Adiemus Care Limited

Briar House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 02, 08 and 11 December 2014 and was unannounced. We had previously carried out an inspection in July and August 2014 where there were breaches in five regulations.

Briar House is a residential care home providing care and support for up to 62 older people, some of whom live with cognitive impairments such as dementia. The home had a registered manager, although this person resigned from their position with the organisation shortly before our inspection. The registered manager did not notify us that they had left the position. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People told us they felt safe and that staff supported them safely. Staff were aware of safeguarding people from abuse and would act accordingly. Individual risks to people were assessed and reduced or removed.

At our inspection on 07 and 10 July 2014, we asked the provider to take action to make improvements to the

Summary of findings

staffing levels at the home, and this action has been completed. There were enough staff available. People, their relatives and staff members all said that staffing levels had improved to ensure people had their care needs met.

Medicines were safely stored and administered, and staff members who gave out medicines had been properly trained. Staff members received other training, such as for moving and handling, fire safety and dementia awareness. Not all staff received regular individual supervision, but they felt better supported to carry out their roles since the interim manager came into post.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service was not meeting the requirements of the MCA or the DoLS. No mental capacity assessments or best interest decisions had been completed and no assessment had been made to determine if DoLS applications were required for people living with dementia. You can see what action we told the provider to take at the back of the full version of the report.

People enjoyed their meals and most people were given choices, although not everyone was provided with this opportunity. Drinks were available to people, although records detailing how much people drank and ate were not always added up or completed in enough detail. This meant the risks to people were not always identified or reduced as much as possible. You can see what action we told the provider to take at the back of the full version of the report.

Health professionals in the community were contacted by the home to ensure suitable health provision was in place.

At our inspection on 07 and 10 July 2014, we asked the provider to take action to make improvements to the way people were treated by staff. People and visitors were generally positive about staff members and although there had been an overall improvement in how people were spoken to, there remained a few staff who did not talk to or treat people with respect. You can see what action we told the provider to take at the back of the full version of the report.

The home did not properly monitor care and other records to assess the risks to people and whether these were reduced as much as possible. You can see what action we told the provider to take at the back of the full version of the report.

At our inspection on 07 and 10 July 2014, we asked the provider to take action to make improvements to the planning of care needs. Not all of people's needs were responded to well. Most care plans contained enough information to support individual people with their needs, although there was no guidance in relation to people not drinking enough or caring for people with oxygen. There was not enough information about how dementia affected people who lived with it. You can see what action we told the provider to take at the back of the full version of the report.

A complaints procedure was available and concerns and complaints made in the last 12 months had been investigated and dealt with appropriately.

There had been difficulties in the management of the home, with a conflicting relationship between the previous manager and staff members. This had improved since the interim manager had come into post, although there continued to be areas of mistrust and antagonism between some staff.

At our follow up inspection on 07 August 2014, we asked the provider to take action to make improvements to the quality monitoring of the home. There was a quality monitoring system in place and although this identified issues and areas of shortfall, there had been inadequate action taken to address and improve these areas. You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was safe.

People were supported by enough skilled staff to fully meet their needs and to keep them safe.

Risks had been assessed and acted on to protect people from harm.

Medicines were safely stored and administered to people.

Good

Is the service effective?
The service was not effective.

Recent clarification of the Deprivation of Liberty Safeguards had not been acted upon and mental capacity assessments had not been completed.

Staff members received enough training to carry out their roles and they made sure the health care needs of people were met by local health care practitioners who visited the home.

Meals were supplied with choices and drinks were available, although records to show what people ate and drank were not always completed to ensure a low intake was recognised.

Requires Improvement

Is the service caring?
The service was not always caring.

Most staff were polite, kind and caring towards people. A few staff treated people in a disrespectful way that denied them the opportunity to make decisions.

Requires Improvement

Is the service responsive?
The service was not responsive.

People did not have all of their care needs planned for, which put people at risk.

People were given the opportunity to complain and those complaints were acted upon appropriately.

Requires Improvement

Is the service well-led?
The service was not well led.

Systems required to monitor the quality of the service provided were not always completed and actions were not addressed when areas of shortfall were identified.

Requires Improvement

Summary of findings

People, relatives and staff commented that the management of the home had improved since the interim manager came into the post, although there remained some disharmony between staff members.

