

# Barchester Healthcare Homes Limited

# 12 June 2014

## Inspection Report

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Date of inspection visit: 12 June 2014  
Date of publication: 08/08/2014

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# Summary of findings

## Overall summary

Werrington Lodge is care home providing accommodation and nursing care for up to 82 adults. There were 78 people living there when we visited on 12 June 2014. The care home provides a service for people with physical nursing needs and for people living with mental health or dementia. The home comprises two units that each provides differing care services. There is currently an interim manager at the home.

During the course of our two day inspection on 08 and 12 May 2014 we had found significant concerns about the care people were receiving in the home and we took immediate action to safeguard them. We issued the provider with three warning notices as they had been

breaches in Regulation 14(1)(a) and (c), Regulation 17(1)(a) and (2)(a) and Regulation 9(1) of the Health and Social Care Act 2008. We asked the provider to be compliant with these regulations by 30 May 2014.

We returned on 12 June 2014 to check if the provider had taken action to address the concerns raised and if they could demonstrate compliance with the warning notices.

We found that there had been some improvement in the care that people received, however, we found that there were a number of continued breaches in the Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2010 at Werrington Lodge. 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.

### **Are services safe?**

We found that staff lacked knowledge of the Mental Capacity Act (MCA) (2005). Documentation was incomplete and this demonstrated that staff did not have a good understanding of the MCA and how it should be applied.

We found that information was missing from a Do Not Resuscitate form. This included why the decision had not been discussed with the person and there were no dates recorded when decision were taken. This meant that the formal assessment had not been completed appropriately.

### **Are services effective?**

We found that there were less people nursed in bed in the home during our inspection and that people were now encouraged to spend time in the communal areas within the home. We noted that the number of people nursed in bed during our inspection was based on the person's choice or the clinical needs of the person.

During our inspection on 08 and 12 May 2014 we had looked at ten people's care plans. We looked at these again during our inspection on 12 June 2014 and found that four of the care plans had still not been reviewed. This meant that for these people their care plans were still not clear in relation to their current needs.

We found that the provider was still failing to ensure that people at risk of falling had an appropriate plan in place to minimise the risk of falls and to reduce injury to people if they fell.

We had observed during our inspection on 08 and 12 May 2014 that people who were nursed in bed did not have access to a drink and that staff were not recording when they had given people a drink. We observed on 12 June 2014, that there had been an improvement and that the majority of people that we saw on the day of the inspection had access to a drink in their rooms.

However, there were continued inconsistencies in record keeping and we found gaps in people's food and fluid charts and we were unable to find evidence that these people had had a drink.

During our inspection on 08 and 12 May 2014 we reviewed records of when people were being supported to re-position, in order to minimise the risk of pressure ulcers developing. We noted there had been some improvements in the completion of these records, however, there was still some inconsistency in record keeping.

# Summary of findings

During our inspection on 12 June 2014 we observed the lunchtime period on both units within the home. We found that on the memory lane unit, the lunchtime period was un-managed and lacked structure. The lack of organisation meant that people had to wait for their meals and were not assisted as required.

We looked at two people's care records which stated they needed prompting with food as they were losing weight. We found that staff were failing to keep accurate food and fluid charts for these people and so it was unclear how much they were eating and drinking. This meant that they were not being protected against the risks of inadequate nutrition and hydration.

## **Are services caring?**

We found that there had been an improvement in the number of people who were encouraged to sit in the communal areas within the home. However, we observed a number of missed opportunities for valuable and meaningful interaction between staff and people, especially with people who received one to one care.

There was still only one activities organiser employed to provide stimulation for the 78 people living in the home, and during our inspection on 12 June 2014 we observed no planned activities taking place for people. The emphasis remained on the care staff to support them in providing stimulation and activities for people, however, this did not happen on a regular basis as staff were busy with other tasks.

During our inspection on 08 and 12 May 2014, CQC staff had intervened and alerted staff when people in the home required help. We had also observed that people's privacy and dignity had not been maintained.

During our inspection on 12 June 2014, we did not observe any incidents when we were required to intervene or alert staff and we observed that staff had closed doors to people's bedrooms and communal toilets and bathrooms when they delivered personal cares.

## **Are services responsive to people's needs?**

During our inspection on 12 June 2014 we observed that there was a continued lack of planned activities for people. We saw that people mainly spent their day asleep when they were not having their meals. All three members of the CQC team observed many missed opportunities when staff could have interacted with people who lived in the home.

