Guide Total Care Group Limited

Chelmer Valley Care Home

Inspection report

Broomfield Grange
Broomfield Hospital Site, Court Road
Chelmsford
Essex
CM1 7ET

Date of inspection visit:
15 June 2018
05 July 2018

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We previously undertook an unannounced focussed inspection of Guide at Broomfield, Chelmer Valley on the 2 May 2018. We carried out this inspection due to significant concerns raised about the safety of people living at the service. We inspected against two of the five questions we ask about services, is it safe and is it well led. During the inspection we found breaches of Regulation 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The service was rated as inadequate in both domains and was placed in special measures.

Due to the high level of concerns we found, we imposed conditions on the providers registration restricting admissions and requiring the provider demonstrate to us how they would address the failings we had identified.

Following on from our inspection the provider sent us an action plan, which set out what they would do to meet the legal requirements in relation to the breaches and to improve the service.

On 18 June 2018 we undertook a further inspection to check that the service had implemented their action plan and establish whether they now met the legal requirements. At this inspection we found that whilst there had been some improvements there were still ongoing issues of concern resulting in continued breaches of regulations 12 and 13,17 and 18 and an additional breach of Regulation 5. This meant that the rating for the service remains inadequate.

The inspection team again re- inspected the service against two of the five questions we ask about services: is the service safe and is service the well led.

Guide at Broomfield, Chelmer Valley is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service accommodates up to 140 people in one adapted building across five separate units, each of which have separate adapted facilities. At the time of inspection, the second floor was closed for refurbishment and the third floor which was designated for use for NHS respite beds was closed to admissions and was empty. People requiring support with nursing needs resided on the ground floor of the building. Whilst one side of this floor was to support people with dementia who also had nursing needs, we found that on both sides people may or may not be living with a dementia illness. 22 people were living on the ground floor at the time of inspection. The first floor of the service was a residential unit, split across two sides to support people who may or may not be living with dementia. At the time of inspection 19 people were living on the first floor. In total, 41 people were living at the service on the day that we inspected.

A registered manager was in place at the service. 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.

Staff had received training in how to safeguard people from the risk of abuse and the registered manager had been pro-active in identifying and reporting safeguarding concerns to keep people safe. However, following our inspection we received information that the provider had not notified the relevant authorities of additional organisational safeguarding concerns. We also found several incidents of poor practice where people were not protected from the risk of harm and additional information was received following our visit that highlighted historical and ongoing poor practices at night.

This was a continued breach of Regulation 13; safeguarding people from the risk of abuse.

Improvements had been made in terms of identifying and managing risks to people. However, information sharing about risks to people was not always accurate. This placed people at risk of harm, such as choking. People were supported to have enough to eat and drink however recording practices around food and fluid intake were inconsistent. This meant it was not possible for the service to have robust oversight of people's nutrition and hydration requirements.

This was a continued breach of Regulation 12; safe care and treatment.

On the day of inspection there were sufficient numbers of staff available to meet people's needs as the number of people living at the service had significantly decreased with no reduction in the number of staff on each shift. However, the provider had failed to meet one of the conditions imposed on their registration as was not able to provide a rationale for staffing numbers or demonstrate an awareness of the skill mix and competency of staff and how staff were being deployed. Following on from our site visit the provider also found additional evidence where staff were not appropriately deployed by team leaders at night.

This was a continued breach of Regulation 18; staffing.

There were systems in place to manage people's medicines safely. We found that the storage, administration and disposal of medicines was undertaken safely.

Staff understood the importance of good infection control practices. We observed staff using protective gloves and aprons and hand-washing before providing care and support to prevent the spread of infection.

Whilst improvements had been made in terms of monitoring the safety and quality of the service, further work was required to ensure robust oversight of the service at provider level to prevent further breaches of the regulations. An action plan was in place setting out the improvements required to ensure the safety and effectiveness of the service but many of the target dates set for completion of tasks had been missed and had been put back.

