Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Church House Care Home

Coole Lane, Austerson, Nantwich, CW5 8AB

Tel: 01270625484

Date of Inspection: 12 November 2012

Date of Publication: December 2012

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✗ Action needed
Safety and suitability of premises	✗ Action needed
Staffing	✗ Action needed
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	Akari Care Limited
Registered Manager	Miss Anita Temperley
Overview of the service	Church House Care Home is a 44-bed nursing home situated about a mile from the facilities available in the town of Nantwich. Church House Care Home has a conservatory, quiet sitting areas and a large lounge area which looks out on to the front garden and car park. It has off road car parking facilities available.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Church House Care Home had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Management of medicines
- Safety and suitability of premises
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 November 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and talked with stakeholders.

Fire and Rescue Service

What people told us and what we found

The majority of the people we spoke with made positive comments about the care provided at the home. One person using the service told us: "The staff are very approachable." Another person said they were, "sometimes" well looked after.

We spoke with a regular visitor to the home who told us: "The staff are very approachable". A relative told us that they had no concerns over the standard of care their family member received.

We spoke with five people about medicines handling at the home. Everyone we spoke with was happy with the arrangements in place when nurses and care workers administered their medicines. However, as identified by the manager in their medicines audits, we found that the home's medicine policies were not consistently adhered to. And, there were occasions where people missed doses of medication because there were none left in stock to give, putting their health and wellbeing at risk.

We found that there were areas where improvements were needed. These included care plan and risk assessment documentation; contingency planning for staff sickness/absence levels so they do not impact on the people who used the service: staff training and fire safety checks. We did see that the manager and regional manager had devised an action plan to address some of the issues raised following their own audits, however some of the

areas of concern were raised during the previous inspection and had not been adequately addressed.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 03 January 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

During our inspection in April 2012 we found that improvements were needed in privacy, dignity and respect. The former manager had produced an action plan to address the concerns raised and then an updated action plan in which it stated that staff employed at the time had all completed training in privacy dignity and respect on the 30 May 2012, with a staff member to be a dignity champion by 30 June 2012. The new manager told us that there was no current staff dignity champion.

We observed the relationships between staff and people who lived in the home were warm, friendly and we saw that people were generally relaxed in the company of staff. Relatives of the people who used the service said they were happy with the care provided. They said the staff were friendly and kind towards people who lived at the home.

We also saw that people had personalised their bedrooms with photographs and individual possessions. They maintained regular family contact and visitors were observed to come and go throughout the day.

We saw that the information from the initial assessment of people's needs, which included information, received from relatives, health and social care professionals, was used to develop people's support and care plans however they were not all completed in full. The care plans suggested that family members gave some information, which helped in the development of the care plan however, we found a lack of people's signatures in some areas of the care plans or that of their representatives in those we reviewed. We found overall that there was a need to improve the staff's completion of documentation.

In one person's care plan we saw written: "Likes things done the way she wants them done," and it also noted that they preferred to socialise at meal times, demonstrating some person centred care planning. The provider may wish to note however, during the course of the inspection we found that they had not had their meal with others as preferred. We also met and spoke with a person who required the use of a wheelchair and was been assisted by staff. When we asked this person where they were going the staff member answered, "the lounge." The person who used the service then said they had no wish to visit the lounge as they did not have their dentures in. This was discussed with the staff

member who informed us that they were told to assist the person to the lounge and did so without question or discussion with the person who used the service. Following this the staff member assisted the person back to their room in accordance with their wishes.

The provider may wish to note we also met and spoke with a person who lived in the home who had no verbal communication but had capacity to discus their preferences and choices non-verbally with us, such as nodding. We saw that agreements to the care plans as an example had not been written in a way that took this into account.

We looked at the information the service had given to people living at Church House Care Home and saw this documentation in one person's room. The documentation seen still referred to the previous provider and had not been updated to show the change of provider which took place in October.

We spoke with people who used the service and one person told us: "The staff know me but they still knock and they know what I like to do now they know my routine and if I choose to change that well that's up to me isn't it." A person's visitor who visits the home regularly told us: "The staff are very approachable, they ask if we want the door closing when we visit for privacy and I've seen them knock on the door and wait before they go in-I think they are very good like that."

