HC-One Limited

Elmwood Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 7 and 9 March 2018. The first day was unannounced.

At our last inspection in September 2017 we identified breaches of regulations relating to safe care and treatment, the need for consent, staffing, person centred care and good governance. We rated the service 'Requires Improvement' and served the provider with warning notices for the breaches relating to safe care and treatment, the need for consent and good governance. We told the provider they must be compliant by January 2018.

Elmwood Nursing Home 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. The service accommodates up to 60 people across three floors. 45 people were living in the service at the time of the inspection, one of whom was in hospital.

The service did not have a registered manager in post. 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.

People continued to be at risk of unsafe care and treatment. Care records contained inaccurate information about people and the support they required to mobilise. Risks to people were increased by the high use of agency staff who did not know people and who were guided by inaccurate care records. Monitoring records for people at risk of dehydration were poorly maintained creating the risk that they may become dehydrated. Pressure relieving mattresses were not always set correctly placing people at risk of developing pressure ulcers.

People's rights under the principles of the Mental Capacity Act 2005 were not always upheld. Some people with capacity and the ability to speak had best interest assessments in place which stated the opposite. People's dining experience was chaotic. There was no visible coordination of staff during people's lunch. Some people sat uncomfortably in their wheelchairs throughout lunch and were not always given the right support at the right time to eat. Staff received training and supervision but their performances were not appraised. People remained at risk of receiving ineffective care because needs assessments continued to contradict other information within people's care records.

There was a significant deterioration in the quality of care people received from staff when compared to our 2017 inspection. We observed people being ignored and spoken to in an impolite manner. We saw people treated in ways that were undignified and we found that people's privacy was not always respected.

Some people's care records continued to contain errors and duplicated information preventing them from

being person centred. This included the wrong names in care records and the descriptions of the wrong person's needs. The service acknowledged that more needed to be done to make it a dementia friendly environment. There was a complaints process in place which relatives told us they understood. Where required the service was capable of providing end of life care to people and received support from specialist to do this.

The service was inadequately managed. There was no registered manager or deputy manager in post. Management responsibility on all three floors of the nursing home was in the hands of agency staff. Some agency staff were new, some worked infrequently and some did not know people well. All were guided in the delivery of care and support by care records which in many cases contained inaccurate information. Despite receiving Warning Notices for three breaches of regulation following our 2017 inspection the provider remained in breach of two at this inspection. Further, we found the provider to be in breach of a total of five regulations at this inspection. The provider's quality assurance processes were inadequate because they failed to identify and correct the shortfalls and poor practice we found.

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.

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.

During this inspection, we identified a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 safe. People's risks were increased by the provider's inaccurate care records which guided staff.

People and staff were placed at risk of injury when moving and handling by the incorrect information in care records.

People at risk of dehydration were not adequately monitored.

One person's risk of pressure ulcers was increased by the incorrect setting of their pressure mattress.

People's risks of receiving unsafe care and treatment were increased because of the high rate of agency nurses and care staff who relied upon inaccurate care records to plan and deliver care and support.

Is the service effective?

Requires Improvement

The service was not effective. People continued to have best interest assessments in place which inaccurately stated they could not communicate.

People were inadequately supported at meal times. Uncoordinated staff did not ensure people were comfortable or ate well.

People received their care from staff who were not appraised.

Needs assessments continued to contain inaccurate information that contradicted other material in care records.

Is the service caring?

Inadequate

The service was not caring. People's dignity was not always protected.

People's continence support needs were not always met in a respectful way.

People's privacy was not always maintained.

Staff did not always talk to people politely.

Is the service responsive?

Requires Improvement

The service was not always responsive. Whilst in some cases care records had improved in other cases they continued to contain incorrect and copied information.

Improvements were required to activities and the environment for people dementia needs to be met.

Relatives told us they understood the provider's complaints procedure.

The service had access to specialist support where people required end of life care.

Is the service well-led?

Inadequate

The service was not well-led. There was no registered manager in post. There wasn't a deputy manager in post.

Agency staff were in change of all three floors of the nursing home throughout the day and overnight.

The quality of people's care continued to be jeopardised by the persistent failure of the provider's audits to rectify shortfalls.

The provider sought input from external agencies and organisations to try and make improvements in service delivery.

