European Healthcare Group PLC

# Bay Tree Court Care Centre

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 29, 30 and 31 December 2015 and was unannounced.

The service provided nursing care and personal care to a maximum of 59 people. At the time of the inspection there were 51 people using the service. These were predominantly older people who required support with their physical needs. Some people also lived with dementia. Services were provided in a purpose built building which provided people with a private bedroom with en-suite facilities. There were ample communal rooms where people could sit and eat together but there were also areas where people could sit quietly or receive visitors privately.

The registered manager had been in position since July 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's individual risks had not been consistently identified, managed and monitored. Some people had been affected by this. People were protected from abuse and those who would be unsuitable to care for them because good arrangements were in place to ensure this. Action was being taken to ensure people were protected under the Mental Capacity Act 2005. There were not always enough staff to attend to people when needed. Action had started to be taken to address this. The environment was kept safe by good maintenance arrangements and robust health and safety checks.

People's needs had not always been effectively met. People had not been involved in planning their care, although work had started to improve the care planning process. Staff had been provided with limited training and support to help them improve their practices and knowledge. The recruitment of new senior staff was helping to address this. People had access to health care professionals and senior staff were proactive in getting advice from specialist health care professionals when needed. People received support to eat and drink and people spoke positively about the standard of food and cooking.

Staff treated people as individuals and were respectful and kind, although some staff were better at delivering caring and compassionate care than others. People were provided with opportunities to take part in group or one to one activities, if they wished to do so. Care records had not been well maintained and at times this had an impact on people because staff had lacked accurate information. Actions were being taken to address this. The registered manager was providing strong leadership and was aware of the services strengths and weaknesses. They were making changes which when embedded and sustained would ultimately improve outcomes for people.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included: people's risks not being appropriately identified, managed and monitored, people's needs not always met, gaps in record keeping and a lack of appropriate staff training. You can see what action we

told the provider to take at the back of the full version of the report.

We also recommended that the service review the number of staff on duty who were available to attend to people's needs to ensure people had support when they needed it.

## 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. People were not always protected against risks that may affect them personally.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

People's needs and risks were not always addressed when they needed to be. The numbers of staff on duty and available to attend to people needed to be reviewed to ensure there were enough staff, at all times, to meet people's needs and to keep them safe.

The services recruitment practices protected people from staff who may be unsuitable.

### Is the service effective?

**Requires Improvement**

The service was not always effective. Some staff lacked suitable skills and knowledge to meet people's needs. Sufficient staff training had not been provided and some people's needs had not been effectively met.

People did have access to health care professionals when they needed it and staff actively involved health care specialists when they needed to.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

### Is the service caring?

**Requires Improvement**

The service was not always caring. Although staff were kind and friendly care was not always provided in a caring and compassionate way.

People's preferences were explored and met by the staff where possible. Staff were working hard to adopt a personalised approach to care.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

## Is the service responsive?

**Requires Improvement**

The service was being responsive but improvements taking place needed to be embedded and sustained for the service to remain responsive.

Although care plans had not always been fit for purpose and people had not been involved in planning their care, action to address this had started and we saw examples of some improvements.

People had opportunities to socialise and partake in activities and there were arrangements in place to try and personalise these.

People's complaints had been taken seriously and responded to fully. There were actions now being taken to learn from these complaints and improve the service.

## Is the service well-led?

**Good**

The service was being well-led. Despite a challenging period the management team were making improvements which would benefit people and the staff.

New arrangements were better able to ensure effective clinical governance which would result in better care practices and a higher standard of care delivery.

Services were monitored and where needed shortfalls were being addressed.

# Bay Tree Court Care Centre

**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 unannounced inspection was carried out on 29, 30 and 31 December 2015 by two inspectors.

Prior to visiting the service we reviewed relevant information we held about it. The provider had 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 also reviewed the service's statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events. These include a person's death, serious injury or any other event that may stop the service running smoothly. We asked commissioners for relevant information they held about the service.

