Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Channel View Residential Care Home

317 Barry Road
Barry
CF62 8BJ

Date Inspection Completed

23/02/2023

About Channel View Residential Care Home

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	Cheerful Elegant Healthcare Ltd
Registered places	11
Language of the service	English
Previous Care Inspectorate Wales inspection	27 November 2020
Does this service provide the Welsh Language active offer?	This service does not offer an 'Active Offer' of the Welsh language or demonstrate efforts to promote the use of the Welsh language and culture.

Summary

Channel View Residential Care Home can accommodate eleven residents with personal care needs. This inspection was unannounced. Abdul Mohammed is the responsible individual (RI) for the service and there is an appointed manager who is registered with Social Care Wales, the workforce regulator, in accordance with legal requirement.

There are not enough staff to provide prompt assistance and suitable arrangements are not in place to cover the staffing shortfalls. Staff on duty are respectful and kind.
Staff training is an area where improvements are required. People's voices are not always heard, and their opinions are not always valued. Activities and support in accordance with people's interests and wishes are not identified, undertaken, or addressed.

The management team are not always visible and engaged in the day-to-day running of the service due to staff shortages. Systems are not in place to ensure the quality of the care and support provided. Care documentation needs improvement to reflect the care needs, interests, and wellbeing needs of people living at the home.

People do not live in an environment suitable for their needs and urgent improvements are required. The service requires oversight to address the hazards identified throughout and a deep clean is required throughout the home.

Well-being

Care staff treat people with respect and have good relationships. During our visit we saw staff interacting positively and kindly and people told us staff were *"very good"*. However, people do not get the care and support they need to achieve their well-being outcomes. There are currently no activities coordinators at the home and there is often not enough staff to deliver activities and events to stop people being bored and under stimulated. Staff told us no activities have taken place for several months and people told us the days are long with nothing to do apart from watch TV. People are not encouraged to make choices and their preferences are not always sought and respected.

People we spoke with told us that, although staff are kind, they sometimes had to wait a long time for assistance. Comments included *"the days are long", "I go to bed early as there is nothing at all to do here",* and *"I am not happy living here, I don't want to be here"*. We saw care workers acting kindly and with good intentions, but several staff told us they did not feel confident and competent to properly support people in an emergency. Our inspection, which was undertaken over three days, found times when people were left without safe levels of supervision and observation.

People do not always have a choice of meals and drinks to suit their preferences. Although we saw people enjoying the meals provided there has been no cook employed at the home for some time, contrary to arrangements outlined in the service's statement of purpose. There are only two care staff on duty most days who carry out the care and support required for people living at the home, all the kitchen preparation and the cooking of meals during each shift. The manager is often one of the two staff delivering care. Staff are also required to carry out the cleaning duties and laundry duties as no domestic staff and no laundry staff are employed at the home. Therefore, we observed care staff assisting with personal care needs and then carrying out cleaning and cooking duties without due consideration for the potential for cross infection.

People are not always safe and protected from harm. At various times throughout the day, we saw there were no staff available to spend time with residents for anything other than basic tasks. Additionally, we found that people's freedom and liberty was unduly restricted, due to the practices and environmental constrictions in place. We saw several alarms on people's bedroom doors and asked the manager to activate the alarm and to explain its use. The door was opened, and a piercing alarm sounded. The manager explained the alarm was used as there is *"no other way to know if a resident had left the room at night"*. We saw no evidence that applications for authorisation in relation to Deprivation of Liberty Safeguards (DOLs) had been made. It is important that there is documented evidence in place to support and rationalise decisions where peoples' liberties are restricted or deprived. We looked at staff rotas and identified only one waking staff on duty at night. This is an issue if two people required assistance or in the event of an emergency.

Appropriate recruitment checks are mostly undertaken to ensure care staff are suitable to work with vulnerable people, but we identified areas for improvement. Measures are not in place to promote good practices throughout the home and identify risk. Infection prevention and control measures need improving to ensure they are sufficiently robust.
The RI does not demonstrate appropriate oversight of the home to ensure it operates safely and in accordance with its statement of purpose.

Care and Support

Personal plans do not always reflect people's current needs and desired outcomes. We found personal plans did not always include details of people's personal preferences, and when included these preferences are not valued and respected by staff and management. Further consistency in signing care documentation is required by staff to confirm they have read the documents to provide meaningful care and support to people. People's individual needs do not always reflect their personal plan, and care and support are not adapted to their situation. Risk assessments do not identify people's particular vulnerabilities and strategies for protecting them. This was acknowledged and noted by the manager. We expect the service provider to take action to address this issue and we will follow this up at the next inspection.

People have access to health and other services to maintain ongoing health needs and we saw appropriate referrals had been made to GP and other visiting health and social care professionals. We saw referrals were made in a timely manner whenever people's needs changed, a request for GP was made during our visit for one person who was feeling unwell. When required, care staff mostly support people to access medical appointments, however staff told us this is always difficult due to only two care staff being on duty during the day.