# Summary of findings

When people received one to one care, we saw that there was little evidence to show that they were given any social stimulation or supported to be more involved in activities in the home.

## **Are services well-led?**

We met with the interim manager and the deputy manager of the home before, during and after our inspection. We were informed that the interim manager had been in post since 09 June 2014.

We observed that both the interim manager and deputy manager had established a good rapport with staff and were caring and supportive in their manner.

We saw that there were enough staff on duty to meet the needs of the people. However, it was noted that the number of staff had been supplemented by agency staff. We observed that these staff lacked direction and we fed this back to the interim manager on the day of our inspection.

# Summary of findings

## What people who use the service and those that matter to them say

During the course of our inspection on 12 June 2014 we spoke with seven people who lived in the home. People we spoke with were positive about the care they received, however, felt the recent management changes in the home had left staff feeling unsettled and a relative told us that they felt unsure of who was 'in charge' of the home.

One person who lived in the home told us: "I am quite happy living here. I stay in my room and just go down for lunch. I have no complaints about anything really." Another told us: "I had help this morning to get up and get dressed and I had a lovely breakfast. Am I happy living here, yes I am."

We spoke with one person who used the service who was being nursed in bed. The person told us that the staff were caring and kind but that they wanted them to spend more time with them and others. The same person told us that she would like to go to the shops or out for the day.

We also spoke with relatives who were visiting the home. One person told us: "I have always been happy with the care (relative) has received here. We choose the home for the care and the staff, but we feel that they (the staff) don't know if there are coming or going with all the changes at the moment. It does feel very unsettled, but (relative) is ok and it's not affected her care."

# 12 June 2014

## Detailed findings

### Background to this inspection

We visited the home on 12 June 2014. This inspection was planned to check if the provider had taken action to address the concerns we had raised at previous inspections on 08 and 12 May 2014 and if they could demonstrate compliance with the warning notices which had been issued.

The inspection team consisted of a lead inspector manager and two inspectors. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We spent time observing care and support in lounge areas and dining rooms. We looked at all communal areas of the building and observed the lunchtime meal delivery in both units of the home. We looked at records, which included people's care records.

On the day of inspection we looked at the care records which related to ten of the 78 people living at Werrington Lodge. We spoke with the interim manager of the location, the deputy manager, seven people living in the home, three trained nurses and 11 other staff on duty.

# Are services safe?

## Our findings

During our inspection on 08 and 12 May 2014 we looked at the care records in relation to mental capacity assessments for people who lived at Werrington Lodge and found that the Mental Capacity Act (MCA) 2005 was not being adhered to. This is an act introduced to protect people who lack capacity to make certain decisions because of illness or disability.

During our inspection on 12 June 2014, we reviewed a person's care record that we had highlighted concerns about during our inspections of the 08 and 12 May 2014. Our concerns related to the care this person received and how this was reflected in their care records.

During the review of their care record on 12 June 2014 we found that their Mental Capacity Assessment had not been completed correctly. There were no dates and a poor use of language. The MCA stated: "xxx is not free to leave the service" and that the one to one supervision was to have: "Complete and effective control over xxx's day to day living".

The poor use of language and incomplete documentation demonstrated that staff did not have a good understanding of the MCA and how it should be applied. This also meant that staff did not have the correct information they required to make decisions for people who lacked capacity, based on what was in the person's best interests.

We spoke with the interim manager and deputy manager in relation to the MCA for this person and in general for other people living in the home. They informed us that all MCA documents were in the process of being reviewed and this would be carried out in conjunction with the local authority vulnerable adult safeguarding team. We also spoke with the interim manager and asked whether the service was applying Deprivation of Liberty safeguards (DoLS)

appropriately. They told us that all people currently living in the home would be reviewed and discussed as appropriate with the local authority vulnerable adult safeguarding team.

During our inspection on 08 and 12 May 2014 we looked at people's care records and we saw that some people had a Do Not Attempt Cardiopulmonary Resuscitation (DNAR) form in place.

During our inspection on 12 June 2014, we reviewed a person's care record that we had highlighted concerns about during our inspections of the 08 and 12 May 2014. Our concerns related to the care this person received and how this was reflected in their care records.

We reviewed this person's care records and found that the DNAR form for this person had not been filled in correctly. Not all questions had been answered, there was information missing from the form which included why the decision had not been discussed with the person and there were no dates recorded. This meant that the formal assessment had not been completed appropriately and that the wishes of the person may not be adhered to at the end of their life.

