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Church View

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Church View on 15 January 2019. The inspection was unannounced. At our last inspection of the service, on 22 and 30 November 2017, we found that service overall required improvement, however there were no breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities).

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. Church View accommodates up to 45 people in purpose-built premises.

The home manager had been registered by CQC in August 2017. 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. People we spoke with considered that the manager was approachable and was effective in her role.

We found there were enough staff to meet people's support needs and new staff were recruited safely. Training was provided to ensure staff had the knowledge and skills to work safely and effectively. Staff were supported in their role through individual supervisions.

Health and safety checks were completed on a regular basis and the premises and equipment were clean and well maintained. Risks to people's health and safety had been assessed and action to taken to mitigate the risks. Accidents and incidents were recorded and analysed. People's medicines were managed safely.

People told us they felt safe in the home and that they had no concerns regarding their care. They told us the staff were kind and caring and protected their dignity and privacy.

Applications to deprive people of their liberty had been made appropriately. Records showed that consent was sought in line with the principles of the Mental Capacity Act 2005.

People received the supported they needed to eat and drink and their dietary needs and preferences were catered for.

People's needs were assessed and care was provided support in line with their wishes. People's independence was promoted and they were involved in the planning of their care. People could choose how they spent their time.

People told us they enjoyed the social activities and trips out that were provided in the afternoons.

Complaints were handled and responded to appropriately.

The registered manager and senior managers completed regular quality monitoring audits which identified any areas needing improvement. People who lived at the home and their relatives were able to give their views through surveys and meetings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff to meet people's support needs,

People's medicines were stored and handled safely.

Regular checks of services and equipment were carried out by the home's maintenance team, and testing, servicing and maintenance of utilities and equipment was carried out as required by external contractors.

Is the service effective?

Good

The service was effective.

People's individual dietary needs and choices were catered for.

The home complied with the requirements of the Mental Capacity Act.

Staff received regular training and supervision to ensure they knew how to work safely and effectively.

Is the service caring?

Good

The service was caring.

We observed that staff protected people's dignity and treated them with kindness and respect.

People's relatives were made welcome when they visited and were involved in their care.

People's personal information was kept securely to protect their confidentiality.

Is the service responsive?

Good

The service was responsive.

People's care files contained assessments and plans that were

updated monthly.

A range of social activities and trips out was provided during the afternoons.

The home's complaints procedure was displayed and complaints had been addressed appropriately.

Is the service well-led?

Good

The service was well led.

The home had a manager who was registered with CQC.

People were given opportunities to express their views and their suggestions were acted on.

The management team completed a series of quality audits which were accompanied by action plans for improvement as needed.

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 15 January 2019 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist professional advisor who was a registered nurse, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information that we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law.
During the inspection, we spoke with six people living at the home, four relatives, a visiting healthcare professional, one of the providers, the registered manager, the regional manager, and ten other members of staff. We observed the administration of medicines and lunch being served.

We also spent time observing the interactions between people who lived at the home and staff, and the activities that were taking place. We looked at care records for seven people, and records relating to the safety and quality of the service, staff recruitment, training and support, and complaints.

Good

Is the service safe?

Our findings

Polices were in place for guiding staff on how to identify and report any safeguarding concerns. We found that these had been followed, and suspected safeguarding concerns had been reported appropriately. The manager had an overview of safeguarding concerns and this meant they could be audited and potential patterns could be noted and acted upon. When required to do so, the manager had investigated and responded to potential safeguarding concerns. A policy was also in place to advise staff on whistleblowing. This is when staff report something that they believe is wrong in the workplace and is in the public interest. Staff had a good awareness of safeguarding adults and told us they would report any concerns that they had. One member of staff told us "You have to follow procedures."

The way in which staff were deployed had been reconsidered by the manager since our last inspection. As a result, a member of staff was permanently assigned to the dining room, with a second member of staff assigned at key times to support people who needed help with their meal. This meant that there was always a member of staff available in the dining/ living areas. We found that this made a difference to the overall feeling in this room which was calm and more organised for the benefit of people living there.

Staff had varying views on whether there were enough staff available to support people. One member of staff told us, "It's good, manageable." They explained that changes to staff allocations made by the manager meant routines were clearer and staff could support people more easily. Other staff told us that at times completing paperwork could impact on how quickly they could meet people's support requests. During the inspection we saw that, although staff were busy, they responded quickly to people's requests for support. Relatives we spoke with considered there were not always enough staff and two relatives told us their family member had sometimes waited a long time for assistance to the toilet.

