Windmill Hills Care Home Limited

Briardene Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 15 and 22 September 2015 and was unannounced.

We last inspected this service in January 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Briardene is a care home for older people, some of whom have a dementia-related condition. It provides nursing care. It has 59 beds and had 54 people living there at the time of this inspection.

The service did not have a registered manager. 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. A new manager had just been appointed and was applying to the Care Quality Commission to be registered for the service.

Systems were in place to protect people living in the home from harm. Staff had been trained in how to recognise and respond to any suspicion of abuse, and were fully aware of their responsibility to keep people safe. People told us they felt safe and protected in the home.

Summary of findings

There were sufficient staff to meet people's needs safely. New staff had been carefully vetted to ensure they were suitable to work with vulnerable people.

People's prescribed medicines were administered safety, but we have suggested improvements for the safe storage of medicines, and for their disposal.

Risks to individual people living in the home had been assessed and addressed, but the more general risks to people using the building had not been properly considered.

People told us the staff team had the knowledge and skills needed to meet their needs. However, staff were not fully up to date with their required training, and were not receiving the necessary supervision and appraisal to support their professional development.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom.

Appropriate assessments had been undertaken of people's capacity to make particular decisions. Where it was deemed that people did not have capacity, we saw that appropriate 'best interest' decisions had been taken, with the involvement of the person's family, and these were clearly recorded.

People were assisted to enjoy a nutritious diet. Any special dietary needs were assessed and met, using advice from relevant professionals, where required.

Staff carefully monitored people's health needs and accessed the full range of community and specialist healthcare services available to make sure people received the healthcare they needed. Staff had been trained to pick up any changes in a person's health or general demeanour and to respond appropriately. There were effective working relationships with NHS and other professionals.

People and their relatives told us they were happy with the caring nature of the service, and with the sensitive and personalised care they received. They told us they were treated with respect and their privacy and dignity were maintained at all times. We saw the relationships between people and staff were positive and affectionate, and staff took an obvious pride in their work.

People enjoyed a good range of social activities and other social stimulation, and staff encouraged people to be as independent as possible.

People's needs were assessed before they came into the home, to make sure those needs could be fully met by the service. People and their relatives were encouraged to be involved in the assessment of their needs, and their wishes about how their care should be given were recorded. Detailed care plans were drawn up to meet all identified needs and personal preferences. These plans were regularly evaluated to make sure they continued to meet people's care needs. People said they were given their care in the ways they directed.

People told us they had little reason to complain, but that any complaints were taken seriously and responded to appropriately.

Changes to the ownership and management of the service over recent months had led to some uncertainty in the staff team and to some confusion about current policies within the home. The auditing systems used to monitor the quality of the service had picked up some areas where performance had dipped and steps had been taken to improve quality. The registered manager had recently resigned and a new manager had just been appointed. However, we found the person-centred culture in the home had been maintained, and people's care had not been significantly affected. We found evidence of good partnership working with other health care professionals.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. Assessments were not in place for all potential risks to people.

Some areas of the management of people's medicines were not fully safe.

Staff were given safeguarding training and were aware of their responsibility to recognise and respond to any actual or potential abuse.

There were enough staff to provide people's care in a safe and timely manner.

Is the service effective?

Requires improvement

The service was not fully effective. Staff had the necessary skills and experience to meet people's needs effectively, but had not been given the training, support and supervision they needed to carry out their roles.

People's rights were protected under the Mental Capacity Act 2005 and no one was being deprived of their liberty unlawfully.

People were given appropriate assistance to maintain a healthy and nutritious diet.

Is the service caring?

Good

The service was caring. People spoke highly of the caring nature of the staff team.

Staff demonstrated a sensitive and caring manner in their interactions with people, and listened to what they said.

People's rights to privacy and dignity were respected at all times.

People were treated as individuals and were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive. People's views were incorporated in the planning of their care and staff delivered care in a person-centred way.

Complaints were taken seriously and responded to appropriately and professionally.

People told us they had plenty of suitable activities and social stimulation.

Is the service well-led?

Requires improvement

The service had not always been well led. There had been recent changes in the ownership and management of the service and it did not have a registered manager in post.

Summary of findings

Systems were in place for monitoring the quality of the service, but they had not proved fully effective. People's views had not been surveyed.