Briar House

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 02, 08 and 11 December 2014 and was an unannounced inspection.

The inspection was carried out by three inspectors.

Before we visited the home we checked the information that we held about the service and the service provider. For example, notifications that the provider is legally required to send us and information of concern that we had received. 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.

During our inspection we spoke with eight people who used the service and five visitors. We also spoke with 11 staff, including care, activities and housekeeping staff, and the interim manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We completed general observations and reviewed records. These included 13 people's care records, three staff recruitment records, staff training records, eight medication records and audit and quality monitoring processes.

Good

Is the service safe?

Our findings

Two people said they felt safe. One person told us that, "Sometimes staff don't have enough time to help me with personal care" and another person said, "They have been short staffed". We spoke with three visitors who all told us that they felt their family members were being cared for in a safe way. They said they had no concerns about their relatives' safety. Two visitors told us that the home had been short staffed but that new staff had been recruited and that staff levels had improved in recent weeks.

The staff we spoke with told us that there were enough staff to meet people's needs and we observed this on the day of our inspection. A rota was produced detailing how many staff were needed to provide care. The interim manager and staff told us that new staff members were being recruited and that there had been an increase in the number of staff working each shift in the two months prior to our inspection. They told us that there had been a significant problem with the level of sick leave taken by some staff members and that they were addressing this to ensure there were adequate staffing levels. We concluded that although there had been difficulties with staffing levels this was being addressed and there had been an improvement in the two months prior to our inspection.

The people who lived at the home were protected from the risk of abuse as the provider had taken the appropriate action to protect them. Staff members we spoke with understood what abuse was and how they should report any concerns that they had. They all stated that they had not had occasion to do so. There was a clear reporting structure with the manager and deputy manager responsible for safeguarding referrals, which staff members were all aware of. There were written instructions for staff members regarding what to do in the event that they felt people were not safe or had been abused. Staff members we spoke with knew where these were kept and we saw that information for visitors was located in an easily accessible area within the home.

Staff members had received training in safeguarding people and records we examined confirmed this, although not all staff members were aware of the external agencies involved in protecting people if they wanted to report an incident directly. The provider had reported safeguarding incidents to the relevant authorities including us, the Care Quality Commission as is required.

Risks to people's safety had been assessed and records of these assessments had been made. These were individual to each person and covered areas such as; malnutrition, behaviour, medication, moving and handling, and evacuation from the building in the event of an emergency. Each assessment had clear guidance for staff to follow to ensure that people remained safe. Our conversations with staff demonstrated that they were aware of these assessments and that the guidance had been followed. We saw during our visit that some people who lived in the home displayed behaviour that might upset others. Staff members were able to describe the circumstances that may trigger this behaviour and what steps they would take to keep other people within the service safe.

Servicing and maintenance checks for equipment and systems around the home were carried out. Staff members confirmed that systems, such as for fire safety, were regularly checked and we saw records to support that this was completed. Staff told us that they regularly practised fire drills and were aware of what action they needed to take in the event of the fire alarms sounding. We checked a range of equipment during our inspection including fire extinguishers, hoists and weighing scales and noted they had all been serviced within the last year to ensure their safety for people. However, information to advise staff and visitors of the first aid qualified staff on duty was not accurate, which may lead to confusion in an emergency.

The recruitment records of staff working at the service showed that the correct checks had been made by the provider to make sure that the staff members they employed were of good character.

We found that the arrangements for the management of medicines were safe. They were stored securely in a locked room with access restricted to senior staff only. Temperature checks of the room and fridge where medicines were stored were conducted daily to ensure they were within safe limits. Medicine administration records were fully completed and accurate showing, in all but one instance, that people had been given their medicines as prescribed. We observed staff giving people their medication during lunch, and noted it was done safely and sensitively. We could therefore be assured that people would be given medicines in a safe way to meet their needs.

Requires Improvement

Is the service effective?

Our findings

We found that improvement was required regarding people's ability to consent and make decisions in their lives. Although staff told us they had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), most staff members' knowledge and understanding of this important legislation was poor when we spoke with them. We saw evidence of these principles being applied during our inspection; staff were seen supporting people to make decisions and asking for their consent. However, some staff failed to recognise ways in which people's liberty might be restricted in the home. One staff member consistently told a person to sit down during their lunch each time they rose from their seat. Another staff member told us that they felt staff needed further training in this area, in order to understand that best interests' was for the person's benefit, not the care staff.

