Advanced Caring Limited

Church View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Church View is a residential care home providing personal care to three adults at the time of the inspection. People live in one large house which has been adapted. The service can support up to eight adults with learning disabilities and/or a variety of associated health and support needs. At the time of inspection there were three further people who lived at the service, who were not receiving personal care.

People's experience of using this service and what we found
There were not always enough staff to support people's needs outside the one-to-one support hours. Staff were not always trained sufficiently, and recruitment had not always been fully robust. People were not supported by effective governance systems and processes. Medicines were not always managed safely. People received their medicines on time and as prescribed. However, medicines administration records (MAR) were not always legible and an unexpected drop in the daily medicines count for one medicine had not been identified by the service.

The provider did not always ensure support was provided by staff wearing the correct personal protective equipment (PPE). Immediate action was not taken to update the infection prevention and control (IPC) policy or to put in place an IPC audit.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Based on our review of safe and well-led the service was not able to demonstrate they were meeting some of the underpinning principles of Right support, right care right culture. The lack of governance systems and oversight meant physical risks had not all been identified, this meant people were taking risks that they had not had choice over. People had opportunity to regularly share their views. Staff worked well with other professionals to help identify and meet people's needs.

Right Support
People and relatives told us staff supported people to take part in activities and pursue their interests in their local area. People had a choice about their living environment and were able to personalise their rooms.

Right Care
The service and provider did not have systems in place to fully monitor the quality and safety of the service. This meant they had not identified areas of concern we found on this inspection. Where appropriate, staff encouraged and enabled the person to take positive risks. However, not all physical risks for the person had

been assessed.

People received kind and compassionate care. Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs. One relative said '[person] is happy there'.

Staff promoted equality and diversity. They understood people's cultural needs and provided culturally appropriate care. Staff told us about one service user who was supported by staff to share a special cultural celebration with their relative through a window visit, when the home was unable to accept visitors.

People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs.

Right culture.
Staff placed people's wishes, needs and rights at the heart of everything they did. One professional told us the service was, "Very person centred and reactive to the resident's needs". People led inclusive and empowered lives because of the ethos, values, attitudes and behaviours of the management and staff. Staff turnover was very low, which supported people to receive consistent care from staff who knew them well.

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

Rating at last inspection
The last rating for this service was outstanding (published 29 February 2020).

Why we inspected
We initially undertook this inspection as part of CQC's response to the COVID-19 pandemic. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements. We also asked the provider about any staffing pressures the service was experiencing and whether this was having an impact on the service.

On the first day of our inspection we identified concerns in relation to infection prevention and control. As a result, we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from outstanding to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment of people, good governance (leadership and oversight of the service), and staffing at this inspection.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? Details are in our well-led findings below.	**Requires Improvement**

Church View

Detailed findings

Background to this inspection

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

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

Inspection team
One Inspector carried out the inspection over two days.

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

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

Notice of inspection
Day one of the inspection was announced and the second day was unannounced.

Inspection activity started on 27 January 2022 and ended on 16 February 2022. We visited the location on 27 January 2022 and 16 February 2022.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager. We reviewed a range of records. This included

three people's care records and three medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with one relative about their experience of the care provided. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke to one professional who visits the service regularly.

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

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- There were not enough staff to meet the needs of residents all the time. The service had enough staff to cover one-to-one support but lacked additional hours to supervise in communal areas of the home, for those not receiving one-to-one support. One staff member told us the low staffing levels had in the past made it difficult to manage people's mental health needs.
- Staff were not up to date with training, for example first aid. At inspection we identified some shifts where there had been no staff who were up to date with first aid training. This put people at risk of harm in the event of them needing emergency support.
- Two staff told us training was too basic. One bank staff member, who had worked in the service for six months had not completed any of the online training modules. The lack of training put people at risk of harm as their needs may not be fully understood or addressed.
- Recruitment was not always completed safely. We saw one support worker's recruitment file did not contain full references and the employment history was incomplete.

