Review of compliance

Bondcare Nilerace Limited Church House Care Home	
Region:	North West
Location address:	Coole Lane Austerson Nantwich Cheshire CW5 8AB
Type of service:	Care home service with nursing
Date of Publication:	May 2012
Overview of the service:	Church House Care Home is a 44-bed nursing home, set in approximately one acre of attractive gardens about a mile from the facilities available in the town of Nantwich. Nantwich town facilities include shops and coffee houses with Nantwich Lake and park areas that are within close proximity to Church House Care home.

	Church House Care Home has a conservatory, quiet sitting areas and a large lounge room that look out to the gardens. It has off road car parking facilities available.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Church House Care Home was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 25 April 2012, observed how people were being cared for, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

For the purpose of report writing it was important to note that Church House Care Home had a change in provider in October 2011. The new provider Bondcare Nilerace Limited had inherited an older building with refurbishment and investment needs. The manager had recently been appointed and had taken the manager role in March 2012 and was to apply to the Care Quality Commission to become the registered manager.

We visited Church House Care Home unannounced and spoke to several people about the care and support they received as well as speaking with a number of relatives and visitors to the service.

People told us they had some choice in what they do and when they do things. One person told us: "They ask me what I want to eat and where I would like my tea." Another person told us: "I prefer to sit in the lounge after breakfast and watch television with another lady, the staff know about my preferences and help me to get to the lounge." However one person told us they had hoped to be introduced to the manager as a courtesy but felt that that this had not happened, although they had no concerns to raise.

One person told us: "The staff are great, X, is so lovely, kind and gentle, in fact they (the staff) all help me."

People told us the atmosphere was relaxed in the home and said that people in general got on well with each other.

People using the service said they were regularly asked their opinions about how they were cared for and supported at Church House Care Home and one person said: "I think

they had a relatives and resident meeting not very long ago."

We spoke with one person who told us: "They (the staff) know me well and they know what I like to do and I feel happy here."

What we found about the standards we reviewed and how well Church House Care Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People using the service were involved in making some decisions about their care however, privacy was not always maintained and dignity was not always respected.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People using the service generally received good care, however, some risk assessments within the care plans lacked detail and care plans were not always person centred.

Peoples social welfare needs were at risk of not always being met.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People who used the service benefited from staff who received training and updates in adult safeguarding to reduce the risks of abuse.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People could be placed at risk because there were insufficient arrangements in place in relation to the safe recording of medication administration.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

Appropriate measures were not in place in relation to the security of the premises.

A risk-based assessment was not in place to prioritise the maintenance and repairs program or to ensure that hazards were minimised and actioned where needed for the people using the service.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People were supported by staff who had been properly recruited.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

There were some quality assurance systems in place but not sufficient to assess the effectiveness of the care and support provided to people living in the home.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People using the service told us that they were involved with, and had some influence in, how they were supported. They told us they were aware they had a care plan and that they were involved in the reviews of their care and support.

People told us they had some choice in what they do and when they do things. One person told us: "They ask me what I want to eat and where I would like my tea." Another person told us: "I prefer to sit in the lounge after breakfast and watch television with another lady, the staff know about my preferences and help me to get to the lounge." However, another person told us they had hoped to be introduced to the manager as a courtesy but felt that this had not happened, although they had no concerns.

One person who used the service told us: "I have lived here for a while now the staff are all lovely and they care about you as a person."

Another person said: "If I wanted to have female care staff only I know they would take that into account."

One person living at the home expressed a wish to have their own hairdresser visit for her hairdressing treatments and we were told that their wishes were respected.

Other evidence
The manager told us that information about the home and the services they provide were given to anyone who may be thinking of moving in to Church House Care Home. We were told that anyone moving to Church House Care Home would receive a pre-admission assessment to decide if his or her needs could be met. As part of this process, the manager or person completing the assessment would also gather information from the persons' family, social worker or other professionals to add to the assessment.

We reviewed the care plan documentation to see if some of the preferences expressed by the people we met during our visit were detailed in their care plans. We found that they did not include all detail about peoples preferences such as the time they liked to go to bed or what peoples routines were like in the evening.

During our visit we saw that the relationships between people using the service and staff members were friendly. We spoke to one person who used the service about the language used by some members of staff such as 'how are you today, sweetheart?' and they said: "they (the staff) know most of us very well now and I find it perfectly acceptable and friendly to be called sweetheart, but others might not I suppose." Another person told us: "The staff do ask you about the name you prefer to be called by and they ask if it's alright to call you by that name."