We spoke with a person who required the use of a wheelchair, they said they preferred to be in their wheelchair until lunch and they enjoyed getting themselves ready, such as their hair and make up. When we spoke to the staff it was clear that they knew and understood this person's preferences and support needs.

People who used the service told us that staff were 'kind' and 'caring.' During this inspection we found some areas were improvements in staff awareness of respect and dignity was still needed, however overall the people who lived in Church House Care Home told us they felt their privacy and dignity was respected.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

During our inspection in April 2012 we found that the service was not meeting this standard and improvements were needed in order to support people's care and welfare appropriately. We completed an unannounced inspection on the 12 November 2012 to see what progress had been made to improve the standards of care and ensure the well being of the people who lived at the home.

The Care Quality Commission and the Local Authority were contacted by a whistleblower and the issues raised were being investigated under the local authority safeguarding policies and procedures.

Thirty-two people were living in Church House Care Home on the day of our visit. During the course of the inspection we reviewed four people's care plans and risk assessments. The home had a new manager who commenced their employment in October 2012 as well as a new regional manager who had been in post for a couple of weeks.

As part of this inspection, we carried out an analysis of the care provided by checking on the whereabouts and well-being of each person living at the home. We started this process between 09.15am and continued until 2.15pm. During this process, we visited a person who lived at the home in their room at 1.16pm and they told us that they were, "sometimes" well looked after, but "not today." They said: "nobody wants to know", they had had breakfast and a drink but had nothing since then and it was 1.16pm. The person told us they preferred to use the toilet but had "had to go in their pad." They said they wanted to get up as their legs ached but that: "they (the staff) do not help me."

We reviewed some records kept in their room including the repositioning charts. We saw that that last entry made for 12/11/12 (the day of the inspection) was at 9am, which noted 'sat up' and 'breakfast.' We looked at records for the previous 2 days and saw that there was no record for 10/11/2012 but entries had been made on 11/11/2012.

We visited again at 1.22pm and the person told us they were "fed up" and had had nothing "but a drink of cold tea today," and were still waiting for their lunch which was generally served at 12.30pm. At 1.23pm two carers arrived to assist them with their personal

hygiene. At 1.25pm we spoke with the staff to enquire about the lateness of this person's care and they said that this was because they were "staff short" so they were 'behind.' We enquired about this person's meal and we were told that the meal "had gone down in the hot cupboard" but that they would "give it to her later." It was clear that this person had not received their care and had been neglected by staff during the course of the morning.

We found that the nutrition intake charts were either not completed or incomplete and therefore did not provide sufficient information on the person's nutrition and hydration needs. The charts on 03/11/2012, 04/11/2012 and 05/11/2012 were not completed. Entries were made on the 06/11/2012 chart but the person had refused their lunchtime meal. On 11/11/2012 the entry was that the person had refused breakfast and had only a drink of tea and later 150mls of their dietary fluid supplement. It was not clear how staff reported events such as when people refused their meals and drinks.

We reviewed this person's care plan together with the repositioning and nutritional intake charts. We found records of the person's weight for July and September but not for October 2012 despite the nutritional risk assessment identifying a 'high risk' score. Within this person's plan of care we found that some records had been completed and dated and others had not. The care plan said the person needed: "A lot of encouragement to complete their meals," they liked the company of others and that staff should, "endeavour to bring them down (to the dining room) as this would encourage (them) to eat well."

We found that there was no care plan in place to guide and assist staff to manage the person's pressure area care despite the risk assessment identifying them to be at high-risk. We found that the entries on the repositioning charts were not well maintained which could place the person at additional risk if staff did not change the position according to their assessed needs.

We visited the person again at 6.24pm and found that there had been a change made by staff to the nutritional chart for 12/11/2012. This change did not clearly indicate that the entry was made retrospectively. We also found that contrary to their plan of the care they were eating their meal in their room rather than with others in the dining room. We provided this information in the form of feedback to the regional manager during the course of our inspection.