People's mental state and cognition was assessed by staff. However, this assessment did not give clear guidance to staff about people's level of capacity for consent, and what decisions they could make for themselves, and those they might need others to take in their best interest. In one instance, one staff member told us a person could give their consent, another staff member told us they could not. There was no information in the person's care plan about this.

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards. Prior to the interim manager coming into post only one application had been submitted to the local authority's DoLS team, although there was more than one person without capacity who staff would have prevented from leaving the home. The interim manager was not aware of changes following recent clarification of the DoLS legislation and no further applications or assessments of whether applications may be required had been made. The provider did not have effective systems in place to ensure actions required by the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were followed or carried out. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that improvement was required in the monitoring of people's food and fluid intake. The amount of food and drink being consumed by people was not being recorded effectively to ensure they received as much food as they needed to maintain or increase their low weights. Fluid charts had not always been added up at the end of a 24 hour period, which meant that staff may not always know when people did not drink enough fluid each day. On one occasion a person had less than a litre to drink on six consecutive days, on three of these days they had less than 500ml. The recorded amounts on these records had not been added up. A staff member told us they did not know how much the person had drunk each day. Food records were completed with the amount of food eaten but there were no details of what food had been eaten. This meant that the food records could not enable an accurate assessment of a person's nutritional intake. The provider did not have effective systems in place to ensure accurate records were kept. This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with told us that they liked the meals provided to them. Two comments were, "Food is pretty good" and "In the main the food is good". A relative of one person told us that his parent had put on weight since living at Briar House. Another relative told us that staff monitored her family member's health well, telling us, "They make sure he has his diabetic and warfarin checks all the time, and if he has a fall they always get the doctor straight away".

The staff we spoke with told us that they had received enough training to meet the needs of the people who lived at the service. One staff member recalled a particular training where they were given different types of glasses to wear to emulate various eye conditions. They told us this had helped them better understand the needs of people with visual impairments. Another staff member told us, "I'm always on training" and went on to describe that they would become the home's 'diabetes champion'.

We checked training records and saw that staff members had received training in a variety of different subjects including; infection control, manual handling, safeguarding adults, and dementia care. However, we identified that staff members had not received training in caring for people with oxygen or the equipment used to deliver the oxygen. This put people at risk as staff members did not have the skills to ensure the equipment was working properly or safe to use. Information received prior to our inspection told us that a third of staff members had been gained a national qualification, such as a National Vocational Qualification or

Requires Improvement

Is the service effective?

a Diploma, at level two or above. We observed staff members in their work and found that most were consistently tactful, patient and effective in reducing people's anxiety, aggression or in delivering care.

Only one third of the staff members we spoke with told us that they had supervision meetings with their line manager in which they could raise any issues they had and where their performance was discussed. However, all staff we spoke with said that they felt more supported by the interim manager and the felt they could go to him with any issues. Staff records confirmed some staff had received supervision but that others had received no formal support at all. The interim manager was aware of this and had taken action to address the lack of formal support. One staff member told us about the new supervision arrangements that were being introduced. All staff members told us they had staff meetings, which kept them up to date with changes. We concluded that although not all of the staff working at the home had the opportunity to individually discuss their work and development needs, most felt increasingly supported in the two months prior to our inspection.

In two areas of the home people were provided with a choice of nutritious food. We observed people enjoying the food that they ate. Staff showed people the choices available, offered them the food that they chose and prompted them to eat and drink when necessary. In the third area, people were not offered a choice of meal at lunchtime. One staff member told us this was because people couldn't communicate their preference. However we found that at least two people on this unit would be able to make a choice of what they wanted to eat if supported in the right way.

We saw that staff members adapted their support to each person, for example one person struggled to eat with traditional cutlery and staff offered them adapted cutlery. One staff member used touch well, gently squeezing the person's arm to indicate that the next mouthful was ready. Staff members helping other people were attentive, spoke with people appropriately and allowed the person to eat at their own pace.

There was information within people's care records about their individual health needs and what staff needed to do to support people to maintain good health. People saw specialist healthcare professionals when they needed to and staff members took the appropriate steps to ensure any advice given was followed. For example, some people had been provided with a more specialised diet, such as a puree diet as a result of this advice.

