Mark Jonathan Gilbert and Luke William Gilbert

Church View

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 03 and 08 March 2016. Both days of the inspection were unannounced.

Church View is registered to provide accommodation and care with nursing for up to 50 people. At the time of this inspection there were 44 people living at the home.

Accommodation is provided over three floors. Bedrooms are located on each floor and are all single rooms with a washbasin provided. Bathrooms and toilet are available throughout the home. A very large communal room with a conservatory is located on the ground floor. This provides areas for dining, sitting and watching TV, the conservatory opens of this room which provides additional space. A small room was being prepared on the ground floor to provide a more private lounge for people to use. Car parking is available within the grounds and there is a small enclosed garden space to the front of the home.

Church View is owned and operated by a partnership, Mark Jonathan Gilbert and Luke William Gilbert. They have owned the home since May 2015 prior to which it was operating under different ownership.

The home had 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 2008 and associated Regulations about how the service is run.

At this inspection we found a number of breaches related to treating people with dignity and respect, safe care and treatment of people, safeguarding people, supporting staff and governance of the service. You can see what action we told the provider to take at the back of the full version of this report.

Parts of the premises were unsafe and placed people at serious risk of harm in the event a fire occurred within the home. Equipment did not always work correctly leaving people with no mean to summon help if they needed it. Staff did not recognise and therefore report incidents which placed people at risk of harm.

Staff had not received the support and supervision they needed to carry out their role effectively. There were insufficient staff available to meet people's needs in a timely manner. This meant people did not always receive their personal care or medication on time or when they needed it.

Some people told us they enjoyed the meals provided, however we found that people did not receive a nutritious diet and the support they received at mealtimes was at times unsafe and undignified.

People's privacy and dignity was not always respected. They were not always given their mail, their bedrooms and bathrooms were used as storage areas and their confidential records were left unsecured.

The provider did not meet the requirements of the Mental Capacity Act 2005 (MCA). They had not applied for and received Deprivation of Liberty Safeguards (DoLS) for people who needed them. This meant peoples legal rights were not being protected.

Care plans did not provide up to date information to inform staff about people's support needs. This placed people at risk of receiving unsafe care.

Quality assurance systems were in place but did not operate effectively enough to ensure people received a safe, effective caring, responsive and well led service.

The building had been refurbished and decorated and was waiting a number of finishing touches to make it easier to navigate.

Robust recruitment processes had been followed.

Staff were kind and patient when supporting people. People living at the home and their relatives said they liked the staff team.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the
system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.
Sum

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.

Staff did not recognise and therefore report incidents which placed people at risk of harm.

Parts of the premises and equipment posed a fire risk and placed people at risk of harm.

There were insufficient staff available to meet people's needs in a timely manner.
Medication was not safely managed.

Robust recruitment processes were followed.

Is the service effective?

Inadequate

The service was not effective.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. Proper policies and procedures had not been followed to ensure people's legal rights were protected .

People did not receive a nutritious diet and the support they received at mealtimes was at times unsafe and undignified.

Staff had not received the support and supervision they needed to carry out their role effectively.

The building had been refurbished and decorated and was waiting a number of finishing touches to make it easier to navigate.

Is the service caring?

Requires Improvement

The home was not always caring.

People were not always given their mail, it was found unopened in cupboards and in the medication room.

People living at the home liked the staff team but said they had

to wait a long time for help.

Bedrooms were used as storage areas even when people were in them and parts of the home including corridors and bathrooms had also been used as storage spaces.

Relatives of people living at Church View liked the home and said they thought it was caring.

Staff had a patient kind approach with people and tried to spend time with them where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans and records did not contain all of the information staff would need to understand and meet a person's needs.

Complaints had been taken seriously and investigated by the home.

Is the service well-led?

Inadequate

The service was not well led.

No systems were in place for obtaining and acting upon the views of the people living at the home.

Systems and processes for assessing the quality of the service had failed to identify risks to peoples health and well being and had failed to improve the quality of the service provided.

Church View

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 03 and 08 March 2016. On the first day the inspection was carried out by a team consisting of two Adult Social Care (ASC) Inspectors and a specialist advisor. The specialist advisor had experience of nursing care for older people and people who required support with their mental health including with dementia. On the second day of the inspection the team consisted of an ASC inspection manager and ASC inspector.

