Wirral Christian Centre Trust Limited

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Inspection report

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19 February 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Wirral Christian Centre Trust Limited on 17 and 19 February 2016.

Wirral Christian Centre Ltd is a nursing and care home known as Orton House. It is registered to provide services to a maximum of 39 people. It is situated in Birkenhead, Wirral, close to the town centre and local amenities. At the time of our visit 37 people were living at the home.

The home required a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
There was currently a temporary manager in post as there was no permanent manager employed at the time of inspection. The provider was taking steps to address this.

We spoke with the general manager and the temporary manager who was very transparent and told us that they recognised that the home needed to improve and that they were committed to the work required.

People we spoke with told us they felt safe in the home. They had no worries or concerns other than staffing levels. People's relatives and friends also told us they felt people were safe but also mentioned the low staffing levels. During our visit, however we identified concerns with the service.

We found breaches in relation to Regulations 12 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We observed that staffing levels were a concern as shown by several call bells that were not answered for a considerable period of time. Feedback from staff people who use the service and relatives/visitors also confirmed that they felt there was a problem.

We saw that mealtimes were disorganised and afternoon meals were prepared by care staff at weekends as there were no cooks available.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not always been adhered to in the home. Not all the people at the home who lacked capacity had been assessed or all of Deprivation of Liberty Safeguard (DoLS) applications been submitted to the Local Authority in relation to people's care.

Infection control standards at the home were not monitored or managed and there was no permanent maintenance person employed.

The provider was in the process of working through action plans so the organisation could be reassessed for legionella and electrical safety.

Staff were recruited safely and there was sufficient evidence that staff had received a proper induction and suitable training to do their job role effectively. The majority of staff had been supervised and appraised.

The registered nurses had not had appropriate PIN checks, these checks shows that a person has completed the training and registered to practise with the Nursing & Midwifery Council (UK). This meant the service could not be confident they were currently registered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were not adequate

Medicines were not always safely managed.

Several call bells were not answered for a considerable period of time.

Health and safety checks on the premises were not being carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received appropriate appraisal and supervision.

The requirements of the Mental Capacity Act (2005) had not been fully implemented to protect people's rights.

People's health was monitored and people had access to medical professionals as needed.

People were not given enough to eat and drink or have a choice of suitable foods to meet their dietary needs.

Is the service caring?

Good

The service was caring.

People we spoke with said the staff treated them with dignity and respect and we observed that staff were gentle, patient and caring.

People were able to laugh and joke with staff and they appeared at ease with the staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People we spoke with considered that the care provided was personalised.

The complaints procedure was not openly displayed.

Some information in care plans was not up-to-date

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in post

Nurse registration checks had not been carried out.

All staff positively commented on the support received from the temporary manager

Wirral Christian Centre Trust Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17th and 19th February 2016 and was unannounced.

The inspection was carried out by one adult social care inspector and a specialist advisor who was a healthcare professional with experience in the nursing care of older people and end of life care.

Prior to the inspection we asked for information from the local authority quality assurance team and we checked the website of Healthwatch Wirral for any additional information about the homes. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We reviewed the information we already held about the service and any feedback we had received.

During the inspection we spoke to 14 people. This included people who live in Wirral Christian Centre and family members.

We talked with 12 staff on duty over the two days including the general manager, manager, team leader, registered nurses, care staff and ancillary staff. We also spoke to visiting professionals.

We observed care and support for most of people who lived at the home. We reviewed a range of documentation including 11 care plans, medication records, recruitment and personnel records for seven staff members, staff training records, and other records relating to how the home is managed. We looked at the communal areas that people shared in the home and with their permission visited people's bedrooms.

After our inspection we asked the manager to send us additional information in relation to health and safety. The provider responded by email promptly.

Requires Improvement

Is the service safe?

Our findings

We asked everyone we spoke to if they felt safe in the home and everyone said 'Yes'. A family member told us "I feel she's safe and well care for, I can't ask for more than that."

We saw that some areas of the building were very tired and dated. We saw that areas were currently undergoing refurbishment but several of the rooms visited were poorly maintained. We saw that some curtains were hanging off their rails and that some carpets were worn and taped. We also observed that several fire doors were propped open with either cardboard or wedges. This was brought to the manager's attention who immediately rectified this.

The home did not have a full time maintenance person but had access to an electrician at weekends.

An external infection control audit had taken place prior to our inspection and this had highlighted issues. An example was that water temperature checks were not? taking place. This meant that at the time of inspection there were no certificates to say that electrical systems were safe or that any legionella checks had been made.