People do not have opportunities to engage in leisure and social activities to promote their emotional wellbeing. Staff told us that no activities had been taking place for several months and there had been no activities or entertainment carried out over the Christmas period. The low staff numbers meant that there was no time for meaningful conversation with residents throughout the day. We saw people sitting in the lounge areas, sleeping, watching TV and who told us they were *"always bored"* and *"every day is the same".* Care files did not contain any reference to activities carried out or details for any future activities planned. The manager agreed that a designated person responsible for co-ordinating activities and opportunities to occupy and engage residents would be a welcome feature at the service. Staff told us they cannot always respond promptly to people's needs and help them appear clean and well-groomed due to low staffing levels and lack of time.

We discussed staffing levels with the RI at the inspection visit who told us they would increase staffing to three care staff throughout the day. We conclude that people are not always given reasonable opportunities to be involved in making choices and decisions that may affect their quality of life and promote their rights.

We have issued a Priority Action Notice regarding staffing arrangements at the home and expect immediate action to be taken.

Environment

People cannot be assured that they live in a safe environment that meets their needs. We found there are areas of the home which are cold with no heating, this included the downstairs quiet room and several bedrooms. We saw several people remained in their bedrooms during the day who told us they are cold. We saw one questionnaire, carried out in December 2022, identified one person's window to be faulty which resulted in a cold draught coming into the room. Despite being identified several weeks previously, no action had been taken until we highlighted this to management during our visit. The person had been attempting to stem the cold draught with curtains and the room felt extremely cold. No arrangements had been made and no efforts apparent to address the situation with any degree of urgency, on the part of the provider.

Management does not oversee the home's health and safety requirements. We saw a shower door panel broken which remained in the person's room propped up against the wall with the metal strip causing a further hazard should someone walk into it. The provider has not addressed hazards caused by storage of hazardous fluids and communal items throughout the home. Channel View received a schedule of works from the South Wales Fire Service in February 2022 identifying works required to be carried out as soon as possible. Despite this, the provider could not tell us what works had been undertaken or whether works were complete.

During our tour of the home, we identified further hazards which included fire exit doors obstructed by items, which included a washing machine and tumble drier. Further concerns were identified with the key locking system of the front door in the case of an emergency. Some staff working at the service told us they are not confident of the evacuation procedures in place which puts people at risk in the event of a fire. Such were our concerns that we made an immediate referral to highlight the risks to the South Wales Fire Service.

Channel View does not have appropriate infection control measures in place to reduce and prevent spread of infectious diseases. We saw communal items throughout the bathrooms and prescribed topical creams. The manager told us there are no maintenance persons employed at the home, therefore no routine checks are being carried out on water temperatures, call bell checks or checks for Legionella management.

Confidential care files are not stored appropriately and securely in lockable areas and are easily accessible.

We conclude that the environment does not safely meet the needs of the people living at the home and requires further improvement to demonstrate that it is properly safe and fit to accommodate all residents living there.

We have issued Priority Action Notices to the provider regarding the issues identified and expect immediate action to be taken.

Leadership and Management

People cannot be assured that the service has safe or effective leadership and management. People and staff have access to information. A statement of purpose (SOP) is available but the vision it portrays is not accurately reflective of what people living there experience.

Some staff recruitment files are not kept at the service and, despite our request for four staff files to be made available on several occasions, we were provided with three. We identified from staff recruitment files that improvements are required. This area will be followed up again at the next inspection.

People's needs are not always met in a timely and responsive way despite the manager working additional hours on top of their contractual hours to ensure documentation and office work is complete. The manager told us they are not supernumerary and are required to carry out the cooking and general duties. They are not working in a managerial role most of the time, but as the second member of care staff on the rota which is completed by the RI. The manager is visible at the home on a daily basis and described by staff as *"supportive".*

Systems are not in place for the provider to monitor the quality of the service on an ongoing basis, to develop and improve the outcomes for people who live at Channel View. We looked at the last quality assurance report dated April-September 2022. We saw no evidence that referred to the service, no analysis of data and no auditing and interpretation of falls, incidents or accidents at the home. Questionnaires had been completed for people living at the home but did not contain the name of the person completing the form or any action taken if any issue was highlighted. We discussed the manager's supervision carried out by the RI who told us supervision had not been carried out only *"informal chats".* The last recorded supervision on file was dated 2015.

People cannot be fully assured that staff are competent to undertake their roles. We did not view any training records during inspection and staff told us all training carried out has been undertaken online. Staff told us they had not received any practical Manual Handling training and told us when a resident had sustained a recent fall, they contacted the RI at home to assist. Staff also told us they do not feel confident in the administration of medication. We discussed this with the RI who told us they provide online medication training for all staff and undertake further training with staff in medication administration themselves.

The provider does not always demonstrate that they consistently act with due diligence and care. They do not demonstrate a clear understanding of their duties, responsibilities and accountabilities and do not ensure effective systems are in place, reflective of their statement of purpose and intended operation.

We have issued a Priority Action Notice regarding the issues identified above and expect immediate action to be taken.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
57	The provider has failed to identify potential risks and hazards which may affect the safety of people living at the service.	New
56	The service provider must have arrangements in place to ensure satisfactory standards of hygiene in the delivery of the service.	New
34	The provider has not ensured that at all times a sufficient number of suitably qualified, trained skilled, competent and experienced staff are deployed to work at the service.	New
6	The provider has failed to review their governance and oversight arrangements to be satisfied that the home operates safely and effectively for the individuals receiving care and support	New

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
N/A	No non-compliance of this type was identified at this inspection	N/A

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