Prior to our visit we looked at any information we had received about the home including contact from people using the service or their relatives, agencies including social services and any information sent to us by the manager or provider since they had purchased the home.

We spoke individually with six of the people living at Church View and met with several others. We also spoke with five of their relatives and with two visiting health workers. In addition we spoke with 15 members of staff who held various roles within the home. This included the provider and registered manager.

We looked around the premises and spent time observing the care and support provided to people throughout the day.

We looked at a range of records including five care plans and a sample of medication records and at recruitment records for four members of staff and training records for all staff. In addition we looked at records relating to the quality of the service provided.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe living in the home and their responses were mixed. One person said "I feel like I'm in a cardboard box and I can't get out." Another person said "Sometimes I feel safe but I don't feel safe when they don't come when I ring the bell. I've wet myself waiting for them to come and it's not nice for me and it's not fair." Two other people we spoke with said that they did feel safe.

Prior to our visit we were aware that a safeguarding concern had been raised about the home as visitors including professional visitors had been let into the home and allowed to see people living there without their identity being checked. On the first day of our visit we were asked into the home and nobody asked for our identification. This could compromise the safety of the people living there.

We had concerns about the management team's ability to recognise safeguarding concerns and report them appropriately. During the inspection, inspectors identified four different incidences that were safeguarding concerns where people's needs were not being met safely and they were at risk from harm or abuse. The inspectors had to inform the management team to make the safeguarding referrals to the local authority.

These are breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the home did not have adequate systems in place to recognise incidence of harm and abuse and take appropriate action to protect people.

We asked about safeguarding training and saw that all staff had received training regularly and this had been updated. One staff member was a trainer in safeguarding adults and she told us that she trained new staff as they commenced employment and we saw evidence to demonstrate this.
On the first day of the inspection one of the people living at the home told us that their call bell did not work, they said staff were aware of this but when it did work it showed a different room number. We tested a number of the call bells in the home and found that they did not work, some of these belonged to people who stayed in their room for most of the day. This meant people did not have access to any means of summoning help.

The provider arranged for immediate work to be carried out on the call bell system and it was working prior to us leaving the home that day.

On the second day of the inspection we again tested calls bells and found a number not working. The provider arranged for extra staff to be available on bedroom floors and for repairs to the system to be attempted. However this had again meant that people lacked any means to summon help if they needed it.

On the first day of the inspection we found the home untidy with corridors used for storage and items stored in inappropriate places. We saw a high number of wheelchairs stored in a stair well and a mattress and coving on a set of stairs. This meant the fire escape routes were partly blocked. On the second day of the

inspection we found fire routes blocked with furniture and partly blocked by a hoist. On both occasions we brought this to the attention of the person in charge who took action to clear the fire route.
On the first day of the inspection we saw a number of fire doors propped open with various items, this included bedrooms doors where people where in their room and main corridor doors. In the event of a fire the items wedging doors open would prevent the doors closing and therefore place people at significant risk. A number of these doors were fitted with fire guards that hold the door open but respond to the fire alarm and close the door. One of the people living at the home told us they had told a member of staff their door guard was not working over a week ago. We found that a number of the door guards in the home were not working. This placed people at serious risk in the event of a fire occurring.

We contacted Merseyside Fire Service on the first day of the inspection. They visited the home to carry out an inspection of the premises and advised the provider on work that required undertaking to make it safe.

One bedroom contained an oxygen cylinder; this room was not marked as containing oxygen. As oxygen is a potential fire risk any rooms containing oxygen need to be clearly marked.

We saw a number of other hazards to the environment. This included an unlocked room with decorating equipment and tools and a cleaning trolley left unattended on the corridor with hazardous substances on it. The hairdressing salon was unlocked and we found creams, finger prick needles and prescribed drinks in unlocked cupboards in this room.

Two bathrooms on the top floor were being used as storage and were very cluttered making them unable to be used for their intended purpose. A member of staff told us that the people living on this floor had to use the bathroom on the middle floor. They said that the baths in these bathrooms were not suitable for people living there to use. These rooms were not locked to prevent people entering them.