During our visit to the service we spoke with nine people and sought their view on the services provided to them. We also spoke with four relatives. We spoke with eight members of staff, one volunteer, the registered manager and a senior representative of the provider. We spoke with three health care professionals. We reviewed ten people's care records which included care plans and risk assessments. Three of these care records were for people we had spoken with. We reviewed a selection of people's medicine administration records and other records relating to the management of medicines. We observed interactions between those who lived at Bay Tree Court and the staff who worked there.

We also looked at a selection of records and documents relevant to the management of the service. These included the adult safeguarding policy and procedures, various audits, the service's on-going improvement plan and records relating to how it was staffed. We requested a copy of the service's training record and provider's audit of staff recruitment records be forwarded to us, which was done. We also requested that an audit of the service's call bell response times be done and the results forwarded to us, which they did.

Requires Improvement

# Is the service safe?

## Our findings

People were not always protected from risks that may have an impact on them. Risks to people were assessed and identified on admission however the process of ensuring these risks were reviewed, monitored and effectively managed had not always happened. Risks included, the condition of people's skin and the development of pressure ulcers, risks relating to people's nutrition, for example loss of appetite and weight, risks of falls and those related to the safe moving and handling of a person. Some risks assessments also covered risks associated with fire evacuation and the use of equipment such as bed rails and electronic beds. These had also not been kept fully reviewed. In some cases this had resulted in people not being kept safe. The provider had processes but these had not been adhered to. It was the provider's expectation that people's risk assessments be reviewed at least monthly and whenever needed. For example, when people's health or abilities altered or following a specific event such as a fall.

On the nursing floor, apart from on admission this process had stopped altogether between the months of June and October 2015. On the non-nursing floor it had continued but in one person's case a change in a person's moving and handling needs had not be well managed. A re-assessment had determined that different equipment was needed to move the person safely. This however had not been effectively communicated to the staff. The person's relevant risk assessments was amended and updated six days after the decision had been made. The person was therefore moved with equipment which was no longer appropriate which resulted in an unsafe manoeuvre taking place. Injuries to the person were avoided as staff controlled a fall from the inappropriate hoist's sling.

Nurses on the nursing floor and senior care staff on the non-nursing floor had been responsible for ensuring all risks were reviewed and appropriate strategies were in place to manage these. The registered manager explained the service had lost all of its nurses between June and October 2015 and, prior to this, care staff had lacked suitable and effective direction. Actions already implemented by the registered manager and those due to take place after the New Year holiday would help to ensure risks were suitably reviewed, managed and monitored. Further examples of this not having taken place included: one person's continued loss of weight without a review, an accident to a person from which they were recovering from and one person's falls to the floor which could have been avoided. Some of these also occurred because staff were not always identifying potential risks to people when delivering their care and subsequently taking appropriate action.

We also looked at the process in place which managed accidents such as slips from bed and falls. The registered manager had identified that these were being immediately attended to, so for example, any wounds were being attended to, reassurance was being given and if needed paramedics were being called for. A record of the accident and the immediate action was being made. However, the accidents had not always been reported to the registered manager. The risk management process, which also involved the strategies put in place to then avoid a further occurrence and the process of evaluating this action for effectiveness had not therefore always taken place. How accidents were to be reported had therefore recently been altered and all accidents and incidents forms now had to be sent to the registered manager for review. A daily report, completed by the member of staff in-charge of each floor on each day, was also

due to be introduced. This would include a record of all accidents and incidents which had occurred on the day of the report. The registered manager would then be in a better position to know what had happened, to be able to follow the initial actions up and check if further action had been taken to avoid a reoccurrence. They would then sign off the accident record as completed but also use this for auditing purposes at a later date when the effectiveness of the action taken were evaluated. Not all that was reasonably practicable had been carried out to protect people from risks which may have an impact on them.