This was a continued breach of Regulation 17; good governance.

The provider failed to identify, appropriately acknowledge and adequately address concerns raised to them by staff and professionals entering the home, that contributed to the failings found. They demonstrated a lack of transparency with people living at the home, relatives and staff working at the home, which continued after the inspection in May 2018. The registered provider failed to recognise their own responsibilities to ensure the safety of people living at the home.

This was a breach in Regulation 5; Fit and proper persons: directors.

Lessons had been learned and an action plan developed for a phased re-opening of the third floor. The plan appeared robust in principle with greater consideration given to the planning and risks involved. However, it was not possible to make a judgement on the safety and effectiveness of the proposal as it had not yet been implemented.

Staff reported improvements in terms of improved morale and leadership of the service by the registered manager. The registered manager was 'hands-on' working alongside staff coaching them and leading by example. Staff reported feeling more supported and that the visibility of the registered manager and the clinical lead.

The registered manager continued to remain transparent and open about ongoing concerns at the service and alert the provider of concerns as they found. However, there was a disjoin between the registered provider and registered manager, which was not adequately addressed by the registered provider. The provider had expressed concerns about the registered managers ability to lead to the commission, but did not take action swiftly to address these concerns with the registered manager.

Despite some improvements being made the rating for this service remains inadequate and the service therefore remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Information on risks to people was not always shared or accurate.

Incidents of poor practice were observed which had not been identified or addressed.

The provider lacked awareness of the skill mix and competencies of staff who were not always well deployed; this placed people at risk of harm.

Safeguarding concerns were not always identified and reported appropriately.

Medicines were managed safely.

The service was clean and staff maintained good standards of infection control.

Is the service well-led?

Inadequate

The service was not consistently well managed.

Many of the actions identified by the provider required to improve the service had not yet been completed. This meant that robust oversight of the service at provider level had not yet been achieved.

The provider failed to recognise their own responsibilities to ensure people were receiving safe care and treatment.

There was lack of transparency and candour on the part of the provider.

The registered manager took a 'hands-on' approach and had improved leadership and communication between management and the staff team. This had a positive impact on how the service was managed day to day.

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 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.

The inspection site visit took place on 18 June 2018 and was unannounced. Following on from this we met with the provider on 5 July 2018.

Because of the size of the home and level of concerns the inspection team consisted of three inspectors. Before we carried out the inspection we reviewed the action plan that had been submitted by the provider so that we could check on the progress made with regard to making the necessary improvements to ensure people's safety.

During our inspection visit we spoke to a visiting relative and two people. We spoke with 6 staff including senior staff, agency workers and nurses, the registered manager, the quality lead and the nominated individual.

We reviewed seven people's care plans and used this information to case track people's care needs, observing the care they received, checking their daily records and staff knowledge to ensure that the care people were receiving matched their assessed needs.

Inadequate

Is the service safe?

Our findings

At our previous inspection, the service was rated inadequate in safe as we found breaches of regulations 12, 13 and 18. During this inspection we found that some improvements had been made, however the service was still in breach of the regulations. Therefore, the service remains inadequate.

During the last inspection we found that people were not always protected from the risk of abuse as many staff had not received the required training and therefore lacked knowledge on how to keep people safe from harm. At this inspection we checked what improvements had been made. We saw that all staff had now received supervision and training in safeguarding vulnerable adults and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice using the whistleblowing policy. A staff member told us, "We have recently had this training; I would go to the nurse in charge or the office; If I was concerned I would go to CQC." A senior member of staff confirmed, "I have had safeguarding training, and this was also discussed at supervision. I am aware that it is my responsibility to report incidents of abuse, to the clinical lead and, or the registered manager."

