Barons Park Nursing Home Limited

Barons Park Care

Inspection report

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Date of inspection visit:
04 January 2017
05 January 2017

Date of publication:
15 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 4 and 5 January 2017. The first day of our visit was unannounced.

Barons Park Care provides nursing and accommodation for up to 46 younger and older people with complex, challenging and advanced forms of dementia and significant mental health care needs. Long term nursing care is also provided.

The person managing the service was an acting manager. They were in the process of applying to be the registered manager. 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.

Relatives of people living at Barons Park Care felt they were safe. The staff team were aware of what to do if they felt someone was at risk of avoidable harm and knew the process to follow should they feel that something needed reporting.

Risks associated with people's care and support had been assessed. These assessments provided the management team with the opportunity to reduce and properly manage the risks presented to both the people using the service and the staff team.

Appropriate checks had been carried out when new members of staff had started working at the service. This was to check that they were suitable and safe to work there. An induction into the service had been provided for all new staff members and ongoing training was being delivered. This enabled the staff team to provide the care and support that people needed.

People's feedback on the staffing numbers at the service varied. Some people felt that there were enough staff members on duty to meet people's needs and keep them safe, others thought there were not. We noted during our visit that the staff team were not always suitably deployed to ensure that people's needs were met in a timely manner.

People were receiving their medicines as prescribed by their doctor. Medicines were being appropriately stored and the necessary records were being kept. There were systems in place to audit the management of medicines and medicines were only administered by staff members who were competent and appropriately trained.

The staff team supported people to make decisions about their day to day care and support. Where people lacked the capacity to make their own decisions, we saw that decisions had been made for them in their best interest. The staff team were working in line with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

Relatives we spoke with told us the meals served at Barons Park Care were good. People's nutritional and dietary requirements had been assessed and a nutritionally balanced diet was being provided. For people who had been assessed to be at risk of not getting the food and fluids they needed to keep them well, records were kept showing their food and fluid intake. Though these were not always accurate.

On the first day of our visit we noted that some people's experiences of mealtimes were better than others. This was because the staff team did not always interact well with those they were supporting. The second day however was better, with the staff team making sure that they spoke with the people they were supporting.

People were supported to maintain good health. They had access to relevant healthcare services such as doctors and opticians and they received ongoing healthcare support.

Relatives told us that the staff team were kind and caring and they treated their relative with respect. On the whole, we observed the staff team treating people with respect and when supporting them, did so in a kind and friendly manner.

Plans of care had been developed for each person using the service, though not all of these were up to date or accurate. The management team were in the process of reviewing the plans of care to address this issue. The staff team knew the needs of the people they were supporting.

We noted few meaningful activities or stimulation being offered throughout our visit, though one person was supported to walk around the garden and another was supported to pair up socks. This meant that people were very much left to their own devices. The environment in which people's care and support were provided had very little in it that would be considered dementia friendly. However plans had been drawn up to address this issue and the suggested improvements would create a much more dementia friendly environment.

A complaints process was in place and a copy of this was displayed in the reception area for people's information. Although not all of the relatives we spoke with were aware of this, they knew who to talk to if they had a concern of any kind.

Relatives and friends were encouraged to visit and were made welcome by the staff team. Staff meetings and meetings for the relatives of people using the service were being held. These provided people with the opportunity to have a say and to be involved in how the service was run.

Staff members we spoke with felt supported by the management team and explained that there was always someone available for support or advice should they need it.

There were systems in place to regularly check and monitor the quality and safety of the service being provided, Regular checks had been carried out on the environment and on the equipment used to maintain people's safety and a business continuity plan was in place for emergencies or untoward events. We noted that the monitoring of people's care records had not always identified shortfalls within them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's relatives did not always feel that there were enough staff suitably deployed to meet their family member's needs and to keep them safe.

The staff team knew what to do to help keep people safe from harm.

An appropriate recruitment process was followed when new members of staff were employed.

Risks associated with people's care and support had been appropriately assessed.

People were receiving their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

A balanced and varied diet was provided and people were always offered choices. People's dining experience varied. Whilst some people enjoyed a positive experience, others did not.

