policy had been followed as no concerns or complaints had been recorded as received.

Two people who live in the home told us they had met the new home manager and told us they would feel alright about talking to him about anything they were unhappy about.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There were not enough suitably qualified, skilled and experienced staff to ensure the home could safely meet people's complex needs.

People's risks had not been identified and were not being suitably managed.

Staff recruitment files were missing documents that demonstrate a robust recruitment process had taken place.

People had not received their medicines safely. Although there had been improvements to the management of medicines, further improvements were needed to ensure people were protected against mistakes related to poor medicine management.

Is the service effective?

Requires Improvement

The service was not effective. People who lacked mental capacity had not been protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People's consent had not been sought in relation to the use of some equipment.

Instructions from visiting health care professionals were not recorded and in the case of three people not followed.

Staff had not been supported and some lacked specific training to meet people's complex needs.

People were provided with a balanced diet which met their needs and choices.

Is the service caring?

Good

The service was caring. Staff treated people with respect and compassion and there was a genuine desire to promote people's well-being.

People were provided with privacy when they needed it or when it was required.

Is the service responsive?

Requires Improvement

The service was not fully responsive. People's care and health needs had not always been assessed, planned and reviewed. Staff responded to people's needs when they knew what they were but were not always provided with guidance on how to meet them safely.

Staff could not effectively meet people's needs because accurate records of past care, altered care and health care professionals' instructions had not always been recorded.

Summary of findings

People had not been involved in planning their care and some people's individual preferences, choices and what was important to them had not been explored and recorded for staff guidance.

The new home manager operated an open door policy and was available for people to their concerns.

Is the service well-led?

Inadequate 

The service was not well-led. Staff had not been provided with effective leadership since the home opened in May 2014. Staff had been left with challenges and problems they could not resolve without support.

Quality monitoring of the services and care provided had not taken place. The provider's own monitoring systems had not been robust enough to recognise shortfalls before they had impacted on the people who use the service. Systems to drive improvement were not in place.

A positive culture had not been promoted and a closed culture had developed which resulted in staff feeling dis-engaged and unsupported by the management.

Required notifications of significant events had not been completed and sent to the Care Quality Commission.

Chapel House Care Centre

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 checked 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 was unannounced and took place on 8 and 11 November 2014. This inspection was brought forward in response to concerns which were shared with us by the County Council's safeguarding team.

The inspection was carried out by one inspector. Information that we already held about the service was reviewed prior to this inspection. This included a review of notifications (information about significant events that a service is required to send to the Care Quality Commission).

We spoke with five people who live in the home and two visitors. We looked at eight people's care records, which included care plans, assessments of risk, care monitoring charts and medicine records. We also watched how staff supported people and spoke with them. We spoke with a representative of the provider, the operations manager, the new home manager and eight staff employed by the provider and one agency member of staff.

We looked at records that related to the management of the home. This included accident and incident records, health and safety records and certificates. We looked at three audits and a service improvement plan. We were shown three policies, the home's registration certificate, the statement of purpose and insurance certificates.

Three days after the inspection visit we attended a meeting held by the County Council's safeguarding team. A safeguarding meeting provides an opportunity for the concerns and any new concerns to be raised with all relevant adult social care and health care professionals. The provider can give feedback on the concerns raised and actions required to protect people from further risk can be decided upon and agreed.

Inadequate

Is the service safe?

Our findings

Despite the provider having policies and procedures in place, people were not safe. People's needs and risks had not always been assessed and identified. People's rights had not been protected. Although some actions had been taken by the new management team, some people were not protected against potential or actual harm.

There were not enough suitably qualified, skilled and experienced staff employed by the provider to safely meet people's complex needs and ensure that individual risks were identified, assessed and managed safely. Agency nurses were used to ensure a nurse presence in the home. When agency staff were booked some continuity was maintained by booking the same nurses. Senior nurses were covering nursing shifts and therefore unable to address some of the failing systems.

One person who lived in the home had left the building without staff being aware. The person subsequently agreed to return to the home and was safe. Following this incident the time lapse between the automatic door release being pressed and the door locking again was reduced so as to lower the risk of a reoccurrence.