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

Staff appeared busy at all times however they were not always available to provide people with support when they needed it. We observed one person sitting in the lounge on their own for a considerable length of time. This person then attempted to stand and consequently fell because they were not able to walk. They fell again later in the day whilst still in the lounge with no staff present. This person had been assessed as a high risk of falls and they lived with dementia. Despite this staff had not provided any supervision.

Three people over the last year had raised concerns with us because they considered the service to be understaffed. They told us the time it took for staff to respond to their call bells had been too long. The registered manager told us the service was staffed according to the provider's guidance for the number of people using the service at the time. They told us they considered there to be enough staff to meet people's needs. One member of staff however said, "Staff numbers have been cut and it has had an impact, this and the increased paperwork means that the one to one time that we were spending with people just isn't happening at the moment". The registered manager told us there had been no alteration in staffing numbers since they had started in post in July 2015. They explained staffing numbers were designed to alter at certain levels of capacity. For example, there were 21 people on the nursing floor; its full capacity being 28 people. At the point of there being 24 people or more the staffing numbers would increase. The registered manager told us there were enough staff in numbers but they were not properly directed and deployed. The registered manager had taken some action to address this and plans due to be implemented after the New Year holiday aimed to address this further.

We asked the registered manager to carry out an audit of the call bell response times, which they did and which they shared with us. This showed call bells were responded to on average in just over four minutes. This was an improvement from six months ago when an average of six minutes was reported to us. The registered manager however wanted the more recent response times improved and took some immediate action to help achieve this. When we spoke to a member of staff about answering call bells they said, "Call bells are not answered quickly enough, it is staffing levels that are a problem because of the people who require two staff to assist them". One person's relative told us their relative had commented about the time it took their call bell to be answered. They said this had not always been a problem for their relative, but it had impacted on them when they had needed the toilet urgently.

People were protected against abuse because staff knew how to recognise this and how to report any concerns or allegations. The provider's policy and procedures for safeguarding people had been reviewed in December 2015. The service was aware of the county council's wider policy and protocols for safeguarding people and adhered to these. For example, they ensured they shared any safeguarding concerns or allegations with external agencies who also have responsibilities to ensure people's protection from abuse. The service had a whistle blowing policy where staff could share concerns without fear of reprisal. This included any concerns they may have about poor or unsafe practice. An example of where a member of staff had raised concerns in this context was discussed with the registered manager. Appropriate procedures had been followed and a matter of unsafe practice was addressed.

People were protected from those who may not be suitable to look after them by the provider's recruitment processes. An audit carried out by the provider showed staff were recruited safely. The registered manager told us they received administrative support from the provider's head office when recruiting staff. However, she confirmed that, as the registered manager, she checked that all appropriate checks had been carried out before staff started work at Bay Tree Court. This included, exploring any gaps in employment during the interview and requesting references. Clearances from the Disclosure and Barring Service (DBS) were also a necessary requirement. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children.

People's medicines were managed safely. We observed medicines being administered on both floors. This was carried out safely by staff who had been trained and who had their competencies reassessed regularly in this task. People's medicine administration records were well maintained; following administration staff signed to say people had received their medicines. Other records relating to the medicines system were reviewed and were seen to be well maintained. Medicines were stored safely and those not used disposed of or returned to the pharmacy appropriately. Actions were being instigated by the service to ensure better delivery of medicines needed outside of a person's usual monthly delivery. For example, antibiotics and anticipatory end of life medicines. Specific guidance (protocols) were in place when people were prescribed medicines to be used "when required". This was in line with guidance from the National Institute for Health and Care Excellence (NICE). It gave guidance for example, on the reasons for giving the "when required" medicine, how much to give and the minimum time lapse between doses. Wound dressings specifically prescribed for an individual and for use by the community nursing team were kept in people's bedrooms. This was so community nurses had easy access to these and it avoided confusion as to what was whose. Where equipment was needed to monitor people's blood sugar, in the case of diabetes, this was prescribed for the individual's sole use. This reduced the risk of problem from cross contamination.