The staff team had received training and had the knowledge they needed to be able to meet the needs of the people using the service.

People's consent to their care and support was always sought and the staff team understood the principles of the Mental Capacity Act 2005.

People were supported to access healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

People's privacy was respected and their care and support needs

were met in a kind way.

The staff team understood the needs of the people using the service.

People were offered choices on a daily basis and were supported to make decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's plans of care were not always up to date or reflected the care and support they needed.

People were not always supported to follow their interests or participate in stimulating activities.

People's needs had been assessed and they and their relatives had been involved in deciding what care and support they needed.

People were supported to maintain relationships with those important to them and relatives and visitors were encouraged to visit at any time.

A complaints process was in place. Although relatives we spoke with were unaware of this process, they knew who to speak with if they were unhappy about the service provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Auditing systems were in place to monitor the quality of the service being provided though these did not always pick up shortfalls within people's care records.

People we spoke with felt the management team were open and approachable.

Staff members we spoke with felt supported by the acting manager.

People were given the opportunity to have a say on how the service was run.

Barons Park Care

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 January 2017. The first day of our visit was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who specialised in dementia care and an 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.

We reviewed the information we held about the service. This included notifications. Notifications tell us about important events which the service is required to tell us by law.

We contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had any feedback about the service.

At the time of our inspection there were 44 people using the service. We spoke with one person using the service and with seven relatives and friends of other people living there. We also spoke with the acting manager, the regional manager, the operations manager, the deputy manager, the nursing clinical lead, the cook and eight members of the care team.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences of care. 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 who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. This included six

people's plans of care. We also looked at associated documents including risk assessments and medicine administration records. We looked at records of meetings, three staff recruitment and training files and the quality assurance audits that the management team had completed.

Good

Is the service safe?

Our findings

We asked the staff team working at the service for their feed back on the current staffing levels. Staff member's thoughts varied. Whilst some felt that in their opinion, there were enough staff on duty to meet the current needs of the people using the service, others did not. One staff member explained, "There are not enough staff, often only two up here [first floor in the Lakes unit] and we have to call downstairs if we need anyone." They went on to say that, "It's unsafe upstairs if only two are on, as two service users have a choking risk. If we are in a bedroom assisting someone, how would we know if someone was choking?" When we call downstairs they can't always come if they are looking after a service user with challenging behaviour." Another staff member told us, "There is enough staff to have a safe environment and do our job but not enough for the niceties." A third added, "There is not enough staff all the time which puts added pressure on you and makes you stressed." Whilst another staff member told us, "There's not always enough staff, sometimes it's not lack of staff it's about the quality of staff and what they know. When we are fully staffed everything gets done and you have a bit of time to interact."

A number of the people using the service had complex, challenging and advanced forms of dementia and the staff team had been trained to support them when they displayed behaviour that could challenge. This included using a 'safe hold' during episodes of aggression. This hold was used to support the person from hurting both themselves and others. One staff member told us, "We use it [the safe hold] if they [people using the service] are becoming a risk to themselves or others. It is very effective; if we use it in communal areas then other service users are removed from these areas. This creates a calm environment. We stay with them in the safe hold until they no longer become a risk and are calm. It takes two staff members for the safe hold for as long as needed until the situation is calm. I am confident carrying this out as I have had the training."

On the afternoon of the first day of our visit we observed the staff team on the ground floor of the lakes. A staff member was alone in the lounge as two staff members were assisting a person using the service in their room and another was walking with a person in the garden. The provider explained that in this instance should staff have been required to carry out the safe hold, as a last resort, members of the nursing and management team were available to support them.

In the morning of the first day of our visit we observed the staff team on the first floor of the Lakes. We observed that a member of the staff team had to wait ten minutes for another staff member to come to assist them to support one of the people using the service to the lounge.

During our visit we observed two of the people using the service come into unwelcome contact with each other. One person stood up to scratch another who was standing in the lounge. Whilst there was a staff member present, they were filling out paperwork and did not see this incident until we highlighted it to them.