This meant there had been a continued breach of the relevant legal regulation's (Regulation 18, Regulation 20 and Regulation 9 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

During our inspection we spent some time sat in one of the lounge areas on the memory lane unit. The doors in the unit were open and led out into the garden area. We observed before lunchtime, that vermin were visible in the garden area. The garden area was unkempt with long grass and in need of attention. The vermin did not enter the lounge and they ran across the garden. We informed the interim manager at the end of our inspection who told us that they would take immediate action. We have confirmed with the local authority that action has been taken to address this problem.

# Are services effective?

(for example, treatment is effective)

## Our findings

During our inspection on 08 and 12 May 2014 we had concerns about the number of people who were left in bed for most of or all of the day, for no apparent reason.

During our inspection on 12 June 2014, we found that this situation had improved and the majority of people were sitting in the communal areas on the memory lane unit. We commenced a tour of memory lane between 1200 and 1300 and found that 6 out of 38 people were in their rooms, however, no one was in bed. We observed that people who were in their room had made that choice and were either sat watching television or asleep on their bed.

We found there had been an improvement in the number of people nursed in bed on the elderly frail unit. We observed that between 10:25am and 11:40am, 12 out of the 40 people cared for on the unit were in bed. We spoke with the deputy manager prior to commencing the inspection and they had identified seven people who were normally nursed in bed. We asked them why the five people were in bed as they had not been identified to us. We were told this was due to clinical need or the person's choice. This was confirmed by looking at the care records and speaking with other staff. For example, one person had not slept all night and was resting as they were tired and another had been sat out in their chair and had asked to go back into bed.

During the inspection on 08 and 12 May 2014 we had looked at the care plans, risk assessments, and daily records and raised concerns with the provider in relation to ten people who lived at Werrington Lodge. We had found that the care plans for these people were not clear in relation to their current needs and that staff were not following the care plans in a consistent way.

During our inspection on 12 June 2014, we reviewed the care plans for these people to see if action had been taken by the provider. We saw that there had been some improvement. We looked at the ten care plans and we saw that action had been taken to review and update six of them. However, we found a continued lack of consistency and up to date reviews in four of the care plans. This meant that for these people their care plans were still not clear in relation to their current needs.

People were not protected from falls or the risk of falls. During our inspection on 08 and 12 May 2014 we had reviewed one person who was identified as being at high

risk of falls. Staff had recorded that the person should wear non slip socks as a step to minimise the risk of falling within their mobility care plan. We observed on the 12 June 2014 that they were still not wearing non slip socks.

We observed the falls record for this person and noted that since our last inspection on 08 and 12 May 2014, the person had suffered two further falls. Their falls diary noted these falls on 24 May 2014 and 06 June 2014. There was also an accident record dated 13 May 2014, which recorded that the person had fallen a further time. This was not documented in their fall's diary. There was no action recorded on the accident report form or within their care plan as a result of these falls.

The person's care plan stated their falls care plan should be updated monthly or when required to minimise the risk of falls. The care plan was last reviewed on 29 January 2014. There had also been no change to the risk assessment to minimise the risk of falls. The person had continued to fall regularly therefore, the provider is failing to ensure that people at risk of falling have an appropriate plan in place to minimise the risk of falls and to reduce injury to people if they fall.

We reviewed the care plan for a person whose care had been highlighted within the warning notice (dated 19 May 2014). We saw their care plan identified that a trigger for their challenging behaviour was noise and that they especially did not like loud noises. We observed them in their room and noted that in the room next door was a person banging and shouting very loudly. This happened during the whole of our inspection. This loud noise could be clearly heard in the person's room and may have triggered their challenging behaviour. This meant that the provider is failing to ensure that they are delivering care to the person's assessed needs.

We reviewed another care plan for a person whose care had been highlighted within the warning notice (dated 19 May 2014). We found that their care plan did not state how often they should be assisted with personal care. The chart titled, 'Repositioning Chart' also recorded when personal care had taken place. On four occasions there were gaps of over six hours between being assisted with personal care. We asked a registered nurse working on memory lane how often the person should be assisted with personal cares. They stated it was dependant on which incontinence pad they wore, as the time people needed to be assisted with personal care varied but that it should be recorded in the

# Are services effective?

(for example, treatment is effective)

care plan. We asked the registered nurse to show us where this was recorded in the care plan and they agreed they could not find the information, but that it should be included so that staff were aware of how to meet the person's needs.

