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:
02 May 2018

Date of publication:
26 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Guide at Broomfield, Chelmer Valley on the 2 May 2018. We carried out this inspection due to significant concerns about the safety of people at the service from health and social care professionals and members of the public.

The inspection team inspected the service against two of the five questions we ask about services: is the service safe and is 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 a third ground floor unit had not been opened to admissions. At the time of inspection 74 people were living at the service.

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. 30 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 24 people were living on the first floor.

Lastly, the third floor had opened in January 2018 to accommodate up to 30 people being discharged from Broomfield Hospital. This was for people still requiring assessment and allocation of additional care packages, such as residential care or care at home and re-enablement care. These placements were designed to last for up to 72 hours, although could be longer depending on the availability of the aftercare needed. All 30 beds were being used at the time of inspection.

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.

We found significant concerns about the safety and welfare of people living at the service on the 2 May 2018, resulting in, multiple breaches of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. We found staffing at the service was poor and not enough staff were deployed to meet people's needs. In addition, the staff available did not always demonstrate competencies needed to support people and

some were unkind. There was a serious lack of effective leadership and oversight of staff at the service and due to the shortages, staff had not received regular mandatory training and supervision.

People were not always protected from risks of harm or abuse. We found incidents where concerns had been raised by care staff which had not been escalated by senior staff so appropriate actions could be taken. Staff told us they did not know how to report safeguarding concerns and training in this area was poor. Relatives had expressed concerns to the Commission about loved ones being left and neglected when they needed personal care needs met. During the inspection we also observed this happening. In part this was due to lack of staff, effective staff deployment and delegation of duties. Whilst the registered manager had recognised this they were unable to take robust action because they did not have effective resources or time to address it effectively.

The admission processes to ensure all information received by the service from external services did not demonstrated an accurate picture of people's individual risks, needs, and preferences. Nor were people always discharged from the service with the information needed to support successful placements. The processes in place for admission and discharge were not aligned to National Institute for Health and Care Excellence (NICE) guidance for transferring people between services. Whilst this was especially important for the third floor, we found these concerns across all units. This lack of accurate information about people's needs resulted in poor care planning that did not address people's actual risks and placed them at risk of harm.

On the nursing floor more information was available for staff but it did not always reflect people's current needs. Reviews consisted of staff writing "No change", despite other care records and observations demonstrating care needs had changed considerably. People were not mentally and socially stimulated and engaged. The culture was task led rather than person centred.

The registered manager had voiced concerns about staffing and new working arrangements with the provider's directors. Their concerns had not been appropriately addressed to mitigate potential risks to people. Despite the registered manager sharing these concerns the overall systems for governance and oversight did not support them to ensure changes could be made quickly enough to be sustained and embedded.

The provider's directors failed to mitigate the potential risks identified, whilst continuing to negotiate an additional 10 social care beds for people needing to be discharged from hospital whilst waiting for appropriate care packages. These people were accommodated across the service without adequate planning and consideration of their needs, or the needs of people who were already living permanently at the service.

The overall rating for this service is 'Inadequate' and the service is therefore 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 safe.

Staffing at the service and competency of staff employed was poor. There was little oversight, supervision or training available to staff.

Staff did not have access to the information required to support people who were vulnerable and at risk.

Staff had a poor understanding of safeguarding vulnerable adults and when concerns were identified these were not always properly shared, investigated and managed to protect people.

Medicines were not always managed safely.

Is the service well-led?

Inadequate

The service was not well managed.

Governance systems in place failed to identify failings. When they did there were inadequate actions to fully address concerns.

The providers did not safety plan for and risk assess additional pressures on the service, resulting in neglect of people living at the service and a lack of staff oversight and support.

The registered manager had little control over how the service operated and their concerns had not been properly considered by the provider when commissioning new services at the service.

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 was prompted in part by a number of concerns and notifications from the general public and other health and social care professionals.

These concerns related to poor staffing levels, neglect of vulnerable people, and unsafe care and treatment and poor dementia care. This inspection took place on 2 May 2018 and was unannounced.

Because of the size of the service and concerns raised the inspection team consisted of three inspectors, two specialist nurse advisors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert had experience of residential and nursing care homes for people living with dementia.

Before we carried out the inspection we reviewed all the notification's made to the commission in the last six months, also looking at concerns raised within a 12-month period. Whilst the provider had changed in January 2018, the care and type of service and registered manager and care staff had not.

We spoke to eight relatives and 18 people using the service to find out what they liked about the service and whether they had any concerns. We also spoke to 15 members of staff, including regular care staff, agency staff, the registered manager, and nominated individual.