We observed that not everyone was treated in a dignified manner. One person living in the home told us that their dignity was not always taken into account. The person told us of one event when their dignity was not respected but they could not recall if similar events had happened before.

People did not have a copy of their care plan that they could keep with their personal possessions, although when asked whether they had a copy, one person said: "I know I have one and it's kept in the nurses' office, I can look at it if I wanted to but I am not really bothered."

People who used the service told us they and their families were involved in their care plans and we saw that people had signed the care plans where practicable to do so.

Details of independent advocacy services were available to people living at the home and the manager told us that they would contact Age UK advocacy services if a person living in the home requested advocacy services.

Our judgement
People using the service were involved in making some decisions about their care however, privacy was not always maintained and dignity was not always respected.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We met with several people who used the service. People using the service told us that they were generally happy living at Church House Care home.

We received only positive comments from the people we spoke with about the food or menu choices and comments ranged from good to okay and that there was always enough. Following lunch I spoke with one person living in the home who told me: "I like to go to the lounge first, I have a chat with a few people before I go in for lunch." Another person said: "Sometimes I like to go straight into the dining room and sit at my table, I've got to know a few peoples' names at the table I sit at now."

Comments made included: "The staff are great, X, is so lovely, kind and gentle, in fact they (the staff) all help me."

People told us the atmosphere was relaxed in the home and said that people in general got on well with each other.

When we asked about access to a General Practitioner or dentist one person said: "If I felt unwell the staff would call the doctor on my behalf."

We spoke to people who used the service who told us that they could not recall when they last had an activity such as a 'trip out' but that they were aware that activities were available if they choose to be involved. One person told us: "I'm not too worried about

organised things such as trips out in the winter, but I enjoy a chat with the staff." One person told us: "I'd like to go to the lounge and mix more. The last time I was here I enjoyed the quiz, but I find it more difficult than I did last time I stayed here to get out of my chair, it is easy to get bored in your room. I'm sure the staff would help me if I asked but I've had a few visitors and a friend visit today."

Other evidence
At the time of the visit there were 34 people living in Church House Care Home. The care plans and documentation were a mixture of provider styles due to the changes in October 2011 to the provider of the service. We reviewed four care plans and saw that they needed to be streamlined so that staff had clear guidance on how to support the people living at the home. Information would be clearer for staff to follow if this was broken down to include more detail about the individual activities the person was carrying out, any associated risks identified and the care and support the person required. This would enable the person reading it to have a good idea of what help and assistance someone needed at a particular time. More information was needed in some parts of the care plan to ensure the people using the service received the right level of care and for it to be more person centred.

The care records we looked at contained evidence that care plans and risk assessments were being reviewed. The way the information was provided however, made it difficult to establish if there had been changes from the previous care plan or risk assessment.

Potential risks to people using the service were assessed through a risk assessment and review system. The risk assessments included moving and handling, falls, and a Malnutrition Universal Screening Tool (MUST) as well as other person specific risks such as low and high blood sugar levels for people who had diabetes. We noted that whilst, as an example, a person may have an identified level of risk of developing a pressure sore, the plan of care to reduce the risk did not specify for example the type of mattress to be used for that level of risk. The manager told us that specific mattresses were used when required and at the time of the visit, we were told that no person using the service had a pressure sore. The manager was aware of some of the gaps noted in the documentation and was in the process of developing with the care workers more person centred care plans and risk assessments.

Professional visits, such as a dietician and the outcomes of the visit were held separately in the care plan files. Information would be clearer for staff to follow if the advice from any visiting professionals were documented and updated in the care plan.

The daily record notes in one care plan were not in date order and although legible were therefore difficult to follow. The manager reviewed the file and told us that some documentation had been held in a separate file and they had recently transferred everything into the one care plan folder, she said that the missing information would be found. The care worker once they located the information put the daily record notes in date order within the one care plan file.

One of the relatives we spoke with said: "The staff are very good. This home and staff are making a difference in mum, she is interested in herself and her surrounding again and that is lovely to see and hear when she had been so unwell before she came to live here," and: "I am very happy that my mum seems happy here."

We spoke with several members of the staff team both care workers and nurses who demonstrated good background knowledge of the people they were supporting.