The provider and manager was taking steps to implement an action plan that introduced new systems address the issues identified. This meant that at the time of inspection health and safety checks on the premises were not being carried out effectively and the people who lived at the home were potentially at risk of harm.

These examples are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that policies and procedures were in place for safeguarding. The home reported safeguarding incidents to the local authority and Care Quality Commission appropriately and timely. Internal records had a summary showing what lessons had been learnt, any action plans
and when the action plan has been completed. We saw that staff had attended safeguarding training. We noted that a copy of the home's safeguarding procedure was found on a noticeboard by the dining room. This may have been difficult to find for a visitor who wished to make find relevant safeguarding information.

We observed the lunch time medication being administered. We noted that people did not have any check i of identification prior to being administered medication. We saw that medication was given to people but no check was made to ensure the medication was taken.

We inspected the treatment room. We checked a sample of medication against the Medication Administration Record (MAR) sheets and this was found to be correct. We saw that the locked medication fridge temperatures was checked daily and was appropriately recorded and within safe limits. The lockable drug trolleys were locked and stored in the locked treatment room.

We noted that medication was overstocked. We found that anticipatory medications for end of life care had been prescribed for a person in November 2015. A further supply of the same medications was also prescribed in January 2016 even though the first prescription was fully intact and had not been administered. We also found that some medications were out of date and that another supply of medication prescribed for end of life care for a person, was still in the cupboard even though the person had died eight days previously. This was discussed with the home manager, they dealt with this issue during the course of the inspection and the out of date medications were prepared for safe disposal.

An external audit by the pharmacist in March 2015 highlighted the need for an expiry log to be implemented but there was no evidence that this had been done.

Staff did not administer drugs for end of life care via a syringe driver. No syringe driver was available at the home. People who were in need of a syringe driver were referred to the district nursing team who visit to provide this. The district nurses were also contacted to administer breakthrough pain medication . This could lead to a delay in the medication being administered. The district nurse stated that "There were very few nursing homes in the area where they needed to visit to give medication". They said that it was usual for homes to have their own equipment and for staff to give the medication when the patient needed it rather than have to "Wait for them to visit ". She indicated that there was sometimes a delay in visiting due to the pressure of their workload. This meant that the home was not able to support people who needed end of life care.

During the inspection we noted that several call bells were not answered for a considerable period of time. One person who lived at the home informed us that it was usual to wait for assistance for personal care. A family member informed us that they thought the home was short of staff, mainly at weekends and that they had previously waited 25 minutes to enter the home due to no one being able to answer the door. The majority of the staff and all the people who used the service told us that there were not enough staff for the home's needs. Some of the comments included, "There's sometimes a wait to get a painkiller when its not the normal time", and "I have only one complaint; they haven't got enough staff".

Staff comments included, "It's normal at night for the home to be in the care of someone who hadn't been here before" and "There are never any regular night staff". Another staff member told us, "There's never enough time to complete care records in the day. I often stay back to fill them in as can't do it during shift".

One trainee staff member informed us that they were regularly used as a trained care assistant. Rotas were checked to verify this and the record showed that they had been used as the fifth care assistant on duty, rather than being supernumerary.

We looked at seven staff files which comprised five health care assistants and two registered nurses.

We saw appropriate recruitment procedures were in place for the care staff although there was no evidence that registered nurse PIN checks had been carried out. We discussed this with the manager and the provider. The provider informed us that they were going to change the system immediately.

Personal Emergency Evacuation Plans (PEEPS) had been completed for all of the people who lived in the home and were readily available in a file in case they were required.

Where people were identified as being at risk of harm, assessments were in place and action had been taken to mitigate the risks. For example, we saw people had been assessed for moving and handling, falls, continence, and pressure area risk. However, we saw that some room risk assessments were not up to date,

with one stating that a further review would be made December 2015 which had not been completed at the time of our inspection. We saw that the risk assessments were in the process of being audited.
We noted that the home conducted daily checks of pressure mattresses which reduced the risk of skin damage and bed rail checks which reduced the risk harm through inappropriately fitted or maintained equipment.

Requires Improvement

Is the service effective?

Our findings

When we asked people if they thought the staff had the appropriate skills or knowledge to deliver an effective service, the feedback was very positive. We were told by one family member, "I'm confident of the abilities of the staff." A person who used the service said, "Oh yes, they know what they're doing".