In addition to this we spoke with the director of nursing at the local hospital and their quality manager. We also spoke with a visiting consultant doctor from the local hospital and a number of visiting health care professionals, including from the mental health trust and the local authority.

We spoke with 8 members of care staff, and the senior management team at the service, which included the nominated individual, the registered manager and the clinical nurse lead and team leader.

We reviewed 14 people's care plans, including two who were no longer living at the service, but about whom concerns had been raised. We used this information to case track people's care needs, speaking with them, and checking daily records and assessments to ensure that the care they received was appropriate. Because of the concerns raised we reviewed those who had the highest levels of dependency due to complex health needs.

Inadequate

Is the service safe?

Our findings

Staff did not always know what to do if one of the vulnerable people they cared for was unsafe. They did not know how to report to safeguarding professionals or escalate within the service. In some cases, they did not recognise poor practice which could be unsafe. The registered manager told us that due to staffing shortages and the high level of agency use, it had been difficult to organise staff training in this area.

When relatives, people receiving care and regular staff employed had expressed concerns about two members of staff and their treatment of people, prompt actions were not taken to safeguard people appropriately, leaving people at risk. For example one person had been continent of urine prior to coming to the service but had been placed in incontinent pads which were causing their skin to be reddened. A relative informed staff the person had requested support to access the toilet during the night but the person was told by staff, "Just go into the pad," because they were busy helping someone else. Another person receiving care had told staff they were afraid because of how a carer spoke to them. We found the member of staff received little oversight and observation of their practice and a review of their personal file showed actions taken were not sufficient to safeguard people from their poor practice. Following this feedback, the member of staff was suspended from the service pending investigation and later dismissed. The registered manager acknowledged there had been shortfalls in this case, and whilst some oversight of the staff member had taken place, they should not have been working whilst the investigation was ongoing.

A member of staff told inspectors they had informed the registered manager about another member of staff using a hoist roughly, but did not think anything had been done about it. They told us, "I was told to keep a diary." We also received information from whistle blowers and complaints from relatives informing us of poor moving and handling practices by staff at the service. Older people bruise more easily and it can be an indicator of poor moving and handling. However, these occurrences were not explored robustly enough to mitigate risks, address poor practice or escalate concerns to other professionals.

Relatives contacted the Commission to express concerns that people living on the top floor did not always receive safe care. One relative told us, "I often would come in to find [name of person] soaked in urine and calling for help. On a number of occasions, I watched staff walk straight past [person's] room ignoring them calling out." This is neglectful practice and placed the person who was at risk of pressure ulcers at risk of injury and loss of dignity.
External health and social care professionals had been on regular visits to the service to encourage improvement. They reported leadership of the nursing unit was poor. Lack of sufficient oversight resulted in people being placed at risk of being neglected.

This was a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safeguarding service users from abuse and improper treatment.

Following the inspection, the service took action to ensure that all regular staff had been provided with mandatory training in safeguarding vulnerable adults.

Risk assessments and associated plans of care were reviewed monthly by nursing staff, but they did not always reflect people's current and actual needs. For example, in one care plan a person was described as mobile with the use of a walking frame and only requiring one member of staff to support them to attend to their personal care needs. Review documentation consistently stated, "No change." However, on review of the person and in discussion with care staff we discovered the person was no longer mobilising and required a hoist with two members of staff to move them. Whilst some staff seemed to know what the persons needs were, other members of staff did not. One told us, "I've been moved down here but always work upstairs, I don't know people." The registered manager agreed this was a problem and told us care planning and reviews had become a task for busy staff to complete, rather than a necessary need to ensure care provided remained relevant to the person.

Another person's care notes informed staff they needed to turn the person every two hours due to their risk of pressure ulcers. However, staff told us they needed to be turned every four hours and turning charts showed they were turned four hourly. Another person had received bruising when receiving personal care at night and notes identified that one member of agency staff had supported the persons continence needs. However, the persons care plan stated they required two staff to support their continence needs.
The third floor was used to provide people with up to 72 hours of care when leaving hospital and moving or returning to their permanent home. We found pre-admission assessments did not always cover people's actual needs. For example, one member of staff told us, "One person came here and we didn't even know [person] was blind. We wouldn't have known unless [person] told us. It shouldn't be like that." This lack of essential information could lead to the person not receiving safe care and treatment.

People admitted to the third floor had access to hospital consultant reviews Monday to Friday, often with other health and social care professionals, to discuss the ongoing care needs. We found these reviews were informative and up to date, however the information discussed did not always transfer to the staff responsible for delivering the care. For example, staff handover sheets contained minimum information about people's needs, such as if they had eaten or had care needs met. Consequently, the information staff received, did not support them to ensure and encourage people's return to health and independence.