Elmwood Nursing 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 checked 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.

This inspection took place on 7 and 9 March 2018. The first day of our inspection was unannounced. It was undertaken by two inspectors, one nursing specialist advisor and one 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.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications we received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also received feedback from the local authority.

During the inspection we spoke with five people, two relatives and a visitor. We spoke with 10 staff, the chef, activities coordinator, temporary manager, clinical lead, operations project manager and regional quality manager. We reviewed 10 people's care records including their needs assessments, support plans, risk assessments and medicines administration records. We reviewed four staff records which included details of training, supervisions and appraisals. We carried out general observations throughout the service including people's lunch time dining experience on two floors. We reviewed the provider's quality assurance audits as well as their health and safety, fire safety, food safety and infection control practices.

Following the inspection we contacted six health and social care professionals for their views regarding the service.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection of the service in September 2017 we found the provider to be in breach of regulation. This was because people were at risk of unsafe care as a result of care records containing inaccurate information. We served a warning notice to the provider and told them they must be compliant with the regulation by January 2018.

At this inspection we found people continued to be placed a risk of receiving unsafe care and treatment. Care records continued to contain incorrect information, which if followed by staff could result in harm to people. For example, we found two people's care records which stated on the front page that they required one member of staff to support them to wash and dress. However, both people's assessments and support plans stated that two staff were required to safely meet their personal care needs. This meant people and staff were at risk of injury if they acted in line with the incorrect information stated in care records. A third person who had been assessed by healthcare professionals to have Type 2 diabetes was described by staff in care records as presenting with Type 1 diabetes. People who have Type 1 diabetes are insulin dependent and require regular injections. There was a risk that incorrect information regarding this person's diabetes could be passed to healthcare professionals within transfer documentation in the event of the person being admitted into hospital. A fourth person, who was assessed to have an unsafe swallow, had care records which stated they required a "Puree diet." However, in another part of their care plan it stated they required a "Normal diet." This meant the person's risk of choking was not appropriately managed because of the incorrect information guiding staff in care records.

People who were at risk of dehydration were not always appropriately protected. We found that care records relating to people's food and fluid intake were not always fully completed. For example, one person's care record stated they received a drink of water at 06:30am. There were no further entries that day. Another person's care records stated that they received a drink at 07:05 with their next recorded drink 15 hours later at 22:00. People's fluid intake records did not contain target amounts of fluids they should be supported to consume or the calculated total amount of fluid people drank each day. Managers reviewing the care records of people at risk of dehydration could not be sure whether people had not been supported to hydrate for lengthy periods or if people received drinks which staff had not recorded. This meant people's risk of harm due to dehydration was not mitigated by the provider.

People were not did not always receive the support they required to protect them from malnourishment. We observed people at lunch on two floors on the first day of our inspection. We saw that one person who was seated in their wheelchair could not reach their food. This person fell asleep and was not approached by staff throughout lunchtime and did not eat or drink. When we asked staff if this person would be eating they told us, "Probably not. She is very sleepy." We checked the person's 'Eating and drinking care plan' which stated the person, "Needs prompting and encouragement from staff to make sure she eats all her food and to reduce the risks of weight loss."

People did not always receive practical support to eat their food. For example, one person had their food cut into small pieces in line with their care plan. However, their only utensil was a fork and with shaking hands

they struggled to get food onto their fork. This person was not offered a knife or any adapted cutlery. As a result they did not eat much food and staff did not offer any assistance. We observed another person with a large piece of liver on their fork. They were unable to cut it so had to pierce it with their fork, hold it up and eat around it. Staff did not offer to cut the meat into manageable portions to enable the person to eat safely, comfortably and independently.

The integrity of people's skin was not always appropriately protected. People at risk of pressure ulcers had care plans in place. However, people were not always supported in line with their care plans. For example, one person used a pressure mattress to prevent their skin breaking down. When we check we found this person's pressure mattress was set to more than double their body weight. This meant the bed was too firm and placed them at risk of developing pressure ulcers. Staff we spoke with did not know how to set the pressure pump for the mattress. We asked them to find out how to do this. When we checked later the settings had been corrected. Care records checked for one person who had a pressure sore showed that whilst a body map had been completed the wound had not been photographed in line with good practice.

