Care Quality Commission

Forest Pines Care Limited

Chelmer Valley Care Home

Inspection report

41 Main Road,
Danbury,
Chelmsford,
Essex,
CM3 4NG
Tel: 01245 443680
Website: forestpinescare.co.uk

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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 24 and 26 November 2015 and was unannounced.

Chelmer Valley Care Home, previously known as Broomfield Grange, provides accommodation for up to 140 people who require nursing or personal care. There were 56 people living at the service at the time of our inspection and the service was only occupying two floors of the property. The ground floor was designated for people with nursing needs and the second floor for people who required personal care and did not have nursing needs.

The provider's registration required them to have a registered manager in post. At the time of the inspection there was not a registered manager in place. 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'.

Summary of findings

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. We were told that the provider was actively recruiting for a registered manager. In the absence of a registered manager, the service was being run by a team of three regional managers. The on-going changes in management had resulted in a service which was uneven and unsettling for people, their families and staff.

A range of quality assurance systems had been put in place within the last year and these were effective and thorough, however time was still needed to measure whether these measures and improvements were sustainable.

The service had put appropriate systems in place to keep people safe however not all staff were following the guidelines when supporting people. People were not always treated with respect and their dignity, privacy and choices were not consistently taken into account. Some staff focussed on the tasks being carried out rather than on the people they were supporting.

Staff supported people to have sufficient food and drink; however they did not always offer choice and made assumptions about what people's preferences were. Whilst people were supported to maintain good physical health and access health services, staff did not always make necessary referrals in relation to people's mental health needs.

Assessments and care files contained all the necessary information about a person's physical health however staff did not always have sufficient information about people's social care needs.

There were enough staff with the skills and experience to care for people in a safe way. Staff were recruited safely in line with the requirements of current legislation. The provider had suitable arrangements in place for the management of medicines and people received their medicines safely.

Deprivation of Liberty Safeguards (DoLS) had been appropriately applied for people who required them. These safeguards protected the rights of people who used the services and who did not have capacity to make their own decisions. Appropriate assessment and authorisation by professionals had been completed, where best interest decisions had been taken regarding any restriction on people's freedom and liberty. This ensured that decisions were taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice.

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

Summary of findings

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 consistently safe

Staff did not always follow guidance which was in place to keep people safe.

There were enough staff to keep people safe and meet their needs.

People received their medicines safely and as prescribed.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were supported to eat and drink sufficiently; however staff did not consistently offer choice and people did not always have a positive experience at meal times.

People were supported to maintain good physical health; however staff did not always support them in addressing mental health needs.

Where a person lacked capacity there were correct processes in place so decisions could be made in the person's best interests. The Deprivation of Liberty Safeguards (DoLS) were understood by staff.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff did not consistently treat people with compassion.

Staff did not always support people to maintain their dignity and privacy.

Is the service responsive?

Requires improvement

The service was not always responsive.

Assessments and support plans focussed on people's physical needs and did not support staff to meet their social care needs.

People's concerns and complaints were investigated and responded to promptly.

Is the service well-led?

Requires improvement

The service was not consistently well led.

There was no registered manager in post.

The current management was focussed on improving the service people were receiving, however the managers in post were temporary and any improvements were not firmly embedded.

The systems for assessing the quality and safety of the service were proving effective, although these had only been established within the last year.

Chelmer Valley Care Home

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 and 26 November 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor who was a qualified nursing professional.

We reviewed all the information we had available about the service including notifications sent to us by the provider. This is information about important events which the provider is required to send us by law. We also looked at concerns we had received. All of this information helped us to plan what areas to focus our attention on for the inspection. The provider gave us a list of professionals who we could contact to seek their views of the service after the inspection.

During the inspection we spoke with 20 people who lived at the service and five people's relatives and friends. We discussed the service with three health and social care professionals and received a number of written reports.

People who used the service had a range of different needs and ways of communicating their needs. We therefore used informal observations to evaluate people's experiences and help us assess how their needs were being met. We observed how staff interacted with people and with each other. We spoke with the three regional managers who formed the existing management team at the service. We also met with the Operations Director, and 13 housekeeping, activities, care and nursing staff.

