Barchester Healthcare Homes Limited

Hugh Myddelton House

Inspection report

25 Old Farm Avenue
Southgate
London
N14 5QR

Tel: 02088864099
Website: www.barchester.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 November 2017 and was unannounced.

Hugh Myddelton House is a care home providing nursing care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hugh Myddelton House is registered to provide nursing care and accommodation for a maximum of 48 adults, some of whom live with dementia. At the time of our inspection, there were 46 people living in the home. The home covers three floors. On the ground floor there is capacity for 19 elderly frail people. On the first floor there is capacity for 19 people living with dementia and on the second floor there is capacity for ten younger people with disabilities.

During the last inspection on 29 and 30 September and 2 October 2016, we found the home was in breach of one regulation associated with the Health and Social Care Act 2008 in relation to staffing levels.

A registered manager was in post at the time of this inspection. 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.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least good. We found that improvements had been made to staffing levels and deployment of staff to ensure people's care needs were met. Our observations and feedback received from staff, people and relatives was that staffing levels had improved. On both days of the inspection, we observed there to be adequate numbers of staff to ensure people's care needs was met in an unhurried manner. However, at times we observed communal areas to be left unattended whilst staff attended to people in their bedrooms. Some staff and relatives commented that it would be good if staff had more time available to spend with people on a one to one basis.

Detailed current risk assessments were in place for most people using the service which were updated on a regular basis and as changes occurred. However, we found one instance of a person's risk assessment not being reassessed following a number of incidents of behaviour that challenged.

Accidents and incidents such as falls were recorded and analysed. However, we found an instance of where an incident had been reviewed and signed off by the registered manager, despite inconsistencies over how the incident had been managed at the time.

There were systems in place to ensure medicines were handled and stored securely and administered to people safely and appropriately.

Most people told us they enjoyed the food provided and that they were offered choices of what they wanted to eat. People were supported to eat and drink in a timely manner, where appropriate. Additional staff were deployed effectively at mealtimes to ensure people received their meals in a timely manner.

People received a nutritious diet and enough to eat and drink to meet their individual needs and timely action was taken by staff when they were concerned about people's health. Referrals had been made to other healthcare professionals to ensure people's health was maintained.

Staff training, supervisions and appraisals were monitored and updated regularly. Systems had been implemented to ensure oversight of when staff training, supervisions and appraisals were due.

People were positive about the service and the staff who supported them. People told us they liked the staff that supported them and that they were treated with dignity and kindness.

People told us they felt safe living at Hugh Myddelton House. Staff understood the importance of safeguarding and the service had systems to help protect people from abuse.

The service was clean throughout and there were hygiene controls in place to ensure that the kitchens were kept clean and food was safely stored. Utilities such as electricity, gas and health and safety checks were undertaken regularly and records kept.

A complaints procedure was in place which was displayed for people and relatives. Staff, residents and relatives meetings were held regularly and surveys were completed by people and relatives.

People, relatives and staff spoke positively of the current management team. Quality assurance processes were in place to monitor the quality of care delivered.

Appropriate recruitment processes and checks were in place to ensure that only staff safe to work with vulnerable people were recruited.

People were supported to attend activities and there was an activities timetable in place. We observed particularly caring interactions between the activities co-ordinator and people.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. The policies and systems in the service supported this practice. Care plans contained appropriate documentation confirming consent to care had been obtained and care staff were clearly able to explain their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how this impacted on the care and support that they delivered. Where people's liberty was deprived, the registered manager had applied for authorisation from the appropriate authority.

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 safe, however, further improvements needed to take place before this key question could be rated as 'Good'. Risks individual to people's care were identified and guidance was available to staff to ensure people were safe. However, we found for one person, risks had not been assessed following a number of incidents.

Accidents and incidents were reported and monitored; however, we found inconsistencies around how the incident had been recorded.

Medicines were managed and administered safely.

Robust safeguarding policies were in place and staff understood how to escalate concerns about people's safety.

The service followed robust recruitment processes to ensure appropriate recruitment of staff deemed safe to work with vulnerable adults.

Appropriate staffing levels were observed throughout the inspection to ensure people's care needs were met.

Is the service effective?

Good

The service was effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role.

Mental capacity and Deprivation of Liberty Safeguards were understood and principles of the code of practice were being followed.

People's care needs were assessed prior to coming to the home to ensure their care needs could be catered for.

