Guide Total Care Group Limited

Guide at Sandon

Inspection report

Chelmsford Nursing Home, East Hanningfield Road
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 25 and 26 October 2017 and was unannounced.

This is the first inspection of Guide at Sandon since the service was registered under the new provider Guide Total Care Group Ltd in January 2017. Guide at Sandon was formerly known as Chelmsford Nursing Home and is registered to accommodate up to 64 people some of whom may be living with dementia. The building is split over two floors. Nursing care is carried out on the first floor and people living with dementia reside on the ground floor.

Chelmsford Nursing Home was previously owned and ran by Forest Pines Care Limited. The last inspection of this service under this provider was carried out on 22 March 2016. The final rating for Chelmsford Nursing Home following the inspection was 'Requires Improvement'. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified during this inspection. This was because there was no registered manager in post. Staff morale was low and staff felt they did not have the right amount of staff to care for people. The service relied heavily on the use of agency staff who were often deployed to manage people with highly complex needs. The service had not learnt from incidents of falls, challenging behaviour and safeguarding concerns and had not effectively managed risks to people who used the service.

Before this inspection we received information of concern about medicines errors that had been made, the attitude of staff, poor care and overuse of agency staff who did not know the needs of the people using the service. At this inspection we found a new manager is in post, but they are not yet registered. 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.

Although there has been significant improvement made by the new manager to identify and manage risks to people's health, safety and welfare we identified occasions where these measures were not protecting people from harm, or potential for harm occurring. Following six occasions of aggression between people who live at the service there has been no review of their care or strategies implemented to stop repeat incidents. Where risks to people's health have been identified due to incontinence, poor skin integrity and dehydration, charts are in place to monitor they are receiving adequate hydration and being repositioned regularly. However, these are not being completed properly by staff and it is unclear if people are receiving appropriate care over a 24 hour period. The management team's failure to identify the inconsistencies means people remain at risk of becoming dehydrated, at risk of urinary tract infections or developing pressure wounds.

Systems are in place to manage people's medicines safely. There are sufficient staff on duty to keep people safe, but response times to call bells, especially at night and weekends could be improved. Agency staff are

still being used on a regular basis for consistency, whilst a recruitment drive for permanent staff is in progress. Relatives were complimentary about the attitude and capability of the staff. Staff are kind and caring and have developed good relationships with people using the service.

A thorough recruitment and selection process is in place, which ensures staff recruited have the right skills and experience, and are suitable to work with people who use the service. Staff know the care needs of the people they support well. This is because staff have received training that gives them the skills and knowledge to meet people's specific needs, including how to respond when a person is choking. Where people have been identified as at risk of choking detailed risk assessments with guidance for staff on how to minimise the choking risk have been developed and are being followed by staff.

The registered manager and staff understand the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible, the policies and systems in the service support this practice. People and their relatives are involved in planning and making decisions about their care. Joint working with the GP and the hospice team has provided greater clarity and support for staff so that they know how to manage, respect and follow people's wishes for end of life care.

People are provided with sufficient to eat to stay healthy and maintain a balanced diet. People have access to health care professionals, when they need them. The manager is using innovative ways to improve the service. They have introduced the use of the National Early Warning Scores (NEWS) to monitor people's health. This is an initiative used by medical services and all hospital staff to quickly determine the status of a person's health, for example by checking their blood pressure, pulse and temperature, enabling a more timely response in case their health deteriorates. They are also trialing a development opportunity for care staff in an associate practitioner role. The aim of this role is to assist nursing staff to monitor people at risk of developing pressure ulcers, help with managing wound care and ensure people's personal care is delivered in accordance with their care plan.

The manager and staff spoke passionately about the people they support and knew their care needs well. Staff are aware of the importance of ensuring people's dignity is respected at all times. Staff offer people choices on how they choose to spend their day and what they want to eat. These choices are respected.

People, their relatives and staff were positive about the change of provider and the appointment of the new manager. They felt the service is moving in the right direction, things have brightened and staff morale has improved. Staff felt supported by the manager and felt there was good leadership in the service. Staff were clear about the provider's philosophy of care and how this links to the vision and values of the service in relation to providing compassionate care, with dignity and respect. Staff knew what was expected of them and we observed staff putting these values into practice during our inspection.

People, their relatives and staff are kept up to date at regular meetings about changes to the service, what has worked well and where improvements are needed. The minutes of meetings show there is an open and transparent approach to sharing information including the outcome of incidents, safeguarding concerns and complaints. Concerns or complaints are taken seriously, explored and responded to.

Spot checks and daily audits are being carried out on each unit to ensure people are receiving appropriate care and support and their medicines. However, these had not identified the inconsistencies we found in the recording on people's health charts. The manager told us they were still in the process of developing a raft of audit tools to assess and monitor the quality of the service, but these tools have not yet been used and therefore we could not determine their effectiveness. However systems were in place for reviewing

complaints, safeguarding concerns, incidents and accidents. Documentation showed there has been learning from such events and measures have been taken to ensure these events are less likely to happen again.