People lived in a safe environment. The maintenance team carried out numerous health and safety checks to ensure this remained the case. We saw some of these checks taking place in people's bedrooms. At this point we asked the maintenance team about the heating along one particular corridor. It had felt cooler than other areas and one person had told us they felt cold. It was explained that a heating boost control could be operated by staff on the ground floor. When it got warm down there we were told staff could turn this down which then affected the level of heating upstairs. They confirmed that the one corridor in question was also known to get cooler than other areas. The heating was boosted from downstairs as soon as we brought this to their attention. We later returned to the person who had felt cold and they told us they were "much warmer". Records were kept of all maintenance checks and tasks. Risk assessments were in place for generic risks relating to the safe use of the building, for example, the risk from falling from a window was addressed by window restrictors which were checked on regular basis. Contracts were in place with various service providers and maintenance companies. For example, a specialist company serviced and maintained all lifting equipment, which included passenger lifts, care hoists and slings. Similar arrangements were in place to maintain the nurse call system, emergency lighting, fire alarm and fire safety equipment.

We recommend that the service review the numbers of staff on duty and available to attend to people's needs to ensure these are adequate and people's needs can be met at all times.

Requires Improvement

# Is the service effective?

## Our findings

When talking to people or their representative about the care they received there were mixed views and experiences. One person said, "All the carers are really good. They look after us, really well". We spoke to four relatives during the course of the inspection process. One had made a complaint about the standard of care afforded to their relative. We could not evidence that appropriate care had taken place from this person's care records. This was despite their care plan recording what the person's issues had been and what care staff should provide. Another relative told us they were monitoring the level of care being given but, at the moment, there were aspects of it which needed to improve. They had already discussed this with the registered manager. We looked at this person's care plans and care records which, also showed that the care plan was not being adhered to. The registered manager followed this up with senior staff straight away. Two other relatives spoke on behalf of their relative. They felt their relative had been generally happy with the care they had received. However, they also commented that the turn-over of staff over the last year had caused some problems with continuity in care and staff not always knowing their relative's needs. People had not always received appropriate care to meet their individual needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who did not always have the appropriate knowledge and skill to meet their needs. We observed varied levels of skill, for example, one member of staff demonstrated a high level of skill when managing one person's anxiety and another member of staff clearly required further knowledge and direction to improve their standard of care delivery. All staff who started worked at Bay Tree Court completed induction training. This was a general introduction to the provider's policies and procedures, their expectations, processes and some basic awareness in subjects the provider considered to be necessary for all staff to complete. The registered manager was aware of the care certificate and told us this would be used in the future for all new care staff. This lays down a framework of training and support which new care staff can receive. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed.

The service's training matrix recorded that the majority of staff had received annual update training in fire safety and health and safety. There were gaps on the training matrix for training in safe moving and handling, infection control and safeguarding adults. Training in safe moving and handling and infection control had already been booked to address this. Safeguarding adults from abuse was covered in the staffs' induction training but arrangements were also being made to deliver further training on this. Some care staff, not all, had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. We spoke with five members of staff about their understanding of this legislation and how this impacted on their day to day work. Their awareness and understanding varied considerably. The registered manager was aware that further discussions and training on this subject were needed. Staff had received basic dementia awareness training and we observed some good interactions between staff and people who were clearly living with dementia.

Other areas of training shown on the training matrix such as eating and drinking, end of life care, equality and diversity training and Parkinson's Disease had only been completed by one or two staff. No training had been completed in areas where we had evidenced a particular weakness in practice such as care planning, risk assessment and the use of the Malnutrition Universal Screening Tool (MUST). The training matrix overall demonstrated a limited range of training completed.