We asked the relatives we spoke with whether they felt there were enough staff members on duty to meet the needs of the people using the service. Whilst some felt there were others did not. One relative told us,

"There are two [staff members] up here; there should be three as most people need two to do things, so it often leaves no one [on the floor]." Another explained, "There are enough staff although if someone needs attending too, then it takes two members away. Last week [person using the service] needed three staff so that left just one on the floor."

We looked at the staffing rotas. These showed that there were two nurses, two senior care workers and 11 care workers on during the day time and one nurse and six care workers during the night time. There were also a number of supernumerary staff members available to support the staff team during their shift. These included the acting manager, the deputy manager and the clinical lead.

We discussed the staffing levels with the management team. They acknowledged the comments shared and although they considered there to be enough staff members on duty to meet the current needs of the people using the service, they said they would look at whether the deployment of staff members could be more effective.

Relatives we spoke with felt that the people using the service were safe living at Barons Park Care. One relative explained, "There is always someone in the lounge, I never feel unsafe. If another service user is showing challenging behaviour, they [staff member] are always there to distract them and diffuse the situation which is the most caring way to deal with it." Another relative told us, "I feel [relative] is safe, the staff care for [relative] very well and I don't worry when I'm not here."

Staff members we spoke with were aware of their responsibilities for keeping people safe from harm. They knew the signs to look out for and the procedure to follow should they be concerned about anyone. One staff member told us, "If I saw something that concerned me I would report it to the manager or the next step up if necessary." Another told us, "I would go to the manager first and if I wasn't happy with the outcome, I would go to the manager's manager."

Members of the management team we spoke with were also aware of their responsibilities for keeping people safe. They knew the procedures to follow when a safeguarding concern had been raised. This included referring it to the relevant safeguarding authorities and Care Quality Commission (CQC). This meant that the local authority, who has responsibility to investigate safeguarding concerns, could investigate further if necessary.

The risks associated with people's care and support had been identified and assessed when they had first moved into the service. Risks assessed included those associated with people's mobility, falls, behaviour that could challenge and those related to specific health conditions, for example diabetes. This meant that the management team could wherever possible, reduce and minimise the risks identified and provide people with safe care and support.

Regular checks had been carried out on both the environment in which people's care and support had been provided and on the equipment used. This made sure that people's safety was being maintained. An up to date fire risk assessment was in place and regular fire drills had been carried out to ensure that the staff team knew their responsibilities in the event of a fire.

Personal emergency evacuation plans had been completed. These instructed the staff team on how to assist people in the event of an emergency and a business continuity plan was in place. This provided the management team with a plan to follow should an emergency or untoward event such as loss of utilities, flood or fire ever occur.

We looked at the recruitment files for three members of the staff team and found that appropriate recruitment processes had been followed. Previous employment had been explored, references had been collected and a check with the Disclosure and Barring Service (DBS) had been carried out. (A DBS check provided information as to whether someone was suitable to work at this service.) A check with the Nursing and Midwifery Council (NMC) had also been carried out to make sure that the nurses working at the service had an up to date registration. Nurses can only practice as nurses if they are registered with the NMC.

We looked at the way people's medicines had been managed to see if people had received these as prescribed. We saw that they had. The medicine trolleys were safely stored and secured when not in use.

We looked at a sample of Medication Administration Records (MAR) and checked medicines in stock with the records we saw. The amounts matched. We noted that there were no gaps within the signatures on the MAR's. This was important because it showed us that people had been given their medicines as prescribed.

Protocols were in place for people who had medicines 'as and when' required, such as paracetamol for pain relief or Lorazepam for agitation. Information on when the medicine should be given. For example where someone was given lorazepam for agitation, was included within people's plans of care. Following good practice this information was included within the PRN protocol following our visit.

We observed the nurse in charge during their medicine round. They checked the MAR's. These included a photograph, to ensure they were giving the medicines to the correct person. They potted the medicines out of its container and poured a beaker of juice or water. They took the medicines to the person, explaining what the medicines were for and waited for the person to take them. They then returned to the MAR and signed to say they had taken their medicines.

There was an appropriate system in place for the receipt and return of people's medicines and an appropriate auditing process was carried out to ensure that people's medicines were handled in line with the provider's policies and procedures.

Requires Improvement

Is the service effective?