People were given the assistance they required to access healthcare services and maintain good health.

Most people told us they enjoyed the food on offer and were offered choice.

Is the service caring?

Good

The service was caring. There were positive relationships between staff and people using the service. Staff treated people with respect and dignity.

Staff had a good knowledge and understanding on people's background and preferences.

People were supported by staff to be independent.

Is the service responsive?

Good

The service was responsive. The home had a complaints policy in place and relatives knew how to complain if they needed to.

Care plans were person centred, detailed and reviewed regularly, with the exception of one person's care plan. People's end of life wishes were documented.

People were supported to engage in activities and we received mostly positive feedback from people and relatives.

Is the service well-led?

Good

The service was well-led. People, relatives and staff spoke positively of the management structure in place at the home. Relatives and staff told us that they had seen an improvement at the home in recent months.

Quality assurance measures were in place with regular audits carried out by the registered manager and deputy manager, in addition to quality oversight at provider level.

Systems were in place to support people, relatives and staff to provide feedback and improvements were made following analysis of the feedback received.

Hugh Myddelton 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 checked 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 2 and 3 November 2017 and the first day of the inspection was unannounced.

This inspection was carried out by two inspectors and a specialist nursing advisor. The inspection team was also supported by two experts by experience who obtained feedback from people and relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with 14 people who used the service, 10 relatives, the registered manager, the deputy manager, the regional director, clinical development nurse, six registered nurses, ten care staff, the activities co-ordinator, head chef, head housekeeper, maintenance operative and two healthcare professionals visiting the home on the day.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We looked at 12 people's care files and risk assessments, daily recording records, 36 Medicines Administration Records (MARs), nine staff files, staffing rotas and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt that they and their loved ones were safe living at Hugh Myddelton House. One person told us, "It's a wonderful place here. It's a very nice place I feel very safe. They always come to help me." A second person told us, "Yes, never felt any danger here." A relative told us, "I think [person] is safe here, I am here every day."

When we last inspected this service, we found that there were insufficient numbers of staff on duty at all times to meet people's needs. We received poor feedback from people, relatives and staff about staffing levels and how that impacted on the care people received. At this inspection, we found that the provider had made improvements.

We received mostly positive feedback from people and relatives when asked if there were sufficient staff available to provide support. Comments included, "Yes, If I ring my bell they come quickly", "If I ring my call bell they usually come quickly. If they don't I will shout to get them", "If you ring the bell they come as quickly as they can. It varies. They answer the bell quicker later in the day" and "I haven't found it short of nurses or care staff." One relative told us, "I can see they are making efforts to improve things, especially around staffing." Another relative told us, "Staff always work in pairs, when they are changing people there's no one on the floor."

We received mixed feedback from staff regarding staffing levels, with an acknowledgement that there had been improvements made to staffing levels. One staff member told us, "We have enough staff." A second staff member told us, "There is more staffing. It is much better." A third staff member told us, "My opinion is we need more care staff. Everyone needs hoisting and we can't manage everyone every day. One or two more staff."

When we last inspected the service, we found that on the second floor of the service there was one nurse and one care staff on duty in afternoons which meant that when people required assistance with personal care, assistance had to be requested from another floor. At this inspection, we saw that in afternoons, a second care staff was on duty in addition to two care staff assigned to two specific people.

The provider used a Dependency Indicator Care Equation (DICE) tool to assess dependency levels and calculate staffing levels. The DICE is a tool that takes into account the person's needs and level of support and then calculates how many hours of support the person requires. The DICE tool also takes account national averages of people's assessed needs against the hours recommended by the tool. We saw that the DICE tool had been appropriately completed and reviewed on a monthly basis. Staffing level at the home on the days of the inspection matched the rota, with one nurse on duty on each floor throughout the day. Four care staff were on duty on the ground floor during the morning and three were on duty in the afternoon. On the first floor, there were four care staff on duty throughout the day. At night there were two nurses on duty and five care staff.

We observed that although there was sufficient staff available to ensure people's care needs were met; we

found that on occasions communal areas such as lounges and dining rooms were left unsupervised whilst people were present. This was when care staff were in people's bedrooms providing personal care. We observed that when an activity was ongoing, the activities co-ordinator was present and when the activities co-ordinator left the room, a care staff was present to ensure people's safety. We discussed with the registered manager and the area director how staffing levels may require review to ensure that there was a staff member present in communal areas.