The manager told us that they employed an activities co-ordinator who was not present on the day of our visit. Other than an afternoon film, which was on the television in the lounge area, we did not observe any activities organised by the care workers in the absence of the activity co-ordinator. We were told that activities were encouraged and based on peoples' general preferences, however staff did not take up the role of activity management in the absence of the activity co-ordinator. When we spoke to staff about activities, we were told that the activity co-ordinator 'was really good' and 'took care of all the activities.' Enabling social interactions such as entertainment activity was not seen by the staff as part of everyones day-to-day role.

During the lunch period, people who choose to eat their lunch in the dining room were assisted into the lounge area. This in effect became a 'waiting room' area for the dining room. During this busy time staff were not as engaged with the people using the service and were more 'task' focused.

The manager told us that she had moved her office to the area opposite the dining room. The manager told us that through observation, they had been able to improve the dining experience for people using the service and staff were able to offer more support.

Call bells were heard throughout the visit some were answered quickly and others were less timely. We spoke to the care workers and nurses present and they told us there were enough staff to meet the current needs of the people living in home as they had a few vacant rooms. The staff also said that some people who lived in Church House Care Home did not 'like to use their bell' and that they preferred to shout to gain the staffs attention. We spoke to one person who had shouted for attention and they said when asked about the use of the bell: "I don't like to ring the bell, I think the bell is for a real emergency and I only want to sit up a bit." The manager told us that the call bell system was to be replaced with a wireless system in the near future.

Our judgement
People using the service generally received good care, however, some risk assessments within the care plans lacked detail and care plans were not always person centred.

Peoples social welfare needs were at risk of not always being met.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The people we met who used the service told us that they knew what abuse was, and said they would speak to their family or a member of staff if they or someone else was being abused.

One person told us: "It's not something I think about here because I feel safe."

Other evidence
Discussion with two care staff confirmed they were aware of the importance of keeping people safe. They confirmed that they had recently been provided with safeguarding training. The manager told us that she was setting up a new training matrix to be certain that all staff on a rolling rota would complete all their mandatory training each year including safeguarding vulnerable adults. The manager told us that the staff had recently attended the Local Authority training in safeguarding vulnerable adults.

The care workers and nurses including an agency nurse were aware of the Local Authority adult safeguarding procedure, which they pointed out, was located in the nurses office. They were aware that the Local Authority safeguarding procedures complied with the relevant legislation and offered good practice guidelines.

The staff we spoke with could describe to us what actions they would take if they suspected a person using the service was being subjected to abuse.

Prior to our visit to the home, we looked at the information we held about this service.

We identified that any reported incidents of any safeguarding issues from this service were reported promptly to all the appropriate authorities, including the Care Quality Commission.

The manager told us that she had also completed training in The Mental Capacity Act and Deprivation of Liberty Safeguards. The manager said that once all staff had completed mandatory training she hoped to provide staff with additional relevant training as part of their development. We were told that checks for competency would be completed after training events to reinforce this learning at various time intervals. We were told that procedures were in place to ensure that whilst staff attended training there were sufficient staff on duty to meet the needs of the people using the service.

We were told that procedures were in place to ensure that effective whistleblower systems were available to staff. We spoke with two staff members who were aware of 'whistle blowing procedures' and were able to tell us what they would do if they felt they needed to raise any concerns with the manager or provider.

Our judgement
People who used the service benefited from staff who received training and updates in adult safeguarding to reduce the risks of abuse.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People who used the service that we met and talked to at the home said that they felt satisfied that they were given their medication generally on time and correctly.

One person who used the service told us: "If I have pain or feel unwell I need only mention it to the staff and the nurse comes to see me and check that things are alright or contact the doctor. I know when my medication is due and the staff help me with my medication as I can't manage my own any longer."

Other evidence
The care workers and nursing staff were aware of the pharmaceutical guidance in place about what remedial action they should take in the event of an error in administering medication or should the person using the service refuse medication or if there was no medication available.

The medication was stored in a locked 'treatment' room. Each metal medication trolley could be locked to the wall in the treatment room. During the visit, we found that one trolley was not locked to the wall. We also found that the medication fridge was not locked.

Fridge temperatures were recorded and noted on the notice board wall in the treatment room.

We noted that the files containing the Medication Administration Record (MAR) held a list of signatures for all staff who were responsible for medication administration which was available to cross reference against the MAR sheet.