Our findings

Visitors we spoke with felt that the staff team were appropriately trained and had the skills they needed to support their relatives. One told us, "They [staff team] have the skills to do what they need." Another told us, "I feel the staff have the skills they need. They know how to handle and manage [relative]." One of the people using the service told us, "Staff are always cheerful and know what they are doing."

The staff team had been provided with an induction when they had first started work at the service and training suitable to their role had been completed. The training records showed us that training including moving and handling and dementia awareness, had been provided and staff members we spoke with confirmed that this training had taken place. One staff member told us, "The training is much better since Prime Life took over. It has been useful and training is now up to date." Another explained, "I had an induction and two days of training, I also shadowed, though just for a while, because I knew what I was doing. I have done the Care Certificate as well." (The Care Certificate 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 should be covered as part of induction training of new care workers). This showed us that the staff team had the training they needed to appropriately support the people using the service.

The staff members we spoke with felt supported by the management team. They explained that they were approachable and there was always someone available for support and advice. One staff member told us, "I think [acting manager] is very supportive, she has good listening skills, she is dedicated to the people who live at Barons Park and is always acting in their best interest. If I have any concerns I can speak with her." Another explained, "The manager is approachable, she is always around and always on the shop floor. It makes you feel easier when the manager is around."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The acting manager had a good understanding of the MCA. Applications for DoLS authorisations had been made in respect of people who lacked the mental capacity to make their own decisions about their care and support. At the time of our visit there were 16 authorised DoLS in place. We found that people were being supported in line with those authorisations.

Mental capacity assessments had been carried out to determine whether people lacked the capacity to make a decision about their care or support. For example, when deciding whether to accept support with their personal care or to take their medicines. Where capacity had been assessed as lacking for specific decisions, a decision had been made with others on their behalf.

The staff team had received training on MCA and DoLS and those we spoke with understood its basic principles. One staff member told us, "It is about making sure that they [people using the service] are supported to make decisions for themselves and about talking to the family if we feel it is not the right decision." Another explained, "Some people who really struggle to make decisions, we have to make best interest decisions on their behalf."

We saw that whenever possible, people had been involved in making day to day decisions about their care and support. We observed staff offering choices. For example, what people wanted to eat and drink and where they preferred to take their meals. Staff gave us examples of how they obtained people's consent to their care on a daily basis. One staff member told us, "We always offer choices so that they [people using the service] can make decisions about their care; I ask verbally what they want and show them the options available."

We asked people their views on the meals served at Barons Park Care. One of the people using the service told us, "The food is nice and good." A relative told us, "The food is really good. [Relative] has to have a soft diet. He is also a diabetic. There is a diabetic menu and for his birthday last week; they made a diabetic cake for him."

The cook, had access to information about people's dietary needs. They knew about the requirements for people who required soft or pureed food, for people with cultural needs and those who lived with diabetes. The cook was also aware of people who were on a fortified diet and made sure that foods such as soups, sauces and mashed potato were fortified with full fat milk, cream and butter.

The cook had recently undergone training with the Speech and Language Therapy team (SALT) and was knowledgeable about how special diets should be served and what constituted as a soft diet. We did note that whilst the cook served the pureed food separately, some of the staff team were mixing it altogether in to one bowl before supporting the person with their meal, making it neither appealing nor appetising. This was addressed on the day of our visit.

The cook told us that menus were discussed with the people using the service. For example, we were told that [person using the service] loved curry so they tried to incorporate a curry into the menu at least once a week. The menus we looked at confirmed this.

People's lunch time experience varied. On the first day of our visit, we noted that some people were being supported appropriately, however, others were not. For example, in the Hastings lounge, people who were able to eat their lunch without assistance, were given their meals. They were seen to be eating happily and managed to do so independently. Pudding was sponge and custard, with a diabetic alternative offered to people as required. This again was well received by the people using the service. One person asked for another portion which they were given. One person did not appear to eat their meal. A staff member went over to encourage them but they did not want it. The staff member asked if some sandwiches would be better and once they had discussed the filling, returned moments later with the sandwiches which the person ate.