Staffing levels were determined using a tool that assessed the level of support the people living at the home required. When we looked at the staff rotas we saw that on the morning shift there were two nurses and eight care staff to provide care for 40 people. The manager told us that when the home was full, the number of care staff was increased to nine. The overall dependency of the people living at the home was not high and we considered that this should be an adequate number of staff to meet people's needs. In addition, there were four housekeeping staff on duty each day.
The manager told us that the home's staff were usually willing to work extra shifts to cover for sickness and annual leave. On occasions that cover could not be provided by regular staff, the provider had a bank of casual staff who could be used. The manager told us they had not used any Agency staff recently.

New staff completed a robust recruitment process to ensure they were safe to work with people who may be vulnerable to abuse or neglect. The records we looked at showed that appropriate checks had been completed prior to staff starting to work at the home.

The home was clean and tidy during our inspection and we saw that colour coded cleaning equipment was used. Hand soap and paper towels were available to staff along with disposable gloves and aprons. The laundry room was organised with a clear system in place. All of this helped to minimise the risk of cross

infection throughout the home. The people living at the home and the relatives we spoke with all said that the home was kept clean and fresh.

Regular fire alarm tests took place, along with fire drills, to ensure that staff knew what action to take in the event of a fire. Each of the people living at the home had a personal emergency evacuation plan in their files. This detailed any specific support they would need to evacuate the building safely in the event of a fire or other emergency.

The home's maintenance team kept records of regular checks and tests they carried out. Monthly checks included water temperatures, profiling beds, emergency lighting and fire safety equipment. Contracts were in place to check the gas, electrics, nurse call system, lifting equipment, passenger lift and fire safety equipment. The certificates for these checks were all in date. The home had a four star food hygiene rating.

People's care files contained good evidence of completed risk assessments including assessments for falls, choking, continence, pressure areas, moving and handling, and malnutrition. These had been reviewed every month by the person's named nurse. Risk assessments had been completed for anyone who may require the use of bedrails and this had been discussed with the person and/or their family as appropriate.

If, following assessment, the person was deemed to be at a high risk of developing pressure ulcers, equipment was provided to ensure their safety and wellbeing, for example pressure relieving cushions and mattresses. People who required transfers using a hoist were seen being hoisted. The appropriate number of staff were present and the procedure was carried out safely. Care plans were in place which clearly stated what equipment should be used and when.

If it was identified that the person was at risk of malnutrition, their weight was recorded monthly, and a risk of malnutrition score was calculated. This was noted to have been done accurately in each file we looked at. Out of the five people's files we looked at, four of them had gained weight during their time at Church View, which reflects positively on the care they had received.

We saw detailed records of accidents and incidents that had occurred and actions taken to help prevent reoccurrence.

People we spoke with considered that the home's nurses managed people's medication well and ensured they received it on time. We observed the lunchtime medication round on the top and bottom floors of the home. This commenced at 1:30pm as the medication round in the morning had been slightly late in finishing. A registered nurse carried out the round on the upper and bottom floors whilst a second nurse administered the medications on the middle floor.

The medications were administered from colour coded blister trays. As required and liquid medications were administered separately. The medication trolley was clean and well organised. One person was in receipt of covert medications, that means their medication was disguised in food or drink. The nurse was able to explain the rationale for this and the care plan was evident in the person's file along with the best interest's discussions.
People were asked if they were in any pain before they were given their medication, and if they said yes they were offered pain relief. The nurse took her time and offered support and reassurance to people, explaining what she was giving them and why. If a person initially declined their medications, the nurse waited a few minutes and tried again. If a medication was declined, or could not be given, the reason for this was documented. We saw that if a medication was given late for any reason then the time of administration was documented.

The clinic room appeared clean and tidy. Fridge temperatures had been recorded for the month of January and there were no gaps in the recording. All recorded temperatures were in the desired range. We saw that the fridge was unlocked and the nurse was unsure if there was a key for this. We recommend that the provider gets a key so the fridge can be locked.

The nurse was able to describe the process for the storage and administration of Controlled Drugs. The cabinet was locked and a record kept in the register of when Controlled Drugs were administered. Controlled Drugs were always signed in and out by two staff members.

The nurses took responsibility for checking the repeat prescriptions monthly and ordering the medication when it is needed. When the medication was delivered it was checked and stored away in locked cupboards in the clinic. Any medications for destruction were kept in a separate cupboard then destroyed by two staff and documented.

Good

Is the service effective?

Our findings

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

People's capacity to understand and make decisions had been assessed. Where the person had been assessed as lacking the ability to make an important decision, then clear records had been made as to how they had been supported to try to make the decision. DoLS applications had been made to the relevant authorities for people who were assessed as requiring the protection a DoLS could offer them. Information was recorded in people's care files of anyone who had the legal right to make a decision for the person, for example through a Lasting Power of Attorney.

Documentation around mental capacity appeared thorough and there was good evidence of mental capacity assessments being completed for areas such as medication, the use of bed rails or the taking of photographs, followed by a best interests discussion involving family and carers. The reason for requesting the DoLS was fully documented in the files and it was evident that families had been consulted on these decisions.