We found a breach 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Systems were in place to assess and respond to risk, but these were not always consistently applied or managed to protect people from harm, or the risk of harm occurring.

Staff demonstrated a good awareness of safeguarding procedures and how to recognise and report signs of neglect or abuse.

There were enough staff to meet people's needs. Systems for recruiting new staff were carried out safely to ensure potential employees were suitable to work at the service.

Effective systems were in place to ensure the safe management of peoples medicines. People received their medicines when they needed them and in a safe manner.

Is the service effective?

Good

The service was effective

Staff received a range of training that gave them the necessary skills and knowledge to carry out their roles and meet the specific needs of people using the service.

People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible.

People were provided with enough to eat to maintain a balanced diet. People received support to maintain their health and had access to appropriate healthcare services.

Is the service caring?

Good

The service was caring

Staff were kind and caring and had developed good relationships with people who used the service.

People were supported to express their views and make decisions about their care. People were provided with the care support and equipment they needed to stay independent.

People's privacy, dignity and rights were respected and upheld.

Is the service responsive?

Good

The service was responsive

People's care plans had been developed from the initial assessment and covered all aspects of their care and how they preferred to have their needs met.

Concerns or complaints were taken seriously, explored and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service does not have a registered manager in post.

The manager was using innovative ways to develop the service, including trialing an associate staff practitioner role and introduction of the National Early Warning Scores (NEWS) to monitor people's health, however further work was needed to monitor the quality of service and make the required improvements.

There was an open and positive culture in the service. Staff felt supported and valued. Communication between staff and the management team was good.

People, their relatives, staff were asked for their views about the service. These were listened to and acted upon.

Staff were clear about the vision and values of the service in relation to providing high quality care and treating people with dignity and respect.

Guide at Sandon

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.

This inspection took place on 25 and 26 October 2017 and was unannounced. On the first day of the inspection the team consisted of one inspector, a specialist professional advisor in nursing care for older people 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, on this occasion their expertise was in dementia care. The second day of the inspection was completed by two inspectors.

We reviewed previous inspection reports and the details of any safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us about by law, like a death or a serious injury. We also received feedback from Essex County Council and the local Clinical Commissioning Group (CCG) informing us of the improvements made since Guide Total Care Group Ltd had taken over the service in January 2017.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks. Because the inspection was brought forward to examine the risks to people using the service, a Provider Information Return (PIR) had not been requested for this service. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with nine people who were able to express their views, but not everyone chose to or was able to communicate effectively or articulately with us. Therefore we used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who

could not talk with us.

We spoke with 11 relatives and a GP visiting the service during our inspection. We also spoke with two nurses, five care staff, including one agency, the chef and maintenance person. We spent time discussing the management and leadership of the service with the deputy manager, manager and the registered provider. We looked at seven people's care records, four staff files and reviewed records relating to the management of medicines, complaints, staff training and how the registered persons monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service under the previous provider, concerns had been raised with us that risks to people's safety and welfare were not identified and managed effectively. At this inspection we found there had been improvements made in identifying and managing risks to people. However, we still identified occasions where these measures had not protected people from harm. For example, six separate incident reports referred to hitting and biting occurring amongst three people using the service. These incidents had occurred between 23 May 2017 and 23 September 2017. The manager advised us that the local authority safeguarding team had told them not to refer such incidents between people using the service to them, and to manage these through the care planning process. Although, the incident reports showed action had been taken to intervene and make people safe, the potential for these incidents reoccurring had not been assessed and no plans were in place to mitigate the risk of this happening again.

Individual risks to people, such as incontinence, dehydration or developing pressure wounds had been assessed and management plans were put in place to minimise the risk of harm. These provided guidance to staff regarding what help people needed to stay safe, including regular monitoring, repositioning and application of creams. Monitoring charts were in place, however these not been completed properly. Running totals of what people had drunk were being kept, but were not being analysed to ensure people were receiving sufficient fluids to remain hydrated. Additionally, recording of people's fluid intake was not measured against output placing them at risk of dehydration and/or water retention and urinary tract infections. For example, the charts for one person dated 23 to 25 October recorded their fluid intake over 24 hours as below 900 millilitres, which was below that recommended for a person of their weight. Their continence pad had been recorded as being changed once on 23 October, twice on the 24 October and once on 25 October 2017.

At the top of the monitoring charts was space for headline information about the person's required fluid intake, frequency of repositioning and the pressure required for air mattresses based on the person's weight. None of this information had been added to the chart to guide staff. For example, one person's care records reflected they had a PEG in situ and needed a minimum of 2000 mls of fluid per day. However, their monitoring chart did not have this target information recorded to guide staff and the running total showed they were not receiving the correct amount of fluids. The records showed they were receiving half their recommended target intake of fluid. We found care and nursing staff were keeping separate fluid charts for this person. The nursing staff claimed by combining the two charts the information showed that sufficient fluid had been provided to the people. However, having two separate charts meant there was the potential for double entries and therefore would not always accurately record the level of care provided. Additionally, at the bottom of the health charts a senior person was instructed to review and sign the health charts to confirm the person had received appropriate care over a 24 hour period. However, there was no sign off of these sheets to show these were being reviewed to establish if people were receiving adequate hydration.