One staff member said, "We are fire fighting at the moment." One member of staff told us it was better when three staff were on duty on their particular floor but confirmed this did not always happen. On the morning of 8 November 2014 there were insufficient staff to meet the needs of nine people who lived on the top floor. Two people in particular required a lot of individual attention and one other person was agitated and required direction. Five people required two staff to get them up and several people required supervision once up because of their degree of confusion and agitation.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were put at risk because their medicines weren't managed safely. Poor management of replenishing stocks of medicines had resulted in some people not receiving their prescribed medicines. One person had required hospital treatment after their medicine had not be administered for four days.

An audit carried out by the home manager confirmed medicines had not be managed safely. This audit also found one other person had not received their medicine because it had run out of stock, whilst another person had not had their medicines because, although in stock, staff thought it had run out.

As a result of the home manager's audit better storage and arrangements for re-ordering medicines had been put into place. MARs were also being checked against the stock to ensure medicines had been administered and there was suitable stock in place.

Medicines which were waiting for disposal were not being stored in an organised fashion. In the medicines storage room we found these medicines stored in an unlabelled bag on one side of the room and in a cardboard box amongst other empty boxes on the other. We found rubbish in this box amongst the medicines. We were told these medicines were waiting to be returned to the pharmacist. Initially no records could be found to clarify what these medicines were and what stock was present, but later records were found which showed these medicines were recorded as ready to return to the pharmacy. This demonstrated poor organisation and unsafe practice.

We checked the stock of controlled medicines (medicines at higher risk of abuse) against the records held for these. The stock and records tallied with each other but controlled medicines which had not been needed for several months were still in stock. This increased the risk of these medicines being abused or going missing.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw medicines being appropriately administered from a medicine trolley during the inspection. One person self-administered their medicines and showed us how they kept these safe in their bedroom. A secure facility was provided in each bedroom for this purpose.

A recent audit of staff recruitment files had been carried out by the home manager. The audit showed some of the staff files did not contain necessary documents and employment checks. The home manager was able to confirm that all staff had started work with clearances from the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB). What the home manager could not confirm was

Inadequate

Is the service safe?

whether staffs' existing DBS clearances had been re-checked with the DBS and a new one applied for. The home manager therefore told us they could not be confident that the recruitment process had fully protected people against staff who may be unsuitable.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were protected from abuse. Three members of staff described the types of abuse people may be at risk of and they knew how to report allegations or actual acts of abuse. Two members of staff and an agency nurse knew where the contact number was held for the County Council's Safeguarding Helpdesk. The care staff told us they had received safeguarding training when they started work at the home. A member of staff told us all new nurses were issued with information on the safeguarding adult procedure when they started work. We saw workbooks which had been completed by two care staff during their induction training. One of the subjects was safeguarding adults but these had yet to be marked and validated.

The home manager had found the main staff training record for the home had not been maintained. We were told they had therefore planned to check all staffs' knowledge on safeguarding procedures during their first supervision and support session with individual staff. The service had a copy of the provider's safeguarding policy but not a copy of the County Council's safeguarding protocol for reporting abuse.

People were not protected from avoidable harm as a cleaner's trolley containing cleaning products was stored in an unlocked, unoccupied bedroom. As soon as we spoke with the member of staff about this they stated the unattended trolley should have been secured.

We found the environment was safe and clean and records relating to these areas had been well maintained.

We recommend that the provider ensure all staff are made aware of and understand the Control Of Substances Hazardous to Health Regulations 2002.

Requires Improvement

Is the service effective?

Our findings

People's relatives and visitors were positive about the care people received. One visitor said about their relative "It's the best place for her, she has really come on" and another said their relative received "excellent care." A third visitor said their relative received "terrific care."

People who lacked mental capacity had not been protected by the Mental Capacity Act 2005. Legislation related to the Deprivation of Liberty Safeguards (DoLS) had not been followed. Staff told us they had been instructed by health care professionals not to let one person leave the home. This person was being deprived of their liberty unlawfully because staff were actively distracting this person and preventing this from happening without a DoLS authorisation in place. There was no care plan or risk assessment in place explaining why health care professionals had requested this.

Another person had been appropriately assessed earlier in the year and a Deprivation of Liberty safeguard authorisation issued. We found the referral paperwork but not the DoLS authorisation. The home manager was unaware of this referral. We subsequently learnt that the supervisory body had issued the authorisation and sent it to the home in September 2014. There were no care plans or risk assessments referring to this authorisation for staff information or guidance.

People's levels of supervision and control had not been reviewed, as current legislation requires, to ensure people were not deprived of their liberty.