Some aspects of the home's environment were responsive to the needs of people with dementia. There was dementia friendly signage indicating to people where toilets and bathrooms were. There was easy access to outdoor areas, although we noted some of the pathways were overgrown making them dangerous for people to use. Corridor walls had been decorated with reminiscence items, and tactile objects for people to fiddle with. Corridors were uncluttered and wide, making them easy and safe for people to walk along. However, other aspects of the home's environment were confusing with poor signage and orientation aids to help people find their way about. There were no signs to indicate where people's bedrooms were, or where key areas such as the main lounge, dining room or manager's office were. Information displayed for people on some walls was out of date. In one area, the activity schedule was dated 17 November 2014, and the menu in the dining was very of date, and did not reflect the food that was actually served. This could be confusing for people.

Requires Improvement

Is the service caring?

Our findings

We carried out an unannounced inspection of this service on 07 and 10 July 2014. At that inspection we identified a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because of concerns in relation to how people were treated by staff members and that their privacy and dignity was not respected.

During this inspection we found that improvement was required regarding how some people treated or spoke about people. We noted some disrespectful and labelling behaviour from one staff member who used terminology such as, "Feeds", "Those lot" and "You lot" to describe and speak about people. This staff member continually berated one person during their lunch meal when they acted in a way the staff member did not feel was appropriate. Other staff members did not always take people's wishes into account and presumed that all people on one unit would not be able to make a decision. We noted one person still wearing a dirty lunch tabard at 3.30 pm. This person still had food on their chin and jumper that had not been wiped away by staff. We recognised that there had been significant changes since our inspection in July 2014, however further improvements are needed to ensure that people are treated with respect and dignity.. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the people we spoke with were happy living at the home and most were happy with the staff members. One person said, "Staff are mainly okay, they are a bit too talkative" and another person commented that, "Staff are a bit abrupt sometimes when they bring in meals and drinks". All of the visitors that we spoke to told us that they were happy with the care provided by staff members. One relative told us, "[Member of staff] is always coming in to check on dad, and to see if he needs anything. The staff take the time to talk to us when we visit". Another relative reported, "Staff all know me, If I'm a bit upset they always give me cup of tea and sit with me".

Most of the interactions we observed between staff people throughout our inspection were good, with staff showing respect and understanding of people. One member of staff assisted someone to eat their lunch very sensitively, talking to them throughout, explaining to them what they were eating and ensuring the person was ready for the next mouthful. People looked well cared for and were relaxed with the staff who were supporting them. Most of the staff were polite and respectful when they talked to people. They made good eye contact with the person and crouched down to speak to them at their level so not to intimidate them. Where staff members did not understand the requests of people who found it difficult to verbally communicate they showed people using actions, which sometimes helped. One member of staff told us that when she visits her hometown on holiday, she always brings back particular sweets made at a local factory which she knows one person likes.

Staff involved people in their care. We observed them asking people what they wanted to do during the day and asking them for their consent. Most people were given choices about what to eat, drink and where to spend their time within the home. There was little evidence to show that, where appropriate, people's relatives and advocates were actively involved in their care planning and review. Three relatives we spoke with told us they had never seen their family member's plan of care, despite visiting them regularly, and being very involved in their day to day lives.

We observed staff respecting people's dignity and privacy. They were seen quietly asking people whether they were comfortable, needed a drink or required personal care. They also ensured that curtains were pulled and doors were closed when providing personal care and knocked on people's doors before entering their rooms.

Staff were able to demonstrate a good knowledge of people's individual preferences and information in relation to the people's individual life history, likes, dislikes and preferences was recorded in care records. However, we saw that records usually kept with people in their rooms were often collected by staff members but left in communal areas on the floor or chairs when the staff member left the area. This puts the confidentiality of information about people using the service at risk.

Requires Improvement

Is the service responsive?

Our findings

We carried out an unannounced inspection of this service on 07 and 10 July 2014. At that inspection we identified a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because of concerns in relation to personalised care for people generally and for those living with dementia, and in the planning of care for people with a high risk of developing pressure ulcers.

At this inspection we found that there continued to be shortfalls regarding planning care around care needs identified for some people and further improvement was required. Care plans had not always been written for all identified needs and where they were written they did not contain adequate guidance.