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

The provider had plans in place for responding to emergencies or untoward events. Staff were aware of these and knew who to contact in an emergency. Keeping safe assessments had been completed for each person covering risks such as, temperature and ventilation in their rooms, moving and handling requirements and use of bed rails to prevent the person falling from bed. Each person had a personal emergency evacuation plan in place providing guidance to staff on how to support them to evacuate the building safely in the event of an emergency. Risks to people were reviewed monthly or sooner if something changed. Staff demonstrated a good up to date knowledge of the risks to people and what they needed to do to ensure their safety. For example, one staff member told us, "[Person] had thickened fluids and a pureed diet, this is a recent change."

Following the death of a person using the service due to choking the manager had completed a full investigation. As a result of their findings they made a number of changes to mitigate the risks of this happening again. A full review of people's needs was undertaken and those identified as a risk of choking had been referred to external agencies such as speech and language therapy (SALT). Detailed risk assessments with guidance for staff on how to minimise the choking risk had been developed and were being followed by staff.

Irrespective of the incidents described above people and their relatives told us they felt Guide at Sandon was a safe and secure place to live. One person told us, "I feel safe here the staff are happy and content and know what to do, you can trust them." A second person told us, "I feel safe, they [staff] care and look after me well." One relative commented, "My [Person] is very safe here; they have a crash mat in their bedroom with an alarm under to alert staff if they fall out of bed. Also the bed has been lowered as far as possible so they do not have far to fall onto the crashmat, they [staff] are doing a good job and when I go I know they are safe here."

Staff demonstrated a good knowledge of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. One member of staff told us, "It's about making sure that residents are safe and raising any concerns with management." Staff were aware of the whistle-blowing policy and told us they would feel confident that any concerns they raised would be actioned. One member of staff said, "If I saw anything, I would let it be known, people are the priority."

The last inspection of this service under the previous provider identified insufficient staffing levels and a heavy reliance on the use of agency staff who were often deployed to support people with highly complex needs, often isolated away from regular staff. At this inspection we received mixed feedback from people, their relatives and staff in relation to staffing levels. One relative told us, "Weekends there could be more staff on duty, the whole of Saturday and Sunday there is not adequate staff, they [staff] are occasionally run ragged but they do their best." Another relative commented, "They could do with more staff but it is gradually improving." Other comments included, "There is enough staff and always one in the lounge." And, "Staff move themselves around a lot and generally they manage okay with the amount of staff they have." Staff told us there were enough staff to carry out their roles effectively and meet people's needs, including weekends. One member of staff said, "We can't complain, agency staff are used to provide cover for annual leave and staff sickness." Another member of staff told us, "We have enough staff for the residents we care for."

During the inspection we saw there was enough staff available to meet people's needs. Staff were visible in communal areas or nearby and if people called out staff responded promptly. However, people and their relatives told us response times to call bells, especially at night and weekends could be improved. One person told us, "Buzzer, sometimes takes ages." Another person told us, "Call bell, staff come sooner in the day times, there are always staff about. Night I don't feel it is so good, it feels like it is a long time. A third

person commented, "Buzzer, sometimes staff come quick but worse in evening and night, best times are during the day. The longest I have had to wait is 20 – 40 minutes, but not worth complaining about, carers are good and friendly." Other people told us they had more positive experiences when needing assistance. One person told us, "Last week, I slid off the bed and crawled on the floor and pressed the buzzer and within seconds two staff came and lifted me off the floor." One relative told us from their experience, "Staff are not rushing around, I don't hear call bells and they seem to be managing well enough with the staff they have got." Another relative commented, "If you are in the lounge and you don't see staff they come quickly enough if someone needs them." A third relative said, "I hear occasional buzzers, but these appear to be answered quickly, I can always find staff if I need them."

The provider and manager confirmed staffing numbers had been calculated based on the needs of the people using the service. The manager acknowledged there had been issues with staffing levels particularly at weekends, which had been due to high levels of sickness. They advised a recruitment drive was in place and acknowledged they were still using agency on a regular basis, but wherever possible used the same agency staff who knew the needs of the people using the service. The manager advised when they are fully staffed the aim was to have their own bank of staff to cover staff absences. The provider told us they currently do not have a system in place to analyse the number or duration of calls, to ascertain why staffs responses to call bells at night and at weekends were less responsive than during the weekdays. They said they would look into obtaining equipment compatible with the call bell system to analyse this information and review the staffing numbers accordingly.