On the ground floor a keypad lock was in use to keep the door locked. The fire opener fitted to this door was not working. This meant people using the rooms on the other side of this door could not get out of this part of the home without help. We discussed this with the manager on the second day of the inspection and she told us that the keypad was due to be removed.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the premises and equipment used within it were not safe.

Following the inspection the provider contacted us to inform us that a new call bell system was being fitted to the home on 14 March 2015. On the second day of the inspection new magnetic fire door openers were being fitted throughout the home. Once completed this means people can have their door open if they wish but the door will close in the event of a fire alarm.

Certificates and records were in place to show that up to date checks had been carried out on the lift, small electrical appliances, the gas and main electrical systems.

We looked at arrangements for laundry within the home. A member of staff was assigned to work in the laundry room seven days a week. The room was small and very cluttered. This meant that it was difficult to access the hand wash basin and impossible to get to a larger sink located in the corner of the room. No clear system was in use for separating clean and dirty laundry. As a result clean laundry was folded next to unwashed laundry. This heightened the risk of cross infection occurring.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because risks to the health and safety of service users had not been assessed and mitigated.

Most of the people living in the home whom we spoke with said that they had to wait for long periods to get the help and support that they needed because there was not enough staff and they were too busy.

Staffing levels for the home were set at 2 members of staff in the kitchen, 3 domestic staff and a laundry assistant. We were told that there were always two registered nurses working during the day and eight carers during the morning, seven carers in an afternoon. The rotas we looked at showed these figures had been maintained. However staff told us that these numbers had not been maintained due to sickness and staff being moved to another home owned by the provider.
Staff told us that because the building had three floors it was difficult to maintain a staff presence. During the inspection we walked the building and saw that often there were no staff available on every floor and there were people who were unwell being cared for in bed.

Care staff consistently told us that they did not have enough staff to meet people's needs. Their comments included, "Not enough staff, residents have high needs, most need two staff," "The low staffing levels impacts on the care that we can give to the residents because we can't get to them in a timely manner," and "You say to people I'll be back in five minutes but you know you won't be because it's impossible." "I don't think I am providing a good quality of care." "I constantly say I won't be a minute I have had enough." "It's like a conveyer belt."

Registered nurses and the manager told us that they though there were sufficient staff available, one nurse explained, "I would always like more staff but there is enough staff on duty to meet the needs of the residents." However this was not what we observed.

The care we saw indicated to us that there were insufficient staff available to meet people's needs. On the first day of our inspection we saw five people sitting in their wheelchairs in the lounge. We discussed this with a member of staff and established that one person had been in their wheelchair for over 4.5 hours. At lunch time we saw that people were taken for their meals and remained in their wheelchair to eat. A member of staff told us, "I am the only carer in the dining room and cannot transfer residents on my own, residents should not be sat in wheelchairs all this time."

We spoke with one person who was in bed. At 11.30 am they told us they were still waiting to receive their personal care. They had an empty cereal bowl in their room and no access to a drink. A second person was also waiting for their personal care at 11.30am they told us that sometimes this support had not been provided until the afternoon. A relative told us that there had been weekend days when their relative had not received support to have a wash at all due to staffing issues.

We were informed that the vast majority of people living in the care home required two staff to support them to meet their personal care and mobility needs. Some people at times required three carers. We asked to see if the provider used a dependency tool. The regional manager showed us one that had recently been introduced in the last month. This showed that the staffing levels were at an average level. However this was not apparent from our observations and peoples experiences of the care they had received.

On the first day of the inspection we saw two people whose catheter bags appeared very full, we asked staff to empty these. Om the second day we saw a relative emptying a catheter bag, the person told us this was because they worried when it was full and nobody had been to empty it.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was insufficient staff to meet people's needs effectively. This is also a breach of Regulation 17 because systems did not effectively assess, monitor and mitigate risks to the health, safety and welfare of service users.

On the first day of the inspection we saw that people were still being given their morning medication at 11. 50am the nurse told us that they began giving medication out at 9am but it took a long time. She told us not many people had lunchtime medications and she would ensure there was a sufficient gap between these being given. However receiving morning medication at that time meant that people are not getting their medication as prescribed. On the second day of the inspection we saw the morning medication being given at 11am.