A member of staff told us, "Handover and hospital discharge notes don't always reflect the needs of the person which can impact on the number of staff needed." They gave the example, "Information could state that the person is independent with personal care but they are not and are at risk of neglect which means that they would need prompting and support." Another said, "The paperwork gives no evidence of what a person was able to do before they went into hospital and what we should aim for, carers get frustrated and it impacts on relative's expectations that a person can do more than they can." One staff member said, "We have had some people here for three weeks without care equipment in place.' Another told us, "We have so many complaints from relatives."

The first floor of the service cares for people living with dementia. We saw staff were told they would be receiving four additional admissions from hospital. Staff informed us they had not received any handover of people's needs or when they would arrive. Staff expressed concern to inspectors about the impact on other people already living at the service, concerned the amount of admissions would be unsettling for them. The registered manager knew about the admissions but not when they were coming or what level of needs people had. This meant they were unable to effectively plan for safe admissions in a calm and organised way which ensured people's wellbeing and consistency of care to those already being accommodated to reduce anxieties.

Because admissions and care were not managed effectively this also led to poor quality discharges. Information sent from the service to people's new care providers did not always give thorough or accurate

information about needs and preferences. Staff and management were not aware of nor were they following NICE guidance; (National Clinical Centre of Health and Social Care Excellence, discharge planning).

We observed a member of staff who did not know a person's needs was assigned to serve lunch. However, a regular member of staff had to intervene because they had dished up a regular meal for a person who required a soft diet due to risk of choking. In another case, the staff member served meat for a person who did not eat it due to their religion. We reported this to the registered manager and the provider.
A number of people staying on the top floor had received surgery for hip replacements and were living with dementia. One person had a leg cast on and could not weight bear but was unable to remember this due to their dementia. No risk assessments had been carried out to identify risk of falls or how the person should be supported to mitigate risks of potential injury or accident. We found there had been a large number of falls in people's bedrooms but this had not been explored by staff to understand why or explore how they might reduce them.

The registered manager had attempted to make improvements to the service as issues arose. However, this was reactive and often in response to concerns raised externally. There had been little planning by the leadership team a whole to ascertain and plan for risks to the service, in particular in regard to staffing and agency use. There was no effective system for the provider to review incidents and ensure lessons could be learned and practices improved. The registered manager was aware of their responsibility to do this but were unable to due to the complexity of the day to day risk management. Without significant changes to this we were concerned risks would not be mitigated going forward, learning from incidents/accidents would not be achievable and people would remain at risk of receiving poor care which could place them at risk of harm.

This was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safe care and treatment.
Staffing available was in line with the provider's assessment of staffing needed and a dependency tool. However, all staff we spoke with said they did not have the time and resources to support people's needs. We saw people being left for long periods in their bedrooms and communal areas without support, social interaction or stimulation. One member of staff said, "Do you see any activity going on? It's always the same and I haven't time to do it."

People at the service told us staff were too busy to talk to them. One person said, "They change my pad and go." One relative said, "There are never enough staff to help people go to the toilet."
The provider and registered manager had identified that they did not have sufficient staffing to manage the complexity of needs of people admitted from the hospital. The provider told us, "Due to winter pressures some people coming to us had more complex needs than those we initially planned to manage." The provider had increased staffing to include an additional senior carer, however rotas demonstrated they were not always able to fill the additional post. This was confirmed by the senior nurse who told us, "We cannot always fill the senior carer role."

On the day of inspection, we found one person had been waiting for care support for over three hours. They had been left to sit in soiled clothing for this length of time. We found staff had responded to repeated requests by the person and their relative to be told that they were busy and would come back, and later that there were not sufficient female staff (the persons preference) to support them. A visiting health professional overheard staff talking about the poor physical state of the person and their care needs in the communal corridor and informed the inspectors. Staff told inspectors, "…[member] of staff just decided to go on a break. We haven't got enough staff." Another member of staff attempted to get help from the adjacent unit but there were no staff available to assist. The nurse in charge was present throughout these conversations

which took place adjacent to the nursing station, however did not offer help and staff did not seem to request it.

The provider' directors told us it had been the intention to open the top floor using agency staff, however they had not considered how they would be supervised and trained or how they would ensure effective oversight to ensure that staff had the appropriate competency and skill was sufficient. Some staff working at the service spoke of their unhappiness of working with such high level of temporary agency workers, who they felt did not have the same commitment to the service and people living there. One member of staff told us, "I love the work here with the residents but there are so many agency staff who come here and they do not know the residents."