Staff were recruited safely. Checks on the recruitment files for four members of staff evidenced they had completed an application form, provided proof of identity and satisfactory references were obtained. The provider had also undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Before the inspection we received information of concern about medicines errors which resulted in people not receiving their prescribed medicines. During the inspection we looked at the records detailing the medicines errors and found these had been fully investigated by the manager.,. People told us that they received their medicines when they needed them. Random sampling of people's medicines, including controlled drugs against their related Medication Administration Records (MAR) charts confirmed people were receiving their prescribed medicines. The controlled drug record book had been signed by two staff and the stock of people's medicines matched what was recorded. Where people had been prescribed 'as necessary' medicines, such as analgesia for pain relief, specific plans were in place, including the details of the medicines and how to administer it. Pain management charts were used to manage and monitor people's pain.

Only nursing staff who had been trained and assessed as competent administered people's medicines. We observed a nurse completing the morning medicine round. They were patient and interacted in with people in a positive way. The nurse took the time to explain what the medicine was for, gave people a drink of their choosing and gave people their tablets one at a time, ensuring those at risk of choking were sat upright and had a drink. The nurse asked people if they had pain and where they had communication difficulties completed a thorough physical assessment.

Good

Is the service effective?

Our findings

Staff told us they received training which ensured they had the knowledge and skills to meet people's needs. One member of staff told us they had done virtual dementia training and said, "I like to see things through other people's eyes; it's great for helping to understand how it feels to have dementia; it helps us understand that people need to be given time and not rushed." Training had also included how to move and position people using equipment such as slide sheets, hoists and slings. Staff told us they were regularly observed by senior members of staff to check their competence. We saw people being supported to move safely and in accordance with instructions in their care plans. For example, one person's care plan stated, "[Person] has arthritis, please assess for pain before moving me." We saw staff gave particular attention to the person's wellbeing and comfort when supporting them to move.

When new staff joined the service they received an induction. This included time spent shadowing more experienced staff so that they could learn about people's needs and how best to support them. A new member of staff described their induction experience. "I spent three weeks shadowing, the first week just observing, I read care plans and talked to people, getting to know them." Agency workers also said that when they started working for the service they initially worked in pairs with existing members of staff to get to know people.

Nursing staff told us that they had received specialist clinical training to meet people's specific needs, for example, Percutaneous Endoscopic Gastrostomy (PEG) feeding and catheter care. The manager told us they were in the process of training four staff to take on an associate practitioner role. This post was currently in trial stages, but the role had been developed to assist nursing staff to monitor people at risk of developing pressure ulcers, help with managing wound care, PEG sites etc and ensure personal care was delivered correctly.

People's ability to make decisions was assessed in line with the requirements of the Mental Capacity Act (MCA) 2005. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. For example, where a person had been assessed as needing their medicines administered disguised in food or drink (covertly) an appropriate MCA assessment had been completed. This agreed it was in the person's best interests to receive their medicines covertly. A care plan was in place providing guidance to staff on the process for administering covert medicines, however, this needed expanding to guide staff to use the least restrictive option of offering the person their medicines first before administering covertly. Where the person was receiving their medicines crushed, authorisation from the pharmacist to confirm that it was an appropriate means of administering their medicine had been obtained.

Staff had received training in MCA and demonstrated how they applied the principles of the legislation in

their daily practice to support people to make decisions. Staff told us they always asked people for consent before providing care and support and described how they would help people who might find it difficult to give informed consent. One staff member said, "I would explain everything I am doing and the reasons why and the benefits. If necessary I would find someone who knew them better to help." People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We saw appropriate DoLS authorisations were in place to lawfully deprive people of their liberty for their own safety. The manager was in process of carrying out an audit of DoLS to ensure they were in date and still relevant.

People told us they were supported to maintain their health. One person told us, "I could see a doctor if I wanted." Relatives were confident that their family member's health was being monitored and that they were kept informed if they were unwell. One relative commented, "The chiropodist comes regularly, and the GP came today. Another relative told us, "They [staff] phone me, the last time was to say my [Person] had chesty cold, another time because they had a cut on their finger." A third relative commented, "I am very pleased with the home, even a scratch on [Person] they ring and tell me."

People's records confirmed they had access to a range of healthcare services including the GP, optician, therapy specialist nurses and dietician. We saw that advice from health professionals was clearly documented and followed. For example, one person had their catheter removed on advice from the GP. Following on from this an additional care plan was written and added to the person's care records to provide guidance to staff to monitor the person's urinary output in case they went into 'retention' which would require re-catheterisation. Body maps were kept which monitored any change to people's skin or injury which may require observation and treatment. We saw that when staff noticed any changes referrals were made to the GP. The service was using the National Early Warning Scores (NEWS) to monitor people's health. This is an initiative used by medical services and all hospital staff to quickly determine the status of a patient's health, for example by checking their blood pressure, pulse and temperature, enabling a more timely response in case their health deteriorates. These were being monitored daily to assess if people's vital signs had changed.