We looked at a random sample of call bell print outs for October and November 2017 and found many calls extended beyond the providers five minute guideline for being answered. The registered manager was unable to demonstrate that these extended response times had been investigated and followed up.

The registered manager provided evidence that some call bells had been reported as faulty during this period but there was no information available which offered a clear and acceptable explanation for most of the extended call response times. The regional director advised that the call bell system was old and would benefit from update in the future. We were advised because of how the current system worked, if there was a fault with one call bell this could have an effect on others spontaneously activating, not activating and or recording as activated when they hadn't been. We saw evidence where call bells had been reported to maintenance on a number of occasions between May and November 2017.

We looked at how medicines were managed. One person told us, "The staff are good at my medication." Nurses were trained and assessed as competent to administer medicines. We saw people being given their medicines in a safe and caring manner. Care workers applied people's creams and topical medicines when they supported them with their personal care. They recorded these on a chart which had clear instructions for use.

Some people needed blood tests to monitor their medicines, we saw that these were done and doses adjusted when necessary. There were clear guidelines available for staff to follow if people were prescribed fluid thickeners.

When medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist. A relative told us, "Yes [person] refused her medication. There was a best interest meeting about her medicine and it's now put in her food."

Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971. Staff completed audits on each unit to check that medicines were being managed safely and we saw that where discrepancies were noted, actions were taken and recorded. Unit managers were able to explain the process used for ordering people's monthly medicines to ensure that these were received on time and making sure people had their medicines when they needed them. Some people were prescribed medicines to be taken 'when required'. 'When required' protocols were tailored to the individual and provided staff with guidance on when these medicines should be administered.

We saw that medication administration records (MAR) were clear and had been completed accurately showing that people received their medicines as prescribed. We found one medicine error on inspection, where a person did not receive one dose of eardrop as prescribed. We fed this back to the nurse and registered manager.

Risks associated with people's care and support needs were assessed and provided clear information and guidance to all care staff on how to support people appropriately in order to reduce or mitigate any risk

identified. Examples of risk assessments that formed part of the care plan included falls, moving and handling, bed rails, use of call bells and choking. Individual risks associated with people's care and support needs were also identified and assessed, such as risk of infection.

Monthly observations such as blood pressure, pulse and respiration were completed and maintained and these were signed and dated by the nurse completing the observations.

For one person who was an insulin dependent diabetic, their daily blood sugar monitoring was recorded prior to breakfast and supper and evidence on the blood sugar monitoring chart showed that the person's needs were well controlled. Each person with diabetes had their own blood sugar monitoring machine with control solution which was used to make sure the machine was functioning properly.

Nutritional profile charts showed that people's height and weight were recorded on admission and monthly weights with dates, BMI, any weight loss by month, and the overall risk factor were also monitored.

Skin integrity was assessed using Waterlow charts to determine risk levels. Waterlow charts were reviewed and updated on a monthly basis and Waterlow scores had been correctly calculated. We checked hoists and pressure relieving mattress motors and saw that these were maintained with dates serviced indicating that they were in working order and safe to use.

One person displayed behaviour that challenged and had a risk assessment in place; however, we found that although their risk assessment was updated on a regular basis, significant incidents of behaviour that challenged, a referral to the local safeguarding authority and community mental health team and a recommendation to commence a behaviour chart for the person had not been included in their risk assessment updates. We raised our concerns with the registered manager and regional director, who following the inspection provided an updated risk assessment and evidence of a behaviour chart specific to the needs of people living with dementia. We were also advised by the provider that they were in the process of implementing a new dementia care strategy where staff would undergo distressed reaction training to enable them to better manage situations where a person was observed to be acutely distressed.

Accidents and incidents were recorded and analysed. Staff knew how to report accidents and incidents. However, on review of the accidents and incidents log, we found a record of an incident and the way it had been handled at the time, caused concern. When asked about this incident, the registered manager advised that incident was not as described in the form, despite the registered manager having signed off the incident confirming that it had been analysed. Following the inspection, the registered manager sent a statement from the staff member correcting their initial version of events. However, we could not be assured that documented incidents had been appropriately documented and analysed.