Other people had to wait for staff members to become free to assist them with eating their lunch. This was

done by three staff members who took it in turns to assist them. This was done at a slow pace, but was done so generally in silence. One staff member tried to engage in conversation, but others did not start any conversation. There was little communication and the staff members were seen to be very task focused. There was no atmosphere in the room and the meal time did not have the beneficial impact that it could have had.

In another of the lounges however, a staff member was seen assisting four of the people using the service with their lunchtime meal. There was light hearted banter throughout the meal time which people clearly enjoyed and a relaxed and happy atmosphere was noted.

We shared our findings with the management team and people's experiences on day two of our visit were much more positive and inclusive. We heard conversations taking place and staff members interacted throughout the mealtime.

One of the people using the service had been assessed at risk of choking and it had been recommended by the SALT team that they had slightly thickened fluids to reduce this risk. We observed at lunchtime this person being assisted with a drink of blackcurrant, this had not been thickened and the staff member who was assisting them was not aware of the need for this. We informed the clinical lead and this was immediately removed in order to maintain their safety.

For people assessed to be at risk of dehydration or malnutrition, monitoring charts were used to document people's food and fluid intake. We did note that whilst the majority of these were up to date, not all had been signed or totalled to show how much fluids each person had had. We also noted that they did always correspond with the daily records kept. For example, one person's records showed that on 2 January 2017 they had consumed only 400ml of fluids, their recommended fluid intake was 1500ml, their daily records stated, "Good fluid intake." We shared this with the acting manager. They acknowledged this and told us this would be looked into. We were told that the acting manager had commenced a daily walk a round and records were being checked during this time. This would enable them to identify and address any discrepancies within people's daily records.

Many of the people using the service were living with advanced dementia. The environment in which people's care and support were provided had very little in it that would be considered dementia friendly though the acting manager had created tactile boards for people to use. Whilst bedrooms had photos and names on the doors, these were very small and could not easily be used to identify people's rooms. There was limited signage within the service to direct people to different areas and little resources to stimulate or promote reminiscence. The management team acknowledged the issues within the environment and shared their plans for the future. This included many improvements such as themed areas, focal points such as fireplaces and improvement of the décor. These improvements would create a much more dementia friendly environment.

Good

Is the service caring?

Our findings

Relatives we spoke with told us the staff team at Barons Park Care were kind and caring and looked after the people using the service well. One relative told us, "Staff are very caring, they really are." Another explained, "They are all caring, they are very patient with everyone." A third stated, "[Relative] said after just a few weeks, 'they really care for me', which considering his dementia is really good."

We observed support being provided throughout our visit and we asked one staff member how they got to know what people liked if they were unable to communicate with them. They told us, "I watch eye and mouth movements as you can sometimes pick something up or you may notice that they spit out the same vegetable and you would note that down so that you don't offer it again. You also have to speak to the family to make sure you don't offer them anything they wouldn't normally have."

We observed the staff team supporting people in a relaxed and kindly manner. They reassured people and when they were feeling anxious and a little comfort was needed, this was provided in a caring manner. For example, staff members held people's hands and when needed, put a reassuring arm around them. We observed a staff member assist a person to the toilet. They talked with them throughout, making them feel at ease. We observed another staff member taking a walk with a person using the service. They were chatting with them and asking questions, they went to the lounge window and they talked about the weather and the garden. They then continued on their walk.

We did note however, that there were also periods of time when people were left without any interaction which resulted in them falling asleep.

We saw staff members calling people by their preferred name and engaging in conversation which people clearly appreciated. We did note one occasion however, when a staff member assisted a person with a drink whilst standing over them, rather than getting down to their level.

For people who were unable to move around independently, assistance was provided by the staff team with the support of a hoist. We observed the staff team supporting one of the people using the service. They checked that the person was ready to transfer; they talked them through what they needed to do, they put them at ease, then slowly at the person's pace assisted them to transfer. This was done in a caring way.

The staff team gave us examples of how they ensured that people's privacy and dignity was respected. One staff member explained, "I draw the curtains and if it is a double room there is a privacy curtain that we use. I also whisper rather than shout and explain what I am doing." Another told us, "I make sure I have everything I need, clothes, towels and toiletries. I cover them with a towel when doing personal care. I always knock on the door and introduce myself when I come into the room. I have had dignity training."

Relatives confirmed to us that the people using the service were treated with dignity and respect. One relative told us, "[Relative] is treated with respect, very much so." Another explained, "Yes, [relative] is definitely treated with respect."

We saw that whenever possible, people had been involved in making day to day decisions about their care and support. For people who were unable to do this, either by themselves or with the support of a family member or friend, advocacy services were made available. This meant that people had access to someone who could support them and speak up on their behalf.

Relatives and friends were encouraged to visit and they told us they could visit at any time. One relative told us, "I can visit anytime." Another explained, "I can come in when I want to, I can eat with [relative], and I usually do on a Sunday. I just have to order it on the day before."

Requires Improvement

Is the service responsive?

Our findings

Relatives we spoke with told us that they had been involved in the planning of their relatives care when they first arrived at the service. One told us, "I was involved in both the assessment and the care plan." Another explained, "I was involved in the care plan when [relative] moved in."

People's care and support needs had been assessed prior to them moving into the service. This was so that the management team could assess whether the person's needs could be properly met. From the initial assessment, a plan of care had been developed.

We looked at six people's plans of care to determine whether they reflected the care and support that people were receiving. We noted that whilst some did, others did not. One person's plan of care contained a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. However, in another section of their plan it stated 'I would like to be resuscitated'. We heard after our visit that this had been rectified. This person had been on 30 minute observations due to their behaviour however; following an incident their plan of care had recently been updated. This now instructed the staff team to carry out 15 minute observations. When we checked the observation records we found that these were still being completed every 30 minutes. We asked two members of staff how often the person should be observed. One staff member stated every 15 minutes, the second stated every 30 minutes. This meant that the plan of care for this person was not being followed. Another person using the service was also on 30 minute observations, though part of the plan of care stated carry out 15 minute observations. When we checked their records they did not demonstrate that these checks had been carried out regularly. We also noted that part of their plan of care stated liaise with their family when the person had no family.

The plans of care were in the process of being updated onto new documentation therefore some plans of care were easier to follow than others. The new plans of care were centred on individuals and included people's preferences in daily living, for example their favourite foods. They were comprehensive in detail and provided a clear picture of people's needs and the actions to be taken to meet those needs.

A care plan summary was also in place at the front of the plans of care. This gave the reader an 'at a glance' overview of the person's needs. This included what name people preferred to be called and the activities they were interested in.

Not all of the staff members we spoke had read people's plans of care but they were aware of what people liked and the support people preferred. One staff member told us, "I've not read any care plans but we can suggest things to the senior if we think people's care has changed." We asked the acting manager whether staff members had read the care plans. They told us that plans of care were made available though it was their intention to involve the staff team more in the future.

The plans of care we looked at had been reviewed on a monthly basis. When changes in the person's health had been identified, input had been sought from relevant healthcare professionals and their plans of care had been reviewed and updated to reflect this. For example when someone had been identified at risk of

choking, the local SALT team had been contacted. This showed us that people's health was monitored and the appropriate action taken.

When people first arrived at Barons Park Care their hobbies and interests were explored and included in their plan of care. An activities leader was employed but this was only for four hours a week. We saw evidence of activities taking place when the activities leader was at the service. These included, sensory sessions, music and poem sessions and artwork sessions. Trips had also been organised. These included visiting the local garden centre and a trip to see the Christmas lights. However, we noted little meaningful activities being offered throughout our visit. One of the people using the service constantly paced around one of the lounge areas with little interaction from the staff team, only the occasional hello as a member of staff walked past. Staff members appeared to spend a lot of their time filling in paper work rather than interacting with the people using the service. We heard one of the people using the service frustratingly request for something to do. The staff member suggested that they sorted the socks and promptly went for a bag of socks to sort. A staff member told us, "There are not enough activities." The activities organiser only comes in a couple of times a week. She might do a hand massage but she has everyone to see and so she might not see people for a week or two."

Relatives gave us their feedback of the activities available to people. One explained, "[Relative] is unable to participate in activities or one to one conversations, so not sure what they [service] could do for him." Another told us, [Relative] gets a lot of one to one time which he loves and they take him for a walk down to the village which he loves as he used to walk miles when he was at home."