We observed people eating their midday meal. This was a positive experience for people with a good ratio of staff present to ensure they received the support they needed to eat their meal. Staff gave people choice about meals by showing the options available on plates to help people make a decision. Where a person was unable to decide, the carer told the chef, "[Person] wants to taste a bit of each." This was duly provided to enable them time to make a choice. Where people required their meals pureed each food item was pureed separately and was placed on their plate in a way that still made the food look appealing.

People told us the chef came round regularly to get feedback on what they thought about their meals. One person told us, "The chef came and saw me in my room and asked if I was satisfied with the food, I have the pureed food and it was really lovely." Another person fedback to the chef that the, "Meat was really tender, lovely, just right, nice, meat lovely." People were complimentary about the food. Comments included, "Food is good, nothing wrong with it." And, "If you don't like the food they will get you something different like an omelette and I have eggs and chips instead of the fish and chips." And, "Food extremely good, today I said to the cook that the lunch was absolutely wonderful." People's relatives were equally positive about the food their family members received. One relative commented, "Food is good, good variety and hot."

Staff were aware of people's dietary needs and the support they needed to eat their meal. Where people had been identified at risk of choking staff were following guidance provided by the Speech and Language

Therapist (SALT) and provided people with soft or textured diets and thickened drinks. One member of staff told us, "We put two small spoons on [Person's] tray to encourage small mouthfuls." We also saw staff encouraging people to retain their independence to eat. A member of staff was observed telling a person, "Try and do a little bit yourself and I will come back, you have a go." The member of staff returned a short time later and assisted the person to finish their meal.

Good

Is the service caring?

Our findings

Prior to our inspection we received information of concern about people not receiving appropriate care and that some staff were rude and abrupt. During this inspection people told us they were happy with the care and support they received and were positive about the staff. We saw people were clean, dressed in appropriate clothing, their nails were clean, hair was tidy and their glasses were clean. One person told us, the, "Carers are kind, very kind." Another told us, "I find it very good, I like the company, the staff are lovely and kind." A third person told us, "It is very good, they feed you well and clean you well and staff care for you, they are very good and I cannot praise them enough."

One relative highly praised the staff and told us, "My [Person] has been a resident here for four years and I have no concerns what-so-ever. They are always clean and tidy, the food is always good and I am absolutely delighted with the care given." Another relative commented, "Care is good, any issue I can go and get it resolved. I can either go to carers, senior staff or management."

Relatives were complimentary about the attitude and capability of the staff. Comments included, "I think [Person] is lucky to be here, it is clean and the carers are friendly." And, "My [Person] gets on wonderfully with the carers. They are happy with them all and if they were not, they would tell me." And, "Staff seem very pleasant, very kind, considerate and respectful." One relative told us, "[Staff member] is on top of everything, outstanding, aware of everyone's dietary needs, leads the staff well and has control of their team." Another relative commented, "[Staff member] knows how to get my [Person] to do things, they are very good with the residents and sits and talks to them and gives them encouragement. They know what is going on." Another relative told us, "They have Carer of the month and you can vote. I voted for a member of staff as they are always polite and relate well to [Person] and they are a good worker. The carers who stand out in my opinion get my vote."

We saw positive interactions between staff and the people they supported. Staff were smiling and using humour as they engaged with people. They were friendly, affectionate and showed concern for people's wellbeing. One person told us, "One of the staff on nights is lovely, they bring me a sweet and we talk, they are cheeky and I love to laugh." Another person told us, "[staff member] is my best girl, they do everything for me, and they are my best friend." Staff adapted their style of communication to meet people's needs. For example, one member of staff described how they interacted with a person who had lost their sight. They said, I always knock and verbally announce my presence so as not to scare them; I tell them when I'm leaving the room and also when I have moved outside the door so they know where I am and that I am going so they don't feel that they are just suddenly left on their own."

Relatives told us they and their family member were involved in planning and making decisions about their care. One relative told us, "Care planning we sit together, normally a nurse, but last time it was the Manager. My [Person's] digestive condition had never previously been written into their care plan, but as a result of this meeting it is now and they are checked regularly by the nurse." Another relative commented, "With the new manager I am fully involved in [Person's] care plan. We talked about resuscitation and discussed end of life care arrangements."

People were supported to express their sexuality, maintain good hygiene and were given choice about personal grooming. One relative told us, "My [Person] can decide if they are going to have a shave or not. Another relative said, "My [Person] is always washed, staff encourage them to have a shave, but sometimes they say no and this is respected, they are always in their own clothing which is clean and laundered." We saw that female residents were wearing co ordinated clothing, jewellery and makeup. Those who wanted to had their nails painted. One relative told us, "We are happy as a family as they look after [Person] extremely well and we feel confident with their care. [Person] never smells and is always well turned out and they are always happy."

Staff were aware of the importance of ensuring people's dignity was respected at all times. Staff were observed gaining people's consent to enter their rooms and provide personal care. Staff knocked on people's doors whether or not they were open or closed, rather than just walking in.
One person told us, "Staff generally knock and come in at the same time, but do knock." Another person told us, "They [staff] always knock on the door, and they ask permission to give me my tablets, at the shower they knock on the door and when I am on the toilet they say shall we leave you on your own, they cover me up, they always show me respect."