The service worked well in partnership with other agencies and professionals.

Briardene Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and 22 September 2015. The inspection was unannounced.

The inspection team was made up of one adult social care inspector; an expert-by-experience; and a specialist nursing care advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities, clinical commissioning groups and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we toured the building and talked with 12 people, six relatives and visitors, and two visiting professionals. We spoke with 14 staff, including the new manager, regional operations manager, peripatetic manager, deputy manager, projects manager, four nurses, six care staff, four ancillary staff and the activities co-ordinator. We 'pathway tracked' the care of two people, by looking at their care records and talking with them and staff about their care. We carried out a 'short observational tool for inspectors' (SOFI) to gather the experiences of people who could not communicate with us verbally. We reviewed a sample of ten people's care records; six staff personnel files; and other records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with confirmed that they felt safe and that their possessions were also safe. One resident said, "The staff are great, they are helpful and they don't rush us about." Relatives told us they felt the home provided a safe environment. One told us, "I have no concerns about this home."

We looked at how the service protected people from abuse. The safeguarding file contained relevant policies, which were in line with the local authority safeguarding adults team expectations. Staff were given appropriate guidance by means of flow charts and sample documents for reporting abuse. Staff we spoke with told us they had received training in safeguarding training and 'whistle blowing' (exposing bad practice) and were fully aware of their responsibilities for recognising and reporting any suspicion of abuse. Safeguarding records were well-kept and up to date. They contained full details of allegations, any investigations carried out and outcomes. They showed appropriate actions had been taken by the service, including disciplinary action, where necessary. Our records showed the service was diligent in notifying the appropriate authorities of abuse.

We found that risk assessments were in place for people living in the home. Risks had been identified as part of the assessment and care planning process. These included the measures to be taken to reduce the risk of falls whilst encouraging people to walk independently, measures to reduce the risk of pressure ulcers developing or to ensure people were eating and drinking. Standard supporting tools such as the Braden Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments.

We found evidence of the regular checking and testing of fire safety systems and equipment, and of daily maintenance checks of staff call systems and window restrictors. Servicing and maintenance contracts were evidenced in areas such as commercial cleaning, clinical waste disposal and water hygiene testing. However, we found no evidence of the assessment of general risks to people, staff and visitors from, for example, fire, infection or the use of chemicals. The regional manager accepted this and said it had been identified in a recent internal audit.

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

A business continuity plan was in place, with guidance on how the service should respond to threats such as severe weather, utility failure or mass staff sickness. Plans for the evacuation and re-location of the service in an emergency were available.

We saw accidents and incidents were recorded in detail in the accident records. Accidents and incidents were monitored on a monthly basis, but there was insufficient evidence of lessons learned from this analysis. We noted this issue had been identified in the internal quality monitoring report of August 2015.

We noted the service had opened a new nursing unit for people with dementia-related conditions in June 2015. Staff told us this had significantly increased the work load for nurses and care staff, and had made it increasingly difficult to maintain up-to-date records of people's care. We were told by the acting manager one new care worker had been appointed to this unit. We asked the acting manager how staffing levels were calculated. We were shown a dependency rating tool, but offered no documentary evidence that it had been used in practice since being introduced in June 2015. We could not, therefore, assess its effectiveness or the appropriateness of current staffing levels. The regional manager accepted this and showed us a new dependency assessment tool which was being introduced to the service by the new manager. They told us this tool took account of the layout of the building, included non-care hours, and was flexible.

We looked at the recruitment records for the last six staff members employed. Systems were in place for checking people's work and health histories, identity, right to work, and any criminal record they might have. Work and character references were taken up. We found the recruitment systems to be generally sound, but pointed out that two people's employment history had not included full dates of employment.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Systems were in place to ensure that the medicines had been ordered, stored, administered, audited and reviewed appropriately. The staff member checked people's

Requires improvement

Is the service safe?

medicines on the medicines administration record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines. Medicines were given from the container they were supplied in and we saw staff explain to people what medicine they were taking and why. Staff also supported people to take their medicines and provided them with drinks, as appropriate, to ensure they were comfortable in taking their medication. The staff member remained with each person to ensure they had swallowed their medicines. The MARs showed that staff recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. Medicines were stored safely and securely.