Some people had not given permission for bed rails to be used. Bed rails restrict people's ability to leave their beds independently. Some people who live with dementia had bed rails in use but they had not had their mental capacity assessed in relation to the use of this equipment. There were no best interests decisions in place with regard to the use of this equipment. We asked one person if they knew why the bed rails were up on their bed. This person said "I don't know why these are here". This person was living with dementia but there was no mental capacity assessment in place in relation to whether they could consent to the use of the bed rails or to show their understanding of why these were in place. There was no best interests decision in place.

Another person was agitated and shouting for help from their bed during this inspection. We found bed rails in use for this person. There was no mental capacity assessment or best interests decision in place in relation to this equipment. A health care professional subsequently reported to us that this person had climbed over their bed rails and hurt themselves. They confirmed that these had been removed and safety mats placed alongside their bed instead.

The evidence above shows that people were not protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People had access to appropriate health care professionals such as their GP, community nurses, diabetes nurse, speech and language therapists, chiropodist and mental health specialists. Despite these visits however, instructions from health care professionals had not always been recorded and communicated to the staff. This led to people's needs not being effectively monitored or met.

Some people were at risk of weight loss and their weights had not always been consistently monitored. However, some people had been prescribed a calorie supplement drink by their doctor.

Risks associated with people's eating and drinking had either not been clearly identified and communicated to staff or not clearly reviewed. One person's medicine administration record (MAR) showed they had been prescribed a fluid thickener to help them swallow drinks. A risk assessment recorded this person was at risk of choking and referred to the thickener. When we witnessed their drink being given to them the thickener was not added. We asked about this and two members of staff said they were "pretty sure" the speech and language therapist had spoken with a colleague and said the person did not need this any longer. There was nothing recorded to reflect this change in treatment. This person had also been prescribed and was receiving a calorie supplement drink but there was no care plan in place referring to its use for staff guidance.

Another person had suffered a stroke which had affected their speech. A thickener was also in their bedroom with their name on it but there was no care plan advising staff about this or how it should be used. The fluid in the person's beaker, alongside their bed, did not have thickener in it when we looked at it. Although this person's food intake had been monitored the records completed

showed this had been inconsistent. There was no care plan or risk assessment in place stating if there was a risk to the person's swallowing or nutritional intake. This person's visitor told us the staff fed their relative.

This person was unable to tell staff about their preferences and what was important to them. One specific preference relating to how they preferred their personal care to be delivered had been recorded, but a specific care plan, for staff to follow when providing personal care had not been devised. Daily records, completed by the staff, showed that this preference had not been recognised and met by staff. This person was not having their preferences met because their care had not been planned to meet their individual needs and preferences.

This person was also at risk of developing pressure ulcers. Records showed that this person was having their position altered albeit inconsistently. There was no care plan in place to instruct staff on how frequently this person needed to be repositioned in order to reduce the risk of pressure ulcers.

Another person had been prescribed specific medicine to be given at specific times by their GP. This medicine regime had not been effectively communicated to staff, there was no care plan outlining the reasons for giving this and how to give it correctly. Staff had not therefore understood the importance of administering this medicine as it had been prescribed. On the second day of this inspection this person received an urgent visit by a specialist health care professional. After speaking with the necessary staff, this specialist found staff lacked understanding of the management and benefits of the medicine prescribed. The specialist found, although staff had been monitoring the person, there had been a possibility of confusion over which equipment to use to do this. This could have resulted in incorrect readings. This was resolved by the specialist removing all existing equipment and providing new equipment specifically for this person. At the end of the specialist's visit there was a clear plan in place as to when and how the medicine should be used and how often the person should be monitored. We spoke with one of the regular agency nurses and found they had also been made aware of the specialist's treatment plan.

This evidence shows that people's care had not been appropriately and individually planned and reviewed which meant they were at risk of receiving unsafe or inappropriate care and treatment that did not meet their individual needs or preferences.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us how they managed people's behaviour that could be perceived as challenging. They gave us an example of one person who needed as much one to one support as staff could provide because they responded well to this. We were told it reduced the behaviour that could be perceived as challenging. Staff told us it was not always possible to provide this level of support because of the numbers of staff. Staff knew this person's behaviour patterns well and were aware of the signs of when this person's behaviour was beginning to become challenging. One member of staff told us, when this happened, staff would aim to provide one to one support at that point.