Mealtimes were relaxed social occasions which people appeared to enjoy. Throughout the morning we saw people sitting at the breakfast table enjoying breakfast at a time of their choosing. We saw that people could ask for something to eat or drink when they wanted to and their request was responded to positively. People had access to fruit and cold drinks all day on a sideboard in the dining room. Staff said there was access to the kitchen 24 hours a day so people could always have something to eat. A drinks trolley was brought around twice a day with drinks, snacks and fresh fruit, but people could ask for, and receive, a drink at any time.

Tables were laid for lunch with tablemats, cutlery, jugs of juice and condiments. There were menus on the tables showing the meals for the day, plus an 'anytime menu' of alternatives such as soup, sandwiches, jacket potatoes and salads. Picture menus for the day's meals were shown on the notice board in the dining room and there was a folder showing pictures of the various food options, their content and nutritional value. People were asked for their lunch time choices just before lunch started. We observed that staff asked people's permission to put a protective bib on before their meal. People were encouraged to eat and alternatives were offered (soup and sandwiches). Some people had one to one support with their meal and

this didn't appear to be rushed.

The meals were prepared by an external catering company and brought in weekly, although breakfast was prepared in the home. We spoke to the kitchen manager who said that the menus were on a four weekly cycle which was changed every three months. The menus were decided by himself and the manager of the home with input from the residents and relatives meetings. He liked to incorporate dishes with a local flavour such as scouse. People's dietary needs were written on a white board in the kitchen and were communicated to the catering company.

Training records showed that a programme of essential training including moving and handling, dignity and respect, and safeguarding was provided. Members of staff we spoke with said they found the training useful. Staff were supported to complete the Care Certificate, which is a nationally recognised qualification designed to provide staff new to care with the skills and knowledge. New staff completed a three day induction. Staff had regular supervision meetings with their line manager and an annual appraisal.

People we spoke with said that staff called a doctor for them as needed and that a chiropodist and optician visited regularly. Care records showed that people had access to healthcare professionals including speech and language therapist and dietician. During the inspection we spoke to a visiting health professional who gave us positive feedback about the care plans and the home's staff.

The environment was clean, bright and airy. It was well decorated and furnished. A new central heating system had recently been installed. Equipment was provided to support people with their mobility and care. This included specialist beds, a lift, hoists, call bells and grab rails. Corridors and doorways were wide enough for people using a wheelchair to move around easily.

Good

Is the service caring?

Our findings

We saw some very positive interactions between staff and people living at the home. On one occasion a person asked for a piece of toast. The member of staff responded by quietly discussing their need for a soft diet with them and agreeing a compromise with the person before swiftly meeting their request. People we spoke with told us "The staff are great."; "They do a brilliant job." and "Staff are all good, no one you could complain about." A visitor told us that their relative had recently been poorly and "The staff managed it very well. Rather than leave her in bed, they got her up so she could be with people and this helped her pull through – hugely grateful to them."

Staff appeared kind and caring and we observed staff talking to people in a compassionate manner. We also observed care staff knocking on the door before they entered people's rooms and ensuring they maintained people's privacy and dignity. Staff members appeared to know people well and were able to talk to them about their individual interests and family members.

Relatives told us they could visit at any time, although visiting at mealtimes was discouraged so that people were not disturbed while eating. They could visit their family member in the privacy of their own room if they wished to. One visitor told us "They have an understanding of us as relatives." and another commented on the "general friendliness to the place".

Throughout the day we saw that staff promoted people's independence and involved them as much as possible. A member of staff told us, "We don't take it away from people. We promote doing things for themselves." We observed one person being moved on a stand aid. Staff gave the person time to settle themselves and to attach their own straps to the aid before checking and moving the person. This gave the person control over what was happening. We also saw that during a game of Bingo, one of the people living at the home acted as Bingo caller. This was not only a fun activity for the person, it also helped to involve them in the everyday life of the home.

The manager advised us that currently wi-fi was only available in selected parts of the home. However, work was currently being undertaken to make this accessible throughout the home. This would mean that people living there would have ready access to wi-fi as a means of communicating with their family and friends.

At lunchtime we observed that the staff were patient and allowed people all the time they needed to finish their meals. One person was quite slow at eating due to their medical condition so the staff warmed his meal up halfway through so that he wasn't eating a cold meal. There were plenty of choices at lunchtime and when someone didn't want what was on offer, the care staff and the chef went out of their way to find something the person would eat.

People's personal information was stored securely in locked cupboards and on computers that were password protected. This ensured confidentiality.

Good

Is the service responsive?

Our findings

We asked people if they could make choices about their support, and one person said "I come and go as I please." Another person told us they could get up and go to bed when they wanted to but had made a complaint about not being able to go to the toilet promptly. A third person said that they received care and treatment when needed and that the staff would "do anything for you, whatever you need". One person said they could not choose when they went to bed as they had to wait until staff were available to help them.