Staff continued to be safely recruited. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Records confirmed that staff had received training in safeguarding people. Staff also confirmed that they could access the safeguarding policy. They were able to describe the types of abuse to look out for and the steps they would take if they had concerns. Staff identified that they could report abuse concerns outside of the organisation to the local safeguarding authority and the Care Quality Commission.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella, lifts and hoisting equipment were undertaken. The service also had contracts in place for the routine maintenance and servicing of equipment.

Personal Emergency Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency.

People were protected by the use of safe infection control procedures and practices. Staff were trained and kept up to date with good practice. The home was clean and well maintained on the days we visited. Staff had access to personal protective equipment (PPE).

Good

Is the service effective?

Our findings

People spoke positively about staff and told us they were trained and skilled to meet their needs. Comments received from people included, "They know how to hoist me. Yes", "Yes they know how to deal with catheter and PEG feed. Staff went on training last week" and "Yes they change my suprapubic catheter regularly."

The service had systems in place to keep track of which training staff had completed and future training needs, staff supervisions and appraisals. Staff told us that they had access to training and had received regular training. Training records confirmed that staff attended regular training which included infection control, manual handling, dementia, mental capacity/DoLS, food safety and safeguarding. One staff member told us, "We get training on everything." A second staff member told us, "I did dementia training and level three NVQ. I study to learn lots of things about dementia. Try to learn why people do what they do."

All newly appointed care staff were required to undertake an induction process which consisted of a five day corporate induction which covered topics such as, health and safety and infection control procedures, meeting of the senior management team and the provider's values and expectations. The corporate induction was followed by a local induction which lasted a minimum of two weeks, dependent on the experience and skills of the newly appointed staff member. Records confirmed that all staff had completed the induction. A staff member told us, "I did induction and training for nearly three weeks." Staff told us and records confirmed that staff received regular supervisions and an annual appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Where people were deprived of their liberty the registered manager had made appropriate applications to the local authority for DoLS assessments to be considered for authorisation. Records confirmed that where appropriate, people consented to their care and where people lacked capacity a best interests decision had been taken with the involvement of their relative.

Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been provided. The staff we spoke to had a clear understanding of the principles of the MCA and how it was applied. A staff member told us, "Some people have mental capacity and they can make decisions. Some residents can't do it. As a carer I know what is good for my residents."

People and staff told us consent was obtained prior to assisting people. One person told us, "They do check

how comfortable I am and what I would like when they are washing and dressing me." A second person told us, "Yes, they ask me if I want to get up, If I don't we then agree that they will be back later say at 11am."

Records showed that people were seen by other healthcare professionals, including speech and language therapists, physiotherapists, dieticians, podiatrists and chiropodists when required. There was guidance from healthcare professionals and this was followed through with monthly reviews in care plans. People and relatives told us that they could access medical assistance if needed. One person told us, "No problems in getting my GP in." A second person told us, "When I felt something was wrong in the night the staff made me comfortable and arranged for the GP to come next morning."

We received mixed feedback from people and relatives regarding the food and choices on offer. Feedback from people included, "Food not very good, not a lot of choice", "Generally it's not too bad" and "The food is very good here." A relative told us, "The chef is good. Everybody loves him. He's very caring, will make anything you want or ask him to do. He makes my mum fruit smoothies twice a day." Three people told us that the food was not to their taste and they made their own arrangements for meals which included eating out, ordering take-aways and relatives bringing in food. One person told us, "I go out for lunch occasionally and go to [place] to get food. I bring in food to eat and treats. They will heat up the food for me."

We observed mealtimes at the home throughout the inspection and saw that people were offered choices of meals and where required, staff assisted people with their meals. We found that on one floor pictorial menus were used and on another floor, we saw that people were offered a visual choice of the options available. We observed the chef and staff created an animated atmosphere. They talked with people at the tables as well as serving the meals. We observed positive, encouraging and patient interactions between staff and people. Staff demonstrated knowledge of people's likes, dislikes and preferences.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk or malnutrition. We saw evidence where a risk was identified a risk assessment was implemented in order to manage this risk. The MUST was reviewed on a regular basis and people had regular weight checks. Weight loss was recorded and referrals were made to a dietician in a timely manner.

People who received nutrition via a percutaneous endoscopic gastrostomy (PEG) feed regime were supported by trained nursing staff. Guidelines were available to support staff to monitor for complications which included flushes with water and resting periods. We saw trays for feeding with new syringes and feeds. A photo of the PEG tube was kept in the person's file with guidance for signs of infection.