We reviewed two peoples' MAR sheets with a care worker and nurse. The MAR sheets we audited did not have the correct numbers of medication remaining. The medication had been signed for by the staff and any refusal of medication recorded and accounted for which demonstrated that the number of medications carried forward for two medications prescribed had not been correctly counted. We were told by the nurse that the night staff were responsible for the change over of medication from one months supply of medication to the next. We were told that the numbers of tablets carried forward were written on to the MAR sheet. The nurse advised that they would look at the previous MAR sheet to establish where the error had occurred as she could not account for the deficit in one record and excess in the other. In one persons record dated 15 April we found that staff had not signed for one persons insulin medication administration.

The manager informed us that there had been some improvement to the systems in place to ensure a clear audit trail of medicines throughout the home, to ensure the safety and protection of people living in the home. She told us that she had instigated the staff signature lists with the MAR sheets and that staff had recently received further training in medication administration. The manager told us that staff have completed competency assessment and accountability training for medication administration and that these were recorded in work books. We were told that the senior care workers administered medications to the residential side of the home. We were told that their pharmacy supplier was Boots and that the pharmacist was booked to provide further training in their systems.

Our judgement
People could be placed at risk because there were insufficient arrangements in place in relation to the safe recording of medication administration.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is non-compliant with Outcome 10: Safety and suitability of premises. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We sat with one person who uses the service in the lounge who told us: "The staff brought me into the lounge as I enjoy the television but I have been sitting in the wheelchair for a while now and I think they have forgotten to move me into the chair." This person did not have an accessible call bell and said: "The call bells are not always easy to reach."

One person told us: "It always smells nice here and the staff work very hard to keep it looking clean."

Another person told us: "The call bells are not always easy to reach."

When we asked about their room one person told us:"The place is clean and tidy and in its place, it suits me."

Other evidence
The manager told us that she was aware that there areas within the home which required updating and refurbishment. The Local Authority Quality Assurance Cheshire East team were involved with the home by providing information, monitoring and training. The manager told us that they had been working towards compliance in infection control and there was an action plan in place. The home had a new front door which had recently been replaced. When asked about the prioritisation of the refurbishment program and its planning we were told that this would be addressed following discussion with the providers' operational directors, as they were the budget holders.

The manager told us that the corridor carpets had been replaced where there was a trip risk hazard identified. The larger lounge carpet also looked worn and we were told that they were awaiting further information about what capital expenditure would be available for the homes refurbishment. We visited several people in their rooms. We observed that some carpets in peoples rooms were worn and rucked. The manager was aware and told us that they would be addressing the risk areas with replacement carpets as quickly as possible. We asked if the manager or maintenance person had completed a risk assessment of each room to identify and prioritise the risks and hazards such as rucks in carpets and repairs to furniture. The manager told us that they had a generic home risk assessment in place but not one for each room. She told us that the maintenance person completed all the checks in respect of fire, water temperature checks, heating, lighting and ventilation and completed the homes maintenance.

In the bathrooms visited there were areas to be addressed and the manager told us that she was aware that the bath panels needed to be fit for purpose and replaced as soon as possible where required. The manager told us that they had already replaced 15 toilet seats and they were on a program of replacement throughout the home. The hoist equipment was old and although it had been serviced within a 12 month period and in working order, the service engineer also wrote that it was in only 'fair condition' and we noted it had peeling paint in areas and looked 'rusty'. We were told that the maintenance person had been tasked with assessing the areas in the bathrooms where bathroom sealant and tile grouting were to be replaced and made good.

The sluice to the first floor was housed in the boiler room which the manager told us although not ideal was at present usable. The room housed sluicing sinks and a wall mounted rack that held bedpans, which were old and worn, the flooring was also worn and marked in areas. The manager said that the moving of the sluice area would be an investment that would be discussed with the provider.

The glazed doors to the side garden from the quiet lounge area were not secure and it had a fire door push bar operation which was easy to push open but difficult to close and did not alarm when opened. This door opened into the side garden which in relation to the security of premises was not secure. The manager was made aware of this during the site visit and we were told that action would be taken to address the security of the premises.

The manager told us that they hoped to replace the call bell system with an up to date wireless system. They were awaiting an assessment to see if the system they had considered was suitable for the home. We saw that the current call bell system was in working order but there was less access in the communal areas such as the lounge which could cause delay for people who used the service in getting help when their mobility was limited.