People told us they received the care they needed from staff who knew and understood their needs. One person told us, "Today my arm hurt so a member of staff helped me to eat my lunch, they were friendly and we talked. However, I didn't want them to attend to my personal care so they went and got a female carer for me." One relative told us, "Staff know what [Person] likes and dislikes, and that they prefer a female for personal care. It is written into their care plan and they [staff] stick to that." Another relative commented, "Staff are extremely caring, they know the names of all the residents and they care for my [Person] very well. They are in safe hands." A third relative told us, "My [Person] gets their nails and hair done, clothes are laundered and they are always in their own clothes. Often when I come in they [staff] have washed their hair, it is done regularly."

The manager told us they had previous experience working of working in a hospice as a head of clinical governance. They had used their knowledge and experience to improve this aspect of the service and told us they were committed to ensuring people received a dignified and pain free death. We received feedback from a visiting GP that the manager had improved links with the surgery and local hospices and had really improved arrangements for people nearing the end of their life. They had implemented new processes including better recording of end of life medicines and when these were to be administered. This joint working with the GP and hospice had provided greater clarity and support for staff so that they all knew what they were doing and ensured people experienced a dignified and comfortable death.

People had been supported to complete an advance care plan which gave them the opportunity to express any wishes for their end of life care and funeral arrangements. These were in date and had been discussed with their family members, if appropriate. As part of their end of life planning where it had been agreed people had a Do Not Attempt Resuscitation (DNAR) orders in place. A DNAR form is a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR).

We saw an assortment of thank you cards from people's families expressing their gratitude to the staff for the care and kindness shown to their family members. One relative had commented about the exceptional end of life care provided to their [Person]. They commented, "The loving care, kindness and absolute professional attitude that you and the staff concerned showed to [Person] and us at a very difficult time will always stay with us. It was so apparent that [Person] wasn't just another resident, they were really cared about and the staff involved in their care, especially the last few hours, was like their extended family."

Good

Is the service responsive?

Our findings

Before people began using the service an initial assessment was completed to make sure that the service could meet their needs. This also gave people and their relatives the opportunity to talk about how they would like their care and support delivered. We saw that people or their representatives had signed consent forms which evidenced their involvement in care and support planning. Care plans were personalised and gave a clear picture of people's needs and preferences. For example, people had night-time care plans which provided details such as how many pillows they preferred and whether they liked a lamp left on or the door left open.

People's care records held detailed information about their care needs, for example catheter care and how to move and position people safely, including the type of equipment and size of sling. Staff were aware of people's care needs, such as catheter care and were able to tell us what they would do to keep people safe and healthy. One staff member told us, "I always check for any blockage, look at the colour and smell of the urine and check the site to see if it's sore; if I was worried I would immediately report this to a nurse." People's care plans were being reviewed monthly, or sooner according to their clinical needs. Where changes in people's needs were identified these were responded to promptly. For example, a person's care records showed their mobility had decreased putting them at increased risk of falling. They had been provided with equipment such as bed rails, floor sensor and crash mat to minimise the risk of injury if they fell from bed. Another person's care records showed due to a deterioration in their behaviour due to their dementia a referral had been made to the 'Dementia Access Team'. Following a visit from the team their care plan was amended to reflect advice on 'Behavioural and Psychological Symptoms of Dementia' and how to support the person to manage this aspect of their care. Staff were able to explain strategies for supporting people whose behaviour could be challenging to themselves or others. They described the techniques they had been taught to deflect incidents of aggression and anxiety. One member of staff told us, "Giving residents' time to express themselves was important." and described approaching people in a calm manner and if required a change of carer could help the situation.

People told us they received care and support that met their individual needs. One person told us, "I wake at 7am, my choice and have all my meals in the dining room, but I spend most of my time in my room doing my tapestry and listening to the TV. I go to bed anytime; and I like and love my Horlicks drink at night." Relatives confirmed their family members received consistent personalised care and support. One relative told us, "Excellent, I always feel [Person] is always happy, well turned out, hair nice, glasses clean, and nails trimmed and painted." Another relative told us, "One of the staff took my [Person's] new jumper home to wash rather than put it to the laundry, it was nice of them." A third relative told us, "[Staff member] is brilliant, they are quick to respond to people's needs and will sort anything for you, always reassuring, for example, my [Person] lost their glasses and [Staff member] let everyone know and they were found. I feel I can go to them with trivial things rather than bothering the Manager. For example, when [Person] refuses to eat and drink [Staff member] can persuade them. I can't speak highly enough of them."

We observed staff responded to people's needs promptly. For example, at lunchtime we observed a person started choking and a member of staff went quickly to them followed by a nurse who sat with them, took

their temperature and gave lots of reassurance to them and their relative. One relative told us, "If I ever had any concerns, staff always deal with it properly and quickly."