For example, for people who received oxygen and for people who were at risk of dehydration. We looked at plans for two people who received oxygen. One person had a care plan for this, although it provided no guidance for staff to ensure the oxygen delivery equipment was monitored or working properly. The other person had no care plan to guide staff in looking after them or their oxygen equipment. Oxygen for one person had run out while they had been out of the home and this had meant the oxygen in their blood dropped to a very low level. Although the provider had an oxygen management policy to guide staff, staff members were not able to tell us the checks that should be carried out on the equipment. One staff member told us that although checks were carried out on face masks and nasal cannulae for debris, these were not recorded anywhere. We also noted that when checks had been completed, these were not as frequently as the provider's policy required. This placed the people receiving oxygen at an unacceptable risk of machine or equipment failure.

Similarly, there was no guidance for staff members for those people whose fluid intake they measured, who were at risk of dehydration. Nearly all of the fluid intake records that we looked at had days where people had drunk less than a litre in a 24 hour period. There was no guidance for staff members about how much fluid each person should drink, nor what action they should take if the person did not drink the desired amount. This puts people at risk of dehydration and increases their risk of other health issues, such as pressure ulcer development and urinary tract infection. The provider did not have effective systems in place to ensure care and welfare was properly planned for. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People living in the home and the relatives we spoke with told us the interim manager and staff listened to their concerns and tried to resolve them. One person told us, "If I had worries I would speak with the deputy or senior". One visitor told us that they had had concerns about their relative before the interim manager had come into post that had been, "Brushed off". However, they were increasingly reassured as action was taken after they had discussed their concerns with the interim manager.

The care and support plans that we checked showed that the service had started to change the format of their written documents. Where the new format was being used a full assessment of people's individual needs had been conducted to determine whether or not they could provide them with the support that they required. Care plans were in place to give staff guidance about how to support people with most of their identified needs such as personal care, medicines management, communication, nutrition and with mobility needs. There was information that detailed people's daily routine, their preferences and what they may be reluctant to participate in.

Care plans provided some guidance for staff in caring for people living with dementia. These were plans written for other areas, such as personal care, but where staff members had difficulty helping or supporting people with those activities. For people who displayed behaviour that may upset others that was not associated with other areas of their care, for example, taking food from another person's plate or calling out frequently, there was no guidance for staff members. Staff who we spoke with were familiar with people and were able to provide us with clear explanations or descriptions of the behaviour. However, this would not be adequate guidance and information for new or inexperienced staff members.

Not all staff members regularly looked at people's care plans as a means to better understand their care needs. One staff member told us that senior care staff wrote the care plans and other care staff were told they needed to read the plan if the person's care needs had changed. Another staff member told us they, "Never bothered" to read people's plans of care, stating that they were boring to

Requires Improvement

Is the service responsive?

read and they never got the time to. Without reading people's plans, it was not clear how the staff member knew how to care for them consistently and in a way that they had agreed to in their plan.

People had access to a number of activities and interests organised by a designated staff members on each floor. We spoke with one of the home's activity co-ordinators. She had undertaken a level 3 qualification in reminiscence therapy and demonstrated a good knowledge of the types of activities suitable for people in the home, and the importance of sensory stimulation for people living with advanced dementia. She told us she was working with people to document their life history, and using this information to create bespoke activities for them. For example, a number of people had enjoyed gardening when they were younger so she had purchased a greenhouse for the home. She had also recently started a knitting club in response to people's requests. She reported the home had good links with local community groups such as primary schools, The Lions Club and Duke of Edinburgh groups, who visited to help provide activity and entertainment for people.

However, we found that the people's diversity and wishes around religious beliefs was not well documented or supported. One person's care plan stated they did not want to attend religious services. However, when we spoke with them they told us they were religious and actively enjoyed attending the home's monthly church service. They also told us they enjoyed going to the pub and watching sport but had little opportunity to do this in the home.

We observed that staff were responsive to people's needs. They provided them with drinks when people indicated that they were thirsty, food when it was requested and provided personal care in a timely manner. Although care staff regularly interacted with people in all areas of the home, there was no meaningful activity offered by them to anyone throughout our visit. In one area six people spent the day in bed, and three people spent the day in the lounge with little stimulation. We found that although the service had employed designated staff to assist with sensory stimulation, the lack of involvement by care staff meant that people did not receive enough interaction or positive stimulation for their wellbeing.