Our previous inspection also found that potential safeguarding concerns had not always been identified, reported and investigated appropriately by the provider. Poor practice had placed people at risk of harm and compromised their dignity and wellbeing. Because of the concerns found at the service, external health and social care professionals were regularly visiting the home to check that people were cared for safely. Despite improvements in staff training and knowledge around safeguarding, visiting social care professionals identified safeguarding concerns that the service had not identified or not reported using their own internal systems and processes.

In addition, whilst we found that the hands-on approach of the registered manager providing support and mentorship to staff had a positive impact on the standard of care people received, further work was still required in terms of supervision and leadership of staff to ensure consistently good practice. During our inspection we found several examples of poor practice which placed people at risk of harm. In one instance, we were advised by a member of care staff that they regularly repositioned a person who had a history of pressure ulcers using the persons bed sheet rather than a slide sheet. Slide sheets are the proper equipment to use when moving and positioning people in bed to ensure their comfort and prevent shearing which can damage the skin. We reported this to the unit lead who immediately took the appropriate action. We also saw a member of staff helping a person to eat whilst at the same time writing up people's notes. This was fed back to the quality manager as it represented undignified practice. In another example, we found that a person had been sat out in a chair for six hours despite their care plan instructing staff to ensure they only sat out for a maximum of two hours. As a result, this person's sacrum had reddened and they were then confined to their bed on pressure relieving equipment so that their skin could heal. Additional information was received following our initial inspection visit that highlighted historical and ongoing poor and neglectful practices at night which also placed people at risk of harm.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

During our last inspection we found that risk assessments and associated plans of care on how to manage those risks did not always reflect people's actual needs. The provider sent us an action plan which set out how this concern would be addressed through the allocation of suitably qualified staff responsible for reviewing each person's care plan. The purpose was to ensure each care plan provided an accurate picture of people's needs including any risks and how these would be managed.

We saw that two supernumerary staff had been allocated whose role was to review care plans and associated risk assessments for all people living at the service. We found progress had been made with only eight care plans left to complete on the nursing unit. We reviewed the information held in people's care plans and saw some marked improvements had been made. Greater consideration had been given to people's individual needs and there was sufficient guidance for staff to follow on how to manage risks. We looked at seven people's care plans and observed that the care provided in practice matched what was recorded in the care plan. We also spoke with care staff who were able to demonstrate that they were aware of people's needs and any risks and were providing care and support that matched what was described in their care records. However, we found some discrepancies between the information held in people's pen portraits (a summary at the front of the care plan which briefly highlights relevant needs and risks). This was with particular regard to people's nutrition and moving and positioning needs. For example, one person's pen portrait stated they were on a normal diet whereas in fact they required a pureed diet. This information was in the main body of the person's care plan but had not been transferred into the pen portrait. Whilst this was a concern, we checked staff knowledge, including agency staff, and found that all of the staff we spoke with were aware of the persons current dietary needs. The potential for risk remained as if staff were to refer to the pen portrait as their source of reference they would not have access to the most up to date information which would place the person at risk of choking. In the seven care plans we looked at we found seven examples where the information in the pen portrait did not match peoples current care needs.

We discussed our concerns with the provider and made a recommendation that they review all pen portraits as a matter of priority to ensure the information was accurate so that staff had the correct guidance to provide safe care and treatment.

In addition, when we asked a senior staff member responsible for care plan reviews on the nursing units how they shared information on any changes we were advised that all staff had been asked to read and sign a form to evidence they had read the revised care plans. A chart was kept which showed that only 12 staff across both nursing units had signed to say they had read the revised documents. This senior member of staff was unable to tell us how many staff worked in the nursing units, to know who had and had not read the amended care plans. Additionally, there was no testing of staff understanding of the content of the new care plans, where people's care needs had changed. Therefore, it was not clear how the provider could assure themselves that staff were being made aware and had sufficient knowledge of people's current needs.