We observed a group activity where people were engaged in colouring, and making shapes using play dough. Others were taking part in a game of bingo and a game of throwing balls at a target. We observed people having fun and staff noted when they were losing interest and encouraged them to try an alternative activity. The GP told us from their experience of visiting the service people's care needs were being met and for those with dementia there was a good range of activities that provided meaningful engagement, however for people of 'sound mind' there was minimal stimulation. This was confirmed in discussion with people, who told us they often felt isolated and lacked stimulation. One person told us, "I personally want more activities for people like me who tries to be independent and have a mind." The manager acknowledged this was an area for development and told us engagement with people, their relatives and staff had been a key priority to improve the service, including activities. One person told us, "I was asked if I was happy here and if there was anything I would like to do. I told them [staff] I get lonely in my room and that I used to go to an exercise class, so now we have one, this started a few weeks ago."

Relatives told us they felt the service went out of their way to provide activities that were relevant to their family members. For example, one relative told us, "It was my [Person's] birthday last week and they did a cake and the chef and all the staff sang happy birthday to them. I brought a box of biscuits in and one of the staff took [Person] round with the tea trolley so that they could offer all the residents a biscuit, that was nice." Another relative commented, "My [Person] recently celebrated their 90th birthday. Staff asked them what they wanted to do and suggested we used the private lounge. A member of staff made them a birthday cake in the shape of a Policeman's hat, as they used to be a policeman." Another relative told us, "Today we are in the private lounge as it's [Person's] birthday and we are getting fish and chips from the shop and having a small family birthday party." A cake had been made for them and decorated resembling pattern pieces on the top as they used to be a seamstress.

One relative told us, "The activities staff are marvellous, they are good at organising things and try to keep people active." Another relative commented, "They [staff] put on an afternoon tea which was very good and a Harvest Festival where the Vicar came and communion was offered." Another relative told us, "Always a lovely atmosphere in here and in the summer they made good use of the gardens. I bought geraniums and they planted them everywhere, the residents potted out the plants." They also had singers come in and some men brought in some motor bikes as one resident used to ride motorbikes. They sat on one and had their photograph taken which is now up on the wall in the dining room."

People and their relatives told us they were able to give their views and raise concerns or complaints. One person told us, "Got no complaints, getting exercise now I asked for it and [staff] comes to my room and they are helpful, and stay with me for a long time, and chat to me." Another person told us, "I could talk to the staff but I have got no concerns." The registered manager confirmed concerns or complaints were taken seriously, explored and responded to. The complaints folder showed there had been thirteen complaints raised about the quality of the service since January 2017 when the new provider Guide Total Care Group Limited had taken over the service. The manager told us eight of these complaints had been made in person and had been dealt with and responded to at the time. The five remaining complaints had been fully investigated and a response and apology provided to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager for this service left employment in April 2017. The new manager commenced employment on 27 February 2017 initially in a consultant role, but took over the role as manager on 19 April 2017. They have not as yet made an application to CQC to become the registered manager. This was discussed at the inspection and they advised they were in the process of applying for their DBS and will then be submitting their application to us.

The manager told us engagement with people, their relatives and staff had been their top priority since taking over as manager. They had spent a lot of time on the floor supporting staff and had rewritten 98 per cent of people's care plans, but had not yet fully implemented systems to assess and monitor the quality of the service. They provided examples of some audits that had been carried out. For example, the deputy manager had carried out spot checks and daily audits on each unit monitoring that people were receiving appropriate care and support, receiving their medicines, incident and accidents and to ensure there were sufficient staff available to meet people's needs. However, these had not identified the inconsistencies we found in the recording on people's health charts.

The manager told us they were still in the process of developing a raft of audit tools to be used. Examples, included management of health and safety, infection prevention and control, pressure ulcer and catheter management. The manager also showed us a range of documents they had developed to demonstrate safety including an ad hoc medications register, guidance for nurses and senior care staff on checking daily care records and an admissions procedure. However, none of these tools had been used and therefore we could not determine their effectiveness in assessing and monitoring the quality of the service. Systems were however in place for reviewing complaints, safeguarding concerns, incidents and accidents. Documentation showed there had been learning from such events and measures had been taken to ensure these events were less likely to happen again. For example, following a complaint about meals audits of the mealtime had been carried out on both floors in April 2017. These highlighted good practice and where improvements were needed. For example, they had identified that more finger foods and fruit needed to be available for people to access. This had been reported to the chef who had immediately ordered the additional food items. Following the audit the manager had developed an action plan detailing what action was needed, by whom and by when; with a review date to check progress.

At the last inspection of this service, under the previous provider, concerns had been raised about a lack of leadership and low staff morale. At this inspection people, their relatives and staff told us the new provider and manager were visible, approachable and making a difference. One relative told us, "There had been a significant drop in standards over the past two years, but the new manager is trying to improve the service." Another relative told us, "Since the new provider has taken over things are improving." A third relative commented, "The service previously had staffing issues and used a lot of agency, but I am now seeing lots more permanent staff. Other comments included, "The core staff have not changed, they know us, and know my [Person] well" and, "Since the new manager came the staff team is vastly improved."