Another person sometimes needed time away from the home but required support from staff when out in the community. One member of staff told us they had built up a good relationship with this person and they often went on walks with them. Staff knew the triggers that may cause this person's behaviour to escalate. We witnessed an incident during the inspection and saw that staff acted swiftly by using distraction techniques to de-escalate the situation.

One person had witnessed their relative exhibit behaviour that was challenging towards the staff. They said, "(person's name) can get nasty with the staff". They said "the staff just talk to (person's name) and she calms down." This showed staff were managing this person's challenging behaviour effectively.

Three people told us the food was nice and tasty. They confirmed they were able to make a choice about what they ate. One relative told us they had stayed for a meal once and the food had been served cold. They wondered if this would put their relative off eating but they said "she is eating well." We watched people on the top floor receive the support they required to eat and drink. Where people required special diets the cook had been made aware of this and they made arrangements to meet people's needs.

Staff were able to make people drinks and provide them with biscuits in between meals. We observed one member

Requires Improvement

Is the service effective?

of staff serve people cups of tea without providing a saucer. We fetched a saucer for one person who had also accepted biscuits and they said "that's better". This seemed to be a blanket approach for all present rather than one that considered each person's preference and ability to manage a cup, saucer and biscuits. This indicated that staff may not always be considering how to promote and retain people's existing skills or preferences.

Staff were aware that people had different religious beliefs and when required, accommodated these. We learnt that one person, for religious reasons, chose not to eat certain foods. This had been respected and accommodated.

Not all staff had received adequate support to carry out their role. The home manager told us staff supervision and support had not been provided consistently and not at all for some staff. Staff had not received feedback on their performance. We spoke with two members of staff who said they had never been provided with supervision sessions since working in the home. They also said the new managers had been supportive and they would ask for help if they needed it. The home manager was about to address this shortfall and had planned one to one support sessions with all staff.

One member of staff had specific training in dementia care to a higher level than other staff. Their role was to support staff in improving outcomes for people who live with dementia in the home. Other staff had completed training in dementia care or had previous experience of this care when they joined the home. The member of staff who supported other staff explained they had not had time to develop this role but hoped this would improve under the new management. We spoke with them about one person who lived with dementia and whose behaviour escalated during the late afternoon. The member of staff had found when this person listened to music they were calmer. They had shared this information with other staff and we witnessed this activity being used effectively.

Good

Is the service caring?

Our findings

One person said “they (the staff) have treated me with utter respect” another person said “the staff are very considerate and they are kind.”

We witnessed staff talking to one person, who was confused, in a patient and kind manner. This person responded to them positively and followed them to the dining room, which is what the staff wanted the person to do. This person was also free to explore their immediate environment without restrictions. Another person, receiving personal care, had their needs met in a way that upheld their dignity.

We watched staff closing bedroom and toilet doors when providing personal care so as to preserve people’s privacy.

The second day of this inspection took place on 11 November 2014 when a two minute silence was held around the world to honour the fallen in the First World War. Two people in the ground floor lounge responded to this on the television and stood in silence; others watched from their chairs. The home manager and staff who were present showed compassion and respect to these people by doing the same alongside them. They were aware of people’s emotions following this and asked them if they were alright. This showed staff had understood that this was important to these people.

Staff cared for and supported people who became upset in a respectful manner. For example we saw staff responding to one person who became increasingly distressed in a caring manner. When the person swore at them they remained respectful towards them.

One person’s care records showed they had been involved in deciding what level of support they received and how they spent their days. This person could exhibit behaviour that could be perceived as challenging so staff needed to communicate well with this person in order to avoid situations that could become difficult.

People were supported to be independent. One person was supported to make daily decisions and to lead as much of an independent life as possible. Staff provided support without the person feeling this was intrusive. Another person had been supported to self medicate but was given additional help when they felt they needed it.

People who live with dementia were supported to explore their immediate environment. We witnessed staff gently re-directing one person when they came to the end of a corridor by casually holding their hand and talking to them whilst at the same time, re-directing them.

We witnessed people receiving their visitors and visiting was unrestricted.

Requires Improvement

Is the service responsive?

Our findings

We asked two visitors who acted on behalf of their relative whether they had been involved in the person's assessment and care planning. One said "briefly", the other said they had not been asked anything about their relative but they confirmed staff gave them an update on their relative's well-being each time they visited.