We reviewed another care plan for a person whose care had been highlighted within the warning notice (dated 19 May 2014). We found that there was no record for this person having been assisted with personal care between the hours of 11:42 and 19:10 on 11 June 2014.

During our inspection on 08 and 12 May 2014 we reviewed records of when people were being supported to re-position, in order to minimise the risk of pressure ulcers developing.

We noted there had been some improvements in the completion of these records, however there was still some inconsistency in record keeping. We saw that one person on the 10 June 2014 had been re-positioned at 16:50 and then there was a gap until 23:25. Another had been re-positioned on 11 June 2014 at 16:00 and then a gap until 22:55. We spoke with staff who told us that these people would have been re-positioned but that it had not been documented on the charts. This meant staff were placing people at risk of developing a pressure ulcer by not evidencing that they had changed the person's position.

We also noted that some charts had not been completed correctly and did not have identifiable information recorded on them, for example the person's name, their room number or the date the chart was commenced.

This meant there had been a continued breach of the relevant legal regulation's (Regulation 9 and Regulation 20 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

During our inspection on 08 and 12 May 2014 we noted that people who were in bed for the duration of our visits did not have access to a drink as they were unable to get out of bed independently and drinks were not within their reach. Staff were also not recording when they had given people who stayed in bed a drink.

During our inspection on 12 June 2014 we reviewed each person who was nursed in bed to check if they had access

to a drink and if it had been recorded when they had last had one. We observed that 12 people out of 40 were nursed in bed between 10:25am and 11:40am on the elderly frail unit.

We noted that there was a jug of water and a glass in each room of the people who were nursed in bed and that where appropriate, the bed side table was near the person so that their glass was within their reach so that could help themselves to a drink. We found two people did not have fluids within their reach and we highlighted this with the deputy manager who took action immediately.

We looked at food and fluids charts for these people to see if staff had recorded when they had last been offered a drink. It was evident since our last inspection on 08 and 12 May 2014 that new documentation had been introduced to ensure that a person's food and fluid intake was monitored and staff told us that it was something they were ... "Getting used of completing them".

Of the 12 people that were nursed in bed, we saw that 10 of them had fluid charts available in their rooms. We highlighted the two people who did not have a fluid chart with the date of 12 June 2014 with the deputy manager. They took immediate action and spoke with staff and charts were put in place. However, if we had not intervened this would have meant that people were being placed at risk of de-hydration and there was no evidence to show when they were last given a drink.

During our inspection on 12 June 2014 we observed the lunchtime period on both units within the home. On the elderly frail unit we found that the mealtime delivery was structured and that it was well managed by staff. However, on the memory lane unit we found that there was no system in place for staff to assist people with their meal. This was confirmed by staff we spoke with.

People were assisted to have their starter before anyone was allowed to have their main course. This meant that people had to wait long periods between courses. We observed that the lack of organisation resulted in one person being assisted with two starters by two different members of staff because staff were not aware of who had already been assisted.

# Are services effective?

(for example, treatment is effective)

During our inspections on 08 and 12 May 2014 we reviewed one person whose care had been highlighted within the warning notice (dated 19 May 2014) and that their care plan stated they needed prompting with food as they were losing weight.

During our inspection on 12 June 2014, we observed the person during the lunchtime period. We noted that they only ate a couple of spoonfuls of their lunch. When we reviewed their food and fluid chart at 15:40, we found that staff had documented on the food and fluid chart that they had eaten  $\frac{3}{4}$  of their lunch. This meant that staff were failing to keep accurate food and fluid charts for that person and so it was unclear how much they were eating and drinking.

The person's care plan stated that they should be prompted and encouraged to eat as they were losing weight. During the lunchtime period, we observed staff say: "Come on xxx eat up" twice during the 45 minutes that their food was on the table. At no time during the 45 minutes did any staff member sit with the person to support them to eat and it was not acknowledge that the person had only eaten a few teaspoons of their lunch. The person was asked if they had finished and the food they had left was scraped into a bin by the care assistant. The care assistant did not inform the registered nurse of the amount that the person had eaten. This meant that staff were not supporting the person to enable them to eat sufficient amounts to meet their needs.

We reviewed a food and fluid chart for another person during our inspection on 12 June 2014 and found that on 10 June 2014, it showed that they had had a drink and biscuits at 15:00 however, and then no food or drink was recorded as being offered or consumed for the rest of the day. We were unable to determine if this person had had any food or fluids on the 10 June 2014 as it had not been documented.