These issues demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

There are a number of safeguarding matters currently under investigation by the police and Local Authority safeguarding team at Elmwood Nursing Home. We will not refer to them in this report because the outcome of these investigations is not yet known.

At our last inspection we found there were insufficient staff deployed to deliver people's care safely. At this inspection we found the ratio of staff to people had increased. However, we also found that the use of agency staff had increased. One relative told us, "I have an issue. There are too many agency staff. When I come in I don't recognise anyone and it's making my [family member] very confused." Another relative said, "We don't even know who cares for our [family member]." On the first day of our inspection half of the carer staff on duty were agency staff. This increased to over half on the second day of our inspection. On both days of our inspection all of the nurses on each of the homes three floors were agency staff. Our concerns regarding the provider's high use of agency staff were increased by the reliance of agency staff on inaccurate records. This created the risk that staff who were unfamiliar with people might follow inaccurate care plans and deliver care unsafely. The provider had taken action to recruit permanent staff. This included advertising and hosting an open day.

The provider followed safe recruitment procedures to assure themselves that staff were safe to work in a care setting. Managers interviewed those who submitted satisfactory applications and took up two references for those who were successful at interview. Where potential staff were appointable the provider undertook a series of background checks. These included checks against criminal records and barring lists, confirmation of address and identity and establishing eligibility to work in the UK.

People received their medicines safely. Medicines records were kept in good order and we did not see any gaps in recording. Medicines were stored securely in locked medicines trollies and lockable fridges in locked nurse's offices. We found that records were maintained of temperatures in fridges which stored medicines to ensure they remained safe. We observed the administration of medicines at lunchtime on all three of the service's floors and saw that the nurses ensured people had swallowed their medicine before signing the medicine administration record [MAR] charts.

People were protected by safe food hygiene practices at the service. Kitchen staff followed good hygiene practices to ensure food safety. Staff wore the appropriate personal protective equipment (PPE) including

hairnets, gloves and aprons. Refrigerated foods were clearly labelled with the dates products were placed in the fridge and when they must be used by or discarded. The kitchen had separate sinks and counters for food preparation and washing up. Staff wore single use PPE when supporting people with their personal care. This prevented staff from transferring any infections from one person to another where such a risk was present.

The service maintained a preparedness to support people in the event of an emergency. Staff and specialists undertook checks of fire systems and equipment. Staff conducted fire drills and noted the time taken by staff to report to the person in charge and to evacuate the whole building. The service had contingency plans in place to support people in the event they could not return to the nursing home following an emergency evacuation. This included temporary accommodation within the provider's other services.

Requires Improvement

Is the service effective?

Our findings

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.

At our last inspection we found that people were not always treated in line with the principles of the MCA. This was because staff had completed best interest assessments for people which presented inaccurate information about people's communication and mental capacity.

At this inspection we again found the provider was not upholding people's rights under the MCA. We reviewed people's care records and found instances where people were deprived of their right to have presumed capacity. This was because people's best interest assessments continued to contain inaccurate information. For example, one person had a best interest assessment carried out by staff which stated, "[Person's name] is unable to communicate basic needs due to their cognitive impairment." However, this person's communication support plan stated that they were, "Able to communicate their wishes and needs to staff [and were] able to express themselves clearly." It further said, the person, "Speaks in a loud and clear voice [and is] able to express themselves and their wishes clearly." Another person's best interest assessment stated, "[Person's name] is unable to communicate basic needs due to her cognitive impairment." This was contradicted by their communication support plan which stated, "[Person's name] is sometimes very clear with speech however at other times when in a manic mood will be very repetitive." A third person's best interests assessment also stated they were, "Unable to communicate basic needs." This too, was contradicted by the person's support plan which stated, "[Person's name] is able to understand simple instructions, also able to indicate some basic needs." This meant that people with the capacity to make decisions were at risk having being denied their right to do so.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Need for Consent.

At our last inspection we found that staff received supervision but that the records of them were poor. At this inspection we found that staff were receiving supervision and the records of these meetings were detailed. We found that supervision meetings were used to discuss people's changing needs and developments to the service. However, all of the nurses at Elmwood Nursing Home were agency staff. They did not receive supervision from either the manager or clinical lead but from their own employer. Nurses told us that the

provider could give feedback to their agencies about their performances or directly to them when they were in the service.