We were concerned about the numbers, skill mix and delegation of staff to ensure people received the care they needed. We received a number of safeguarding alerts prior to our inspection, including concerns over management of medication and pressure area care. On two occasions an external professional discovered people had sustained pressure ulcers, yet this had not been picked up by the staff on duty. Following this the registered manager worked hard to support improvements, however some regular staff informed the inspection team that they did not feel safe working with some staff. For example, a member of staff had developed their own tool to induct agency staff, ensuring they signed to say they understood their duties. This was not part of the official induction provided by the service, but the member of staff felt they needed to protect themselves as "agency staff do not read peoples care plans." This issue was also highlighted by visiting health and social care professionals and a specialist nurse advisor for the Commission recorded, "Staff were not properly deployed."

At the time of inspection, the registered manager confirmed they continued to have concerns over the temporary agency staff competency, however, were struggling to fill care shifts to ensure that they had enough staff on duty to care for people. Although there was a system for calculating staff numbers, this did not accurately reflect the up to date needs of people, it also didn't consider some vital areas which impact people's wellbeing, including isolation, communication needs and social interaction.

At the time of the inspection the provider and senior nursing team had undertaken a large recruitment initiative to try and encourage more registered nurses and care staff to come and work at the service. This included trips abroad to recruit from other countries. Whilst this was a positive step, they had not firstly considered how to manage the poor morale, the high turnover and sickness rates of existing staff.
This was a breach in Regulation 18 of the Health and Social Care Act, Staffing.

Prior to the inspection we had received concerns around staff competency in medicine management from external health and social care professionals. During inspection we found the registered manager and clinical nurse lead had worked with nursing staff and external support to improve management of medications. This included ensuring that agency staff employed were also competent. Medicines were safely stored and managed appropriately. For people in receipt of 'as required medications' (PRN), such as pain relief, appropriate PRN plans were in place. These plans inform staff when to provide people with additional medication.

Following the inspection, the service notified us of a medication error. Whilst there was no adverse effect to the person the error had been completed by two qualified agency staff and not been identified until some hours later by another member of staff. However, we observed that the registered manager took immediate action to safeguard the person, notify the person and relatives, seek medical advice and ensure the members of staff received additional training and competency checks. This met with duty of candour requirements and promoted a positive culture of reporting and learning from errors.

Staff had access to protective wear, available for use when providing personal care, for example, gloves and aprons. We observed staff wearing and disposing of theme safely. There were appropriate bins for these items to be disposed of. Other clinical waste and soiled laundry was also managed appropriately.

Not all staff had received safe hand washing training and we noted a number of hand gel dispensers around the service where empty. These provide an extra layer of protection for staff and visitors entering the service to prevent spread of infection. Whilst this was the case, we observed that people's bedrooms and bathrooms were maintained well and were clean and free from dirt. Relatives visiting the service and people told us the service was always clean and presentable.

Inadequate

Is the service well-led?

Our findings

Providers are required to provide a statement of purpose under the Health and Social Care Act. The provider had not updated the statement to include their objectives and aims, vision and strategy following taking over the service in December 2017. There was no recorded statement of purpose for the top floor of the service where the new collaborative service between the local hospital and the care service had commenced in January 2018. Whilst planning and discussions for the new service had taken place over a 12-month period, no documentation or risk assessment had been recorded to identify risks to the service, for example, operating on temporary agency staff and how to monitor effective admissions/discharges to ensure they were safe.

The service had received significant oversight from the local authority and the health commissioning teams who had all identified concerns about care standards and staffing over a period of months. The registered manager had made attempts to improve things by engaging with the "Home life" programme, a training support for registered managers provided by the local authority to help drive up care standards. They informed us that this training had been very helpful, however they had been unable to use the learning and implement changes due to lack of regular, experienced and competent staff available, and the constant struggle to keep the service running day to day. For example, much of the registered managers time was taken up reviewing incidents and accidents. It was not clear

Some regular staff told us they were leaving or looking for jobs elsewhere as the working conditions were poor and they worried about agency staff competency. Some staff told us there were not enough staff to meet people's needs and they were unable to provide care the way they liked. Some expressed anger at how they would be moved around the service to units they did not know to support agency staff. This issue was also highlighted by visiting health and social care professionals and a specialist nurse advisor for the Commission recorded, "Staff were not properly deployed."

Staff also spoke about how some of their work conditions had changed under the new provider. For example, the provider preferred to offer overtime shifts to agency workers instead of regular staff, and overtime payments had been reduced. This made staff feel undervalued. Some care staff spoke of the lack of leadership during shifts worked, regarding qualified agency nurses on duty. Whilst some staff were supportive of senior managers, including the registered manager and clinical lead, voicing that they felt able to report concerns and these would be acted on, some staff told us that managers were not visible on the floor.