We spoke with a specialist health care professional who told us they had delivered training in the last year to some staff. The large turn over in staff would explain why this was not shown on the matrix for current staff. Some nursing staff had received additional training in the use of syringe drivers; sometimes used to administer medicines at the end of people's lives. It was evident that there were insufficient staff with the appropriate knowledge and skills to fully ensure people's needs were met at all times.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager explained that on-going staff supervision had ceased in July 2015 when the staff who then took a lead on this left. However, since then, when staff had required supervision following an incident or report of poor practice this had been carried out. The registered manager told us she had recently started the on-going supervision program again and so far, heads of departments had received this. It was planned that in the New Year the deputy manager would also start to help with these.

Where people were able to consent to their care and treatment they were given an opportunity to do this. People were not therefore receiving care which they had not agreed to. We observed staff asking people for their consent before they went ahead and delivered care. People's care records however needed to better reflect that people were giving their consent to the care written in their care plans. The registered manager already knew this needed improvement and was working to improve care plans generally and how people's consent was recorded.

Where people were not able to give their consent the staff were taking steps to ensure they were protected under the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The task of assessing people's mental capacity and recording the fact they were unable to provide consent had been delegated to the deputy manager. Mental capacity assessment had been completed on the nursing floor. This process was due to start on the non-nursing floor after the New Year holiday.

We saw in people's care records consent forms signed by people's representatives but staff were unaware of whether these people held power of attorney for health and welfare. There was no information in people's care records for staff about this. Staff assumed the finance department held this information. Staff gave some examples of relatives making decisions about people's care and treatment and wanting their decisions to be carried out. This was qualified by a member of the staff telling us that no decisions were made by the staff unless they were in the person's best interest and then they told us "the correct process would have to be followed". This told us, that in practice, staff were aware of the Mental Capacity Act's code of practice and understood the point behind the legislation. We fed back to the registered manager the need for care and nursing staff to be aware of who holds power of attorney, who is signing what consent form and the need for better reference to consent being given generally.

As a result of completing the mental capacity assessments 12 people had been considered as deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The service had correctly submitted applications under the Deprivation of Liberty Safeguards (DoLS) to the county council (the supervisory body). They were waiting for responses to these. One person had previously been considered by staff to be deprived of their liberty when they had been admitted. An authorisation under the DoLS had been granted to ensure the person lived in a place that could provide them with the care they required to maintain their well-being.

People had access to community health care professionals when they needed this. One person had been admitted with a pressure ulcer which, because of their poor health, had deteriorated considerably. The staff had involved specialist health care professionals to help them monitor this and plan the required treatment. These professionals told us the registered manager was very good at seeking their involvement and the staff always followed their advice. During their visit the health care professionals had identified a training need in how wound management documents were being completed. They were not being completed in a way that recorded the information needed. The registered manager was going to address this by organising further training. These professionals were also asked to review another person's skin which was almost healed following an accident.

There were arrangements in place for the allocated GP for the service to visit on a regular basis. However, people's health could be discussed with a GP in-between these visits and they would visit if needed. We observed a member of staff reporting concerns they had about a person's health to a GP over the telephone. They were able to give the GP necessary information and this resulted in the person being prescribed a course of antibiotics. We spoke with another health care professional who had visited people at the home. They told us the care of those they had visited, at the time, had been met. People's care notes recorded that they had access to a chiropodist on a regular basis. Although many people made private dental care arrangements the service would help people access a NHS Dentist if they needed one. Assessments and advice had also been sought, for some people, from specialists such as a speech and language therapist and occupational therapist.

People received the help they needed to eat and drink in order to maintain their well-being. We observed the interaction between staff and people at lunch time. Staff were attentive and supported people where needed. We also observed some people being fed their food. This was done discreetly and in a dignified way. Kitchen staff were involved with serving food and any requests for changes or additions were dealt with swiftly and without question. The food looked appetising and we were told by people it was of a high standard consistently. One person said, "The food is really good".