On the day of our inspection the regular cook was not on duty. Our observation of the lunchtime meal showed that many people did not eat the main course. On the day of our inspection, we saw that beetroot was placed on every plate irrespective of whether the person liked it or not. One person had their meal in front of them for two to three minutes and then asked staff for one without beetroot. The plate was then removed but was given to a person on another table. The atmosphere in the dining room was very sombre. No music was available in the room although a radio could be heard in the kitchen which was set to a local commercial radio station. We did not see any available adaptive cutlery and saw that some people struggled to cut their meals. We did not see any alternatives offered to people who had not eaten their meal. Plates were just removed after they had been asked, "Have you finished?" At least two residents had only eaten a mouthful of food.

Staff did not appear to be aware of what the meal was. One person asked a staff member what it was and was told, "No idea, it might be stew?"

Staff appeared to be task orientated and did not appear to use their initiative to support people. During our observation of meal time people were not all seated prior to lunch commencing. Three people came to the dining room after the main course had been served. One of these was mobile and independent but the others were assisted to the dining room in wheelchairs. Little or no interaction was observed between the members of staff and the people they were settling into the dining room. We asked one of the wheelchair users if they had been offered the opportunity to wash their hands prior to being brought into lunch and they laughed saying "You must be joking".

There were only two members of staff in the dining room. One was occupied assisting a person with their lunch and the other served meals and removed dishes following the meal.

The member of staff assisting the person with lunch was observed to be very caring and interacted with the person throughout the meal and they took their time with the task. They informed us that this was the first time they had worked at the home, and said, "It seems to be very disorganised. I expected to stay on one floor to provide care but have been sent all over the place to help several members of staff. There doesn't seem to be a clear routine".

There was mixed feedback from people regarding the food the home provided. One person said the meals were, "Alright", and another said there was, "No choice, don't know why we have a menu; its always the same". We observed one person sending their meal back as he had been served roast potatoes. He said he couldn't manage them and, "Just wanted mash". He said he asked for mash every day but never got it. His meal was returned to him with the roast potatoes mashed up. Another person told us that they asked for

changes to the meat at mealtimes and it was catered for A third person said, The food is ok, if I don't like it then I don't eat it".

Files containing the food charts were brought into the dining room and placed on a table in the corner. We asked a member of staff why they were there and she said it was so she could note what people had eaten at each meal. We returned to the dining room mid-afternoon and saw there was another member of staff with the charts which were still on the table. None of the charts had been completed.

We were told by staff that at weekends the staff who delivered the care were responsible for the afternoon meals as there was no cook available from 1pm. This limited the food options available to people as this was an additional duty which care staff had to carry out.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff stated that they had been given an induction programme on appointment and did have access to training. We saw that staff were mentored by the dignity champion of the home who had devised and implemented an induction notebook for new staff. We noted that staff had attended a variety of training that included first aid, fire training, dementia, and safeguarding. We also saw the training plan for the coming year. We looked at training records which showed 12 staff either had or were working towards their Health and Social Care Diploma Level 3 and 11 staff either had or were working towards their Health and Social Care Diploma Level 2. We spoke a staff member from the provider's human resources department who told us that all new staff were registered for the new Care Certificate, which was accredited by 'Skills for Care'.

We saw evidence that staff received appropriate appraisal and supervision. This included both individual and group sessions. We saw this was recorded in staff files and was also discussed with individual staff members who confirmed they had received supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. It was clear that the manager had a full and detailed understanding of the MCA and its application. We saw that although some people had received a mental capacity assessment and the home had followed the appropriate procedures to apply for DoLs, this had not been carried out for all the people who required it. This was discussed with the manager who assured us that this was to be actioned as a priority.

At the time of inspection we saw that there were five bathrooms, but two were out of commission and two were awaiting new bath chairs. We saw that 14 bedrooms were en-suite which meant that the one bathroom available for assisted bathing was for 23 people. Staff informed us that there were no facilities to offer a shower to residents as the shower was inaccessible. This meant that as bathing took place in one bathroom this was very time consuming and staff were not able to bathe as many people as they would like each day.

An alternative bed bath was offered.

Good

Is the service caring?

Our findings

Responses from the people who used the service indicated that the staff were very caring and all of the people we spoke with described the care they received as good, very good or excellent.

People's comments included, "I'm very satisfied with the care" and "The staff are absolutely fabulous". Another person who used the service told us, "We have a laugh, there's no shouting".

Relatives views of the care provided were positive and one relative told us, "Yes, they are very in- tune with [name], they have picked up on [name's] sense of humour". Another relative told us, "They've been brilliant".

We asked people whether staff showed people respect and whether they protected their privacy and dignity and told us that staff did. People also agreed that they were supported to be as independent as possible. One person said, "I can have help if I need it".

We observed staff throughout the day interacting with people who lived at the home and saw that they were respectful, pleasant and patient.