The lounge and conservatory area was set out with chairs around the room and the lounge housed a large screen television, chairs and a few side tables. The manager told us that they had cleared out a lot of the older furniture but that there were still sufficient chairs for the users of the service and their relatives or visitors.

The manager told us: "You've told me nothing new or that I'm not already aware of," when we spoke of some of the décor issues. The manager gave us a verbal assurance

that she would request from the provider a plan of action to prioritise and address the safety and suitability of the premises to meet the needs of the people using the service with immediacy. The manager was aware of the need to complete risk assessments throughout the home, prioritise, and address those risks identified in a timely manner.

Our judgement
Appropriate measures were not in place in relation to the security of the premises.

A risk-based assessment was not in place to prioritise the maintenance and repairs program or to ensure that hazards were minimised and actioned where needed for the people using the service.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We spoke with one person who told us: "They (the staff) know me well and they know what I like to do and I feel happy here."

Other evidence
We randomly reviewed some staff records. The staff recruitment files were organised into folders and held securely in the managers' office.

Three of the records reviewed included application forms outlining the skills and experience relevant to the roles applied for and in two records we saw that two references had been received, medical declarations and interview questionnaires which had been completed prior to commencing employment. In one staff record there was only one reference found. The new manager told us this would be followed up immediately. Following the visit the manager confirmed in writing that a reference had been requested. Criminal Records Bureau (CRB) checks had been completed in the records reviewed.

In one personnel record there was no copy of the UK Border Agency update to a nurses' passport. The registered manager immediately requested further information and for a copy of the updated information from the UK Border Agency to be held on file. The staff member was certain that this information had already been provided. Following the visit the manager confirmed in writing that she had sight of the staff members' most recent valid UK Border Agency update.

There was no central list for the manager to rely on in respect of the nurses up to date Nursing and Midwifery Council (NMC) registration as the homes administrator had left suddenly and we were told without a formal handover. We randomly selected a staff members personnel file and there was evidence provided of their up to date NMC registration. The manager told us that she would go through each nurses file to ensure that their registration details were up to date and contact the NMC for updates were appropriate to do so.

The manager told us that they had advertised for administration support. At the time of the visit, the manager was the only person who was regularly available to answer phone calls and to open the door to welcome people into the home. The manager told us that she had requested administration support via the Regional Manager and she had received the support of three days over two weeks. The manager described the impact this had had in her ability to undertake scrutiny and audit of files since the commencement of her role six weeks earlier.

We spoke with the relatives of two people who used the service. They were of the view that the care and support was competently delivered. One relative said they were kept informed of what was happening generally and considered their relatives to be well cared for and felt included in any reviews of care.

Staff said they had an induction and training on commencement of their employment. One member of staff said: "I had an induction and then I shadowed people for a week or so, before I started looking after people." Another member of staff told us: "I had left the home and came back. This is a lovely home to work in, it is the best job I have had." One member of staff told us: "We had supervisions every couple of months or six weeks." Another member of staff said: "We have regular supervisions but we can talk to the manager at anytime, I enjoy working here."

Our judgement
People were supported by staff who had been properly recruited.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People using the service said they were asked their opinions about how they were cared for and supported at Church House Care Home and one person said: "I think they had a relatives and resident meeting not very long ago."

Other evidence
The manager told us that the last resident and relative meeting took place in March 2012 with one planned for May. The minutes from the meetings were seen in the staff break/rest room.

We were told that staff talked to people living in the home informally as well as having resident and relative meetings so that people living in the home could air their views and ideas about the home.

The staff told us that they had staff meetings. We were told they were held regularly to make sure that they were up to date with any changes in the home and for the opportunity to exchange views and ask any questions. The manager told us that she wrote regular 'memo's' with information in brief given to staff for them to sign to say they had received and understood the updated information.

The new manager was unaware if there had been a survey about the quality of the service people received in the last 12 months. The manager told us that quality surveys or questionnaires would be forwarded to people who used their service and to

stakeholders in the service, such as health and social care professionals to gather their views on all aspects of the service they provide. The manager told us that her plans were to forward the quality service surveys on a quarterly ongoing basis but said that this had not been her immediate priority. The manager did not state when this would take place. We discussed that by completing the survey the views gathered would assist in focussing the priorities in order to meet the needs of the people using the service and would in fact help them develop their improvement cycle.