We also found that handover sheets which are used to provide guidance to staff on people's current needs did not always contain important and up to date information about people's risks and needs. The handover sheet on the residential unit had not been updated to include people's current nutrition/dietary needs. For example, the sheet stated that one person was on a normal diet when in fact they were on a soft diet. We did find that in practice, staff were aware of people's dietary needs but once again there was the potential for risk of harm such as choking if new staff were to be employed who used the hand-over sheet for guidance without referring to the person's care plan.

We discussed our concerns with the unit manager who agreed to review and update the handover sheet to ensure it was an accurate reflection of people's needs including any risks.

We also found that the current risk assessment used to evaluate people's risk of choking was not fit for purpose. We saw that a person who's risk of choking was high had been assessed as medium using this assessment tool. This placed the person at risk of not receiving the level of support required to keep them safe. This concern was shared with the provider who agreed that a review of the assessment tool was required.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there were concerns raised regarding the quality of care plan reviews. Regular care reviews are required to ensure people's care records remained up to date and accurate. We were advised that senior staff were responsible for reviewing care plans and had received training and support to improve the process. It was difficult to assess whether improvements had been made as the majority of care plans were newly re-written so had not yet been reviewed. We did see one example where a person's care had been reviewed and found that the quality of the review process had improved. For example, previously reviews had often consisted of a one line entry stating, "no change". Whereas, now more detailed information was recorded which highlighted peoples' current needs.

Previously, concerns had been raised regarding the level of support people received from the service to prevent malnutrition and weight loss. During this inspection we reviewed the care plans for two people identified at risk of malnutrition to check that they were being supported to maintain their health and wellbeing. We looked at one person who had a history of weight loss and dehydration. Food and fluid charts had been completed and we saw that the person had consistently met their fluid target. This person had also been referred to Speech and language therapy as it had been identified that they were struggling to chew meat. In the interim the service had been pro-active and were pureeing the person's meat to support them to eat. However, this action had not been recorded on the person's pen portrait. Nonetheless staff were aware of the person's need to have their meat pureed. This person's care plan also stated that they should be provided with regular milkshakes but these were not always recorded on their food and fluid chart so we could not be sure they had received them. However, the person's weight had remained stable which suggested that they were receiving sufficient support with eating and drinking to prevent further deterioration. In another case, we found that a person's care plan held contradictory information regarding the texture of food the person required to help them eat safely. We did observe that in practice staff were aware that the person required a soft diet and we saw the person's food arrive with the correct texture.

Where people were identified at risk of not eating or drinking enough, food and fluid charts were kept to record food and drink intake. However, we found that these charts had not always been signed to indicate that they had been reviewed by senior staff to check if any action was required. In addition, the charts did not represent an accurate picture of people's food and fluid intake as when people were prescribed and administered food supplements, these had not always been added to the charts. It is essential that people at risk of dehydration have their fluid intake carefully monitored and reviewed, particularly in high temperatures.

We recommend that the service review their systems and processes for recording and monitoring food and fluid intake to ensure more robust oversight of people's nutrition and hydration needs.

Whilst improvements were required in terms of recording people's needs and the amounts of food and fluid

being given, in practice we found people's nutrition needs were being met as people's weight was stable or in some instances had increased. A senior member of staff advised us that they were now holding regular meetings with the chef to discuss any weight loss and dietary requirements. We looked at the minutes of these meetings and found they were comprehensive in detail with actions identified such as fortifying people's meals, providing additional snacks and making referrals to relevant health professionals. In addition, the service had now implemented a twice daily 'Take 5' meeting. The purpose of which was to discuss any changes to people's needs including their appetite and food intake. Any actions required were identified and then logged once completed. For example, one person had been identified as not eating their breakfast due to being sleepy. The action identified was for staff to return later and encourage to eat; the action completed and logged was that the person was awake and had been assisted to eat.

Our previous inspection identified that the provider had failed to ensure sufficient numbers of suitably skilled and competent staff were deployed to safely meet people's needs. We therefore imposed a condition on the provider's registration requiring them to demonstrate that the numbers, skill mix and competency of all staff employed met the assessed needs and managed any risks to people who used the service.