Between June 2015 and October 2015 people's nutritional risks assessments on the nursing floor had not been maintained. From October 2015 nutritional risk assessments had been completed again. People's weights had continued to be monitored but records did not show that any loss in weight had been adequately reviewed and managed. The chef informed us that he was aware of who was losing weight and who required foods with additional calories. Where this was needed foods were fortified with cream, butter and whole milk powder. The chef was also aware of how he needed to alter how he cooked food to suit the needs of individual people. An example was given where some vegetables were cooked less for some people and more for others. Snacks were available and we saw biscuits and cake being provided at set tea and coffee rounds. The chef held regular monthly meetings with people to ensure they were happy with what was being provided on the menu. People had been involved in devising the four week rolling menu which we were told changed when the seasons altered. The chef explained that ideas would soon be sought again

for a change in menu when the colder months faded.

Requires Improvement

# Is the service caring?

## Our findings

People did not always receive caring and compassionate support. We observed interactions between staff and people, which were on the whole, friendly and kind. However, some staff were better at demonstrating a caring and compassionate approach when delivering care than others. One person told us they had asked for help in a particular situation and had been given a response which had upset them. The person had felt staff had not been caring and had not understood the situation they were in. This feeling had obviously stayed with the person and they wanted to tell us about it. The person went on to say, "On

the whole they are pretty good here".

We observed an action carried out by one member of staff which resulted in the person receiving a lack of caring and compassionate support. This was not done maliciously but from a lack of thought. In contrast we observed very compassionate and caring support given by another member of staff to another person. This member of staff demonstrated this in the way they spoke to the person, what they said to them to reassure them and by giving the person time. This member of staff really made this person feel as if they mattered and demonstrated that they wanted to improve the person's immediate well-being. This had a positive effect on the person who was less agitated and restless as a result. One relative said, "The staff here are lovely".

The registered manager told us some staff had better approaches in certain situations than others. They were taking action to address this and to balance out the teams strengths and weaknesses overall.

People made day to day decisions and choices and staff supported them to do this. One member of staff told us the involvement of people's relatives was always welcomed and staff kept relatives aware of any changes in people's care or health. Two relatives confirmed this had been the case for them. People's care records had recorded evidence that showed staff had communicated with relatives where needed. There were no restrictions in place either in the way relatives could be involved or on people's visiting rights. We saw visitors coming and going at all times during the inspection and we saw them being welcomed by the staff. We did not see any information obviously available for people on advocacy services.

People's care records were not on display but they were also not always secure. Staff were aware that people's confidentiality had to be upheld.  This was discussed in staffs' induction training and we observed discussions about care and treatment being held privately. People's privacy generally was maintained with care being provided behind closed doors. People were treated with dignity and respect and this included times when people were obviously confused and particularly vulnerable.

Requires Improvement

# Is the service responsive?

## Our findings

There was little evidence to show that people had contributed to the planning of their care and its review. The registered manager confirmed this had been the case and explained to us she was trying to get staff to think in a more "user led" way. She said, "Service user (the person using the service) involvement is crucial". Staff told us some relatives were very involved in representing their relative and reviewing the care their relatives were receiving. We understood this was done on an informal basis when they visited.

People's needs were assessed before they were admitted to ensure the staff were able to meet their needs. Care plans for the person's first 72 hours of admission were seen. These gave an initial outline of the person's needs and the care staff were to provide. The management of care plans after this initial period then varied between the two care floors. We saw a mixture of well updated care plans on one floor and on the other, gaps in care plan reviews of up to four months between July and October 2015. We were informed that this was when several staff had left. The provider's expectation was care plans must be reviewed each month as well as when necessary. For example, when people's health and abilities altered and when there was a necessary change in care delivery. Examples of poorly maintained care plans included, one person's care plan for anxiety and depression, another's eating and drinking care plan and one person's mobility care plan. When these people's needs had altered, their care plans, as well as other relevant care assessments, had not altered. In these cases the records showed that the person's care had altered however, poor record keeping and poor maintenance of care plans meant staff and other health care professionals did not have access to accurate information. This potentially puts people at risk of inappropriate or unsafe care.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had been aware of this shortfall when they started work in the home in July 2015. They had not been able to successfully start addressing this until more recently when staff capable of resolving the problem had been recruited. Some improvements to people's care records had started but this work was very much work in progress. We reviewed the one care file that had been completed in the registered manager's new care file format. The completed care plans were more detailed and gave clear and up dated instruction to the staff. There was a better emphasis on the person's individual likes, dislikes, preferences and choices which made the care plans more personalised. The registered manager explained that this could only be achieved if people and their relatives were involved in this process, which, they said took time to complete.