We looked at fifteen people's care records and examined information relating to the management of the service such as recruitment, staff support and training records and quality monitoring audits.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe at the service. One person told us, "I feel very safe living here, I am well looked after, they keep me well protected I can tell you." A person's relative said, "My [relative] is safe here, safer than at home, and I can go home knowing that which is the main thing for me."

We saw that staff had completed assessments to measure risk for each person and plans were put in place for them to be managed safely. These risks included where people might need to use a hoist or to be assisted to move and care of their skin. People and their relatives were involved in decision making about risks to their health and wellbeing. We noted however, that many of these assessments had been completed recently and were not yet fully embedded in staff practice. We became aware immediately prior to our inspection of an incident where a person had received an injury when receiving support from a member of staff. It was clear from investigations which had taken place, that correct risk assessments had been in place; however they had not been correctly followed by the member of staff. The manager had responded swiftly in dealing appropriately with the member of staff involved and arranging for additional guidance and training for all other staff. The manager had demonstrated a commitment to putting measures in place to minimise the risk of a similar incident occurring in the future. We were also assured that the improvements being implemented were effectively addressing issues of safety across the wider service.

Where people were being cared for in bed, there were appropriate measures in place to meet their needs and promote their safety. Staff completed daily progress notes, and associated welfare checks and re-positioning charts were filled in correctly. We noted for example, one person had an air mattress and a sensory mat in place, and to minimise risk of pressure sores, there were thorough assessments and wound care plans in place. Advice on care had been sought from a local hospice and the person had recently been reviewed by the GP.

The environment was safe for people to explore different areas and to use the dining room and lounge areas. Personal evacuation plans were in place. We observed that staff supported people to walk and move around the building safely, maintaining their independence through prompts and encouraging words whilst they were walking.

The provider had a safe system in place for the recruitment and selection of staff. We looked at staff files and saw that these were all being reviewed by the new management team and checked for gaps or possible issues. Where nurses were employed, their pin numbers were checked to ensure that they were suitable to be employed. Staff told us that they had only started working at the service once all the relevant checks had been completed.

There were sufficient staffing on the day of our visit to meet people's needs. We saw that staff were not rushed and assisted people in a timely and unhurried way. One relative said, "It feels a bit better here now that they have a few more staff around." Another family member told us, "The on-going use of agency staff who do not know people's needs is a worry… seeing so many different faces around is off putting and makes [relative] distressed." We discussed this with the managers who told us that the provider had recently increased the hourly rate to help improve recruitment and retention and reduce the necessity for agency staff. In the meantime, the manager was improving the flow of communication between staff, through improved care planning and information sharing. We observed the manager shadowing a handover meeting to ensure staff were correctly sharing information with their colleagues. Staff also told us that there had been a recent increase in staffing which had helped with managing workloads.

Staff understood how to protect people from harm and how they would deal with any concerns should they hear or see any abuse taking place. They were aware of who to speak to, should they have any concerns. The manager understood their responsibility to report concerns to the local safeguarding authority for investigation, and to CQC. This was evidenced by the records we held about the organisation. There was safeguarding information available for staff and others to refer to, which included the local authority safeguarding information team contact details. The management team told us they were committed to enforcing a culture where people's safety was a priority. Staff had to complete forms daily to report on any changes which might indicate areas of concern, for example unexplained bruising. The reports were compiled and examined daily by the manager to enable them to address areas of concern. We observed a member of staff record that a person had bruising on their arm, which was found to be as a result of recent blood tests.

Requires improvement

Is the service safe?

Medicines were given to people in a safe and appropriate way. We observed a senior member of care staff carrying out the medicine round and they were competent at administering people's medicine. They did this in a dignified manner, speaking to people about what medicine they were having and supported them in taking it.

There were appropriate facilities to store medicines that required specific storage, such as medicines that required to be kept in a fridge. Medicines were safely stored and administered from a lockable trolley. Records relating to medicines were completed accurately and stored securely. People's individual medicine administration record sheets had their photograph and name displayed so that staff could identify people correctly before giving medicines to them. This minimised the risk of people receiving the wrong medicines. People were asked discreetly if they required any pain relief. Where medicines were prescribed on an as required basis, clear written instructions were in place for staff to follow. This meant that staff knew when as required medicines should be given and when they should not.