On the day of inspection, we observed sufficient numbers of staff deployed in a way that was meeting people's needs as the number of people living at the service had reduced from 74 to 40 with no reduction in staffing numbers. This meant that people were currently benefitting from a greater number of staff per person. We saw that people had call bells within reach and those that could not reach call bells were regularly checked. However, in discussions with the provider they were still not able to provide a rationale for staffing numbers or demonstrate an awareness of the skill mix and competency of staff and how these resources were being safely and effectively deployed. After our inspection we were provided with additional information from the management team that there continued to be issues around deployment of sufficient suitably skilled and competent staff at night-time to ensure people's safety and wellbeing. During spot checks at night staff had been found asleep or poorly allocated putting people at risk of harm.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The provider advised us that tools were being developed to assess people's level of dependency as well as assessing staff skills and competency but this was an ongoing piece of work which had not yet been completed. In the interim, the registered manager along with senior members of staff had been informally assessing and monitoring the skill mix of staff and making adjustments. For example, one member of staff who had been placed upstairs was brought down to manage the behaviour of a particular person who responded well to their interaction. We spoke with staff on the day shift who reported that progress had been made in terms of staff numbers and skill mix. One staff member told us, "There are enough staff at the moment, they [management] make sure there is a mix of skills and the communication between nurses and senior carers is very good." A senior member of staff said, "Prior to the last inspection in May 2018, staff were stressed, since then morale has improved. There is now better communication, staffing has improved, there is not so much agency being used, but then we don't have the third floor." All of the staff we spoke with reported that morale had improved and they felt more supported and that there had been a positive impact of less agency staff use. One staff member told us, "There is usually enough staff now, some let us down but they try to cover, the nurses and manager help if we need it. There are a lot less agency staff which helps."

Lessons had been learnt with regard to staff recruitment and the service had recently employed their own in-house recruiter to support the hiring and retention of a permanent staff group. The service had started to use social media as a way of introducing new staff to existing staff to help them settle in and feel supported. The purpose of which was to create a more positive culture to attract and retain staff.

We found that the storage, administration and disposal of medicines was undertaken safely, and in line with current professional guidelines. There were systems in place to manage people's medicines safely. Staff confirmed and we saw evidence that only the senior or nursing staff who had been trained and assessed as competent administered people's medicines. Medicine administration records (MAR) charts had been completed correctly and there were no omissions of the staff signatures. Medication administered from a locked trolley. Each person had an overview in place that included their preferences for administration. Where people were on medicines which were prescribed 'as required' (PRN) basis, for pain for example, guidance was in place as to when these medicines should be given. The amounts of loose medication was checked daily and we found that the stock count tallied up demonstrating that people had received their medicines as prescribed.

We observed that staff maintained appropriate standards of infection control. All areas of the home were clean and hygienic. Staff had access to personal protective equipment (PPE), such as gloves and aprons, when providing personal care. All bathrooms had soap and paper towels available. A nurse told us, "We have everything available and staff do stick to protocol. If I saw someone leaving a room with gloves or aprons still on I would address it straight away."

Inadequate

Is the service well-led?

Our findings

The previous inspection identified significant failings in terms of management and oversight of the service which meant the provider was in breach of regulation 17; good governance and the service was rated as inadequate in well led. Whilst we found some improvements in the day to day management and leadership of the service, ongoing concerns and a failure to meet conditions placed on the provider's registration has resulted in continued breaches of the regulations and the rating remains inadequate.

At our last inspection we found that the provider had failed to give sufficient consideration to the planning and management of risks associated with opening the top floor for the new NHS unit, for example, risks relating to staffing and monitoring of admissions and discharges to ensure people's safety. Because of the level of concerns, we had for people's safety we placed conditions on the provider's registration to restrict admissions until we could be satisfied that people would be safe using the service.