People at risk of malnutrition and dehydration had food or fluid charts in place to monitor people's food and fluid intake. These were documented and signed appropriately.

The service carried out comprehensive pre-admission assessments to ensure that they understood and were able to meet people's health, care and medical needs which included assessments of communication, hygiene, mobility, skin integrity, nutrition, breathing, medication and pain score, cognition, psychological wellbeing, behaviour and end of life care.

There were three daily hand overs, which were in the morning when the night staff handed over to the day staff, in the evening when the day staff handed over to the night staff and at 11am when there was a feedback and update session with any changes to the nurses, chef, laundry team and maintenance man. This meant that any concerns or updates regarding people's care needs were communicated throughout

the home and escalated to senior staff in a timely manner.

The home was decorated to a high standard and was decorated in a dementia friendly manner. On the dementia unit, the person's life story was displayed outside their bedroom door which provided the person reading the document with a person centred snapshot of their life.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and spoke positively about the relationships they had with staff. Feedback received from people included, "The girls [staff] are very nice. Amazing. Very loving girls [staff]", "They [staff] are all kind" and "Yes, all but the chef because he is an Arsenal supporter and I am a Chelsea supporter. We always have a good argument, but we have to keep the language okay when the ladies are about."

We received positive feedback from relatives regarding the caring nature of staff at Hugh Myddelton House. One relative told us, "I find the home and care offered here to be wonderful. [Person] had a lovely time and said the staff are all wonderful." A second relative told us, "A lot of care staff laugh and joke and dance with the service users, you need staff to be happy with people." A third relative told us, "The way the staff help my relative who is disabled when they visit here is great, it makes me feel happy. They are really caring, it is automatic."

Some relatives told us that although they found staff to be caring, they commented that staff did not have enough time to spend talking or sitting with people who were unable to leave bed. A relative told us, "What's needed is for staff to spend time on one to one, [people] do respond when there is one to one attention." This was reiterated in some of the comments we received from staff.

We observed many kind and caring interactions between staff and people who used the service and their relatives when they visited. We saw a member of staff giving a person a hug and doing a high five with her. We saw that the person enjoyed this. The member of staff looked for her chewing gum for her and joked with her about a picture of a good looking man. They laughed together and the person clearly enjoyed the staff member's jokes and banter. We observed that the activities co-ordinator had a particularly positive relationship with people. We observed that on one occasion when a person living with dementia became distressed, they advised care staff on how to calm and reassure the person.

We did on occasion observe some abrupt and impolite interactions between care staff and people. On one occasion we observed a member of care staff tell a person to "sit properly" in their wheelchair in a brisk manner. On another occasion we observed a care staff member 'shush' a person in an abrupt manner who had become distressed. We fed our observations back to the registered manager who advised that would investigate and address with staff involved.

Staff respected people's privacy and dignity. We saw that doors were kept closed when people were receiving personal care. The majority of people we spoke to stated that staff were respectful and careful when undertaking personal care tasks. A person told us, "I think with care, dignity is very important." A relative told us, "Yes. There used to be a man that cared for [person] during the night. I asked that [person] only had female care staff. Now she only has women to do her care."

We asked if people were supported to be independent. We heard how a nurse had arranged for a person to get a self-propelling wheelchair which as a result, one person was able to leave the home on their own to do

shopping and maintain their independence. The person told us, "Now I have my electric wheelchair I can go out and do what I want. Go to the shops, take the bus." A relative told us, "Yes, [Person] is a very private person. They help him into the shower and then leave him to wash himself as he does not like anyone to help him do it or to see him undressed."

Staff we spoke with had a good understanding of people's individual backgrounds, ages, likes and dislikes. Care plans also detailed people's cultural and religious preferences and whether people practiced a faith and whether members of the local religious community visited the home on a regular basis. People were addressed by the staff using their preferred names. Staff told us they had read peoples care plans. When asked if they thought staff knew them and their needs, a person commented, "Yes they do." A relative told us, "Yes they understand Dad." As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. We saw that one person was supported to ensure that they only received visits from relatives they wanted to and their wishes in this regard were noted in their care plan.

People's friends and relatives were able to visit and keep in contact without being unnecessarily restricted. We observed a steady stream of visitors throughout our inspection. A relative told us, "It's a nice place for relatives to come to. It's bright, clean and there is space for you to have break and a drink. It makes it easier to come regularly." A person told us, "I rely on staying in contact with friends, family and what is going on by phone and the internet."