The member of staff administering medicines told us, "I can't rush it as I have to do it as carefully as possible." We observed that where a person initially refused their medicines; the staff member took time to consider all the different reasons for their refusal, for example checking their blood sugar level and chatting with the person until they felt able to accept the medicines.

We noted that staff referred to a board in the nurse's office which listed when dressings were required, and details around catheter care and pain relief patches. The office was kept locked when not in use, to ensure confidentiality. This positive initiative was introduced by a staff member who said the current managers were keen to promote new ideas which would improve people's safety and care.

Requires improvement

Is the service effective?

Our findings

People told us staff supported them to meet their needs and family members said that although there had been issues, the service was improving. A relative said, "The staff…look out for my [relative]." Whilst we observed some high quality care being provided, not all staff had the necessary skills required to provide consistently effective care.

Managers carried out observations to assess whether staff were providing good quality care, however did not consistently act on the findings from these observations. We examined the records related to a member of staff we had observed and found that their manual handling practice had been highlighted by a previous manager as requiring improvement, but there was no record of any action. On further inspection we found that the member of staff had not attended their mandatory manual handling training. We raised this matter with the manager who took immediate action and re-assigned the member of staff. They also removed another member staff who had also not undertaken all of the necessary training.

In our discussions with the manager we were assured that they had put measures in place to resolve the concerns we had raised. We were shown a training matrix which showed that in the future all new staff were now being given the mandatory training in advance of providing support to people. Staff told us that the training which was in place supported them to develop their skills. A member of staff responsible for supporting people with their health needs told us they had received high quality training since starting at the service, for example they had attended courses on the use of syringe drivers and PEG feeding.

Staff received on-going supervision and told us they felt supported by their team leaders, who were a consistent presence through the changes in management. Issues of poor practice were picked up but some suggested actions were not followed up, for example a manager had suggested a member of staff went on dignity training but had not followed up this recommendation. We found evidence that the new management team were being more proactive in relation to ensuring staff had the necessary skills. A recent audit of care plans had determined there was not sufficient guidance to staff on whether a person should be resuscitated and that staff needed to better demonstrate how decisions were reached in this area. The managers and staff had reviewed the guidance and put safer and more robust processes in place.

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. Staff had a good understanding of Mental Capacity Act (MCA) 2005 and DoLS legislation and new guidance, to ensure that any restrictions on people's activities were lawful. Records and discussions with staff showed that they had received training in MCA and DoLS and they understood their responsibilities. Whilst the necessary paperwork in place in relation to people's capacity to make decisions and some staff had a good awareness in this area, we observed that other staff did not consider people's capacity to make decisions. For example, they were observed making assumptions about the food people wanted to eat or where they wanted to sit during the day.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People who could not make decisions for themselves were protected. The manager had made Deprivation of Liberty Safeguard (DoLS) applications for people living at the home, for example one application related to a person being restricted from leaving the building unattended. They were waiting for the outcome of the applications from the local authority.

When new people came to the service they were asked about their food likes and dislikes however there was limited involvement from people in helping create the

Requires improvement

Is the service effective?

menu on offer. We spoke to one person who told us they saw the chef regularly who enquired about quality of food, they told us, "The food is good and the chef often pops in to check how pleased I am with the quality of food. I can request particular food which I like such as pasta." However, there did not seem to be processes in place to ensure people across the service were involved and informed about food. Menus were in very small print and appeared to be written for staff and were not used to support people with dementia to make informed choice about food, for example pictures were not used to aid communication.

People were not consistently given a choice about what they ate and drank. We observed people in certain lounges were only offered blackcurrant juice to drink, although a selection of cold drinks was offered in other parts of the service. People were given a biscuit from a variety tin but they were not given a choice of which biscuit they might like. We were also told by a health and social care professional that they observed staff placing vegetables on people's plate at lunchtime without telling them what the vegetables were or offering any choice. We did observed some staff offering people a choice, for example, one person asked for orange and apple juice to be mixed and although the member of staff remarked that this was an unusual choice, they gave the person what they had requested.