The medication room was cluttered and medication was not always stored correctly. For example we saw a box containing different loose dressings these had no name on them and should not kept other than in a named box to be used as prescribed. In this box we also saw a bottle of medication prescribed for someone living at the home. Four boxes of insulin were stored on the window sill in this room. They were clearly marked, 'store in refrigerator.'

We checked a sample of Medication Administration sheets (MAR) and saw that some of these had not been signed. We checked a sample of medications and found that stocks did not tally with the amount received by the home and the amount signed as given. This was because more medication remained in stock then had been signed for as given. This means people were potentially not receiving their medication as prescribed and records were being signed that it had been given.

We saw that a number of people had prescribed creams on display in their bedrooms. One person had a tub of prescribed cream on the floor of their room and the lid of this cream had a thick layer of dust on it.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because medications were not safely and properly managed.

We observed medication being given out and saw that it was administered safely and correctly. The Nurse gave each person a drink, explained to them they were being offered their medication and gave them time to take each tablet before signing the MAR sheets.

The organisation had a whistle blowing policy in place. Whistle blowing protects staff who report something they think is wrong in the work place that is in the public interest. We read a copy of the policy and found that no phone number or email for the provider was listed for staff to use. We also found that the policy was not displayed anywhere in the home that staff could easily access. This meant that staff may not understand their rights and how to whistle blow effectively if they wished to.

Personal emergency evacuation plans had been completed for people. These provided advice on how to evacuate the person in the event of a fire. However the plans were kept in people's care files on the middle floor of the home. This would make it difficult to locate all the plans require in the event an emergency evacuation of the building was needed.

Staff knew the location of first aid boxes for use in an emergency. We looked at three of these and found they were generally well stocked. The kitchen first aid box did not contain any blue plasters; these are required so they can be easily seen if they fall into food. A member of staff responded they made sure they did not cut themselves, but would order some.

Staff knew and were able to explain the actions they would take in the event of a medical emergency or the fire alarm sounding.

We looked at recruitment records for four members of staff who had recently commenced working at the home. These showed that before being offered the job a formal interview had been held and once an initial job offer had been made the provider obtained and verified references and carried out a Disclosure and Barring Service check before the member of staff commenced working at the home. These recruitment practices helped to check the person was suitable to work with people who may be vulnerable.

Inadequate

Is the service effective?

Our findings

Comments we received about the meals at Church View from the people living there included, "its lovely," and "I get a choice" A relative commented, "I have never seen an ugly meal. They say check the menu if (relative) doesn't like it you can change it."

A visiting health worker told us, I visit every month to review. The (team name) have no problems with the home. There is always staff around to give us the information we require." A second visiting health worker told us, "Never problems with this home, we would know if the residents were not having their (medication) from the blood results."

We asked about staff training and support and we saw that staff had access to regular training in applicable areas. We met with a staff member who was also a moving and handling trainer and assessor who supported staff with on the job training and they regularly observed practice to ensure that people where kept safe during moving and handling procedures. However we also saw that only 13 out of a possible 30 staff had received training in the Mental Capacity Act and for 10 people this had been three years ago.

We asked about support and supervision and read the supervision tracker for 2016. Only three staff out of a possible 47 had received supervision this year. We asked for the records for 2015 on a few occasions during the inspection but these records were not produced. We asked about team meetings and saw that there had not been any since June 2015. Staff we spoke with expressed a number of concerns particularly around staffing levels and their workload. The lack of team meetings combined with the lack of individual supervision meant that staff had not been given the opportunity to discuss their concerns, development or job roles either individually or in a group.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff had not received appropriate support.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. We found that they were not.

We asked the manager for a list of people who had a DoLS in place or for whom a DoLS had been applied.

We were given a list with the names of 29 people on it. The manager confirmed that she had assessed all of these peoples as requiring the protection of a DoLS application being made for them. We saw that of the 29 people only one had a DoLS in place and only four applications in total had been made. This meant people were living at the home without their legal rights being protected and their capacity to consent had not been explored lawfully

These were breaches of Regulations 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured service users were not being deprived of their liberty without lawful authority and lawfully application of the Mental Capacity Act 2005.