We also saw in another person's care plan that their total weight loss between August 2012 and September 2012 was 6.05kg which was of concern. We saw no associated action plan in place about how they were addressing the weight loss, no reassessment of their nutritional needs and no record to show that the weighing scales had been checked for accuracy. However, we saw in a separate file that they had been weighed in October and weighed 72.10kg a weight gain of 8.9kg, which could bring into question the reliability of the weighing scales. Information had not been transferred into the care plan from the 'resident's monthly weights' chart. We brought this information to the attention of the regional manager and manager who told us that they would ensure that the person's care plan, their weight and nutritional care was reviewed and reassessed to ensure their needs were met.

Information held in separate files if not transferred into the person's care plan could lead to vital information being missed. The nutritional care plan contained only basic information and did not guide staff to what actions they should take if a person lost weight or what constituted a significant weight loss to that individual.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to safely manage them.

We have judged that this has a moderate impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We spoke with five people about medicines handling at the home. Everyone we spoke with was happy with the arrangements in place when nurses and care workers administered their medicines. One person confirmed that medicines were administered at, "about the same time every day." A second person explained that they "know about my medicines and always have (tests) to make sure I have the right dose."

However, we found that arrangements were not in place to ensure people's medicines needs were met in a person-centred way. We saw that one person missed doses of medication when they were away from the home. There was no evidence that GP advice had been sought to find out for example, if the medicine could be given at other times, rather than just missed. Similarly, there was a lack of written guidance for care workers about the action to take should doses of medication be regularly refused. We saw that the dose of one person's medication had changed with the homes new monthly medicines delivery. This dose change was unexpected, but had not been queried and confirmed as correct. It is important that advice is sought to ensure people's treatment is kept under review and to ensure that the home's records are accurate.

The manager had recently completed audits of medicines handling at the home. These had identified that medicines were not being safely handled in accordance with the homes policies. This had been brought to the attention of staff handling medicines and an action plan had been put in place to try and bring about improvement in medicines handling.

We found that suitable arrangements were not in place for obtaining people's medicines. We saw examples where sufficient stocks had not been maintained to allow continuity of treatment. We saw one record that showed one person had been without two of their medicines for eight days. A second person had also been without one of their medicines for eight days. There was no evidence that medicines had been re-ordered before the last dose was administered.

The medicines administration records were generally clearly presented to show the treatment people had received. However, the home's arrangements for handling prescribed creams had not been fully implemented. Records were not always completed

to show the application of prescribed creams. This meant we were unable to tell whether they were being used correctly, as prescribed.

Suitable arrangements had been made for the safe storage of medication but we found that the remaining tablets from a recently discontinued medication could not be found.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We inspected Church House in April 2012 and found areas of non-compliance with the safety and suitability of premises. These included the call bell system and its accessibility for people who used the service interior décor such as carpets which were slightly raised and could cause a trip risk hazard or were worn and needed to be replaced, also repairs were needed to some furniture. We found that in some bathrooms bath panels and toilet seats needed to be replaced. The sluice room flooring was old and worn and needed to be replaced. The glazed door to the rear garden did not alarm when opened and would not easily close.

During this inspection we found that a number of improvements had been made. The home had a new wireless call bell system in place. People who used the service told us that they found the call bell relatively easy to use. The staff told us that this was an improvement but that they found that there were insufficient call bell panels and that the tone of the call bell did not distinguish enough between a call bell, which had been going for a while, or that of an emergency call bell. The regional manager took immediate action on this information and requested more call bell panels so they can be heard in all areas of the home. They also asked whether a change could be programmed into the call bell system to differentiate between an emergency call and other calls.

We saw that the flooring to the first floor sluice area had improved and that several toilet seats and bath panels had been replaced. We saw that the glazed rear doors were now tied in with the homes alarm system, which improved the homes security.

The new manager and the regional manager had only been in post for a few weeks. They told us that the new provider, Akari Care Limited, has taken over in October 2012 and that they had completed a full audit of the home. Following this they had produced an action plan which was in draft form and addressed the priorities regarding the homes refurbishment and the capital expenditure required to make these improvements.

The regional manager had already established that the Portable Appliance Tests (PAT) were out of date. We saw that the maintenance person maintained a log of the maintenance checks undertaken to both the interior and exterior of the home.