People received their care and support from staff who did not have their performance evaluated. None of the permanent staff at Elmwood Nursing Home had received an appraisal. Appraisals are annual meetings at which the performance of staff in delivering care and support to people is reviewed and evaluated by a manager. Appraisals are also used to identify staff skills and training needs as well as setting goals for the year ahead. Because staff did not receive appraisals it meant they did not have the opportunity to receive formal feedback on their roles or plan their professional development.

Whilst the service had made improvements it continued to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Staffing.

People did not always have a positive dining experience. We observed a lack of leadership and coordination of staff in the dining areas during lunchtime. Where people required staff to support them to eat this was not always done effectively. For example, we saw one person appropriately supported by a member of staff who was feeding them. However, the member of staff left the person mid-meal to assist someone else to eat. When they returned half an hour had past, the food had gone cold and the person refused to eat anymore. Further information about the ineffective support people received to eat and drink can be read in the 'Safe' and 'Caring' sections of this report.

People had assessments in place. These covered a range of issues including people's risks, mobility, oral health, bladder and bowel function and communication. People's assessments reflected input from health and social care professionals. However, people's assessments did not always align with other care records. For example, we found information in people's assessments contradicting information in their 'resident profiles' and information in best interest assessments that contradicted people's care and support plans. As a result the provider was reviewing each person's assessment and associated care plan. The poor quality of record keeping is reported on elsewhere in this report and has been used to evidence breaches to regulation.

People received their care and support form trained staff. The provider coordinated a training programme for staff. This included training in core areas such as health and safety, fire safety and safeguarding. Staff also received training in areas related to people's specific needs. These included dementia awareness, behavioural support and end of life care. Healthcare professionals from a support team within the local authority also delivered training to staff as did staff from a beacon hospice. This meant people's care was delivered by staff with up to date skills and knowledge.

The service was wheelchair accessible throughout and lifts enabled people to move between floors should they choose to. People were supported by staff to mobilise and transfer using equipment such as hoists. Staff were trained to use these and the equipment was subject to routine checks and testing. Whilst the service had been redecorated since our last inspection people's bedroom doors on the second floor were unpainted and unvarnished. They were rough to the touch and one relative told us they were unsightly. The temporary manager informed us that plans were in place to complete this work and it would be carried out shortly.

Inadequate

Is the service caring?

Our findings

At our last inspection we found that people were treated with dignity and respect by staff they considered to be caring. Accordingly the service was rated Good in this key question. At this inspection we found that people were not always treated in a respectful way. We asked relatives if they felt their family member's privacy was protected. One relative told us, "[Family member's] door is always open." On a second floor corridor we observed a member of staff with a person who was using a toilet. The toilet door was open which meant that the member of staff was not protecting the persons dignity. We heard the member of staff instruct the person, "Pull you pants up. Wash your hands." Shortly afterwards we observed this person in the lounge repeatedly asking the same member of staff for their hands to be washed. Initially the member of staff did not respond to the person. When they did, the member of staff let out an audible sigh and said, "If you want to wash your hands again then come." This meant the member of staff spoke to the person in a manner that was not respectful.

Staff did not always take prompt and appropriate action to support people to maintain their dignity. We observed that a person in the lounge on the second floor had been incontinent. When they attempted to get up and walk out of the room a member of staff guided them back to their wet seat. We asked the staff why the person wasn't being supported to get changed and they informed us it was because care staff were on a break. We observed that another person who was in their bedroom with their door open had been doubly incontinent and was very agitated. We informed a member of staff that the person needed to be supported. They responded that the person had been, "Put to bed and changed a while ago." We then raised the issue with a member of staff with greater responsibility on the floor they too told us the person had been changed earlier before being put to bed and that night staff usually change people later on. It was only after we insisted that action was taken that the person's personal care needs were met. We reviewed the persons care records and daily notes and spoke with staff but we were not given an explanation as to why this person had been put to bed at 15:45 in the afternoon.

People were not always treated in a respectful manner. We observed people receiving their lunch on two floors. We staff practice at mealtimes which did not show regard for people's dignity or convey respect. We saw staff place clothes protecting adult bibs around people's necks without asking people's permission or telling people what was happening. For example, we observed one member of staff approach a person, move the person's arms out of the way and place the adult bib on them without speaking to the person at all. We observed that one person received pureed food in line with their care plan. The pureed food had been placed separately on the plate by kitchen staff in line with good practice so that the tastes would be distinctive and the colours on the plate would be appetising. However, the staff fed the person without informing them what was on each spoonful.