On the first day of our inspection we saw people sitting in their wheelchairs at the dining table. They were positioned too far back from the table to eat their meal in a comfortable manner.
On the first day of the inspection we saw one person finished their breakfast at noon. Staff said they had to offer her lunch although they knew the person would not want it. They told us they would offer a snack about 2pm. A number of staff told us that people often got their breakfast later morning as staff were busy.

At 12:40 there were approximately 20 people in the dining room. No condiments, napkins or menus were on the table. Meals were brought out of the kitchen two at a time they were not on a tray and staff did not wear gloves, therefore having their fingers on people's food plates. People were told the meal was "mashed potato, chicken and tomato". These meals were for people who required a soft or pureed diet. One person went to sleep and their meal was left to go cold, there were no covers used for their food. Another person said they didn't want it and was given a plastic beaker of soup. A third kept getting up out of their chair and was encouraged to sit down again but was not given anything to eat. In the middle of the meal two people were taken out of the dining room to see a visiting podiatrist.

At 1pm all of the other people in the dining room were still waiting. One person asked "Get us a meal love," but was not immediately provided with one. People were then offered a choice of white bread sandwiches with either cheese or ham and the option of some soup. This was followed by a bowl of custard with a few pieces of banana in it. This meal did not offer people the opportunity to eat a balanced nutritionally sound meal. We looked at menu records and saw no evidence that these had been nutritionally balanced.

The lunchtime meal was chaotic and unsatisfactory. At tea time we saw one lady with a plate in front of her with two white blended items on it and gravy. We asked her what her meal was and she did not know but said, "It looks like two lots of potato." We asked a member of staff who did not know but came back and said it was potato and blended turkey.

We asked the cook what arrangements were in place for people to have a hot meal after 5pm. We were told that people could have toast or a snack but there was no access for staff to make a hot meal or snack for people after the cook left for the day.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems in the home failed to monitor and improve the quality of the service people received.

Following the first day of inspection we told the provider about our findings at mealtimes. On the second day of the inspection some improvements had been made to the mealtimes in that tables were laid for people with condiments and napkins. However we again asked a member staff supporting people to eat what the blended meal was and they did not know. The provider had arranged a meeting between the manager and an outside catering firm to discuss them providing meals for the home.

We saw one person spent their day in bed. On the floor of their bedroom was an electric mattress plugged in, they were sleeping on what appeared to be an ordinary mattress. Their care plan stated, "Ensure .. all equipment is suitable for (persons) needs." We were unable to find out why their pressure reliving mattress was not on their bed or for how long this had been occurring. Not having the correct mattress placed this person at increased risk of pressure sores occurring. Following a discussion with a Nurse at the home they agreed this was not acceptable and to ensure it was replaced on the bed. We checked this was in place on the second day of our inspection and saw that it was.

A second person had a care plan in place that said they required supervising whilst eating a pureed diet due to a risk of them choking. At lunch time we saw that the person had a beaker which had contained soup in their room, we saw no evidence that a member of staff had stayed with them whilst they ate. The person told us, "I feel as if I should be sat up more, I have eaten my soup. Speech and Language Therapist told me to try and sit up to eat. These pillows are not comfy". We saw that the person was laid almost flat in their bed. This increased their risk of choking.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the home had failed to provide safe care and treatment to people.

Large areas of the home had been decorated and although they looked fresh they appeared bland. We saw limited signage to inform people which bedrooms belonged to them or where bathrooms and toilets where. This could prove confusing particularly for people who had memory loss. We discussed this with the provider who explained that decoration of the home was being completed and they had a number of items on order including signs for doors.
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Requires Improvement

Is the service caring?

Our findings

We asked people living at Church View if they thought staff were caring and people generally responded positively. Their comments included, "There are good staff and not so good staff, but mostly they are good," "This is an above average care home," "Staff are good, they do all that for me" and "It's very good here. Everyone is pleasant." However one person told us "There is a lot of waiting around here. You wait, wait, wait and sometimes nobody comes and I feel like I'm drowning." Other people told us that they had had to wait a long time for their personal care or an answer to their call bell.

A relative of one of the people living at the home told us "I can go home and not worry about her. There are some very good staff here." Another relative told us, "it's great, we get a really warm welcome. I sleep at night now (my relative) is here.)