Where care plans were in place they had not always been maintained in order to provide accurate information and they did not always reflect people's needs. Some care plans did not contain relevant information even though they stated they had been reviewed. Relevant risk assessments were not always in place when risks had been identified in order to guide staff on how to manage these. For example, one person's care plan relating to the risk of them developing pressure ulcers, stated it had been reviewed on 5 October 2014. The review recorded the person had no pressure ulcers. However, the care plan stated, "Currently being assessed to see if (person's name) needs pressure relief mattress". The next recorded review date in November 2014 had not been completed. We asked a member of staff if this person was still awaiting this assessment and they told us an assessment for the risk of developing pressure ulcers had taken place shortly after the person's admission in September 2014. The member of staff said "the new mattress is actually in place" and they confirmed it had been for some time.

People with mental health needs had been reviewed by specialist mental health professionals. One person's mental health needs had not resulted in care plans being formulated so staff could understand what these were and received guidance on how to meet these. A health care professional explained to us that because staff had not fully understood the person's needs, staff had over compensated and made the person more dependent when they should have been promoting independence.

For some people, their care records and care plans referred to behaviour that could be perceived as challenging but these were not written in a way that gave guidance to staff on how to respond to this. Staff were however able to explain to us how they supported one person when they became upset or agitated. One member of staff said, "I just walk away and return once they have calmed down". When people's behaviour had become challenging for staff to manage, entries by the staff in people's care records focused on a description of the event, and not what they had done to manage the situation. For example, one person's care records recorded the following, "scratched two members of staff today during personal care", "lashing out today" and "extremely non-compliant today" but records did not explain how staff had responded and if their actions had helped the situation.

Staff were unable to be fully responsive to people's needs because they lacked information about these as well as guidance. We spoke to two members of the care staff and asked them if they knew the people who they were looking after well. They told us they knew people's basic needs but they did not know the individual person. These staff members told us they had not read the care plans that were written. One member of staff said "they used to all be together in a file but now I'm not sure where they are now". Another member of staff said "When would we have time to read these?".

This evidence shows that people were at risk of inconsistent or inappropriate care and treatment due to a lack of information recorded about them.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One member of staff was employed as the activities co-ordinator but they were also trained to provide care to people when needed. We were not aware of any organised activity taking place during this inspection. One of the inspection days was a Saturday and the activities coordinator was working additional hours to cover care staff sickness. Televisions were on in each lounge area whenever we visited and the television on the top floor was on continuously between 10:30am and 4:30pm on this day. We asked people, who were awake, if they were watching the television and they either said no or we could see they were not engaged with it. This was with the exception of one person who said, "I love watching the television". Staff on this floor, between the hours of 10:30 and 4:30pm on the Saturday did not have time to provide any form of social activity. We spoke to the activities co-ordinator who split their time providing the required one to one support for two people with providing activities for others. When providing one to one support they were unable to spend time with other people. One person told us about the knitting they had previously done with the activities co-ordinator. They were very proud of the knitted toys they had made.

Requires Improvement

Is the service responsive?

We asked the home manager if the service had received any complaints or concerns. None were recorded and the home manager had not received any since starting at the home on 23 October 2014. We could not therefore establish if complaints or concerns were listened to and responded to according to the provider's complaints policy. The provider's complaints policy stated how complaints would be managed and the process that would take place if people were not satisfied with the initial investigation and final response.

The complaints policy incorrectly implied that the Care Quality Commission (CQC) was the next step if people wanted to refer their complaint further. We advised the home manager that whilst we (the CQC) want to hear about people's experiences we do not hold statutory powers to investigate individual complaints and they may wish to amend the policy. The complaints procedure was part of the literature placed in each bedroom. Signposting people to other agencies that do hold the statutory power to investigate complaints, such as funding authorities or the local ombudsman had not been added.

Inadequate

Is the service well-led?

Our findings

The home had not been well-led and this had resulted in widespread and significant shortfalls. The provider had not taken responsibility and ensured that their quality monitoring systems were robust enough to identify shortfalls and make improvements. Systems were not in place to protect people against the risks of inappropriate or unsafe care, identify risk and manage risks associated with people's health, welfare and safety.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Notifications had not been completed and forwarded to us. For example we had not been notified of the incidents described earlier in this report such as the serious injury resulting in hospital treatment for one person and the issuing of a Deprivation of Liberty Safeguard authorisation for another person. Notifications not appropriately forwarded meant we had not been made aware of events that we may need to follow up or check on to make sure the service had managed incidents and situations correctly.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Registration) Regulations 2009.