At this inspection, we were advised that an action plan was being developed, specifically regarding how to manage the NHS unit to prevent a repeat of previous mistakes. This document was later provided to us for review. We found that the action plan provided detailed planning and consideration of risks including additional safety measures to be put in place to address past failings. For example, using a phased admission process to allow staff and the management team time to adequately assess people's needs and match those needs with the appropriate levels of staff who had the necessary skills. The provider had also amended their assessment process to reflect best practice guidelines. In addition, greater consideration had been given to the timing and numbers of admissions on any given day and how people would be safely transferred in and out of the service. Whilst in principle, the proposed plan appeared robust it was not possible to assess and comment on its effectiveness as it had not yet been implemented given that the NHS unit was currently closed to admissions.

The previous inspection identified that the governance systems in place had not always identified and address the failings we found at the service. At this inspection we found this was still the case as the provider had failed to pick up on the concerns we found during this inspection as discussed in the safe domain. For example, inaccurate recording and sharing of information on risk. This meant that the service continued to be in breach of the legal requirements.

In discussion with the provider regarding their progress it was acknowledged that there was still a significant amount of work required to ensure robust oversight of the service at provider level. They told us that it was a bigger job than they first thought and an expressed desire to take the time to "get it right". Whilst the action plan submitted set out how changes would be made and by which date, many of the target dates set had been missed and been moved back which meant that many of the required improvements had yet to be implemented. The provider was also unable to demonstrate they had met one of the conditions we had imposed on their registration as could not provide a rationale for staffing numbers and skill mix and how staff were being effectively deployed.

During our last inspection we also identified a lack of involvement and inclusion of staff in the running of the

service. The provider set out in their action plan how this would be addressed through the introduction of a staff forum. However, at the time of inspection this was one of the actions that had not yet been completed as the first date for the forum had been postponed. Similarly, a relatives and staff joint working workshop which had been scheduled to involve family members in the running of the service had been cancelled at short notice due to other priorities. We were also advised that the quality lead had intended to conduct their first spot check of the service at night-time to look at safety and quality of care overnight but as this had been planned for the day we inspected, it was also postponed. When we met with the provider again on the 5th July 2018 to explore how they would continue to make improvements. They informed us that they had to change the date of the staff forum again to accommodate meeting with us.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider told the inspection team that they had concerns about the managers capacity to effectively manage the home. At the provider meeting on the 5th of July they continued to express these concerns, however, they had not addressed their concerns with the registered manager about their competence. The governance lead informed us that they had undertaken an unannounced night visit without the registered managers knowledge. They had found that one member of staff was asleep; one member of staff had been prepopulating care entries resulting in false care entries, and staff in charge of the shift had poorly deployed staff leaving one person working alone on a unit. This placed people at significant risk of neglect. Whilst the registered manager and registered provider had been made aware of the findings, these had not reported to the safeguarding authorities or notified to the commission. During the provider meeting on the 5 July 2018, this responsibility was highlighted to the provider, and a request was made for the appropriate notification to be made, however it was not received. This demonstrated that the provider did not understand their responsibility to ensure that concerns were reported.

Following the provider meeting on 5th July we were sent additional information that demonstrated that the registered manager had been highlighting concerns to the provider over a significant period of time, regarding the quality of care, the quality of staffing, including outcomes of their own night inspections when staff were found asleep. These concerns had not been reported to the commission.

We found that there had been a lack of candour at the time of the second inspection as the provider had not formally notified people or families of our previous inspection and the concerns that we had found. The registered manager and a senior member of staff told us that they had been informally sharing information about the last inspection with people and relatives. However, one relative we spoke with on the day told us they had not been informed of the outcome of our previous inspection.

The provider could not demonstrate how they included staff and senior staff such as the registered manager in planning the service. We saw evidence where concerns had been highlighted to the provider about service planning and poor care provision, however, these had not been given sufficient consideration and weight, considering senior managers clinical knowledge and responsibilities and their registration requirements. These concerns had been highlighted over a number of months.