Medication audits were undertaken by the registered manager and by a local pharmacist, to check that medicines were being administered safely and appropriately. The most recent medication audits (in August and September 2015) had identified that up-to-date photos (for identification purposes) were lacking for some people; records for the disposal of medicines were incomplete; and the treatment room temperature was too high for the safe storage of medicines.

We noted up-to-date photographs were still lacking for some people, which increased the risk of a person being given another person's medicines. We found gaps in the written records for 'as required' medicines, which meant staff were not provided with a consistent approach when administering such medicines. We found gaps in the records kept of the treatment room and drugs fridge temperatures, and in the records of the disposal of medicines.

All bedrooms and communal areas were mainly clean and tidy although there were some stains on carpets. Relatives confirmed that they were happy with the general level of cleanliness. A visiting health professional told us they felt the cleanliness and hygiene in the home was "Very good". Several relatives had concerns about clothing going missing in the laundry, although one told us it had improved recently.

We recommend that the service considers current guidance on the safe storage, administration and disposal of medicines and takes action to update their practice accordingly.

Requires improvement

Is the service effective?

Our findings

People told us the staff were effective and skilled in meeting their needs.

We looked at the support that staff received in terms of induction, training, supervision and appraisal. We noted the service's internal quality monitoring report for August 2015 had identified that new staff had not been given the necessary induction to the home and to their roles. Our check of training records confirmed that the last 12 staff employed had not been given induction. The service's regional manager accepted this and said they were aware of the deficit.

We asked to see the records of staff training. We were told these were not up to date. We asked for an updated training matrix to be sent to us after the inspection. This showed staff were not up to date in all areas of required training. For example, only 69% of staff had current certificated training in safeguarding adults; 70% in moving and positioning; and 77% in first aid awareness. Staff told us they had not received additional training before the dementia nursing unit had opened, and had not felt prepared for some of the behavioural issues they were required to work with. We saw evidence after the inspection that this training had subsequently been provided to staff.

Some staff told us they received supervision meetings every three months. However, staff supervision records for 2015 showed that eight care workers and seven ancillary staff had been given no supervision, and three of the seven nurses had received only one supervision session. Records showed only one staff member had been given an annual appraisal of their work in the current year. This meant staff were not being given the necessary support to look at their work performance, reflect on practice and discuss any issues.

These were breaches of Regulation 18 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

A relative told us, "I've seen the changes since coming here. My relative is doing much better." A second relative commented, "They have helped tremendously with my relative. The staff are certainly skilled." Another relative said, "The staff really seem to know what they are doing." This was confirmed by a health professional who visited frequently, who told us staff demonstrated an understanding of people's needs.

The Care Quality Commission monitors the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act 2005. They are a legal process followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. Records we looked at provided evidence that, where necessary, assessments had been undertaken of people's capacity to make particular decisions. Where it was deemed that people did not have capacity, we saw that appropriate 'best interest' decisions had been taken, with the involvement of the person's family, and were clearly recorded.

We saw a DoLS screening tool was used to determine if a person's plan of care would amount to a deprivation of the person's liberty. Where this was the case, we saw written applications had been submitted to the local authority for authorisation for such deprivation of liberty. This meant that the person's rights to make particular decisions had been protected, as unnecessary restrictions had not been placed on them.

We saw that the assessment process identified if a person was likely to display behaviours that might cause distress to themselves or to people around them. Appropriate referrals were made to the local authority 'challenging behaviour' team, and behavioural charts completed following any incident of such behaviour. However, we found the risk management plans for such behaviours to be rudimentary and they did not give appropriately detailed guidance to staff. The provider's representatives told us they were aware of this problem and had already arranged a meeting with the challenging behaviour team for advice and guidance on management and recording of such incidents.

We found examples of 'consent to care and treatment' records which had been signed by the person or their relative or representative, if they were unable to sign. However, one person's consent to care and treatment records were unsigned. We noted that a new, clearer,

Requires improvement

Is the service effective?

consent form had recently been introduced. People and their relatives confirmed to us that staff asked for their permission before entering rooms or providing assistance with issues such as mobility, food and drink and bathing.