The registered manager had left their post in September 2014. There had been no quality monitoring of the service or care provision since the home opened in May 2014. A representative of the provider had provided temporary management whilst a replacement home manager was recruited. During this period of time staff were not provided with the support they needed to carry out their responsibilities. One member of staff told us they felt there were not enough staff and they were unsupported.

A new home manager started in post on 23 October 2014. They told us they had found staff "dis-engaged" and "stressed". They told us they had spent their first two weeks in post promoting an open, transparent and supportive culture. They had started to bring structure and improvement to how staff were communicated with, for example, by holding meetings with heads of departments; housekeeping, catering, maintenance, administration and care. They said these meetings helped them to learn what had happened over a weekend, what was planned for the week and to learn where staff needed support. The home manager explained that staff were being encouraged to report issues and concerns to the management team so these could be effectively resolved. One manager said "there is an awful lot to do".

In order to assess the standards of care and decide where initial improvements were needed the home manager had been out and about observing interactions between staff and people who live in the home. They told us they found staff to be kind and wanting to promote people's well-being but communication was poor between the staff.

We spoke to two people who live in the home and they both knew the home manager by their first name. Others were aware of him but could not remember his name. This showed the home manager had made themselves visible and approachable to those living in the home. It was important to one person that they had access to the home manager when they wanted to. During this inspection they made such a request and the home manager provided private time for this person to speak to them.

Just prior to the home manager starting, a new area operations manager had been employed as well as a deputy manager. Since in post the new management team had carried out three initial audits. These had been on staff recruitment files, the medicines system and care plans. The operations manager had talked with staff and found out what induction and training they had been provided with. Together these managers had produced an initial improvement plan which they showed us. This had taken into account key areas that needed support before anything else could improve and these included the recruitment of more suitably qualified, skilled and experienced staff. The improvement plan recorded the delegation of the task and a date which they aimed to complete the improvements by. At the time of this inspection this plan was in its infancy and therefore many of the identified improvements had not been completed. However it did identify key shortfalls and there was a united management team in place wanting to drive improvement.

All three new managers were clear about how they were going to encourage staff to help them improve the quality of the service. This included providing staff with supervision and support sessions where staff could express their ideas and concerns. The home manager told us they

Inadequate

Is the service well-led?

were going to personally carry out each staff members first support session because they needed to reassure staff about the future, identify what support and training they needed and to address specific issues around sick leave.

The first full staff meeting was booked for the week of this inspection where the same message would be delivered, one of support and reassurance on how the home was going to move forward. A 'residents and relatives' meeting was also planned, although the home manager was already demonstrating an open door policy.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use services and others who may be at risk were not protected against inappropriate or unsafe care and treatment because there were not effective arrangements in place to regularly assess and monitor the quality of the services provided. Regulation 10 (1)(a)(b)(iii)(c)(i)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use the service were not protected against the risks associated with unsafe use and management of medicines, by making proper provision for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use the service were not protected against risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of – An accurate record in relation to their care and treatment; and such other records as appropriate in relation to person's employed and the management of the regulated activity. Regulation 20 (1)(a)(b)(i)(ii).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment There were not suitable arrangements to obtain people's consent for care and treatment. The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not being adhered to. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Effective recruitment procedures were not in place to ensure a person employed was of suitable character. Information specified in Schedule 3 was not available. Regulation 21 (a)(i)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Appropriate steps had not been taken by the provider to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed to carry on the regulated activity. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission without delay of an injury which had occurred to a service user and which required treatment by a health care professional and when a standard authorisation under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards was issued in relation to a service user. Regulation 18 (1)(2)(b)(ii)(c)

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered persons had not taken proper steps to ensure that each person was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of – Carrying out an assessment of needs and planning and delivering, or where appropriate treatment, that – met people's individual needs, ensured their welfare and safety, reflected good practice and avoided unlawful discrimination, including, where applicable, making reasonable adjustments in service provision to meet people's individual needs. Regulation 9 (1)(a)(b)(i)(ii)(iii)(iv).

The enforcement action we took:
A Warning Notice was issued under Section 29 of the Health and Social Care Act (HSCA) 2008 for failing to comply with regulation 9 of the HSCA 2008. The provider, Coate Water Care Company (Church View Nursing Home) Limited was required to become compliant with this regulation at Chapel House Care Centre by 1 January 2015.