Relatives did not feel managers were visible. They told us, "No I would not know the manager here;" "I would not know the manager here never spoken to her;" "Manager have we got one here?" "No manager has ever spoken to me," and "I suggested to the manager we have a meeting as a group of family members to discuss things going on, she thought it a good idea but nothing has happened."

Governance systems in place did not always identify failings we found at the service. For example, care practices were task orientated and not person centred. The registered manager told us they were aware of

this culture at the service and had tried to change it, however, there was no evidence of how this had been done or the positive impact on people living there.

Audits had not identified that care plans for people did not capture their needs and preferences, and at times were outdated and consequently irrelevant. People did not have key workers who are a named staff designated to oversee the care for people living at the service. The registered manager told us this was because they did not have enough regular staff in place to provide this system. They had attempted to mitigate this by introducing the "person of the day" method of reviewing people's care and support to ensure one person was reviewed by the team each month. However, the benefit of this was not reflected in care plans.

These issues resulted in a poor culture of care at the service which was evidenced in some interactions between staff and people living there on the day of inspection. Evidence which was also supported by complaints and safeguarding concerns raised about individuals who had and continued to live at the service. Further evidence of this is discussed in the safe domain.

The service had discharged over 600 people during the period of January to May 2018 who had been transferred to the top floor from hospital and had engaged with people on discharge about the quality of care provided. The overall response from people had been positive. However, we observed that complaints raised reflected the same concerns that had been found at the inspection, focusing on poor communication, neglect of basic personal care needs as a result of poor staffing numbers and competency of staff. Yet meaningful actions were not taken to address these issues, for example to ensuring senior staff had proper oversight and staff had sufficient supervision and knowledge.

Staff surveys had yet to be carried out and the registered manager told us it had been impossible to arrange staff meetings as they simply did not have the staff available to attend or cover shifts. This meant the views of staff had not been sought or acted upon. They also informed us that some staff had made it known that they were unhappy with the new provider and conditions. The registered manager had begun to carry out exit interviews due to the amount of regular staff leaving. However, engagement between the staff group and service providers remained poor and consequently some staff felt excluded. Some regular staff told us they were leaving, felt undervalued, un-listened to and uncared for. One said, "I used to enjoy coming to work, I don't any more. There is no support of leadership. I feel undervalued."

Despite poor practices being identified through complaints and safeguarding concerns, the registered manager and junior managers had not provided regular supervision, training, and observations of staff. Consequently, the service failed to learn from concerns raised, and staff continued to practise without support and the necessary knowledge to care for people safely and appropriately. The registered manager had alerted the Commission and the directors of the service about their concerns over staffing and the quality of staffing at the service, and had also expressed concerns that they were unable to meet supervision and training needs due to the poor level of staffing. No immediate action was taken by the providers to ensure that these concerns were considered and assessed for impact on the people receiving care at the service.

Learning from mistakes did not always occur, for example, past actions following safeguarding concerns, such as staff to receive dementia care training, had not taken place. We found good dementia care was lacking, a concern also raised by the local commissioning group in the week leading up to the inspection. The service had also been told to provide training on management of people with soft dietary needs who were at risk of choking. This had also not occurred. The registered manager had told us they had attempted to access training but had not been offered any following the safeguarding outcome and had struggled to

get access to professionals who could help. However, they had not escalated this to commissioners as a concern, nor had they explored other additional training avenues to ensure that staff had the correct skills.

The service had worked with the local hospital to take people who were fit for discharge but required a care package. However, discharge planning from the local hospital to the services third floor was not streamlined. When the new service began in January 2018, initially the registered manager and the clinical lead were responsible for assessing every person they received from the hospital. This was on occasion high volume and had taken considerable amount of the managers time away from managing the whole of the service. This impact had not previously been considered. The providers eventually requested the hospital supported the service by introducing a discharge co-ordinator to assess people for admission to the service. The lack of risk assessment and planning in place further demonstrates that reactive nature of the service.

Despite these concerns the providers expanded their support to the local hospital to accept an additional 10 placements within the service for people who needed to be placed in residential or re-enablement care. The registered manager had expressed concerns about the contract, however, these concerns were not fully explored. On the day of inspection, as discussed in the safe domain, four people were being discharged from the hospital into these additional beds without consideration of the impact this would have on people and staff working and living at the service. The providers had not considered the sustainability of this service considering the concerns that had been raised to them about the current state of care and staffing at the service. This lack of forward planning and governance oversight of addressing known issues affecting the quality of care, resulted in people being placed at risk of harm.

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