However people living at the home also told us that their views and opinions had not always been listened to. One person said, "It's not worth telling anyone because it doesn't get done."

We found a number of unopened letters in the medication room addressed to people living at the home. We asked a member of staff if they knew what these were or why they had not been given to people. However they could not provide an explanation.

We also found a cupboard in the hairdressing room in the home that was full of private and personal confidential information about people who lived in the home. These records included people's personal, unopened mail that had not been given to them, hospital discharge information and personal care records. This information could have been accessed by anyone entering the room including people who were not employees of the home.

Bedrooms had a framed picture of a member of staff and information that this person was their keyworker. We did not see any evidence that people had agreed to have this information displayed in their bedroom. The font and size of this information was small, did not meet good practice guidance on easy to read information and may prove difficult for people living at the home to read and understand.

We went into one person's bedroom and saw three wheelchairs stored in there. The person told us that two of these did not belong to them and staff used their bedroom to store these chairs in. We also saw that the person had a very large number of medical supplies in their room both in their wardrobe and on the floor. The room was very cluttered and we asked the person about this and they said, "This is supposed to be my living room and look at the state all this should be tidied up." We also saw a towel in the room that needed washing, the person told us, "I am always saying will you please take it (to wash)."

We observed that the hairdressing room was small and sat in there whilst two people were having their hair done. One person was having their hair washed and did not appear to be enjoying the experience saying, "Don't you do that." It was clear that this person was becoming distressed. We asked why people could not have their hair done in the bath or shower and then have it dampened at the hairdresser and were told there

was not the time to help everyone have a bath or shower. We asked the hairdresser the name of the person whose hair they were doing and they did not know. There was no social aspect to this occasion and we are concerned that people are having their hair done as part of their personal care not as an activity they enjoy.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people's privacy and dignity was not respected, neither was their right to confidentiality.

We spent time on the first day of the inspection in the communal room of the home. A member of staff was assigned to stay in the room and support the people in there. A lot of this member of staff's time was taken up the helping people with meals and other requests. We saw that they were polite with people, offered a choice of drinks and knew people preferences. Other than this member of staff we saw limited interaction between staff and people sitting in the lounge areas throughout the day.

On the second day of the inspection we saw a number of warm, positive interactions that demonstrated that staff knew people well and knew how to care for them. We saw staff communicating with people respectfully and with gentle encouragement. We saw that people who had dementia were supported in a way that met their needs and supported their well-being. There were people in the home using dolls and soft toys to engage with which they obviously enjoyed and was a source of comfort to them. We also saw that people's independence was promoted when this was possible, for example encouraging a person to eat independently with staff on hand to support them if necessary.

Requires Improvement

Is the service responsive?

Our findings

People told us that they had to wait too long for their personal care and for an answer to their call bell. One person said, "No it's not quick, too long."

Individual care plans were in place for all of the people living at Church View. These were comprehensive documents that had been written in a person centred way. The format included information and guidance for staff on the person's health and personal care needs, assessments of the person's capacity to make and understand decisions and details of checks and monitoring the person needed to maintain their health and wellbeing as much as possible.

However although the format was in place we found significant gaps in the information recorded. For example we saw one person who had refused to be weighed since August 2015. The care plan for supporting him with this had not been updated or reviewed since November 2015. There was no evidence that the home were using other recognised methods of monitoring the person weight such as taking arm measurements. There were also a number of gaps in the person's food records. This meant that the home had no accurate information available as to whether this person was maintaining their weight and no accurate records to audit the reasons for any weight changes.

We asked several times to see records of pressure areas care provided to a second person as identified within their care pan. These records were not provided to us.

A care plan for a third person stated that the safety strap on their wheelchair should always be fastened. We checked with the person and staff and found that they were sitting in their chair and the safety strap had not been fastened.

A fourth person's had a health condition and was also prone to infections which in turn could affect their behaviour. No care plan was in place to provide guidance to staff on the support the person required with these health concerns. We also saw that no system had been put into place to monitor this person's weight loss.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 risks to the health and safety of service users had not been assessed and action had not been taken to mitigate them.

On the first day of the inspection we saw one person who stayed in bed all day. They were staring at a blank wall and there was no stimulation in their room such as music to occupy them. On the second day of our inspection we saw another person asleep in their room. The music was playing so loudly that the sound was distorted.