People's nutritional needs were assessed, using the Malnutrition Universal Screening Tool. There was evidence that advice from dieticians was sought and followed. Where people had been identified as being at risk from malnutrition, their food and fluid intakes were closely monitored. Records showed an individualised approach was taken to diet, support, and any assistive equipment required. Specific dietary requirements were recorded in appropriate detail (for example, "Thickened fluids: use two scoops of 'Thicken Up' clear powder per 200mls fluid"). The person's food likes and dislikes were recorded, for example, "X likes porridge, Weetabix, yoghurts, curry, tuna, likes most foods".

People were registered with local GPs and dentists. Opticians and podiatrists visited the home.

Oral dental and optical care plans were in place. Clear records were kept of visits to and from health professionals, and of any advice given. A relative told us, "They keep an eye on (person's name) and let me know any changes." Another relative said "I've no concerns about Mam's health, they look after her very well and they keep us informed day or night."

Good

Is the service caring?

Our findings

People we spoke with were very happy with the caring nature of the service. One person told us, "The staff are great, things work just great'. A second person said, "Most staff are alright. I get on well with staff. Lately some of them have changed but they're all polite and helpful." Another person commented, "I'm quite happy, the staff are very friendly and helpful'.

Relatives we asked confirmed they were happy with the level of care provided at Briardene. Relatives were also pleased with the caring attitude of staff. One relative told us, "The staff are lovely, and always pleasant. They are getting to know (relative's name). They listen to him and ask him things." Another relative commented, "It's better than I had hoped. They really are good. I'm more relaxed and at ease when I go home. Not worried at all." A third relative said, "This would be a very good place to grow old. It's a lovely care home. I have nothing but good to say about it." A visitor told us, "My relative was so happy here. Staff supported me in every way when she had dementia."

Throughout the visit, the interactions we observed between staff and people who used the service were friendly and respectful. Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, together with their likes and dislikes and were able to describe people's care preferences and routines. One care assistant said, "This is a caring home. We always do our best to give the best care to people. I've seen so many good carers in here, very dedicated. Care is in your heart."

We observed during the visit that staff were friendly and caring with people when supporting them. We spent time observing how staff supported people living at the home and found that staff were respectful in their approach, treating people with dignity and courtesy. We observed that people were asked what they wanted to do and staff listened. We observed staff explaining what they were doing, for example in relation to medication and heard staff say to people "Hello, I've just got your tablets, do you want to take a seat first?", "Hello, how are you feeling would you like (name of medication)?". People responded to staff and seemed very comfortable and at ease with staff.

Our observation during the inspection was that staff were respectful when talking with people calling them by their preferred names. We observed staff knocking on doors and waiting before entering, ensuring people's privacy was respected. People and relatives confirmed that staff treated them with respect and dignity.

People looked well presented in clean, well-cared for clothes with evidence that personal care had been attended to and individual needs respected. People were dressed with thought for their individual needs and had their hair nicely styled.

We spoke with a visitor who was a member of the 'Friends of Briardene', a group of relatives of people currently or formerly living in the home. They told us of their work in supporting staff to give personalised care to people, helping with activities, trips out and fund raising. They told us they also offered support to people and their families, particularly those newly admitted to the home. They said, "We help them with the anger, the guilt and the anxiety many relatives feel, and allow them to express their emotions. We feel very privileged to do this role."

The service had no-one from an ethnic or cultural minority at the time of this inspection. However, staff told us in detail of how people from such minorities had been supported in the past. They told us how they asked the person and their families to give them detailed guidance on issues such as personal hygiene, diet, spiritual needs and communication needs. This information had been used to draw up specific care plans to ensure those needs were met.

Efforts were made to ensure good communication with people and relatives and to pass on information. Each person's care record contained a 'relatives' communication sheet', which recorded all contacts between relatives and staff and was used to pass information and comments. Activities, trips and resident/relatives meetings were advertised on notice boards, and the minutes of meetings displayed. Menus were displayed outside dining rooms.

Each person had a social care plan, with their photograph, personal history, and their likes and dislikes recorded. The Royal College of Nursing/Alzheimer's Society 'This is Me' tool was used to give staff further insight into the person and their life experiences. This is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. Staff told us they kept a close watch on people's well-being and

Good

Is the service caring?

because they knew the people they cared for well, were then able to pick up and report small changes in mood or demeanour that might indicate something more significant.