We identified no people had been harmed however, sufficient and suitably qualified staff were not always in place to support people who live at the service. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Criminal record checks were in place to ensure the staff were suitable to work with people who are (or might be) made vulnerable.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People's physical health needs had not been fully assessed and managed. One person was at risk of choking and had not got a risk assessment in place for this. The choking risk was not mentioned in their care plan and staff were not all aware they should have observed this person when they ate, to slow down the speed of eating and reduce the risk of choking. Staff's lack of knowledge put the person at risk of choking.
- The risk assessments for falls and diabetes were not always in place. The guidance for staff in care notes was confusing and staff were unclear about how to manage the risks. For example, two staff told us no one was at risk of falls, when we identified at least one person who was.
- There was no infection prevention and control audit in place. This was highlighted to the manager on the first day of inspection, but by the second day, 14 days later, this had still not been done. The registered manager had not identified all risks to reduce the spread of infection.
- Staff did not always correctly wear personal protective equipment (PPE). The bins provided to dispose of PPE were not always the recommended foot-operated pedal bins. This put people at risk of catching

infections such as COVID-19.
●We identified that at meal-times social distancing could be improved, as people ate around one large table which does not promote social distancing.
● On the first day of inspection the registered manager told us they would review the infection prevention and control policy, which we found did not contain enough detail about COVID-19. However, by the second day of inspection this had not been reviewed.

We identified no people had been harmed however, people had not always received care and treatment for their physical needs that was safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service prevented visitors from catching and spreading infections.
● The service tested for infection in people using the service and staff.
● The service had not admitted anyone during the COVID-19 pandemic, however their planned processes to admit people were safe.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
● The service supported visits for people living in the home in line with current government guidance. For example, when in person visits were not possible due to a COVID-19 outbreak, window visits were facilitated for people.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Not all staff had completed safeguarding training.
● People told us they felt safe from avoidable harm because staff knew them well and understood how to protect them from abuse. People told us they would ask staff if they didn't feel safe.
● The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned.
● People, including those unable to make decisions for themselves, had as much freedom, choice and control over their lives as possible because staff managed risks to minimise restrictions.
● Staff considered less restrictive options before limiting people's freedom.

Using medicines safely
● Medicines administration records were not always legible.
● Medicines were stored safely.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.
● We observed medicines being given, this was carried out with attention to detail and staff spoke to the person respectfully, explaining what they were doing.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems and processes were not in place to identify gaps in the training of staff. This lack of oversight put people at risk of receiving care that was provided by staff who were not adequately trained.
- Systems and processes were not always effective in identifying required changes. The monthly team leader's audit had identified a fire plan and personal emergency evacuation plan were present for a person who stopped using the service four months ago, but neither had been changed. It was unclear whose responsibility it was to do this.
- Staff were not always able to explain their role in respect of individual people without having to refer to documentation. For example, staff were not all able to clearly describe the steps they would take if a person who suffers from epilepsy was to have a seizure.

Continuous learning and improving care; Working in partnership with others

- There was a lack of infection prevention and control (IPC) oversight at the service because audits were not completed. This was identified on day one of inspection but had not been completed by the second day, which was 14 working days later. This absence of a system in place to identify concerns put people and staff at risk of getting an infection.
- The IPC policy made no reference to COVID-19. This was identified on day one of inspection but had not been improved by the second day.
- Whilst audits were in place for medicines, they had not identified concerns we picked up on at inspection. The systems and processes in place had not identified that the way the paper medication administration record was stored, meant a hole was over the name of a medicine making it unreadable. Also, it had not picked up that one medicine count, the daily total of a medicine, recorded a reduction in the total medicine with no explanation given. This puts people at risk of not receiving medicine correctly.

Due to poor governance of the service people were placed at risk of harm. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- The service worked well in partnership with advocacy organisations/other health and social care organisations, which helped to give people using the service a voice/improve their wellbeing.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● The registered manager was not able to correctly describe what the duty of candour meant, when asked at inspection. We expect registered managers to have a good understanding of the meaning of duty of candour.

We recommend the registered manager review their understanding of the duty of candour and seek current guidance and best practice.

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

● Management were approachable and visible in the service, they took a genuine interest in what people, staff, family and other professionals had to say. One professional told us the registered manager, "Is always available in the home, he seems to know the residents very well".

● The manager worked directly with people and led by example setting a culture that valued reflection, learning and improvement and they were receptive to challenge and welcomed fresh perspectives.

● Staff felt respected and valued by senior staff which supported a positive and improvement-driven culture. Staff told us they, "Can go talk to [the manager] whenever I need to" and they felt the manager would listen if they went to them.

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

● People, and those important to them, worked with managers and staff to develop and improve the service.

● Staff encouraged people to be involved in the development of the service.

● The provider sought feedback from people and those important to them and used the feedback to develop the service. People told us about resident's meetings they attended, they said they took place every month and, "We talk about everything". People told us they felt positive about these meetings and their views were listened to.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not always received care and treatment for their physical needs that was safe. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Due to poor governance of the service people were placed at risk of harm.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient and suitably qualified staff were not always in place to support people who live at the service. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice