Barton Place Limited

Barton Place Nursing & Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19, 23 and 27 September 2016. The first day of the inspection was unannounced. The last inspection of the service took place on 4 June 2014 when the service was found to be fully compliant with the standards we looked at.

Barton Place Nursing and Residential Home is registered to provide accommodation for 42 people who require nursing and personal care. At the time of this inspection there were 36 people living there. The home specialises in caring for people with dementia and mental illness. Many of the people we met were unable to hold a conversation due to dementia. We therefore used our observations of care and our discussions with staff, relatives and professionals to help form our judgements.

There was a registered manager in post. 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.

Since the last inspection we received some concerns about the service. These included concerns about continence care, pressure care management, staff training and support, needs, assessments and referrals and moving and handling, low staff numbers, lack of training, poor moving and handling practice, and poor communication skills of overseas staff. Some of these concerns were investigated by the local authority safeguarding team. They carried out investigations and held strategy meetings to discuss their findings and agree actions. The action plans were agreed with the provider who responded pro-actively in a positive way and the safeguarding process was closed a few days before this inspection took place.

During this inspection we heard that the home had recently experienced a period of high staff turnover. They were in the process of recruiting new staff. There had been some changes in the management of the home over the last year. At the time of this inspection a registered manager had recently returned to work in the home after a break in their employment. Their return to Barton Place was welcomed by relatives and staff we spoke with. The staff team spoke positively about the teamwork and communication in the home since the registered manager's return. We saw evidence of many improvements that had recently taken place in recent weeks to improve the care of people living in the home. Issues that had been raised through the safeguarding process had been, or were in the process of being addressed. During the inspection we identified some further improvements were needed and the provider and registered manager took prompt actions to address these, or put plans in place to address these as soon as possible.

Where people lacked capacity to make an informed decision the records did not always provide evidence of an assessment of their mental capacity. Where restrictions such as bed rails or pressure mats had been put in place we were unable to check that agreement for these restrictions had been reached through a 'best interest' process with people who were lawfully acting on their behalf.

People had not always been protected by robust recruitment procedures. Where potential concerns had been raised through one person's recruitment checks we could not see evidence that a formal risk assessment had been carried out to determine further actions necessary to ensure the applicants were entirely suitable. The new registered manager and provider gave us assurances that in future safe recruitment procedures would always be followed.

There were sufficient staff employed to meet the needs of people living there. Deployment of staff (staff being in the right place at the right time) had at times been a problem, but was improving. Recent staff changes meant that some new staff were still in the process of learning the job. Senior care posts had recently been established. This had brought about positive changes in the way staff worked. Senior staff carried out regular checks to ensure each person's care needs were being met in a timely way. For example, records showed people may not have received regular continence support. The provider acted immediately during the inspection to improve the care planning and recording system. This enabled them to monitor staff routines and make sure people received regular continence checks.

The home had recently introduced a new computer based care planning system. Each member of staff had been issued with a hand-held device the size of a mobile phone which they used to record the care tasks they completed throughout the day. The devices gave them access to each person's care plan and the care the person needed. Information about each person's needs had been transferred onto the computer system in recent weeks. The care plans provided good information about potential risks such as weight loss, dehydration, pressure sores and choking. Staff were alerted to important actions needed to reduce the risks. There was also evidence of good liaison with other health and social care professionals.

Medicines were generally stored and administered safely. We noted some problems with missing signatures in the medicines administration records (MARS). The registered manager took prompt action to ensure daily checks were carried out on MARS to ensure all records were accurate and provided evidence to show that all prescribed medicines, including creams and lotions are administered safely.
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The home was well maintained and equipment was serviced and checked regularly. There were mild odours in a few areas despite regular 'deep cleaning'. The providers were aware of the problem and new flooring had been ordered and was due to be fitted in the near future to address the problem.

People were treated with respect and dignity. Staff were compassionate and kind and recognised people's right to make choices about their daily lives as far as they were able. A small number of staff recruited from overseas had poor English language skills and this meant they were unable to always communicate effectively with people who used the service. The provider was supporting these staff to learn English and there were always staff with good English language skills on shift with them, however this issue needed more monitoring to ensure good communication with people living in the home.

People were offered a range of meals to suit their individual dietary needs and preferences. If they needed assistance with their meals the staff were attentive and offered gentle encouragement at the person's own pace. However, many people ate their meals while sitting in lounge chairs rather than being assisted to moving to the dining room. We have recommended the provider and registered manager reviews people's individual seating needs at meal times and seeks further guidance if necessary on supporting people to eat comfortably at mealtimes.

During activity sessions there was a lively 'buzz' about the home. Each person's social needs had been assessed and there was a wide range of activities offered to suit all interests and abilities. An activities organiser was employed on a full-time basis with an advert out for a further activity assistant. A weekly

programme of activities had been drawn up which included individual and group activities such as games, arts and crafts People were encouraged to participate in daily routines such as gardening, maintenance, decorating, folding laundry, and cleaning tasks. Even regular activities such as hairdressing had become social events with discussion, music and singing while people waited to have their hair done. During these activity sessions we saw people smiling, happy and relaxed.

People and relatives we spoke with were happy with the care provided. Comments included, "They are all very nice and all respectful" and "The staff seem respectful and get on with each other. They are lovely, very caring, very gentle…everyone is very friendly". Another relative told us, "They are always very good and respectful. They always respond appropriately to people and difficult situations. I think they do a good job. I am happy with the care". The provider had sought relatives' views on the service through questionnaires. People knew how to make a complaint. Where concerns and complaints had been raised we were given assurance these were taken seriously and acted upon promptly.

The provider and registered manager had systems in place to regularly monitor the service and make improvements where necessary.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).You can see what action we told the provider to take at the back of the full version of the report. We have also made one recommendation relating to seating arrangements at mealtimes.

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 fully safe.

People had not been fully protected from the risk of harm or abuse by the home's recruitment procedures, although the provider took prompt action to ensure staff are recruited safely in future. .

Medicines were administered and stored securely.

People were supported by sufficient numbers of staff to safely meet their needs. However deployment of staff may have resulted in some tasks not being carried out in a timely way.

Risks of abuse to people were minimised because staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not fully effective.

People received care and support from staff who had the skills and knowledge to meet their needs. However, a small number of staff recruited from other countries were unable to communicate with people effectively.

People's capacity to make informed decisions about their care and treatment had not been fully assessed in accordance with the Mental Capacity Act 2005.

People had access to healthcare professionals according to their specific needs.

Food was served in accordance with people's dietary needs and preferences.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind, caring and compassionate.

People were supported by staff who knew them well.

Staff understood the need to respect people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received care and support which was responsive to their needs and wishes.

People and/or their relatives knew how to make a complaint. Staff were confident they would be able to identify if people were unhappy about any aspect of their care.

People had opportunities to take part in a range of activities.

Is the service well-led?

Requires Improvement

The service had not always been well led but this was improving. The new quality monitoring procedures had not been in place long enough to show they were embedded and fully effective.

People benefitted from a staff team who felt supported by the registered manager and provider.

The registered manager was committed to ongoing improvements to promote people's health and well-being.

Barton Place Nursing & Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 19, 23 and 27 September 2016. The first day of the inspection was unannounced. The last inspection of the service took place on 4 June 2014 when the service was found to be fully compliant with the standards we looked at.

The inspection was carried out by two adult social care inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at all of the information we had received about the service since the last inspection. This included notifications about deaths, accidents, incidents. We also looked at concerns and complaints we have received. Before the inspection, we requested that the provider complete 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. This was received from the provider.

We spoke with, or observed staff interacting with most people who lived in the home. We also spoke with the provider and registered manager, eight relatives and seven staff. We looked at care plans, daily reports, medication storage and administration, menus, staff rotas, staff recruitment records, staff training records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Since the last inspection we have received some concerns about the service. These included concerns raised through the local authority safeguarding process which included continence care, pressure care management, staff training and support, needs assessments and referrals and moving and handling. The local authority safeguarding team carried out investigations and held strategy meetings to discuss their findings and agree actions. Some of the concerns that had been received were not substantiated. Where concerns were found to be correct, action plans had been drawn up and agreed. The provider responded pro-actively in a positive way. The safeguarding team were satisfied the issues had been addressed and the process was closed a few days before this inspection took place. In the last year we had also received other concerns about the service including low staff numbers, poor recruitment procedures, lack of training, poor moving and handling practice, and poor communication skills of overseas staff. We looked at these issues during this inspection.

People had not been fully protected by the homes' recruitment procedures. The provider told us their normal procedure was to carry out checks with the Disclosure and Barring Service (DBS) to ensure the applicant had no significant criminal convictions and had not been barred from working with vulnerable adults before an applicant was employed. We looked at records of staff employed since our last inspection and found safe recruitment procedures had not always been followed. In one file we found a DBS check highlighted a potential concern. A risk assessment had not been recorded to show any additional measures taken to ensure the applicant was suitable. Some recruitment files did not contain at least two satisfactory references. The provider told us the staff had been recruited by a previous manager who had not followed their recruitment policies and procedures. However, there was no longer a risk because it had been resolved through staff changes. The registered manager and provider gave us assurances that in future they will ensure they follow safe recruitment procedures and records will be in place to provide full evidence of the recruitment checks they had completed. The provider also assured us they will be monitoring recruitment closely in future to ensure their recruitment procedures are followed.

There had been a high staff turnover in the last year, with some staff leaving at short notice. There had also been high sickness levels. The provider told us they had addressed the risk of low staffing levels by bringing in staff from other homes operated by the provider, and also through the use of agency staff. They had also recruited new staff from overseas through specialist agencies. Staff told us morale was improving since the current registered manager returned to work in the home. Staff spoke positively about the registered manager's open door policy. They said they could speak out and raise any concerns. The registered manager was addressing sickness levels by implementing performance monitoring procedures. This meant the risk of unexpected staff shortages had been reduced and the staff team had stabilised. Despite the recent high staff turnover relatives praised the staff, for example, "They are all so lovely - that's all I can ask" and "I know they are having trouble with [retaining] staff but the staff are all very good".

New staff were given information about the organisation's safeguarding policies and procedures at the start of their employment. Most staff had received further training or guidance on recognising or reporting abuse, and the remaining staff had been booked training for the near future. Staff told us they were confident they

knew how to report any suspicions of abuse. We had received notifications of any potential safeguarding issues following the correct local reporting procedures and these had been dealt with appropriately to keep people safe.

There were sufficient staff employed to meet the needs of people living there. The staff rotas showed there was one registered manager plus ten nursing and care staff on duty each day. In addition, there were three housekeepers, one laundry person, one kitchen assistant, one activities person, one maintenance person and one administrator. Agency staff had been used to cover vacant shifts where necessary, although the use of agency staff had been kept to a minimum where possible. Staff told us they were busy at times but thought the staffing numbers were generally sufficient. One member of staff said, "It's fast and hard but very rewarding." They told us staffing problems were improving and they felt there were enough staff employed.

Deployment of staff (staff being in the right place at the right time) had at times been a problem, but was improving. New staff were in the process of learning the job. Senior care posts had recently been established and this was beginning to bring about positive changes in the way staff worked. Routines were being established. For example, before the inspection we heard that some people may not have received assistance with continence at regular intervals throughout the day. During the inspection we found improvements had been made to the care planning and recording system. Continence checks were being recorded and senior care staff were carrying out regular checks to ensure staff were providing assistance with continence in accordance with each person's individual care plan. This meant there was improved evidence of regular continence checks which meant the risk of people being left for long periods in wet continence pads, and subsequently wet clothing, was reduced. Continence training was booked to be provided to all staff by a local health professional in the near future.

Some people were at risk of becoming agitated or upset which may result in them becoming aggressive or displaying behaviours that might cause upset to other people around them. Staff used a variety of methods to calm and reassure them. They offered diversions such as going for a walk or participating in an activity to help calm them down. Music and recordings of bird songs were used to create a calm atmosphere.

During the inspection we saw that call bells were answered quickly by staff. The provider told us they had recently checked that all call bells were working effectively, and that each person who was able to use a call bell had one within easy reach of their bed.

Risks to people's health and safety had been assessed and reviewed regularly. For example, people had been weighed regularly and the care plans highlighted those people at risk of weight loss and malnutrition. Plans were in place to ensure they received regular meals and high calorie diets, for example. Detailed assessments were in place to identify those people at risk of choking, giving information on the preparation of food and drinks and the support each person needed to eat and drink safely.

Each bedroom has been equipped with a specialist bed that could be adjusted to allow staff to assist the person to move safely in and out of bed. Specialist mattresses and pressure cushions were in place for those people at risk of pressure sores. Mattress settings were correct and monitored. At the time of this inspection there were no people with serious pressure sores and staff were managing people at high risk of pressure damage well.

Actions had been taken to assess the risk of falls and minimise the risk of injury. Where people had been identified as being at high risk of falls, equipment had been put in place such as 'crash mats', pressure alarm mats and adjustable beds. The crash mats were used at night to provide a soft landing if people fell out of bed. One person had a low bed. Door alarms and pressure mats were used in the bedrooms of those people

who sometimes woke up during the night without being able to use a call bell and walked around the home. The alarms alerted staff that the person may need some assistance. Alarms were also placed on the doors of people who may be disturbed during the night if another person walked into their room by mistake. Lighting around the home was operated by motion sensors which switched lights on automatically when people moved. This meant people could move around safely without having to search for light switches.

Medicines were stored safely. There was a large secure room on the ground floor that had been equipped for medicine storage and administration. There was a large wipe board displaying essential information about each person living in the home and contact details of medical professionals such as their GP. The room contained secure storage facilities for stocks of medicines including controlled drugs and medicines that required refrigeration. Medicines in daily use were kept in locked medicine trolleys in the main lounges on each floor. The trolleys were secured when not in use.

There were some unexplained gaps in the medicines administration records (MAR) that indicated that medicines may on a few occasions have been missed. Staff and monitoring systems had failed to note the gaps in the medication records and report these to the registered manager. This meant there was a risk that potential errors were not investigated and addressed promptly. During our inspection the registered manager and provider took actions immediately to ensure the MAR charts would in future be checked at each handover to ensure no medicines were missed.

We also found that prescribed creams and lotions had not been recorded each time they were administered, although we were assured the creams had been correctly administered. Pain relief patches had been recorded, but the records did not show the position on the body the patches had been placed. This meant there was a risk that the site of the patches was not alternated in accordance with the manufacturer's recommendations. During our inspection the registered manager and provider made changes to the care planning and recording system to ensure that all creams will be recorded when administered in future. They also put in place a recording system to ensure staff record the site of each pain relief patch administered.

We observed a member of staff administering medicines. They followed safe procedures by administering each person's medicines individually. The member of staff told people about the medicines they were being given, and why. Staff understood each person's long term health needs and the member of staff asked people, "How do you feel today?" to find out if they required 'as needed' medication. Medicines were audited monthly.

Without exception all the relatives we spoke were confident that their relatives are safe. One relative who was about to go on holiday and had just visited their relative told us, "I have left that home knowing [my relative] is safe and will be well cared for" and "I would recommend it to anybody. They look after [my relative] like I would". Another person explained, "The safety thing I am happy about" in relation to how the staff met the needs of their relative. Another person, said, "[My relative] is safe - that is one of my big plusses".

Before the inspection we received concerns that some areas of the home were not cleaned regularly. During the inspection we noted some mild odours in some parts of the home. The provider told us they were aware of the odours, and despite regular 'deep cleaning' using industrial cleaning machines they had been unable to overcome the odours. Therefore they had ordered new flooring for these areas. At the time of this inspection we saw there were usually one head housekeeper and four housekeeping staff on duty. There were plenty of disposable gloves and aprons available around the home and we saw staff wearing these when the supported people with personal care.

The laundry was well equipped, clean, and spacious with plenty of storage space for clean laundry. Trolleys and bags were used to transport dirty laundry safely. There was a laundry assistant who took a pride in ensuring all laundry was clean, neat and in good order and returned to the correct person. Sheets and towels were in good condition, and any damaged items were promptly discarded and replaced.

There were effective systems in place to make sure all equipment in the home was safe and in good working order including slings used for moving and handling. Gas and electrical checks were carried out at required intervals. Hoists were serviced regularly and new slings were discarded when any sign of wear was noted and new slings purchased. Fire safety equipment was checked and serviced regularly.

Requires Improvement

Is the service effective?

Our findings

Although people generally received effective care and support, there were some areas that required improvement. Some staff had been recruited from other countries. Most staff had very good English language skills but a small number had a very limited understanding of English. One member of staff assisted a person to eat in complete silence. Another member of staff did not understand when a person tried to tell them the tea was too weak and said they could not drink the tea. When we spoke with the staff member they did not understand our questions. This meant that people may be at risk of poor care from staff who are unable to understand written or verbal instructions and communications. We spoke with the provider and registered manager who assured us they were aware of this problem and were supporting these staff to learn English as a matter of priority. This included paying for English classes. They also told us the staff worked alongside other staff who were able to speak their language and act as interpreters. The provider also told us they will in future be monitoring staff recruitment much more closely in future, saying "I now insist on personally speaking to all foreign staff before they come to Barton Place so as to assess their spoken English skills."

The registered manager and provider were aware of their responsibilities under the Mental Capacity Act 2005 (MCA). Staff had received some basic training at the start of their employment on the MCA. The provider told us they plan to provide more detailed training on this topic in the near future. 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff offered people choices, for example people were given a choice of meals, and the activities they wanted to participate in. The new care plans provided information on most people's mental capacity, although in some instances this information was either missing or very brief. More detailed information was held in the old care plans and this was still in the process of being transferred to the new computer care planning system. Where restrictions such as bed rails or pressure mats were in place for people who lacked capacity the records did not always provide evidence that 'best interest' meetings and agreements had been reached with relatives and professionals. Some evidence of best interest agreements was held in the old care plans but the registered manager was not confident this process had been followed for every restrictive practice. They assured us they will address this as a matter of priority.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). 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). Assessments about people's capacity to consent to living at the home had been completed and some DoLS applications had been completed for people who were unable to consent to this and for those who required constant monitoring by staff. During

the inspection we spoke with the provider about DoLS applications for other people in the home. They realised some applications had not been submitted and completed these immediately.

The provider told us all new staff received induction training at the beginning of their employment. Training records also showed that most staff had received essential training on topics such as health and safety, infection control, dementia, dignity and respect, diet, fire safety and tissue viability. The provider told us they had recently changed their training provider as they want to improve the range and quality of training they provide. Staff spoke enthusiastically about the dementia training they had attended and how this had helped them review the way they supported people with dementia. For example, they had found that people were calmer when they listened to birdsong

Before this inspection took place we received concerns that some staff may not have received adequate training in some essential topics such as moving and handling. During this inspection the registered manager assured us she had made sure all staff had received updated manual handling training. Staff had received both practical and workbook based training on moving and handling. The registered manager and provider assured us that all staff recruited in future will have practical and theory training on moving and handling at the start of their employment.

Before the inspection took place the provider completed a Provider Information Return (PIR) containing information about the service, including staff training. This showed that nine staff had achieved a relevant qualification such as a National Vocational Qualification (NVQ). Seven qualified nurses were employed in the home. A member of staff told us that new staff received thorough training at the start of their employment and they were offered a good range of training and regular updates after completion of their probation. They told us "I've gained a lot. I've done NVQ level 3. They have offered us a lot."

None of the staff had completed the Care Certificate – this is a set of standards that social care and health workers should follow in their daily working life. It is the new minimum standards that are recommended for new care workers. The provider told us they planned to introduce this training in the near future.

Staff told us they received supervision approximately every three months with their line manager. They told us they were well supported. They had a handover session every day at the start of a shift and these sessions kept them up to date with any changes in people's care needs.

All the relatives felt that the staff supported people well. Comments included, "They have been brilliant, absolutely brilliant. I can go in any time and I speak any time and if I have concerns I can say and it is sorted", "They [staff] know the situation I have. I know if there is a problem they will contact me" and "They are always asking if there are problems please contact us". Some relatives commented on recent changes of staff and the impact this has had on the effectiveness of the service recently but recognised recent improvements in the staffing and a more stable staff team.

Some care plans did not contain instructions to staff to assist people with oral care where this was necessary. This meant there was a risk that some people may not have received effective support with oral care. One relative told us they were concerned about the oral health of their relative. The relative had asked care staff to use a mouth cleaning product on the person's gums but they were concerned this request had not always been actioned. They told us their requests were not always passed on to all staff. They were hopeful that the recent allocation of senior care staff will address this. We spoke with the provider and registered manager who immediately amended all the care plans to include oral care and staff were expected to record when this task had been completed. They told us this would in future be closely monitored and if oral care was missed in the future this would be identified quickly by the new care planning

and recording system.

People had access to health professionals when they needed treatment or advice. There was evidence in the care records of contact and visits by health professionals including GP's, continence specialists and community nurses.

People received a diet that met their nutritional needs and preferences. Comments from people living in the home included, "The food is good." The home purchased a range of frozen meals from a specialist company. These were reheated on the premises and accompanied by vegetables prepared and cooked on the premises. The provider told us they had found the frozen meals enabled them to offer each person a much wider choice of meals each day. It also meant they were able to meet each person's individual dietary needs. Staff told us they gave people a choice by showing them photographs of the meal.

There was an information board in the kitchen showing each person's dietary needs and preferences. For example, one person requested a salad on Tuesdays and Saturdays. Another person did not like mushrooms or liver. People could request a 'fry up' whenever they wanted.
Meals were served onto plates from the hot trolley in the kitchen and taken to each person individually. Staff said they felt the quality of the meals was good.

We saw breakfast being served in communal areas. People were offered a choice of foods including porridge. We also saw people sitting in communal areas during the day with hot and cold drinks offered regularly along with snacks such as homemade cakes and biscuits. Drinks were placed close to hand to enable people to reach them easily. Staff monitored fluid intake levels of those people at risk of dehydration and offered encouragement to these people to drink regularly.

One person had not eaten all their breakfast and said, "There is nothing wrong with the cornflakes, but there was too much". They went on to say the bowls were too big. We asked the registered manager about the use of different sizes of plates and bowls. They told us staff usually knew the size of meal each person preferred and sometimes used smaller plates and bowls. They told us they would review the portion sizes and presentation of meals to ensure each person's needs and preferences are catered for.

Many people living in the home needed assistance from staff to eat their meals. This meant that meal times took place over a period of one to two hours. We saw staff sitting with people who required assistance and allowing people time to eat their meals at their own pace. The length of time taken by some people to eat their meals meant there was a risk the meals may be cold before they finished eating. One person was asleep and staff could not rouse them. We were given assurance that if the person could not be woken at lunch time they would be given the main meal at tea time. They said the person usually had a very good appetite at tea time. They monitored the person's weight and offered additional foods throughout the day to ensure the person received adequate nutrition and maintained a safe weight.

We observed meals being lunch time most people remained sitting in lounge chairs using over chair tables to eat their meals. A few people were assisted to sit at dining tables but most people remained sitting in lounge chairs for their meal. We observed one person who was able to eat their meal unaided but ate very slowly. The meal of fish cake, chips and peas had not been cut up. They managed to eat the meal with some difficulty (peas especially). We asked a member of staff why the meal had not been cut up for the person but their English language skills were poor and they were unable to answer our questions. Their posture in the lounge chair looked uncomfortable. We asked the registered manager and some staff why they did not encourage more people to sit at the dining tables and they told us this had happened in the past. They were unsure why this practice had changed. However, they hoped to encourage more people to sit at the dining

tables for meals in the future.

We recommend the provider seeks further guidance on arrangements for people to sit comfortably at mealtimes, including seating arrangements people with dementia.

Good

Is the service caring?

Our findings

People received assistance from staff who were cheerful, kind and understanding. For example, during meal times we saw staff sitting with people face to face, chatting with them and offering gentle encouragement to eat their meals. Relatives told us staff were polite, caring, friendly and respectful. We observed a number of notices around the home reminding staff about good practice, for example 'A resident's room is their home', 'Put yourself in their position', 'Keep an open mind', 'Focus on what they can do', 'Adapt your language' and 'Be aware of how you communicate'. We also saw a notice reminding staff of forthcoming birthdays to ensure the day was celebrated.

Relatives told us staff treated people with dignity and respect. Comments included, "They are all very nice and all respectful", "The staff seem respectful and get on with each other. They are lovely, very caring, very gentle…everyone is very friendly" and "They are always very good and respectful. They always respond appropriately to people and difficult situations. I think they do a good job. I am happy with the care". Another relative told us, "The owners - if they think a person (staff) is not respectful or caring they are gone."

We saw staff supported people to maintain their dignity by ensuring their clothing was clean and in good order. For example, staff supported a person to change after the person had spilled tea and breakfast on their clothes. Staff spoke to the person kindly and took time to encourage the person to return to their room when they were ready. The laundry assistant took a pride in people's laundry and ensured it was clean, ironed and in good order and returned to the correct person.

Staff understood each person's individual needs, preferences and personality. One relative praised the staff, saying, "They seem to support [my relative] very well. She has to have so much done for her and she unfortunately doesn't like some things done for her. [My relative] is definitely in the right place and very well looked after. It is understanding her needs and I think they do a grand job. There is nowhere else she could be".

Staff demonstrated patience when supporting and interacting with people. They allowed people time to move, or express their needs without rushing them. A relative told us, "I think they are amazing, they seem to have endless patience". Another relative said, "I think at a basic level they support [my relative] very well - physical caring, positioning, and care when using the hoist…they talk to him, tell him what they are doing and overall kind and caring."

Staff demonstrated compassion and understanding when they talked about people in the home. For example, a member of staff told us "[Person's name] is a lovely lady. She won't come out of her room though we have encouraged her. We coax her out for a shower". They went on to say, "I helped her do her hair and she looked in the mirror and said 'I look like a princess'." The person's care plan gave good information about the person and their daily routines and preferences.

Staff understood the needs of people with dementia. We observed a person saying to a member of staff they wanted to go upstairs because their family were there (which they were not). The member of staff knelt

down to speak to the person face-to-face. They gave the person gentle reassurance and agreed to accompany the person to their room. When people showed signs of becoming anxious or agitated staff noticed and offered support, for example a member of staff said to a person, "Would you like a cup of tea?" The person agreed, and when the staff gave the person the tea they reassured them saying, "If you need anything else I am right here."

Around the home we saw examples of good practice that enabled people overcome difficulties such as finding their way around. The provider had followed nationally recognised good practice advice on ways of decorating the home to make areas calmer or more interesting. There were signs on toilet and bathroom doors with both a picture and the words to help people who had difficulty recognising text. Bedroom doors were personalised to help people find their own room. One person had been upset by other people walking into their bedroom by mistake. Staff had researched good practice advice and decided to decorate the person's bedroom door to make it look like a bookcase. They told us this had been effective in discouraging other people to enter the room by mistake. A relative gave an example of why they felt happy with the care in relation to their relative who has vascular dementia, saying, "I know when he is happy and not and he always has a smile…when he could walk about he used to wave".

Two relatives compared Barton Place favourably with other care homes. One person said that Barton Place was, "More caring" and that their relative "blossomed" when they moved to Barton Place. The other person said this was the third home their relative had been in (the others being respite care) and [Barton Place] was the one that was best able to meet their relative's needs. This person explained that their relative had a lot of difficulties and that, "The staff are doing a good job under difficult circumstances".

Two people specifically mentioned a member of staff they felt was exceptionally caring. One explained that when their relative first went to Barton Place and was more able to communicate the member of staff would shake the hand of their relative (who had been in the militarily) and talk to him about his experiences. The member of staff also took the person into the garden when they were able.

Care plans contained information on the care each person wanted at the end of their lives. Each person had a Treatment Escalation Plan (TEP) in place that specified if the person wanted to be resuscitated in the event of cardiac arrest. The plans set out any specific information about the person's care needs and wishes at the end of their life.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. One person said, "It's is nice here. I am very happy here". Another person said "They are very well looked after in this house."

People's health and personal care needs had been assessed and regularly reviewed. People and/or their relatives had been involved and consulted in the care plans where possible. The provider had recently introduced a new computerised care planning system. Each member of staff had access to the care plans by a small hand-held computer device they used to record care tasks throughout the day. When staff entered a bedroom to provide personal care they used a barcode over the person's bed to record on the computer records that they had entered the room. Each care task completed was then recorded separately. Some staff thought the hand-held devices were good while other staff were struggling to get used to the system. For example, one member of staff said "I hate it, but I accept it is necessary. I am getting used to it." Another care staff told us it was very time consuming to scroll through the information on their hand-held device and found it quicker to go and look at the computer in the staff office which gave easier access to the information. During the inspection we saw evidence that the computerised care plans were being improved and adapted to enable staff to find and record relevant information quicker and easier.

Staff also told us they recognised the new care planning system had some good features. For example, the system produced an electronic handover providing staff with effective updates on each person's current care needs. The handover sheet included information such as continence problems, infections and people at high risk of falls.

One relative said that they had found it helpful to be shown the hand-held devices as they showed the times their relative had received care from staff, for example when they had been turned in bed and when they had been given breakfast. They also were impressed with the barcode over the bed which showed that a member of staff had been in the room. However they also commented "It's a good idea as long as they all do it". During our inspection we were assured the recording of care tasks by staff was being closely monitored, and was improving.

Information from the old paper care plans had been transferred to the new computerised care plans. Files in the staff office contained the old paper care plans. This gave staff access to both sets of information. The new care plans were almost complete, but we found some errors and omissions. For example, we saw some old care plans contained detailed information about daily routines such as a person's preferred time of getting up and going to bed, and about ways of supporting people who may become agitated or upset. The registered manager told us they had recognised the new care plans needed further work and said they expected to complete this in the next few weeks. This will mean that staff will have access to up-to-date paper care plans as well as computerised care plans. It will also mean that people and their relatives can see a paper version of their care plan. During the inspection, when errors were noted in the computerised care plans, the provider acted immediately to update and amend them.

The care plans provided good information about each person's individual preferences. For example, people could choose if they wanted a male or female member of staff to carry out their personal care. Care staff had good knowledge and understanding of each person's individual needs. They were able to give us additional information that had not been included in the new care plans, for example, staff understood the reason why one person was often unhappy. They knew the things the person didn't like, and also the things they could 'tempt' the person with such as flapjacks, that made the person happy. The registered manager told us they planned to include care staff in future reviews of people's care plans. They recognised that care staff had good knowledge of people's needs and knew many additional details that could be added to the care plans to improve the consistency of the care. This was being done.

People were offered a wide range of activities to suit their individual abilities and interests. One activities co-ordinator was employed and the provider was advertising for a second activities person. On the first two days of our inspection the activities co-ordinator was on leave and we found the level of activities was significantly reduced. The provider said this would improve when the second activities person was employed. The atmosphere in the home was calm and quiet, but many people were sitting in lounge chairs fast asleep. On the third day of our inspection we saw activities being provided in the ground floor lounge. There was a high level of participation in the activities. People were alert, smiling and interacting well with staff and other people around them. One person who had earlier displayed agitated behaviour was relaxed and happy and fully engaged with the activities. Records of activities people participated in had recently been incorporated into the new care planning system. This meant that in future the provider and registered manager will be able to monitor the level of activities each person participates in each day.

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The activities co-ordinator explained how they planned the activities around each person. The old care plan files contained detailed information about each person's social history, family, employment, hobbies and interests. This information would be retained and incorporated into the new care planning system. Care plans identified a range of activities each person wanted to participate in. For example, people who liked gardening had been supported to plant and maintain the garden. There was an old tractor in the garden which brought back happy memories for people who had previously worked on farms. Several men enjoyed engineering and mechanics and the activities co-ordinator had organised sessions for people to take apart engines and machines and put them back together again. A person who was a railway enthusiast was supported by staff to talk about their interest, and staff regularly offered to help them watch DVDs on railways.

People were encouraged to help with daily routines such as maintenance, decorating, cleaning shoes, and sorting and folding clothing. They had an arrangement with a charity shop that provided clothing that had not been sold at the end of each season. People were encouraged to sort the clothing and fold it up. They had held 'fashion sessions' where people could try on any clothing they liked, and talk about the clothing they liked and disliked.

Activities such as visits from the hairdresser were treated as lively social events. A group of female residents were sitting in and near the hairdressing room. There was music playing and people were singing and chatting while having their hair done. Staff knew the music each person enjoyed and made their favourite music was played regularly. Other group activities included games such as skittles, puzzles, quizzes, bingo, scrabble, arts and crafts and reminiscence. The home had a large range of activity equipment including 'memory boxes' to assist with reminiscence sessions.

Staff supported people to follow their individual faiths. For example, staff talked about one person whose faith was very important to them. They had regular visits from a member of their church and staff supported the person by giving them excerpts from the bible. On Sundays they had a hymn singing session for those

people who wanted to join in.

There were places people could sit if they wanted peace and quiet. One person's care plan said they liked to sit in the quiet lounge. We saw the person was in there doing their hair with a mirror and music.

Staff had access to a vehicle they could use to take people out into the community. People were escorted to the shops or to local clubs and social events. Some relatives told us they thought people should have more access to the garden saying, "It is such a lovely garden, but they don't always have the back doors open." One relative asked, "Why don't they take them out for a walk - they all sit around". We spoke with the provider and registered manager who told us that despite secure high gates and fencing there were some people who could easily climb over. These people were at risk of harm if they went outside of the home without staff escort. They told us people went out into the garden as often as possible but this was only possible when a member of staff could be with them.

A member of staff told us the atmosphere in the home was always happy. They told us they always sang while they were working and people often joined in, and sometimes also danced with them. They said all staff enjoyed joining in the activity sessions, and loved to sit with people chatting and playing games. The provider and registered manager told us care staff did their best to provide activities when the activities organiser was not on duty but they recognised this could be improved. They were in the process of addressing this by recruiting a second activities organiser.

People knew how to make a complaint and were confident these would be taken seriously and addressed. The complaints procedure was displayed on the notice board in the entrance hall. Relatives generally felt confident about making a complaint if they needed to and talk to the manager. One person said, "The nurses do listen to what I say and will phone and if I have suggestions they will listen." People who had raised concerns felt they were dealt with appropriately. A relative said "I ask questions all the time" and felt that staff understood why they did this and listened, taking appropriate action.

Requires Improvement

Is the service well-led?

Our findings

The management of the service had not been fully well-led in the previous year but was improving. Before this inspection took place the home had been through a period of staff and management changes. We had received concerns and complaints about the service. A whole service safeguarding enquiry had taken place a few weeks before this inspection, actions had been agreed and members of the safeguarding panel (including health and social care professionals) had been satisfied the provider's responses and with the actions taken and had closed the process.

Before this inspection took place we asked the provider to complete 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. This was received from the provider. However, the information was very brief and did not give us sufficient detail to reassure us about the quality of the services and care people received. For example, in response to our question about how they ensured the service was well-led, they told us they had a quality assurance system in place. However, they did not give any further details or explanation about the areas this covered or how the process helped them identify areas where improvements were needed.

The provider had a quality assurance system in place that helped them monitor the quality of the services people received. However, we could not be certain the quality monitoring systems were fully effective in identifying potential problems or putting in place actions to address these. Recent concerns had been investigated by the local authority safeguarding team and the providers had taken prompt action to address these. The provider told us they had recognised their quality monitoring systems had not been fully effective and had received support from the local authority quality assessment and improvement team (QUAIT) to help them improve the systems. During this inspection we found some further areas where improvements were needed, such as staff training, staff English language skills, medication administration records Including topical creams), oral care and recruitment checks. The provider's quality monitoring processes had already identified some of these issues, but not all. Over a 12 month period they planned to review medication administration systems, staff training, appraisals and supervisions, health and safety, care plans, accidents, incidents and complaints. The provider told us they will be receiving further support from the QAIT team in the near future and said they will seek their advice on any further improvements necessary to their quality monitoring processes.

The providers maintained their knowledge of their legal obligations, and of current good practice through attendance at conferences and meetings regarding the care industry. They were members of a care provider's organisation that offered support, information and guidance to care home owners.

Communication and involvement with people who used the service and their relatives had been variable. The providers had sought the views of people living in the home and their relatives through questionnaires in the past but this had lapsed over the last year. We also heard that meetings with relatives and people living in the home had been held regularly in the past but over the last year the meetings had been less frequent. Relatives told us they would like the regular meetings to be reinstated. Comments included, "We

don't get a lot of communication with relatives - two meetings in two years - nothing regular." They also told us there had been plans to produce a regular newsletter but this had not materialised. Most relatives said they were confident to talk to the registered manager if they needed to, although two relatives said they were, "not always able to get through to care staff". They said that messages to the registered manager were not always passed on by the care staff. One relative was concerned about the number of changes in the management team over the last year and the difficulties of getting to know new managers and staff saying, "I feel I am fighting a losing battle. They change different lines of management".
After this inspection the provider told us they held a meeting with people living in the home and their relatives. They told us the meeting was positive and "Without exception all commented how much things had improved at Barton over the last month".

There was a registered manager in post. This person had been the registered manager of the home until approximately 18 months previously. After a period working elsewhere they had returned to manage Barton Place. Their return had been welcomed by people living in the home, staff and relatives. We saw they had already put in place many actions and improvements. They were aware of areas that needed further attention and we were assured these would be completed in the near future. There had been recent changes in the structure of the staff team to provide new senior care posts. We heard this had resulted in more effective monitoring of staff routines and improved communication and support for the staff team to ensure people's needs were met. Relatives commented on recent problems with staffing but they thought this was improving.

The registered manager and providers told us they were willing to step in when needed to provide additional help and support to the staff team, for example when staff went off sick at short notice. Comments from relatives included, "The owners are really friendly and hands-on. He is there doing all sorts" and "[Provider's name] owns the place - he has a good team around him now and the care they receive is just first class".

Relatives also spoke positively about the registered manager. Comments included, "Very pleasant, very nice, very approachable, very human". One relative said there were, "Three good clinical nurses who have a management role as well" and they were pleased about the recent introduction of a key member of staff who had been allocated to each person. Another relative said, "Hopefully the new manager will help with staffing levels". We have said there is enough staff Relatives said the provider and management team were honest with relatives about problems and they appreciated this.

Staff told us there were good systems of communication, support and supervision in the home. They thought the service was well managed. For example, we asked one member of staff if they felt the service was well managed and they replied "Yes, and it's even better now." Another member of staff told us that in addition to their regular supervision they could, "Have a chat with the manager at any time. She's approachable. If we find any problems we tell the manager and she gets it done." They also told us they was a happy working atmosphere, saying, "We all work together. We all help each other."

The providers had systems in place to ensure the home was regularly maintained and equipment was safe and regularly serviced. There was a detailed maintenance plan in place that identified where actions and improvements were needed, including management of odours around the home.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that assessments were carried out and recorded in accordance with the Mental Capacity Act 2005 for those people who lack capacity to make an informed decision. Records did not contain evidence of 'best interest' procedures where restrictions or restraints were necessary to keep people safe.