We discussed the lack of social activities and stimulation for the people using the service with the management team. They acknowledged that more needed to be done and they were looking at ways to provide more opportunities for activities using the current staff team.

A formal complaints process was in place and a copy of the provider's complaints procedure was displayed in the reception area for people's information. Relatives we spoke with were not aware of the complaints process however, they knew who to talk to if they were unhappy about anything. One relative told us, "I have no idea about the complaints procedure, I was probably told when we came here but I have not remembered. I have no complaints, but the manager is approachable if there should be anything to raise." Another explained, "I would talk with the manager, they are approachable."

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor and check the quality and safety of the service being provided. Monthly audits had been carried out on areas such as falls, nutrition, safeguarding, infection control and medicines. Environmental audits had also been completed.

The acting manager had also monitored people's care records including people's plans of care, food and fluid charts, observation charts and turn charts. It was noted that although monitoring systems were in place, shortfalls within the care records had not always been identified through this process. ABC charts, used when monitoring people' behaviour, were being completed when incidents occurred. However these had not been analysed to identify possible triggers. The acting manager explained that this was something that they planned to address and include within the monitoring process. Following our visit the provider informed us that these charts were being analysed as part of the on-going development of the service and the home management were fully aware of any incidents, especially those that may have required further investigation and reporting.

Senior management visited the service on a regular basis to support the acting manager and during these visits audits were also completed. These included audits on the environment, care delivery, the quality and safety of the service, the annual quality assurance survey, staffing and safeguarding. Where issues had been identified an action plan with agreed timescales had been developed and the acting manager was addressing the shortfalls.

Relatives we spoke with us told us that they felt the service was properly managed and the management team, nurses and the staff team were open, friendly and approachable. One relative told us, "I can't fault it! I have to travel further to this home, but I am happy to do so as the home is so good. It is fantastic, the best place I could find." Another told us, "It is very good. They always contact me if anything happens. The new manager is very friendly and I feel I can approach her."

Staff members we spoke with told us they felt supported by the management team at Barons Park Care. One explained, "[Acting manager] is supportive. Both [deputy manager] and [acting manager] are visible. They walk round the home each morning and we see them at meal times." Another explained, "The manager is very approachable and she holds surgeries where you can go and chat."

We saw that staff meetings had taken place. These provided the staff team with the opportunity to have their say and be involved in how the service was run. The acting manager also held a surgery every Wednesday between 2pm and 4pm where staff members could meet with them in private and share any ideas or concerns that they had.

Daily handovers were taking place. These provided the staff team with the opportunity to discuss the needs of the people using the service, discuss day to day issues that arose during their shift and encouraged open communication. One member of staff told us, "The biggest challenge, is communication, for example if you are away on your days off, the handovers are not detailed enough. You never know why a person has been

prescribed an antibiotic or if and why a doctor came. It has got better though over the last 2 months."

Relatives and friends were encouraged to share their thoughts on the service people received. Monthly meetings were held and relatives and friends were encouraged to attend. One relative told us, "There are monthly meetings, but like we keep saying to them, there is nothing much to say. Although it is nice to see the manager and senior on their own. We always get told of the developments and changes." Monthly newsletters had also been introduced. These informed people of events and happenings at the service on a monthly basis. One relative told us, "The communication is good; they always let us know what's going on."

An annual quality assurance survey had been carried out to gather people's views of the service being provided. The information in the surveys returned had been analysed and a summary report had been produced. A copy of this had been made available to all interested parties. Issues raised within the surveys had been looked into and addressed. One of the issues raised included having the reception 'manned' so that visitors didn't have to wait so long to be let into the service. As a result, we saw that a new administrative assistant had been employed and based in the office by the front door, enabling them to let visitors in on arrival.

A copy of the provider's aims and objectives were displayed at the service for people to view however, when we discussed these with members of the staff team, not all were aware of these. One staff member did tell us however, "It is to give people the best quality of life we can and to promote privacy and independence."

The management team were aware of and understood their legal responsibility for notifying Care Quality Commission of deaths, incidents and injuries that occurred for people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.