The acting manager told us that independent advocacy services were available to support those people unable to make decisions about their care and who did not have family or friends who could speak on their behalf. We saw the roles of advocates, including Independent Mental Capacity Advocates were clearly advertised in the service. Staff were instructed to never discuss people they cared for outside of the home or on social media.

The deputy manager told us the confidentiality of people's personal information was taken seriously by the staff team, and gave examples such as asking the administrator or relatives to leave the office when discussing people's personal information with professionals.

Privacy and dignity issues were addressed in people's care plans. We saw staff were careful to knock on bedroom doors and to ensure privacy when carrying out personal care tasks. People were offered the choice of either female or male care workers for their personal care. A 'dignity policy' was displayed in the entrance to the home.

Staff told us they tried very hard to maintain and, where possible, improve people's independence skills. They gave us examples such a person who no longer needed their wheel chair for mobility; a previously bed-bound person who now spent most of their time out of bed; and people who could now eat independently because of the provision of adapted cutlery and crockery. One staff member told us, "We try to re-empower people who are often demotivated on admission." We saw evidence of the use of physiotherapists, speech and language therapists and occupational therapists to maintain people's independence. A relative told us, "(Person's name) is getting out of his room more, now, and walking to the dining room. He is getting physio and it has improved his independence."

We saw people's wishes regarding their end of life care were recorded when they came into the home. A health professional who attended the home weekly told us, "People's end of life care is very good."

Good

Is the service responsive?

Our findings

People told us they felt staff responded well to any requests or to any changes in their needs or wishes.

We asked the opinion of a visiting health professional about the standard of care provided and the responsiveness of the service: they told us it was "Excellent. They identify problems promptly, call us appropriately, and put the needs of people first."

Records showed that people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit to the service. Where available, assessment documentation from the person's social worker or other professional was obtained. The assessment document used by the service prompted the assessor to clearly state if a care plan was required to meet the person's needs in each area. This helped ensure all needs were supported by a care plan.

Care plans detailed the care needs/support, actions and responsibilities staff were to take to reduce the possibility of harm. Plans were specific to the person and often described people's preferences in the first person, for example, "I wish my personal care needs to be met in the following ways…..." The deputy manager told us "We involve carers in drawing up care plans so they are personalised and not too 'nurse-orientated'." We saw examples of this approach in care plans. For example, "X loves to look her best, so having a bit of make-up on and her hair tidy makes her feel much better about herself." Although personalised, not all care plans were signed by the person or their representative.

Care plans were reviewed monthly and on a more regular basis, in line with any changing needs; they were duly signed and dated by a senior member of staff. Staff told us that they were responsible for updating designated people's care plans and we saw that care plans had been reviewed. Relatives told us were aware of, and had been involved in, their relatives' care plan. One relative said. "If there's any change in (my relative's) care needs I just talk to staff or the manager and we just alter things to suit'.

The home had an activities co-ordinator who organised a daily programme of social activities, which included arts, crafts, baking, board games, dominoes, karaoke, bingo and ball games. There were weekly exercise classes and trips out, and monthly visiting entertainers and massage sessions. A pantomime involving staff (and, we were told, hopefully people living in the home) was planned. The service had recently bought some hens which people showed great interest in. The morning activity involved templates of hens to be coloured in or adorned with buttons and craft materials. People's artwork was then put on the wall in the dining room.

The afternoon activity involved both residents and their relatives taking part in an old-time karaoke session which was facilitated by staff. Everyone was fully engaged in the activity and all joined in singing and moving to the songs and music. Around 12 residents and five relatives took part in the activity.

Staff we spoke with demonstrated a good knowledge of people's individual interests and hobbies, and told us how they supplied knitting needles and wool for one person, and helped another person with their crochet work. Staff and relatives gave us examples of people who had previously been withdrawn and avoided social contact becoming more sociable and engaged. A relative told us, "(Person's name) is definitely getting social stimulation. He's not isolated any more, he now joins in things. They ask him what he likes, and let him know what's going on."

We saw people were given choices in areas such as what name and/or they preferred staff to use; what they wore: their make-up, jewellery and hairstyles; meals; rising and retiring times; activities; and where they spent their day. People's wishes about their care at night was recorded, including how many pillows they wanted, whether to have their door or window open, and whether to be checked by staff during the night. The deputy manager told us, "We make it very clear to staff it's the person's choice, and we watch to see they don't get pushed into decisions." Our observations on the units confirmed this. People confirmed they could have their meals in their rooms if they did not want to eat in the dining room. One person told us, "I always have my meals in my room, I prefer it that way."