This was a breach of Regulation 5 of the Health and Social Care Act, 2008 (regulated activities) Regulations 2014.

Despite of the failings at provider level to meet many of their targets for improvement, we did find improvements in the day to day running of the service. We saw improvements in terms of the quality assurance mechanisms in place to monitor the safety and effectiveness of the service. The clinical lead had

been given the role of completing audits to ensure more robust oversight of people's clinical needs. They completed a 'managers daily report' which was a daily audit of the service to check that people were receiving appropriate care and support and receiving their medicines. In addition, a senior member of staff had been brought in from another service to act as the 'Unit lead' of both nursing units. They told us, "My role is supernumerary, I walk the floor, carry out checks and audits and encourage improvement. It's not a quick fix, can't fix things over night, need time to change culture. Need someone who is consistent, visionary and enthusiastic, that's me, I liked it as soon as I came here, I could see the vision of how the home could be and what needed to improve."

During the previous inspection, concerns were raised regarding a lack of visibility of management on the floor. At this inspection we found significant improvements in this area. We observed the registered manager, dressed in uniform, working alongside staff, coaching them and leading by example. For example, we saw the manager and another staff member walking along singing with a person who was anxious. This helped to reassure and calm the person. Staff we spoke with told us that this 'hands-on' approach had had a positive impact on their morale and leadership of the service.

The registered manager had taken positive steps to inspire staff to take a more person-centred approach and take ownership of the service. This had been accomplished through the introduction of a core leadership group which met weekly to talk about best practice and how this could be achieved. The staff in the group were chosen for their abilities to be positive role models and support improvements in the practice and culture within the home. Brainstorming sessions formed part of the weekly meeting and the ideas that were generated were introduced around the service. For example, one of the ideas the group came up with was the introduction of pledges which all staff at the service had signed up to. The pledges were on display on each floor. Examples of staff pledges included; "Make at least 10 residents smile each day." And "Treat people like they are my mum." We saw evidence of these pledges being enacted in practice. The leadership group was also looking at ways to improve team spirit and bring everyone on board, so that all staff were on the same page. We saw that this had been effective as observed that the culture within the service had improved along with staff morale.

The quality lead for the service told us they were working at the service full-time to provide guidance and promote improvements in practice. On the day of inspection, we observed that the quality lead was visible at the service, providing support for the registered manager and supporting the staff team. This had a positive impact on staff who reported feeling much more supported and stated that the management team were far more visible and checked in with them more frequently. Staff comments included; "I like working here and management are supportive; we are doing our very best and try to provide good care." And, "I feel supported here, handover is very good and many issues have been addressed and continue to be addressed, I think people get above average care here."

Staff were also very positive about the registered manager who they found approachable and supportive. One staff member told us, "I love the registered manager, they are a good manager, if I have any problems I know I can go straight to them." Staff reported that communication had improved through the introduction of a daily meeting to share information about people and the service. One senior staff member told us, "Everyone communicates with each other, it's so much easier, we know what's going on. There is a meeting with seniors from each unit at 11 am with the registered manager every day. Any issues are discussed with the registered manager at this meeting."

Feedback we received from the quality improvement team at the local authority reported that improvements had been made in how the service was managed on a day to day basis and we saw that the registered manager had been pro-active in looking for ways to support improvement. They had read the

CQC report on driving improvement and arranged to visit other care services which had made significant improvements to seek guidance and inspiration on how to turn a failing service around.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 HSCA RA Regulations 2014 Fit and proper persons: directors The registered provider lacked awareness of their duties and responsibilities to ensure the safety of people living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not consistently well managed placing people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Lack of supervision and observation of staff resulted in failure to identify and address incidents of poor practice placing people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to identify and address failings and make the necessary improvements to ensure the quality and safety of the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider was unable to provide a clear rationale for staffing numbers, skill mix and deployment putting people at risk of harm.