Some interactions were noted which showed that the staff had good knowledge of the peoples preferences, however some staff appeared to be task orientated. We were told by one person "They [staff] are always very busy running around".

The home had completed the "Six Steps" programme with the focus of this being care in the last six months of life. We were told by relatives that their family member was very well looked after and that the staff always attended when pressure area care or other care was needed. They also told us how the staff ensured the dignity and privacy of their relative throughout the care being delivered. We were shown an example of staff going 'the extra mile' for the relatives, as we were told that staff had offered to give lifts for those family members who were having transport problems so they could visit their relative. We also saw there was opportunity for relatives to stay at the home if this was needed.

We looked in the entrance area for any information about the home. The manager showed us the 'Residents Guide' that was available for people and families which was kept on a small table at the entrance of the building. We found that this difficult to find for a visitor who wanted to know any information. The manager was also able to how us a booklet they had made available for families about the Deprivation of Liberty Safeguards.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with said that the care provided was personalised. People told us they were able to choose what time they went to bed at night. Visitors said they were involved in their relative's care, had been involved in an initial assessment and were informed of any changes, however some they told us they did not know about care plans and had not seen them.

We saw that care plans were reviewed and updated on a monthly basis, however those we examined appeared to have been completed 'by rote'. We saw that the care plans were in the process of being audited. We noted that some Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not up to date. Two of these documents did not reflect the correct care setting. When reviewing the care plans we saw that not all contained a "This is Me" booklet.

We saw that there was frequent use of abbreviations which could be misinterpreted. An example of this was the use of the abbreviation, 'levo', rather than the full name "levomepromazine" which we saw was noted on several sets of care notes, this abbreviation could have meant something different such as levothyroxine. We noted that there was conflicting information about the frequency of administration of medication. An example was that one page in the care notes stated to stop one particular drug whilst the next page stated to increase it.

We asked people about the social activities provided and people told us they enjoyed the activities provided. A programme of activities was put on the day room wall but most due on the day of the inspection, were not taking place, apart from a church service on the afternoon of the inspection People who attended appeared to enjoy it. We saw that each person at the home had completed an activities survey which noted their likes and dislikes.

People we spoke with were able to name members of staff who would they would speak to if they had any concerns, these were mainly the manager and the team leader.

We looked for a copy of the home's complaints procedure, a copy was found on a noticeboard by the dining room. This may have been difficult to find for a visitor who wished to make a complaint.

We saw records of complaints received in 2015 which showed that people knew how to make a complaint. Complaints had been investigated and the records included any action plans that had been put in place as a result of the complaint.

We observed an interaction between nursing staff and an occupational therapist which showed that the staff had excellent knowledge of the people in the home and that they were committed to the best outcome for an individual.

We also observed how the staff team dealt with a situation when the lift broke down in the morning. We saw how the staff ensured that the people affected were still able to eat together, this meant that they minimised

the risk of social isolation.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in place. The service had been without a registered manager for several months and had tried to recruit one. There was a temporary manager in place who had previously been the registered manager for the home. There was no deputy manager but the home had a team leader in post.

We asked people who used the service if they could access the manager, one person told us "If I have a problem I'd speak to manager [name] or team leader [name]".

We asked staff if they thought that the service was well led and had very positive responses about the manager. One staff member told us "They are really good as a manager, you're well supported by them", another staff member said "I'm listened to".

We spoke with the manager and the team leader and they were very transparent and told us that they recognised that the home needed to improve and that they were committed to the work required.

We asked relatives if they had been asked to complete any quality questionnaires. The majority of people said "Yes" and one relative told us, "Once or twice". We saw evidence of these but there were only a few examples available. The manager told us that they were due to be re issued to relatives and visitors.

We saw no evidence that registered nurse PIN checks had been carried out. We asked the nurses if they had been asked for their information and we were told no. This meant that there was potential risk of unregistered staff carrying out clinical tasks. This was brought to the manager and the providers attention. The provider informed us that they were going to change the system immediately.

We looked at the policies the home including health and safety and we saw that they were relevant to the home, however it was not always clear when they had been reviewed as not all had been dated.

As the home used a number of agency staff we asked how the staff and the agency were checked and the manager was able to show us the processes that was followed to check the people who came to work at the home.

All the staff we spoke to told us how they worked as a team, this included the manager and team leader. One person told us "I think we do a good job, I've never worked in a place that's been so kind."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not ensure persons providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely Regulation 12 (2) (c). People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 12 (2) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who use services did not have their nutritional and hydration needs met Regulation 14 (2) (b).