Good

Is the service responsive?

Our findings

People using this service and their relatives told us that the management and staff responded to any changes in their needs. We saw from people's care records and by talking with staff that if any changes to people's health were noted by staff, they would report these changes and concerns. Relatives told us they were kept up to date with any issues. A relative told us, "Yes I am very involved they always ask me. They call me if the GP is coming in." A person told us, "I went to hospital and when I came back I had sores on my legs. The staff here made them better." A second person told us, "I wanted the air mattress to be taken away as it was so noisy. I asked [registered manager] and within in a short period of time he arranged for me to have a different mattress. He said if I had a problem with my skin we might need to go back to a different type of mattress."

People's individual care plans included information about life history, cultural and religious heritage, daily activities and communication. Care plans were reviewed regularly and updated as changes occurred. Core care plans were completed based on the person's assessed needs such as communication, hygiene, mobility, skin integrity, nutrition, breathing, medication and pain score, cognition, psychological wellbeing, behaviour and end of life care. Care plans were also in place to provide guidance for staff when a person had a specific medical condition and the symptoms of ill-health associated with the condition were explained.

However, we found one instance of a person's care plan not being updated accurately following a number of incidents of behaviour that challenged. The care plan did not identify the types of behaviour the person displayed or provide guidance for staff on how to support the person. Following the inspection, the registered manager sent an updated care plan which addressed the issues identified on inspection.

People and relatives told us they were involved in planning of their care. A relative told us, "Yes, when he came in they even asked him what Telly programs he liked." We saw that most reviews of people's care needs involved the person and their relative and their input and suggestions were documented. However, some relatives fed back to us that they found it difficult to arrange a review meeting. A relative told us, "I don't like to keep asking, they say they have been busy with other things." A second relative told us, "They should be proactive in updating the care plan with us." We discussed this feedback with the registered manager who confirmed a review meeting with the person and/or their relative or next of kin should take place every six months. The registered manager confirmed that they will review when people last had a review meeting and if overdue, would arrange as a priority.

Care plans documented that advanced care planning and end of life care was discussed with most people and their relatives. People's choices and wishes were recorded in relation to planning the way in which they wanted to be cared and preferred funeral arrangements. Some people preferred to let their next of kin make the decision which was documented. All care plans viewed showed that the staff worked closely with the palliative care team to provide end of life care and this was reviewed monthly. Pain assessments were maintained, and analgesia was prescribed and administered as required. People were also assessed for complications where strong analgesia and laxatives were prescribed and administered as required.

People were supported to engage in activities if they chose to do so. We received positive feedback from most people and relatives about the activities on offer. Comments included, "Activities are alright. I do word search", "They had Irish Dancing here, and [person's] granddaughter was in it last Sunday. The first Saturday he was here they had a lovely celebration for Barchester Homes 25th Anniversary. It was a lovely day" and "The entertainment here is pretty good." We received some feedback from relatives and staff relating to improving the provision of activities for people who were bedbound or unable to leave their room. A relative told us, "What's needed is for staff to spend time on one to one, they do respond when there is one to one attention." A second relative told us, "I see they have recently making efforts to increase activities."

The home had an activities timetable in place which included a visit from the hairdresser and film club on the first day of the inspection. We observed the activities co-ordinator attend to people in a lounge in the morning which was to be on a one to one basis. People did not receive the one to one attention as scheduled and the activities co-ordinator was left alone with nine people and assisted with feeding one person and calmed a person when they became distressed. Some other staff at times passed through the lounge but did not remain. On the afternoon of the first day of the inspection we observed a music therapy session led by a musician, which was well attended and enjoyed by the people in attendance.

Some people spoke of not being interested in activities on offer as they were at a different life stage to the other people living at the home and had different interests. We spoke to the registered manager and staff about how these people's social needs was met. We were advised that attempts had been made to engage people in activities of their interest but some people preferred to remain independent of the activities on offer at the home.

A complaints policy was available and processes were in place for receiving, handling and responding to comments and complaints. Information about how to make a complaint was on display in the home and the majority of people and relatives we spoke with told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. A person told us, "Yes. Would start with nurse and go to [registered manager]." A second person told us, "My experience is they do listen and seek to take on board requests/changes." However, a relative told us, "If you raise questions or concerns, the staff reaction is sulky; it makes you feel like you are being a nuisance." A second relative told us, "When [person] was first here there were things I was not happy with. They listened to me and understood what the issues were."