People had opportunities to take part in social activities. The service had an activities co-ordinator who organised and co-ordinated various activities each week. A weekly program showed these were varied and included regular games of scrabble, quizzes, various fitness activities and music. One to one time was factored in around the group activities for people who preferred not to or who could not take part in these. We observed one group activity taking place with people animated and engaged in what they were doing. Monthly activities included tea dances and various entertainment. Opportunities for "Prayer and praise" were provided. One person said, "(name of member of staff) is fantastic. We go on lots of trips and have lots

of activities". Another person said, "She is really good". We also spoke with a volunteer who told us she was one of a team of volunteers who was co-ordinated by another member of staff. This volunteer told us they spent two hours per week predominantly spending time with people on a one to one basis. They told us people liked to talk and they gave examples of what some people had an interest in. They explained one person liked to play "high level" scrabble so they played with them on a one to one basis. This volunteer had previously completed work with the Alzheimer's Society so they also carried out reminiscence work with some people. They also took one person from Bay Tree Court to a regular group who sang together. People from Bay Tree Court used the local community which had a pub, post office, shops and a library.

The service had a complaints policy and procedures and people were able to raise concerns and complaints and have these taken seriously. The registered manager told us they had addressed each complaint they had received (since July 2015). A complaints file was used to record each complaint and record investigations, findings and responses. There were eight complaints recorded between our last inspection in June 2013 and December 2015. Three of these had been about dissatisfaction in call bell response times. We had been copied in to these by the complainants when they had been submitted. The issues in these complaints had been investigated and a response given to the complainant. One verbal complaint had been made in December 2015 and the registered manager was waiting for the person to submit the detail of their complaint to them and they told us they would then investigate this. Another complaint submitted in 2015 had been investigated by the registered manager and their findings completed. A response was about to be forwarded to the complainant. We had been made aware of this complaint by the complainant. The investigation had been thorough and an honest response had been given. The registered manager was keen that complaints were used as a form of learning and that improvements were made as a result of these. Some of the actions already taken and the work in progress at the time of the inspection, if successfully implemented and embedded, would help address some of the issues raised in people's complaints.

Good

# Is the service well-led?

## Our findings

People and staff were benefiting from an improvement in how the service was being managed. A programme of improvement and change was underway. Some staff however told us they did not feel valued and needed better support. One member of staff said, "I would like to see more interaction with management and recognition and support for what we do". Another said, "The manager doesn't spend enough time with us. It would be good if she came once a week to a handover and see how the residents are getting on and be supportive to us". A further member of staff said, "Teamwork is good and we support one another but I feel we have been left on our own to get on with it". In contrast one member of staff told us the registered manager was very supportive and was making changes which were for the good. Another told us they had always personally found the registered manager to be supportive. They told us they loved working at Bay Tree Court. Another member of staff, when talking about working at Bay Tree Court said, "I've never enjoyed my job so much".

The registered manager started work at the service in July 2015. A representative of the provider told us the service had gone through a period of unrest prior to this and shortfalls had been identified. They confirmed the registered manager had inherited a lot of problems which needed to be resolved but they had been hampered in doing this by the turn-over in staff and the need to recruit appropriate staff. The arrival of the present registered manager coincided with the departure of several staff, predominantly nurses. We were informed this was a result of the issues taking place before the registered manager started. This left the registered manager with no option but to rely on agency staff to cover nursing shifts. As a nurse herself she also completed nursing shifts when needed. Although this had meant that a registered nurse was always present on the nursing floor, it also meant there were was a lack of permanent senior staff to delegate on-going responsibilities to. This had resulted in some of the provider's systems and processes not being maintained. It also delayed the implementation of the provider's and registered manager's improvement plans.