We reviewed another person during our inspection on 12 June 2014. There were gaps and inaccuracies in the food and fluid charts for this person. It was not clear from the records if the person had taken a supplement drink or not. It was recorded in one place that it had been taken and then in another that it had been declined. Their care plan stated that the person was at risk of malnutrition and needed to be encouraged to eat. We also saw that there care plan had not been updated to show that the person needed close monitoring for food and fluid intake. There had not been an increase in the monthly weight monitoring and no indication that the provider had picked up the person's weight loss.

This meant that people were not being protected against the risks of inadequate nutrition and hydration.

This meant there had been a continued breach of the relevant legal regulation (Regulation 9, Regulation 14 and Regulation 20) of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

# Are services caring?

## Our findings

Although we observed that the number of people nursed in bed had decreased and that people were now sat in the communal areas, we found that there was a lack of positive stimulation for people for lived at Werrington Lodge. We observed on the memory lane unit, in the dining area (sensory room) that people were sat in the room all day. The TV was on (a video of a fish tank) and other than when they were offered food and drink people were not interacted with.

There were no newspapers, games, or jigsaws and although there were adequate numbers of staff working in the lounge area, they were busy with their tasks and very rarely spent any time with people other than to serve food and drink. Overall, we observed a number of missed opportunities for valuable and meaningful interaction between staff and people.

We noted similar concerns on the elderly frail unit. There was one activities organiser employed to provide stimulation for the 78 people living in the home. We spoke with the activities organiser and they acknowledged that it was difficult to provide group and one to one sessions on both units during the day. They told us that other activities organisers had left and their posts had never been replaced. The emphasis was on the care staff to support them in providing stimulation and activities for people, however, this did not happen on a regular basis. On the day of the inspection (12 June 2014) we did not observe any activities taking place and all three members of the CQC team observed missed opportunities when staff could have interacted with people who lived in the home. We did observe one carer placing hats on people and this got a positive response from two people.

During our inspection on 08 and 12 May 2014 we had observed several people within the home shouting for help and staff ignoring their calls and walking past them. We had also found people lying in urine soaked beds and they had received no assistance as they did not have access to a call bell. We had intervened on these occasions to instruct staff to assist people who needed help and support.

We reviewed the people who had been highlighted within the warning notice (dated 19 May 2014) and observed generally within the home during our inspection on 12

June 2014. We did not observe staff ignoring people's calls for help and noted that the majority of people were up and dressed and sat in the communal areas, especially on memory lane.

We reviewed one person whose care had been highlighted within the warning notice (dated 19 May 2014). During our inspection on 12 June 2014, we saw that there was a member of designated staff who stayed with them all day on a one-to one basis. The carers were observed to treat the person kindly and were gentle in their approach when handling them.

However, we noted that they did not interact with the person unless in response to them shouting or moving. We observed a registered nurse (the deputy manager) interact in a positive way with the person and this made them respond positively and with a smile. They did not respond in this way with the carers.

At 10:51 on 12 June 2014, a CQC inspector observed the person attempting to get up and go for a walk and they were told to: "Sit down". At 10:56 a CQC inspector observed the person attempting to get out of their chair, and they were again told to: "Sit down xxx". At 10:59, the person attempted to get up of their chair and go for a walk and they were told: "Sit down". At the time the person was sat at a bare table with no activity available or any meaningful stimulation.

The carer's were both agency staff and one carer had worked with the person before and had some knowledge of their needs. The second carer was working with the person for the first time on the day of our inspection. The agency staff member only had a very basic awareness of the person's needs and was observed to frequently call for help.

The person had been sleeping in a room next door to their usual room whilst their room was redecorated. This room was not suitable for the person to reside in. The wardrobe was turned around, there was an upturned lamp on the floor along with a few screws and broken wood scattered on the floor. It was clean but not safe. The person had been moved back into their own room on the day of the inspection.

## Are services caring?

This meant there had a been a continued breach of the relevant legal regulation (Regulation 17 and Regulation 9 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

Throughout our inspection on 08 and 12 May 2014 we observed that there was a lack of dignity and respect afforded to people. Examples included, people being assisted by staff with personal care and toilet and bedrooms doors left open which exposed people's nakedness.