Following a whistleblower contacting the Local Authority and the Care Quality Commission an allegation was made that the manager and staff did not appear to know what to do in the event of a fire when the fire alarm sounded. This allegation was substantiated. The Fire and Rescue Service inspected in October 2012 and found several areas of concern. The manager told us she has produced an action plan to address the issues raised. The Fire and Rescue Service continue their involvement with the home.

We found that a suction machine had not been serviced or recently PAT tested which we brought to the attention of the regional manager. The regional manager informed us that they had identified through there audit process that this required attention and this would be addressed as a matter of priority.

Pavement slabs to the garden areas were uneven and needed attention as they posed a trip risk hazard. The regional manager informed us that they had identified this hazard during their audit of the home. We were told that the people who used the service did not in general use the rear garden but preferred the front garden patio area where they would normally be supervised by staff.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

Suitable arrangements had not been initiated in a timely manner to cover any identified staff shortages which meant that people who used service did not always have their needs appropriately met.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We reviewed staffing levels within the home following information provided by a whistleblower. Cheshire East Council also received this information and conducted a visit to the home to discuss the concerns which were received in October 2012. One concern raised was agency-to-agency staff handovers without permanent staff involvement to ensure continuity of care for people who used the service. The outcome of their investigation was that this allegation was partially substantiated and the new manager had produced an action plan to address these issues.

On the day of our visit the new manager told us that two staff members had 'called in sick' and said they would support the staff and look to arrange cover with the assistance of the homes administrator. The manager told us that one staff member had called the evening before the shift commenced but staff had not acted on this information to source cover for the following morning. They also said the deputy manager had recently left and a carer had handed in their notice.

We saw there were thirty-two people who lived at Church House Care Home on the day of the inspection. We saw as well as the manager there were two qualified nurses on duty. The manager told us that one of the nurses was now a regular agency staff member to ensure that people received continuity of care. The activities coordinator who provided activity support, such as quizzes, was on duty from 11am until 4.30pm. The manager said that the staffing levels when the home was full would normally be five care staff with two qualified nurses on day duty and one qualified nurse with three carers on night duty.

The manager told us they were working towards achieving a full complement of staff and had advertised for two carers, one for day and one for night duty. They had advertised for three qualified nurses and were interviewing staff on the day of our unannounced visit. They had requested agency cover of two full time qualified nurses for a month to cover shifts whilst recruiting and this would be monitored and evaluated if staff were not recruited during this timeframe. The provider had agreed staff overtime whilst observing the Working Time Directives until carers were recruited. The manager told us they were trying hard to achieve constancy of staff and maintain staffing levels to meet people's needs with the use

of a preferred agency.

Staffing numbers should be determined and led by people's care and support needs and the manager told us that when she commenced employment as the manager in October 2012 she found there was no dependency-rating tool in place. The manager said she was in the process of getting to know the people who used the service and reviewing their care and support needs to develop new care plans. This we were told would inform and underpin the staffing levels. The manager said she was meeting staff and getting to know their skills and competencies. The manager told us that It appeared from the staff numbers that without sickness there were sufficient staff to meet people's needs.

On the day of the inspection from 8am in the morning until 10.45am there were four carers on duty, as two carers were off sick. Two of the homes care worker staff were contacted and agreed to cover the shifts required from 10.45am. This meant there was a staffing gap from 8am to 10.45am, which would affect the provision of care and support available to people who used the service.

The manager and regional manager told us that there was a policy on reporting sickness and absence and sourcing appropriate staff cover in the event of an emergency. They told us that this information would now be posted on staff notice boards to enable all staff to familiarise themselves with the information.

We spoke with people who used the service, staff and relatives during the course of the inspection visit. One person who used the service told us: "They need to improve their staffing levels. Sometimes when the girls go sick they don't have enough staff." Another person said: "There are not enough staff, we have to wait a long time" for assistance. One person gave an example that they had waited for over an hour to have their personal care toileting needs met and they told us that this was because they 'had no staff.' One person told us they were 'happy with staff levels.' Another person said: "It's very nice here, don't get me wrong, the staff are kindness itself, but they don't really have time to chat. Sometimes you hear the buzzer going and going and you know it's because there are not enough of them (staff)." This person also told us: "Staff sickness happens all the time here if it's not one it's the other, you overhear staff talking so you get to know these things."