A television was available in the lounge; however this was a relatively small sized TV for the size of the room and would be difficult for people sitting further back to see.

We asked on several occasions to see records of activities for people living at the home but these were not provided. On the second day of the inspection we saw a member of staff sitting with people making Easter decorations.

We looked around the foyer and communal areas of the home but found no copy of the homes complaints procedure displayed so that people could easily access the information.

On the second day of the inspection an up to date complaints procedure had been displayed in the foyer in the home and contained details of who to contact if people wished to make a complaint. We saw that three complaints had been made in the last year. These had all been responded to formally and we could see that every effort had been made by the provider to reach a satisfactory outcome.

Inadequate

Is the service well-led?

Our findings

The home has a registered manager who has worked at Church View for several years as the registered manager. This included working as the registered manager when the home was owned by a previous provider. Staff told us that they found the manager approachable.

On our arrival at the home the member of staff who answered the door was unsure who was in charge of the home as the manager was off. We were then introduced to a senior carer who explained there were two registered nurses working at the home. We asked the nurses who was in charge that day and they said it was the nurse who was a permanent member of staff. However this information was not clearly recorded anywhere. When we asked staff who was in charge some thought it was the senior carer, others said 'The nurses.'

Care staff told us that in their opinion the manager was hindered in her role as manager as she regularly had to cover nursing shifts in the home. We discussed this with the manager who confirmed that since 01 January 2016 she had covered 15 shifts as one of the nurses on duty. This meant that she would be carrying out nursing duties which would limit the time she had to directly manage the home. We were informed that the deputy manager was currently working nights and that anybody covering the deputy manager role worked shifts as a nurse and did not have any supernummary time to carry out management duties.

The home did not employ an administrator which meant that staff were hindered by having to answer the telephone during the day and deal with visitors to the home. This had an impact on the care being provided as we saw that staff were constantly interrupted to answer the phone. The phone was located in the hallway which meant conversations were not always private and the member of staff supporting people in the large dining / living room was called away.

We were concerned that there was a lack of overall leadership and management at the home and that quality assurance systems in place had failed to identify and therefore take action on some of the serious concerns we found during this inspection.

The management team were on both days of the inspection unaware of call bells not working until informed by us. Similarly they were unware that fire systems were compromised by door guards not working, wedges in doors, ill fitting fire doors and blocked fire routes. The management team were unaware of the quality of meals and the service provided at meal times and had not identified issues with care people had received. We were concerned that people living at the home raised concerns with us that should have been known to the management team. An effective system for gathering people's views was not in place.

We looked at records of checks of the call bell system carried out in January and February 2016. All had been ticked on a weekly basis to show that they were in working order. However, given that we found the system not working on two occasions and people living at the home and their relatives told us there had been issues previously with the system, we were concerned that these checks had been ineffective.

On the first day of the inspection we saw a number of records relating to people living at the home that were stored on the dining room window sill. This area was accessible to people living at the home, staff and visitors. There was one occasion during the afternoon when we saw a person living at the home pick up a file and read it.
Some of these records related to people who stayed in their bedroom. We asked several times to see records relating to nutrition and pressure relief for two people but were not provided with these. A member of staff told us, "The food diaries and turn charts should be kept with the resident; the girls have to come down off the upstairs floors to complete them."

On the first day of the inspection we saw a number of records piled on top of a trolley at the end of the middle floor corridor. We looked at a sample of these and found records relating to people who had not lived in the home since 2015.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes were ineffective at assessing monitoring and improving the quality and safety of the service people had received and records were not maintained securely.

The regional manager showed us a new audit tool that they were planning to introduce into the home to improve the systems and monitoring of the service. We saw that if the new system was used appropriately it would significantly improve the standards in the home.

During the inspection we spoke with the management team and the provider on a number of occasions. They were very responsive to our concerns and the provider demonstrated before the inspection was concluded that they were already taking significant steps to improve and tackle issues that we had identified. This included arranging for a new call bell system to be fitted and looking into alternative meal provision.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users privacy, dignity and right to confidentiality were not respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the 2005 Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes failed to recognise abuse and to ensure peoples legal rights were protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support and training to enable them to carry out their role effectively.