The care files we reviewed were well organised which made it easy to find certain care plans or assessments. People had a personal care booklet (getting to know you) in their files. This contained information about their family, relationships, work history and pets as well as social interests and activities. This helped staff to provide person-centred care for each individual. Each person had an admission form and a personal details form which included next of kin details as well as their medical history.

Each person had an Activities of Daily Living assessment looking at how staff could provide them with a safe environment and meet their physical needs, for example what support they needed to wash and dress. The care plans covered all areas of daily living, for example activities, mobility and personal care. The care plans were clear and easy to follow and had been reviewed every month, but on some occasions the person or their family did not appear to have been given the opportunity to contribute. Daily progress notes were made for every person and these included information on the person's mood and mental state that day, and their engagement in activities and diet taken.

Where the plan identified that the person needed repositioning during the night to prevent tissue damage, this appeared to have been done and the charts were completed in the carers' files which were kept in people's bedrooms. Body maps had also been completed. Staff told us that prior to anyone moving into the home the manager always arranged for any equipment the person needed to be available. This meant that they could support the person safely and well once they arrived.

Several people had a 'Do Not Attempt Resuscitation' (DNACPR) order in place and it was clear that the team had been involved in the discussion as well as family involvement where appropriate. Dates of review or whether this order should be indefinite were also included. The DNACPR decision sheets were always stored at the front of the files to ensure quick access if needed. If appropriate an anticipatory care plan was also in place, looking at the person's wishes, as well as those of their family, at the end of life.

People told us they enjoyed the social activities and trips out that were provided. However, these only took place on a weekday afternoon with nothing available in a morning or at the weekend. We spoke to the activities co-ordinator. She told us she worked as a carer in the morning and did activities in the afternoon. There was a weekly activities timetable on the notice board showing activities for morning and afternoon but it appeared the morning activities did not happen. Trips out took place every two weeks and an entertainer came in once a month. One to one holy communion was given every Monday. A relative also told us that a local church group visited once a month and sang hymns.

Information on how to make a complaint was available throughout the home. This meant it was easy people living or visiting the home to access. People told us that if they had a concern or complaint they would feel confident to raise it. They said that they would approach the manager or a member of staff. We looked at the complaints file that the manager maintained. The records showed that complaints had been recorded, investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

The manager had been registered with CQC since 10 August 2017. She was supported by a deputy manager who was a registered nurse. The registered manager told us she was supervised in her role by the senior management team who visited the service regularly. She attended meetings with the senior management team and the managers of the provider's other services at which they could discuss any issues they have and share good practice.

The manager worked with other organisations to keep her knowledge up to date and share good practice. This included attending a regular meeting for registered managers held by the Local Authority and attending a course arranged for registered managers to share good practice. Staff told us that they found the registered manager supportive and approachable. One member of staff said "A big improvement. Staff can approach her. A good manager she knows the staff." Another member of staff described her as "on the ball." A third member of staff said "The manager is fair. She listens. She's made a massive difference."

When asked what her views were on the management, one relative said that she found the manager very approachable and would respond to any questions. She described the atmosphere in the home as "friendly, warm, business like". Another relative told us "The management are approachable." She knew the manager, said she was nice and that she comes around and says hello.

A number of systems were in place for obtaining the views of people living at the home and their visitors. This included surveys of people's opinions and experiences of meals and mealtimes and a general survey regarding their views of the home and the service provided. Results were collated and a clear action plan put into place and followed to address any areas for improvement that had been highlighted. Regular meetings for relatives and people living at the home also took place. There were also daily handovers and regular team meetings for staff. This kept them informed of any developments or changes to people's needs.

A robust system was in place for checking the quality of the service provided and identifying where improvements were needed. Audits were completed by a range of staff including the registered manager, compliance officers, regional manager, catering manager and estates manager. Once an area had been audited, any improvements required were noted on an action plan which was then followed. For example, an infection control audit had found that the percentage of staff up to date with training in this area needed to increase. Within a couple of weeks action had been taken to address this.

In addition to the audit processes, the registered manager inputted data in several monitoring tools which generated the 'home manager's weekly report' and contributed to the regional manager's weekly report to the providers. The regional manager visited the home at least weekly, but often more frequently to review action plans and provide support to the home manager.

During the inspection we were able to meet with one of the providers who expressed their commitment to the continuous improvement of the service and their support for the registered manager.

The registered provider is required by law to display their current CQC rating in a prominent place within the service. During the inspection we observed that the home's last CQC inspection report was available for people to look at and the quality rating was clearly shown on the organisation's website.

Registered providers are required to notify CQC of significant events in the home which adversely affect the wellbeing of people who used the service. Our records showed that the registered manger had informed us of any significant incidents.