The service's policy was to record all concerns, even if the person said they did not wish to make a complaint. A log was kept of all concerns and complaints, and seven complaints/concerns had been entered in the previous twelve months. We saw these had been recorded and investigated in good detail (although there was no prompt on the log to specify the outcome of the investigation). Where the concern was upheld, the service took full

Good

Is the service responsive?

responsibility and gave appropriate written apologies to the person. Appropriate steps had been taken to address the reason for the complaint, including disciplinary action, where necessary. People we asked told us they had no current concerns about the service. A relative told us, “We have been visiting for four years and never had a problem.”

Requires improvement

Is the service well-led?

Our findings

People who expressed an opinion on the running of the home were positive about how it was managed, and about the staff and the manager. All the relatives we spoke with were positive about the management of the home. They told us that it was well run and that they had no concerns about their relatives' care. One relative told us, "I would say the home is well-managed, yes. I can knock on the manager's door and I always get a good response."

A visiting health professional commented, "This is a good to outstanding home. It is run really well. At the minute the management is changing and there's slight instability, however it will settle down, as there is good continuity."

The regional operations manager told us there had been significant changes to the structure of the company in the previous six months. The previous provider had been bought out by the current provider and there had been major changes in the management structure. They told us there was a lot of developmental work going on within the new company, but that the new provider had yet to release its policies and procedures (due to be issued in October 2015). This meant staff were operating without clear systems and policies, with previous systems not always being followed. The regional operations manager told us the registered manager had just tendered their resignation, and the service was being managed by a peripatetic manager. A new manager had been appointed and was due to take up post shortly after this inspection. Despite these changes and the resulting uncertainties, we found a well-developed culture of person-centred care, which staff at all levels were committed to continuing.

Staff members told us they felt supported and listened to by both the current and previous managers, and were encouraged to put forward ideas for improving the service.

The provider's representative's demonstrated openness and transparency in describing the recent difficulties the service had experienced. They shared with us from the start the results of internal audits which had identified areas of shortfall in systems and performance over recent months, and did not seek to deflect responsibility. They were able to show evidence of the steps taken to improve the service. Managers and the staff team were honest, open and supportive of the inspection process.

The service had a comprehensive quality auditing system in place, conducted by a manager external to the home. It mapped the degree of compliance of the service against the domains of safe; effective; caring; responsive; and well-led. We saw this audit was comprehensive in scope and detailed and insightful in its application. It clearly identified areas for further development of the service and set a plan for action, with dates for completion, that was regularly followed up. We noted some issues had been actioned. However, we saw many areas of required action had not been completed, despite having been identified as being required at least four months previously. These areas included recruitment practice, premises safety, environmental risk assessments, policy updates, management of medicines and analysis of accidents and incidents.

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

The provider's representatives acknowledged that actions had not been taken sufficiently quickly to address identified problems. The regional operations manager told us, "We are fully aware of the problems in the management of the home." They told us the new management arrangements were a result of this failure to address outstanding quality issues.

No survey of the views of people using the service had been conducted for twelve months. We were told the service was waiting to be advised of the new provider's policy with regard to canvassing people's views. People and relatives we spoke with told us they had a general awareness of the recent changes to the management of the service. They were aware of resident/relative meetings and said they attended some of them.

We found evidence of good partnership working with other health care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. Examples included work with General Practitioners, social workers, dieticians, physiotherapists, occupational therapist, chiropodist and dentists. The service was supported by health professionals from the local 'care home project'. We talked to the General Practitioner

Requires improvement

Is the service well-led?

attached to the service as part of this project. They told us that staff were fully co-operative with the project and made good use of the health care support and advice provided to them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Persons employed by the provider in the provision of regulated activities were not receiving the support, training, professional development, supervision and appraisal required to enable them to carry out their duties.** **Regulation 18 (2) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not ensured the premises were safe to use.** **Regulation 12 (2) (d).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not fully mitigated assessed risks relating to the health, safety and welfare of people using the service.** **Regulation 17 (2) (b).**