People's experience of meal times was variable. When we asked one person what they were having for lunch, they replied, "It's probably meat and two veg again." In one of the units we observed that the delivery of the meal at lunch time was noisy and uncoordinated. People were asked by three members of staff at different times what they wanted to eat and so appeared confused. We observed a staff member attempt to assist a person to eat without their consent. The member of staff said, 'I'll help you with this' and put a spoon in the person's mouth without any discussion with them. The person still had a mouth full of food which the staff member had not noticed. There was no apology by the staff member or any recognition that the person had not been supported in a dignified way. This incident also highlighted a lack of awareness in relation to the risk of choking when supporting a person with eating.

People's needs and preferences were not consistently taken into account in the décor of the building. Whilst the environment was safe we noted that corridor wall art was minimal and there were limited attempts to create a sensorial or stimulating atmosphere. In particular, there had been limited attempts to create an environment which supported people with dementia needs, for example through colour choices on the walls, or reminiscence displays.

People's fluid and food charts were completed so that their intake could be monitored to ensure they were hydrated and any weight loss or gain could be monitored and reviewed. Whilst the checks were detailed and regular, there was a focus on whether tasks had been completed rather than how the task had been carried out. Plans were in place for people who had experienced weight loss, for example people might have cream in their porridge. We saw that staff made sure there were regular snacks available for a person who had lost weight.

People were supported by staff to have access to healthcare professionals to meet their physical needs. We saw that referrals had been made for people who required input from a GP and district nurses. For example, a member of staff explained that they were referring someone to their GP because they were refusing to accept help with a health condition. We saw that people had involvement from a wide range of health and social care professionals such as occupational therapists, dieticians, speech and language therapists, social workers, opticians and dentists. We noted that where staff had concerns over a person with leg ulcers, a referral had been made to the tissue viability nurse and the GP was also actively involved.

Whilst staff were pro-active about referring to professional when they had concerns over people's physical health, where people had mental health needs there was less involvement from external health professionals for advice on either diagnosis or managing behaviour. This meant that staff did not have access to information to help support people and meet their needs in a holistic way.

Requires improvement

Is the service caring?

Our findings

People told us the staff were nice to them and treated them well. One person said, "The staff are very kind and caring. Most of what I need is here. I don't need a lot and am satisfied with my lot." Another said, "The staff here could not do any more for us, they are wonderful." However, whilst some staff treated people with kindness, we observed that staff did not always treat people with compassion and respect. Improvements were needed as people could not be confident that they were going to receive a caring response from all staff. For example, we observed a member of staff telling a colleague to, "Put them in the lounge," when referring to a person being assisted after breakfast. Another staff member told their colleague that a person who was confused, "Hasn't got a clue". These conversations took place in front of the people involved and did not demonstrate a respectful attitude.

Not all staff sought people's consent before providing care. For example, we observed that staff did not always give people sufficient time to make a choice about what they wanted to eat or where they wanted to go. We observed that people were not always communicated with effectively. Some staff spoke to people at the side of them so people could not hear staff or see their faces and so did not know what they were being asked. Staff did not always use people's names to get their attention or to engage with them so people did not know they were being addressed and so were not able to respond.

Some staff were very focused on the task in hand and did not check with their colleagues or the people they were caring before providing support. We saw a member of staff discuss with a person whether they wanted an apron on at lunch. They said they did not and agreed with the member of staff to leave it nearby in case they wanted it later. A few minutes later another member of staff came in and put the apron on the person without consulting them, which meant the person's views were ignored. In one lounge, within twenty minutes of people having their drinks given to them, another member of staff entered the lounge and proceeded to offer more drinks. Whilst some people were able to refuse, a person could not communicate verbally with the staff and so was supported to have another drink. When we discussed this with the managers we were told that staff had been asked to be particularly vigilant about giving people enough to drink. There seemed to be a lack of awareness about the impact on people when staff were so focussed on the task in hand.

People were not always treated with dignity and staff did not always maintain people's privacy. We observed staff clustering around the door of people's rooms during a staff handover. There was a discussion about the person inside and no evidence that staff were aware of the need to maintain confidentiality. At one point, another person accompanied the staff on their round, and although staff were being friendly and welcoming, we felt that this invaded people's privacy.