Staff members told us that information was available for people if they wanted to make a complaint. They felt that visitors knew how to raise concerns and complaints and that they would either speak with a staff member or the manager. A copy of the home's complaint procedure was available in the main reception area and provided appropriate guidance for people if they wanted to make a complaint. Information provided prior to this inspection indicated the service had received two complaints in the preceding 12 months, the interim manager confirmed that two further complaints had been received. We were already aware of one of these complaints and the investigations and actions taken around these. We looked at the most recent complaint and saw that actions had been taken to resolve this complaint and an immediate response had been made. We were therefore satisfied that the response to people's complaints had improved and these were dealt with appropriately.

Is the service well-led?

Our findings

We carried out an unannounced inspection of this service on 07 August 2014. At that inspection we identified a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because of concerns in relation to assessing and monitoring the quality of the service provided and the actions taken to address issues identified during this monitoring process.

During this inspection we found that further improvement was required in the quality monitoring of the service. We found that there had been some improvement since our inspection in August 2014 and that the organisation's quality monitoring team had identified issues in October 2014 that we had also identified at this inspection. The interim manager was working through their report to rectify issues raised, although these had only started to be addressed since he had come into post in October 2014. There was little evidence that any adequate action had been taken prior to this. We found that there continued to be concerns in areas that had been raised previously either by us or by the organisation's quality monitoring team, such as the quality of fluid intake charts and care plans to ensure people receiving oxygen were cared for properly. For some people this had resulted in lengthy periods without enough to drink or oxygen running out.

Staff at the home completed audits that fed into the organisation's quality monitoring audit. We looked at the care plan audit for September 2014 and found that of the five audits completed only two had information to show an action plan had been developed or dates when the actions had been addressed. Staff told us their everyday working practices were not formally assessed to ensure they were providing good quality care to people. The provider did not have effective systems in place to monitor the service provided. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our observations, it was clear that the people who lived at the service knew who the manager was and the staff who were supporting them. Staff members spoke of the increased support they felt since the interim manager had come into post. Staff told us they had confidence in the interim manager's ability and that he had brought about much needed changes to the home. One stated, "[Manager's name] a good manager and he's definitely been addressing things". Another commented, "He seems very fair and listens to our ideas". Staff reported their morale was getting 'a little better' as a result. One visitor told us they had previously heard staff members complaining, but that, "Staff much happier now and don't back chat".

However, this was not the understanding in all areas of the home. One staff member told us, "I have had five different mangers in the seven years I've worked here, and another one is about to start". Another staff member described to us tensions between different groups of staff. One family member reported, "It's not a very harmonious place to work, there's lots of back biting. We know as staff talk to us about it". The visitor went to tell us that some staff, "Have got it in for" another staff member.

Staff said that they were kept informed about matters that affected the service through team meetings and talking to the manager regularly. One staff member said that the service was trying to recruit new staff. A relative who we spoke with also told us that they were aware of this and that the home was actively recruiting new staff.

The home no longer had a stable management team in place. The registered manager had been in post since March 2014 and had resigned her position from the organisation two months prior to this inspection. The interim manager told us that another permanent manager had been recruited and would start shortly before Christmas.

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 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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have an effective system in place to assess and monitor the information contained in people's care records. Regulation 10 (1) (b), (2) (b) (iii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider did not ensure that the Deprivation of Liberty Safeguards were upheld to prevent the unlawful restraint of people living with dementia. Regulation 11 (1) (a), (2) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People's dignity and independence was not always maintained and they were always able to make decisions about their care. Regulation 17 (1) (a), (2) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **People were not protected against the risks of receiving unwanted care or treatment because mental capacity assessments and best interest decisions were not made in line with Section 4 of the Mental Capacity Act 2005. Regulation 18 (1) (b), (2).**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risks of unsafe care because accurate records were not kept in relation the care provided. Regulation 20, (1) (a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services were not protected against the risks to their welfare associated with unsafe or inadequate care because not all identified care needs had plans to guide staff in meeting those individual needs. Regulation 9 (1) (b) (I, (ii).

The enforcement action we took:
A warning notice was served on the provider, giving a timescale of 28 days for them to comply.