During the course of our visit we observed that one person did not receive any personal care such as assistance with washing and dressing until after 1.23pm. We asked staff about why this had happened and were told: "Because we were short this morning so we are behind."

A relative said: "I am concerned about staffing levels" they said: "It's never good when staff have to rush." They also said they were: "Very happy with the standard of care and the staff are kind."

One staff member told us: "There are not enough staff, there was a lack of leadership and poor management." Another said: "Staff were leaving and I think nothing was done about it. I was going to leave because there's been too many management changes but I feel settled again now with the new manager."

A staff member told us at 12.20pm: "They don't normally get cover" when people go off sick, and said: "We have not met everyone's needs today – just got behind a little."

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

Staff had not always received the training or regular supervision sessions to support them to deliver care and treatment safely to people who used the services.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Information provided by a whistleblower alleged that staff appeared inexperienced and lacked training. Cheshire East Council conducted a visit to the home to discus with the manager the concerns raised by the whistleblower in October 2012. The manager had produced an action plan to address these issues.

One person who used the service told us that they were 'okay' and said they were 'well looked after, yes I am well cared for they (the staff) are very good." We were also told: "Some staff don't have the patience of others, nothing specific, they don't rush me-I just feel that they need to be elsewhere. Overall they are very good." Another person commented: "They (the staff) seen to know what they are dong and they have contacted the doctor for me in the past and rung my family to let them know."

We reviewed information provided by the manager on how staff were supported in order that they received appropriate training, supervision and appraisals, including an updated list of the training staff had attended.

One staff member told us that they had felt that there had been a lack of continuity of leadership and management within the home. They told us: "You just get used to things and then the management or owners change it again." They told us: "I feel we've not had enough support or information and we've had three managers in less than a year."

The manager showed us a copy of the staff training and the courses each staff member had completed. This detailed training that had been provided to each member of staff and when that training had been delivered. As an example, the record reflected that most staff had received training in 2012 in safeguarding vulnerable adults and the manager told us that for the remaining six staff members training was planned.

We saw that most staff had completed training in food hygiene in 2012, infection control, health and safety and moving and handling. The manager told us that not all staff had received up to date fire training. The manager had arranged for all staff to attend fire training in December 2012. The manager told us that now the staff training records had been audited they could start to plan and prioritise training to ensure they met the care and

support needs of the people who used the service. We were told that this training would be provided in-house and that local authority training courses would also be accessed.

Staff said that they had not yet had a full staff meeting but had received one to one discussions with the new manager on the answering of call bells. We saw that staff supervision sessions had not always taken place regularly. The manager told us they had planned for a staff meeting and that staff supervision sessions were planned in November 2012.

The relative and visitor we spoke with told us they were happy with the standards of care provided and that staff were kind.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our inspection in April 2012 we found that the service was not meeting this standard and improvements were needed.

Church House Care Home had a new manager who commenced their employment in October 2012 as well as a new regional manager who had been in post for a couple of weeks.

Since our last inspection the former manager had sent out feedback questionnaires to people who used the service and had received 15 responses back. There was evidence that this information had been collated, however there was no action plan or evidence of any resultant improvements made. For example eight of the 15 respondents answered "Sometimes" when asked the question: "When you need help from staff, do they attend within a reasonable time?" We saw that the comments included: "Nice friendly atmosphere. Friendly staff, " and "Generally good atmosphere generated by co-operation amongst staff. Positive contribution by all staff and departments."

The new manager and regional manager had conducted a number of audits since they took up their roles. We saw that the manager had commenced weekly medication audits and was reporting any findings appropriately to the person's GP and local authority. We saw within one of the care plans reviewed that an audit of the care plan had taken place and that had resulted in an action plan for the staff to achieve. The manager had reviewed the information held in staff files regarding the training they had attended and set up records to monitor the staff training. They had also reviewed information held about staff supervision and planned sessions in November for all staff. They had had one to one discussions with staff in respect of call bell management. The manager told us: "We have completed lots of audits now. We know where our priorities are." They also said: "We are moving forward and now need to get on and do the work and improve the service." We were told by the manager that further quality assurance questionnaires were to be sent to people who used the service in November 2012. They also said they would be sending questionnaires to other stakeholders such as healthcare professionals and a staff survey was planned for the near future.