During our inspection on 12 June 2014, we did not see any examples of this and observed that staff were assisting people with personal care with the door's shut and also knocking on bathroom and bedroom doors before entering.

During our inspection on 08 and 12 May 2014, we had observed that people who lived in the home did not have their name on their bedroom door. We observed during our inspection on 12 June 2014, that people's bedrooms on the elderly frail unit now had name tags on doors. We spoke with interim manager, who informed us, that memory boxes for each person living on memory lane had been ordered and would be put in place.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

During our inspection on 08 and 12 May 2014 we had noted that staff rarely engaged with people whilst they were carrying out care tasks and did not ask people for their preferences.

During our inspection on 12 June 2014, we noted that there had been some improvement and staff interacted more during the mealtime session. However, we observed that there was a continued lack of planned activities for people. We observed people mainly spent their day asleep when they were not having their meals. All three members of the CQC team observed many missed opportunities when staff could have interacted with people who lived in the home.

We spoke with the interim manager and enquired if there were plans to employ another activities organiser and they were unable to tell us on the day of the inspection. We acknowledged that the current person in post had a lot of experience in the role and we observed lots of positive

interactions they had with people. However, there were not supported by the provider to ensure that they were able to provider stimulation to the 78 people living in the home and carry out their role effectively.

We observed one person, who we had reviewed during our inspection on 08 and 12 May 2014 and then again on 12 June 2014. This person received close one to one supervision from staff, in line with their care plan. However, there was little evidence to show that they were given any social stimulation or supported to be more involved in activities in the home. Their room was barren and empty with no personalisation and their care plan stated that they liked music. We observed them singing to themselves, however there was no opportunity for them to listen to music in their room. The staff member had made no attempt to get the person involved in any meaningful activity.

This meant there had been a continued breach of the relevant legal regulation (Regulation 17 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

# Are services well-led?

## Our findings

Following our inspections on 08 and 12 May 2014, we were informed that an interim manager had been put place by the provider to manage Werrington Lodge. We were informed on the 11 June 2014, that management of the home had changed again and a new interim manager had been in post since the 09 June 2014.

We had noted during our inspections on 08 and 12 May 2014 that there had been a general lack of leadership and direction within the home. We were assured following our meeting with the interim and deputy manager that positive action would be taken to act on the concerns highlighted during our previous inspections.

We met with the interim manager and deputy manager before, during and after our inspection. We feedback that we had received positive comments from the staff about them both. One staff member told us: "It's great having (deputy manager) here now, they are hands on and get out here and work with us and support us". Another told us: "I get the feeling things will change for the better now with (manager and deputy manager) here to help us. Even the training we did today was better".

We acknowledged that staff were in need of support during this time of transition and we observed that both the interim manager and deputy manager had established a good rapport with staff and were caring and supportive in their manner.

We observed on the 12 June 2014 during our inspection that there were enough staff on duty to meet the needs of the people. However, it was noted that the number of staff on duty had been supplemented by agency staff. We observed that these staff lacked direction and were supported by the permanent staff which at times had a detrimental effect on care delivery. The agency staff seemed unsure as to their role and were seen standing around and not interacting with the people who lived in the home. We spoke with the interim manager who agreed that they would be reviewing the number of agency staff booked to supplement staffing levels.

During our inspection on 08 and 12 May 2014 we had found a bed in the main lounge area. We noted during our inspection on 12 June 2014 that this had now been removed.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p><b>Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment</b></p> <p>The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.</p>
Accommodation for persons who require nursing or personal care	<p><b>Regulation 20(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Records</b></p> <p>The registered person did not have effective systems in place to ensure records were kept securely.</p>

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<b>Regulation 9 (1)(a)(b)(i)(ii)(iii)(iv) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</b> <b>Care and welfare of people who use services</b> The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.
Treatment of disease, disorder or injury	<b>Regulation 9 (1)(a)(b)(i)(ii)(iii)(iv) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</b> <b>Care and welfare of people who use services</b> The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.
Accommodation for persons who require nursing or personal care	<b>Regulation 14 (1)(a)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.</b> The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.
Treatment of disease, disorder or injury	<b>Regulation 14 (1)(a)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.</b>

This section is primarily information for the provider

## Enforcement actions

The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

**Regulation 17 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Respecting and involving people who use services**

The registered person did not have suitable systems in place to ensure the privacy and dignity of service users.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

**Regulation 17 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Respecting and involving people who use services**

The registered person did not have suitable systems in place to ensure the privacy and dignity of service users.