Staff recruitment generally and the recruitment to senior posts had become the registered manager's key priority and challenge. The business aspect of the service also had to be maintained and the high demand for respite care meant the registered manager, as the one permanent senior member of staff on the nursing floor, needed to devote time to pre admission assessments and liaising with health and adult social care professionals. A new deputy manager recruited in September 2015 improved the situation and some specific priorities were delegated to her. The increased hours worked by another member of staff who had previous experience in care home management also provided support. This along with the use of agency nurses permanently based at Bay Tree Court meant that some areas such as care planning and risk assessment reviews could recommence again on a monthly basis. Some stability and continuity for the people who used the service and the staff had began to be achieved. The non-nursing floor had been managed for several years by a member of staff who also left in December 2015. This post was to be recruited to after the New Year holiday but for the time being an experienced member of that team was taking the lead.

The registered manager explained that she was aware staff on both floors needed more support and that they required better direction. The registered manager had completed a piece of work which had helped her

identify the strengths and weaknesses within the staff team. Action was planned for the new year which would aim to bring a better balance of skill and abilities across the two floors. The introduction of senior care staff was also to be implemented. Some would be found from within the existing team, giving some staff opportunities for promotion, and others would be newly recruited. Some nursing hours still needed to be recruited to and she would then look at rotating night and day staff so they could experience the service across a 24 hour period. We were told that the recruitment of senior care staff would add strength to the senior team and provide care staff with the support and direction they needed. These staff would also be responsible for promoting good practice and addressing poor practice. Although the registered manager had clearly communicated her expectations and values to the staff team it was clear she had required staff with suitable skills to ensure these were promoted and implemented.

We found the registered manager to be well informed about what was happening in the service and aware of various people's needs. Where information was not being communicated to her effectively enough she addressed this. An example of this was the lack of prompt information relating to accidents and incidents. She had worked several shifts on the nursing floor so had attended staff handover meetings on this floor. She admitted she had not been as focused on the non-nursing floor as up until December 2015 this had been managed by a person very familiar with the needs of the people on this floor and the staff team.

The registered manager also completed various audits so as to measure the service's performance against various regulations, legislation and the provider's own performance expectations. The findings of these were reported to the provider as were actions taken or planned to address shortfalls and to make improvements. An on-going service improvement plan was in place and these actions, as well as any from the provider, were added to this. The provider's representative carried out quality monitoring visits to support the registered manager but also to check the registered manager's performance against the improvement plan.

We were told that the provider's quality assurance and monitoring system was going to alter. Improvements for example to how risks were monitored were going to be introduced. More specific information was going to be requested from the provider's services and this would be collated to help identify potential and increased risks. The information would use a traffic light system of red for areas of increased risk which required further and more frequent monitoring and amber and green for lesser areas of risk. It was also going to be used to prevent admissions to hospital and help registered managers determine if certain admissions were appropriate for their service at any given time.

The provider had reviewed and updated their policies and procedures in December 2015 and these would be forwarded to the service in the new year.

People's views were sought through meetings with people and their relatives. One area of feedback from people who used the service and from those looking to use the service had been a lack of internet access. The registered manager had made arrangements to address this.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People had not always received appropriate care and care their care had not always met their individual needs. Regulation 9 (1)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Not all that was reasonably practicable had been carried out to protect people from risks which may have an impact on them. Regulation 12 (1) (2)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Accurate records had not been kept of people's care needs, their care delivery and treatment. Regulation 17 (2)(c). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not been provided with appropriate support, training, professional development and supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a) |