We saw that people did not always have a comfortable dining experience because they were not offered the opportunity to transfer from their wheelchairs to dining chairs. We observed a person who was brought close to dining table in their wheelchair where two other people were eating their lunch. This person was not offered a meal and became visibly agitated as others around them ate. We asked a member of staff if this person would be served lunch and they informed us the person had to wait for the other people at the table

to finish as they might, "Pull the tablecloth off." When the person was eventually served their meal it was placed out of reach for five minutes because the member of staff told them it was too hot. The person became further agitated during this period. Staff had not considered that this person could have been supported to arrive at the dining table later or to eat at a table without a tablecloth.

These issues demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Dignity and respect.

Despite our findings, people and their relatives continued to have positive things to say about staff and how caring they were. One person told us the staff were, "Very, very nice." A relative told us the staff were, "Very caring without a shadow of a doubt…every carer tries to do their best. I have seen them stay behind when people have been unwell. They give 110%."

People's spiritual needs were identified and addressed. One relative told us that the, "Church comes to see us", in reference to the pastoral care delivered at the care home by visiting priests. People were referred to by their preferred names and titles. For example, one person was referred to as "Sister" followed by their name in line with their preference and in acknowledgement of the role they held in their church for many years. People were supported to celebrate events that were important to them. For example, plans were in place to celebrate Mother's Day and were being developed to celebrate Armed Forces Day. One relative told us their family member was supported to eat dishes reflective of their ethnic origin twice a week.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated that the provider's responsiveness as 'Requires Improvement'. This was because people's care records were not personalised. We found significant amounts of information copied and pasted between different people's care records, much of which was inaccurate. At this inspection we found that some care records had improved and become more personalised whilst others continued to contain errors. For example, two people's care records inaccurately contained names and information about other people. Three people had inaccurate and similarly written care records regarding their communication.

People's photographs were present on the front of their care records along with the date the picture was taken. This ensured care records showed up-to-date likenesses of people. Care records contained care plans which provided guidance to staff. Care Plans reflected people's physical, mental, emotional and social needs. Since our last inspection some people had been supported with reviews of their care plans. These were meetings arranged by staff to which people and their relatives were invited. Care reviews looked at people's physical and mental health, medicines, skin integrity, medicines, nutrition, activities and finances. People's care plans were updated to reflect new information. We saw three examples of where people's care plans had been reviewed, updated and improved. Information within them was more person- centred and guided staff as to people's preferences. However, one of these revised care records continued to contain information that contradicted the person's best interest assessment which had not been updated.

People were supported with a range of activities. These included gentle seated exercises and Zumba sessions. There were also activities including arts and crafts, music, tea tasting with cheese and biscuits. People who chose to were supported with tactile and pampering sessions. These involved hair combing, hand massage and hand holding. The service had one activities coordinator who coordinated activities for people throughout the service. Library staff visited the service every two weeks to enable people to select books to borrow and the service occasionally hosted visiting entertainers. We noted that there were no clocks or calendars within communal areas to support people's orientation to time. Staff and managers told us the service was going to explore developing more dementia friendly activities and to create a more dementia friendly environment.

We recommend the provider finds out more about dementia friendly environments and activities to support people living with dementia.

People's relatives told us they knew how to raise a complaint if they were unhappy about the care and support being delivered at Elmwood Nursing Home. One relative told us they had experience of making a complaint at the service and said it was resolved to their satisfaction. Another relative told us, "When I have a problem I go downstairs to [the clinical lead] who resolves the issue." We reviewed the complaints the provider had received and saw that complaints were responded to in writing and in a timely manner. Where complaints were a safeguarding matter the provider suspended their enquiries so as not to interfere with safeguarding investigations undertaken by Local Authority social care professionals.

Where people were diagnosed as requiring end of life care they received compassionate care. The service received input from healthcare professionals from a local palliative care team. The care home also relied on the expertise of the beacon end of life service, St Christopher's Hospice, which provided advice and training to staff. At the time of our inspection no-one was in receipt of end of life care.