On another occasion, a person was told by a member of staff, "I am taking you to your room to change your pad." This was done in front of a number of people, including a visitor. We felt this demonstrated a lack of respect for person's dignity and privacy and the need to maintain their confidentiality. We discussed this with the manager who acknowledged that as the management team had focussed on keeping people safe and meeting their physical needs, the importance of choice and dignity had not been prioritised with staff. The manager agreed to address this in response to the concerns we had raised.

People were not consistently treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite observing some uncaring attitudes, we also observed staff treating people with kindness. For example, when we observed a staff member enquiring about how a person felt, they knew the person's family history and had a conversation about things of interest to them from their background. We saw that this exchange was warm and caring. Another member of staff described how a person had become distressed overnight so they had chatted to them and offered them, "A cup of tea and Weetabix".

We saw that some staff sought people's consent when providing care by asking them direct questions and waiting for answers. For example, we observed a member of staff asking a person where they wanted to go after lunch and with whom did they want to sit. For people who could not communicate their needs verbally, we noted that some staff understood their facial expressions and body language to make sure people's needs were met.

Requires improvement

Is the service caring?

We observed examples of where people were treated with dignity. For instance, we saw two members of staff assisting a person with a hoist. This was done in a dignified way and staff spoke to the person whilst they were using the hoist to reassure them. We observed that staff knocked on people's doors and kept them closed when providing personal care to maintain their privacy. Medicines were given to people in a discreet way to maintain their dignity and privacy.

Requires improvement

Is the service responsive?

Our findings

People told us that they felt well supported by staff. One person told us, "I am happy here; I come and go as I please." However, we found that support was largely task based and care was not sufficiently personalised to meet people's individual needs and preferences.

Care plans did not always provide sufficient information to meet people's social care needs. There was a lack of personal information about residents' lives, experiences, like, dislikes and preferences throughout the care plans. There was a personal profile for each person; however this information was brief with no more than one or two sentences describing key aspects of peoples' lives. Two people had no information written in their personal profile section. One person's assessment stated that they used to like playing records and we noted that they were not longer able to enjoy this pastime independently. However, there was no guidance to staff in the person's support plan to outline how these needs would be met within the service. Another person had said that they liked beer but the support plan did not advise staff whether they should be offered beer or an alternative, just which hot drink they should be offered each day.

Staff did not always understand how to support people when they became upset or anxious. A person was observed becoming very distressed in the dining room and the staff did not appear to know how to support them. We looked at the person's record and saw that there was not a regular behaviour monitoring chart. Whilst there were some suggested interventions such as offering 1:1 time or a drink, there was not sufficient guidance to staff in the person's records. On another occasion, however, we observed that when a person became distressed staff did know what to do to support them. Staff ensured they were in a room without a television, explaining that the lack of stimulation helped them to calm down. Staff also ensured that the person was supported by a male member of staff, as this was their preference when they became upset. This lack of consistency in the quality of support meant people could not be assured that staff would know how to support them at a time of distress.

The care and treatment of people did not always reflect their preferences. This is a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All residents had been assessed on arrival at the service and this information used to develop care plans in a number of areas such as communication, eating and drinking, personal hygiene, skin integrity, pain and end of life. Whilst the care records, initial assessments and risk assessments were thorough they were orientated towards physical health care.

We discussed our findings with the responsible manager and they showed us they were in the process of reviewing all care plans to measure the quality of the plans and make improvements where necessary. Where checks had been carried out, managers had already highlighted the issues which we had raised. We looked at a new style care plan which had been revised immediately prior to our inspection and noted that it was written in a more person centred way. The care plan was signed to show that the person and his family had been involved in developing the support plan. The manager was putting in place measures to review people's needs on an on-going basis.

Staff were also being supported to learn new skills or refresh their skills and knowledge through access to training and increased monitoring. Although there had not been enough time for to measure the impact of these improvement, the plans which were being put in place would support staff to better meet people's needs.

There was a variety of activities for people to take part in. People told us about recent events which they have been involved in such as a visit from an animal therapy group, fish and chips dinners and a Halloween party. We were shown a plan for activities throughout the week, which were shared across the different areas of the service. These included music, craft and trips out.