The manager provided us with examples of the checks or audits that had been conducted. These included accident and incident monitoring, complaints and concerns, infection control checks and improvements based on the last infection control audit. The last infection control audit completed prior to the employment of the current manager had identified a large number of areas for improvement and an action plan had been produced for the manager to work through. The manager told us that they had addressed areas such as policies for Infection Control and Health & Safety, which were available now to all staff within all departments. We were also told that the infection control team were completing regular monthly monitoring visits to audit their progress with the action plan in place.

The manager told us that the maintenance person carried out audits or 'checks' such as the grounds/lighting/fire alarm and hot water systems throughout the home and recorded these details. The fire inspection had been due to take place on the day of our visit but had been cancelled by the fire inspector but had been rescheduled.

We asked about whether the manager had had the opportunity to develop a training matrix based on the needs of the people using the service and staff development as well as mandatory training. The manager told us that ensuring mandatory training had been her immediate priority and that she had been manually updating the training onto an informal matrix until they appoint an administrator or have administration support in place. The manager was able to demonstrate that the staff training provision had been made and staff attended mandatory training such as safeguarding, medication administration and infection control training, which were booked and were ongoing.

The manager told us that she ensured that the night staff were included in any changes to practice and training updates and staff meetings and that she envisaged that she would work on occasional weekends and nights to check that the support they required was being provided.

We asked to see any compliments or complaints that had been received by the staff at the home. The manager told us that she had put in place a folder to record any informal verbal complaints and written complaints and outcomes as there had been no process in place to record outcomes of verbal complaints prior to her employment. Where one complaint was anonymous, the manager had no opportunity to feedback any findings of any investigation. The manager told us that complaints had been dealt with to the complainants' satisfaction although there were no signatures from the relatives or residents to verify this further. The manager felt that the format she had used could be developed further to demonstrate this.

We spoke with a visiting healthcare professional who told us that this was only their second visit to the home. They said: "The staff are very professional and welcoming. They know I am due to visit and the staff take me to X's room." They also told us:

"People living here appear well cared for and the home looks clean and tidy with no offensive odours."

Our judgement
There were some quality assurance systems in place but not sufficient to assess the effectiveness of the care and support provided to people living in the home.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People using the service were involved in making some decisions about their care however, privacy was not always maintained and dignity was not always respected.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People using the service were involved in making some decisions about their care however, privacy was not always maintained and dignity was not always respected.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People using the service were involved in making some decisions about their care however, privacy was not always maintained and dignity was not always respected.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA	Outcome 04: Care and

	2008 (Regulated Activities) Regulations 2010	welfare of people who use services
	How the regulation is not being met: People using the service generally received good care, however, some risk assessments within the care plans lacked detail and care plans were not always person centred. Peoples social welfare needs were at risk of not always being met.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People using the service generally received good care, however, some risk assessments within the care plans lacked detail and care plans were not always person centred. Peoples social welfare needs were at risk of not always being met.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People using the service generally received good care, however, some risk assessments within the care plans lacked detail and care plans were not always person centred. Peoples social welfare needs were at risk of not always being met.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People could be placed at risk because there were insufficient arrangements in place in relation to the safe recording of medication	

	administration.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People could be placed at risk because there were insufficient arrangements in place in relation to the safe recording of medication administration.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People could be placed at risk because there were insufficient arrangements in place in relation to the safe recording of medication administration.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Appropriate measures were not in place in relation to the security of the premises. A risk based assessment was not in place to review how the service prioritised the maintenance and repairs program or to ensure that hazards were minimised and actioned where needed for the people using the service.	
Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Appropriate measures were not in place in	

	relation to the security of the premises. A risk based assessment was not in place to review how the service prioritised the maintenance and repairs program or to ensure that hazards were minimised and actioned where needed for the people using the service.	
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Appropriate measures were not in place in relation to the security of the premises. A risk based assessment was not in place to review how the service prioritised the maintenance and repairs program or to ensure that hazards were minimised and actioned where needed for the people using the service.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There were some quality assurance systems in place but not sufficient to assess the effectiveness of the care and support provided to people living in the home.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There were some quality assurance systems in place but not sufficient to assess the effectiveness of the care and support provided to people living in the home.	
Treatment of disease, disorder or injury	Regulation 10	Outcome 16: Assessing

	HSCA 2008 (Regulated Activities) Regulations 2010	and monitoring the quality of service provision
	How the regulation is not being met: There were some quality assurance systems in place but not sufficient to assess the effectiveness of the care and support provided to people living in the home.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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 within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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