Inadequate

Is the service well-led?

Our findings

At our two previous inspections of Elmwood Nursing Home in 2016 and 2017 we rated the service 'Requires Improvement'. This was because the provider failed to demonstrate good governance. At our 2016 inspection we found the service did not have a registered manager in post and audits did not lead to improvements in poor record keeping. At our 2017 inspection we found that the provider's quality assurance processes continued to fail to address a range of shortfalls across the service including inaccurate records. Following our 2017 inspection we served the provider with three Warning Notices which included failure to operate effective auditing and governance systems. In response the provider presented an action plan detailing how it would make improvements. At this inspection we found that the provider failed to fully achieve all of the improvements set out in its action plan, the quality of care had deteriorated significantly and auditing and governance systems continued to fail. We identified five regulatory breaches.

There was inadequate leadership throughout the service. The service did not have a registered manager or a deputy manager in post. Leadership arrangements for each of the service's three floors contributed to the management failure we found. The staff in charge of each floor and each shift were nurses. All of the nurses were agency staff. Some nurses were new to the service and didn't know people. For example, one agency nurse we spoke with did not know if any of the people on their floor were receiving end of life care. We met one agency nurse who was in charge of coordinating care staff who had worked at the service for one day. Whilst these agency nurses received support from the clinical lead and temporary manager, they were guided in their work by care records which contained incorrect information.
There was an absence of established and visible leadership throughout the service. There was a temporary manager in post whose basement office could not be seen by people, relatives or staff as they came into and went about the service. One relative told us, "Nobody is in charge." Whilst the temporary manager undertook twice daily walk rounds and held daily flash meetings with department heads, their physical location meant they could not see the poor practice we observed. This included staff treating people in an undignified and disrespectful manner and a lack of obvious leadership and coordination at mealtimes.

People were at risk of unsafe care and having their rights denied as a result of inadequate quality assurance processes. Following our last inspection and in response to our warning notice the provider undertook a review of its care records. However, the review was not competently carried out. This was evidenced by the significant inaccuracies we found in the care records we reviewed. These inaccuracies included contradictory information as to whether people had mental capacity, the ability to speak or weight bear or had insulin dependent diabetes. Additionally, we found examples of poor record keeping on a day-to-day basis where failure to complete records relating to what and when people ate and drank meant risks of dehydration and malnutrition were not adequately managed.

The service continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Good Governance.

Staff told us they had confidence in the current transitional management of the service. There was a clinical lead at the service who was a qualified nurse and a permanent member of staff but a decision had not been

made as to whether their post would remain supernumerary. One member of staff told us, "Morale has improved." An agency member of staff told us, "The clinical lead is very supportive. She shares what she knows. She is in and out of the nursing stations all day every day and you can talk things through. It builds confidence" Another regular agency worker at the service said, "We feel appreciated by the managers here. We are not made to feel outsiders." The provider had taken steps to promote good practice, highlight success and develop role models. For example, one member of staff was nominated for, and subsequently won, the provider's 'kindness in care awards'. A photograph of the member of staff receiving their award was placed at reception to highlight and celebrate their achievement. General staff meetings had taken place to improve communication and practice within the service. For example, we read in the minutes of one team meeting that the acting manager spoke to staff about poor record keeping. In another example, human resources staff from the provider organisation held two open surgeries at the service where staff were able to share the views about staffing issues and service delivery.

The temporary manager received support from the provider organisation. The provider's area manager and quality managers attended the service whilst register managers from the provider's other homes also provided support. Staff had access to both the manager and clinical lead outside of office hours and there was an on-call system which enabled staff to access management support overnight and at weekends.

The temporary manager accessed resources external to the provider organisation to support staff in the delivery of care to people. For example, the assistance of healthcare professionals from a local authority support team had been requested. Input from this team had started with the delivery of training to staff. The service also benefitted from the expertise from another provider organisation which delivered outstanding end of life care. Additionally, the service worked transparently with a local authority monitoring team and ensured that CQC received notifications about important events in a timely manner.

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 18 HSCA RA Regulations 2014 Staffing Regulation 18(2)(a) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. Staff did not receive the appropriate support, professional development and appraisal necessary to enable them to carry out their duties effectively. 1.□Staff had not received appraisals from their line managers.