We spoke to people who used the service and a visitor to the home about whether they knew how to complain. We were told that they or their families would speak to the senior staff or manager. None of the people spoken with wished to raise a complaint.

One staff member told us they found: "There are not enough staff, a lack of leadership and poor management." Another said: "Staff were leaving and I think nothing was done about it. I was going to leave because there's been too many management changes but I feel settled again now with the new manager." The staff we spoke with said they enjoyed their work. The new manager told us they were planning for a staff meeting to take place in November as well as a relatives and residents meeting

The lack of fire drill's for staff had not been picked up though the regular health and safety checks but via a whistleblower to the Care Quality Commission (CQC) and the local authority. The manager assured the CQC that there were appropriate measures now in place which included the ordering and purchase of fire door closers weekly fire drills and staff fire training.

We could see that quality assurance systems were in place to assess the effectiveness of the care and support provided to people who used the service. This system was focused on the needs of the people using the service and was underpinned by effective decision making and the management of risks to the health, welfare and safety of the people who use the service. However, during this inspection we found that improvements had not been made following our last inspection which meant that people were at risk of not always receiving the service they need. We found from the comments some people had made and in the care plan and risk assessment records we reviewed the systems in place had not been effective in improving the service provision for some people who lived in the home.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

There were gaps in some people's care plan and risk assessment documentation which could lead to people not being protected from the risks unsafe or inappropriate care and treatment.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our inspection at Church House Care Home we looked at records concerned with the care of people who lived there, staff training, supervisions and appraisal programme, medications, service and maintenance book and medication administration records.

We met and spoke with people who used the service they told us they had access to some new blue folders, which were kept within their own rooms. They said they had not been given any information about the folders from the staff. We spoke to three people about their records and they said they had no concerns they wished to raise over the management of their records.

We saw that staff could readily access the care plan records and that these files were kept on shelving within the staff office. This office had a lockable door. The provider should note however that when the staff office was unoccupied the door was not locked so these records were not always held securely.

The staff and manager told us that they kept historical records which were archived for people who used the service. This meant that it would be possible to track people's progress and treatment when they had used the service.

We saw some gaps in records when we reviewed four care plans for example risk assessments and care plans had not been updated, signed for appropriately or completed fully. This meant that records did not always provide the information expected.

In one care plan we found a dependency risk assessment which identified the person to be at 'high risk' but from the information provided in the documentation this had not fully taken into account the persons skin integrity risks and was therefore a 'Very high risk'. We saw that a care plan audit had taken place on this care plan on 29 October 2012 and an action plan was in place. We could find no documentation about what action, if any had been taken by staff to address the issues raised in the action plan.

During our visit we found that information about the care and welfare of people who used

the service was being recorded separately to their care records. This information was not always transferred to their care and support plans which could mean that care plans did not always contain the most current information.

We found that people's weights were recorded in a separate file on a chart called 'Residents Monthly Weights', but these were not always transferred into the persons care plan.

In another persons file we found staff had written in the daily record that a person had fallen but had not sustained an injury. We saw that there was no update made to the person's falls log or risk assessment and that they had not completed an accident/incident form. The manager reviewed this information and assured us that this would be immediately rectified. The manager told us that audits of care plans and risk assessments would be completed on an ongoing basis.

The manager told us that their electronic computer systems were password protected and that each staff member who had access to the system had an individual password.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. Regulation 15 (1) (c)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: Suitable arrangements had not been initiated in a timely manner to cover any identified staff shortages which meant that people who used service did not always have their needs appropriately met. Regulation 22.
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Staff had not always received the training or regular supervision sessions, relevant to support them to deliver care and treatment safely to people who used the services. Regulation 23 (1) (a)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: People were not always protected from the risks of unsafe or inappropriate care and treatment. Regulation 10 (1) (b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: There were gaps in some people's care plan and risk assessment documentation which could lead to people not being protected from the risks unsafe or inappropriate care and treatment. Regulation 20 (1) (a)

This section is primarily information for the provider

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 03 January 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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