People were supported to keep in touch with people who were important to them. Family members told us they felt welcome to visit at any time. We observed a member of staff discussing how they were planning to make paper chains for Christmas and that they had discussed this with family members to encourage them to become involved.

Complaints were investigated and people who had complained received a personalised response. We spoke to one family member who told us that they had complained and they felt confident from the manager's response that they would address the concerns raised. In the short term, managers had addressed practice and where necessary, followed up complaints with actions, for instance where a

Requires improvement

Is the service responsive?

complaint related to one particular staff member, they had received additional supervision. In another instance, additional information about a person's needs was discussed at a staff meeting following a complaint from relatives. The lack of a consistent manager meant however, that analysis of feedback from complaints was not used effectively to ensure learning from complaints was implemented in a sustainable way over longer periods of time.

Requires improvement

Is the service well-led?

Our findings

The management at the service had changed a number of times during 2015, resulting in an unsettling time for people, families and staff. People did not really know who the current manager was and a staff member told us, "We need a manager here who is going to stay and really be here for people and the staff."

There was no registered manager in post at the time of our inspection and we were told that the provider was actively recruiting to ensure that they appointed a manager with the right experience and qualifications. Since the departure of the registered manager in the summer of 2015, a temporary Peripatetic manager had covered the post. They had also now left the service. In response to a number of concerns raised by local health and social care professionals about the quality and safety of the service, the provider had arranged for a team of three area managers to be appointed whilst more permanent management arrangements could be made. We noted that many of the changes being introduced by the new team were positive and aimed at improving the support people received. There had not however been enough time for the improvements to become fully embedded and for us to be assured that they were sustainable over time.

There were some issues with the pace of the changes being introduced by consecutive managers. Whilst this new management team was focussed and motivated, some staff did tell us they found the changes tiring. This was filtering through to people and their families. A family member told us, "The managers are failing to connect with people on the floor – they don't listen to the people doing the job." A family member also told us that with each new manager there was a new set of procedures for staff to get used to, which was causing confusion. Some staff were committed to implementing the improvements being introduced by the new management team. Other staff, however, were observed carrying out tasks or processes, without any real understanding of why they were doing these tasks and what the impact was on the people they were supporting. For example, we observed a member of staff ignoring a colleague who told them what they were wearing breached new measures introduced to reduce the risk of infection. The constant changes at management level had resulted in an uneven service for people and they could not be assured that they could receive a consistently good quality of care.

The provider did not ensure that systems or processes were established and operated effectively. This is a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new management team were committed to dealing with poor practice and had dismissed, re-assigned and retrained staff where their investigations had established that the staff were not providing care at an expected standard. As a result of this culture of improvement, the managers told us there had been a significant staff turnover and new members of staff were being appointed who were committed to the improved culture. There was some evidence staff were being encouraged to be involved in the changes, for example there were on-going meetings with staff to introduce any changes. We also noted that a member of the nursing staff had consulted care staff on the introduction of a new resident and staff allocation process, which clarified roles, for example outlining what night staff were expected to do.

The current managers acknowledged that their priority had been on ensuring the safety of people at the service and recognised that there had been less focus on ensuring the service was personalised and people's social needs were promoted. Similarly, there appeared to be limited involvement by people and their family members in decisions regarding the service. Therefore, during a ceremony to launch the new name of the service a senior manager acknowledged that there had been no discussion with the people who used the service when choosing the name. We were assured by the management team that they would be seeking to address the general wellbeing of the people at the service as part of their future plans for improvement. This process had already started, such as the recent introduction of more personalised care plans, however there was still need for improvement in this area.

We observed members of the management team carry out detailed audits of which were effective and were leading to improvements. For example, in a recent audit of care plans a manager had noted that there was no action plan in place for a person who had lost some weight and so they had asked staff to address this. Other audits were in place and were very detailed with associated actions where

Requires improvement

Is the service well-led?

necessary. Audits included checking whether wheelchairs had been maintained and that all window restrictors were working. This was an on-going process however, for example not all the care plans had been audited yet and staff needed more time to make the necessary changes in their practice in response to the improved information and guidance available.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The care and treatment of people did not always reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not ensure that systems or processes were established and operated effectively.