The provider told us, since the takeover of the service they had faced a number of challenges including

dealing with the staff culture. Having made changes to the staff team they were slowly re building staff confidence and morale. They told us they were aware that the service was still in transition and they were not where they wanted to be as a provider yet and recognised there was still work to do. They told us they had every confidence in the manager to make the required improvements.

People, their relatives and staff were particularly positive about the appointment of the new manager. One person told us, "The manager is always busy, but they are always friendly and always listens to you." Relatives told us, "It has changed considerably, this Manager is superb and it (the home) is going up" and, "The change of manager has been positive, there are now activities happening and the home smells cleaner all over." One relative told us, "The Manager is a lovely woman, I can talk to her and ask her things, for example, I spoke about having [Person's] nails trimmed and within two days they were done. I can pop in and see her, she always makes time for me. She is ready to drop what she is doing to talk to you, better than the previous manager. They are more sincere and genuine." Another relative told us, "Any concerns and the manager is keen to sort quickly, I have been very impressed. They are here late at night and at weekends. Occasionally I speak to her, she is welcoming and only one time was she not available to me as was dealing with other relatives but she phoned me in the evening."

One member of staff told us, "I find the manager approachable and they are good at communicating." Another member of staff commented, "I feel well supported by the manager and they have an open door policy, the manager is the best." All staff spoken with were positive about the new change in ownership and management of the service. They said the service was now moving in the right direction, things had brightened and staff morale was much higher. One staff member said, "The new management know they want good quality care as do we so we are all on the same page." Another member of staff commented, "We all help each other, I love this job and this place." Nursing staff also reported feeling better supported as the new manager had a clinical background. An agency member of staff told us, "It feels very different with the new management, much more positive. I talked to [manager] about something that wasn't right, I talked to her and she dealt with it. The previous registered manager didn't respect us but this one does." A new member of staff said, "I feel well supported. The manager is very good, they are a good communicator; I find her very approachable and I can talk to her."

Staff told us they felt well supported and confirmed that since the new manager had been in place they were now receiving regular supervision. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. One member of staff said, "I think supervision is very positive, you get the chance to say what you want and you get feedback on how you are doing." Another member of staff told us, "I have regular supervision with senior staff. They are so lovely, I love them, and they give me loads of support." We looked at two recent staff supervision records and saw that supervision was used constructively to discuss practice, raise concerns, reinforce positive values and attitudes and identify training and learning needs.

Staff had good knowledge of the provider's philosophy of care and how this linked to the core vision and values of the service. Staff told us that when the service changed ownership a meeting was held with the new provider who shared their vision for the service. One staff member told us, "Our focus is on providing people with a good quality of life by interacting with people in more meaningful ways, working at their pace and to their wishes." Another said, "I feel that we have shared values here, treating people like I would treat my parents, we are a great team, I would be happy to be here as a resident."

People, their relatives and staff told us they attended regular meetings where they were kept up to date about changes to the service, what had worked well and where further improvements were needed. The minutes of staff meetings showed that the outcome of incidents, safeguarding concerns and complaints

were discussed. The manager and staff told us there were open and frank discussions about incidents at these meetings about what went wrong and what was needed to make the required improvements. People's relatives told us they also had attended a relatives meeting where they had been told about the new provider taking over the service. They told us they continued to attend these meetings where they are able to have their say and were kept up to date about changes. One relative told us, "Either my sister or I come to the relatives meetings. We can raise anything, there are minutes of the meeting on the desk in reception from the last meeting and I get an email copy as well." Another relative told us, "I have been to relative meetings. People have lots of things to say, it is open and we are able to have our say, the provider and manager want to know how to improve things."

People and their relatives told us they were actively encouraged to share their views and provide feedback about the quality of the service. Comments included, "I cannot praise this nursing home highly enough. Feel very fortunate to have my [Person] in such a lovely caring environment" and "Timely and effective intervention of the manager, all issues were quickly resolved and my [Person] is now content and wonderfully looked after with care and compassion, professionalism and great kindness." And, "[Person] is very well looked after at this care home. Food is well presented and of a very good standard. Happy 'family' feel."

Additionally a comments book was available in the reception area for visitors to write in. Comments included, "My [Person] has been here for two weeks, I can't fault the attitude and care given by all the staff, it just gets better." And, "My [Person] has been in this nursing home since June 2016. They have been given nursing care all this time and has been well cared for in every way. The home is well run and they are doing a superb job." Other comments included, "Chelmsford Nursing Home under the new management is very much improved. I am very pleased with things, nothing is too much trouble." And, "Very good I believe better since the management change, staff always good and very helpful."

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 Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against risks to their health and safety. This was because systems in place to assess and respond to risk were not always consistently applied or managed to protect people from harm or the risk of harm occurring.