Good

Is the service well-led?

Our findings

People and relatives spoke positively of the overall service provided and registered manager who had been in post since April 2017. Most people knew who the registered manager was. One person told us, "[Registered Manager], I have an occasional interaction with him. He sometimes helps me in with my take away." A second person told us, "The manager is okay." A third person told us, "You're wasting your time and money inspecting this place as it does not need to be inspected. The care is exceptional and so is everything else here!"

A relative told us that the registered manager was "Approachable, he's very good, he listens and takes action. He gets things done." Many relatives we spoke with mentioned there had been improvements in the last year, which they welcomed, with efforts around staffing. However, they felt there was still room for improvement in relation to staff being supported to spend time with and pay attention to people beyond ensuring people's basic care needs were met such as accompanying people into the garden when the weather was appropriate.

Staff spoke positively of the registered manager and how they were supported. There was a clear management structure in place at the home and people and relatives knew the nurses in charge on their units. One staff member told us, "I enjoy working at the home and that is why I is still there." They told us that the registered manager was very supportive, approachable and very professional. Feedback from other staff included, "Very good here now, since the new manager much better", "Management is listening", "[Registered manager] is good. He gets involved on the floors" and "I like it. I like the residents."

There were systems in place to monitor the safety and quality of the service provided. These included monthly audits of falls, pressure ulcers, complaints, accidents and incidents, training, supervisions and appraisals, instances of infection, medicines errors and weight monitoring. In addition, a monthly quality and clinical governance meeting took place between the registered manager and deputy managers with unit heads. Topics discussed included nutrition, skin integrity, falls, medicine errors, choking incidents, infection control and lessons learnt. Actions were identified and carried over to the next monthly meeting for review. We looked at the meeting minutes for October 2017 and saw that gaps in food and fluid charts, deployment of staff to the dementia unit at mealtimes, recording on repositioning charts and training for choking and dysphagia had been discussed. Actions were then cascaded to staff on the units via unit meetings.

The regional director visited the home on a regular basis and completed a monthly quality check which reviewed accidents, incidents and safeguarding, clinical meetings, CQC compliance and engaged in discussions with people and relatives, staffing and training. In addition, there was an annual quality improvement review which included health and safety, catering, infection control, leadership, lifestyle, training, care and medicines. Actions were identified following the review which included ensuring care plans were updated and reviewed on a regular basis and ensuring recommendations for health professional input was followed up.

Quality was also assessed through annual feedback surveys from people, relatives and staff. The home used the 'Your Care Rating' system to measure the quality of the service. 'Your Care Rating' is an external independent survey which gathers the views of people, family and friend and rates the home against standard criteria. Ratings were given in the areas of; staff and care, home comforts, choice, having a say and quality of life. We were advised that the 2017 'Your Care Rating' survey was currently in progress, the results of which were as yet unknown. We were shown the results for 2016 survey which included responses from 40 people and 14 relatives and friends. The results showed that the home succeeded the average score for 'Home comforts' & 'Staff and care'. We were advised that the 2017 staff survey was currently in progress and would not be complete and published until early 2018. The last staff survey in 2016 had been provider wide but this year it had been developed to be service specific.

Residents and relatives meetings took place on a regular basis and topics discussed included activities, staffing levels and menu planning. An action plan had been developed after the meeting. We were shown a consolidated June and August meeting action plan which we found addressed all areas concerned, with clear action points, person's responsible and set target/completion dates. Following resident and relatives meetings a 'You said, we did' poster had been displayed throughout the home. Changes made as a result of a meeting included changes to type of cups used, development of a bird watching group and the introduction of smoothies to the menu.

Staff meetings took place on a regular basis across all units. We saw meetings covered areas such as staffing/recruitment, operational issues, personal care, laundry, food and fluid charts, call bells, relatives meeting etc. We noted that although concerns were addressed, actions noted had not been set timescales and it was unclear how these were monitored and followed up.

The registered manager advised that actions were followed up in the monthly manager's audits undertaken by himself and the deputy manager. Staff told us that they attended meetings and found that they were informative and suggestions were welcome.