

One Housing Group Limited

# Baycroft Grays Farm Road

## 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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This inspection took place on 29 June and 3 July 2018 and was unannounced. This was the first inspection of the service since they registered with the CQC in September 2017. Baycroft Grays Farm Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Baycroft Grays Farm Road provides residential, nursing and dementia care and support for up to 75 older people. The service also offers short stay respite care. Accommodation is spread over three floors connected by internal lifts throughout. At the time of our inspection there were 31 people using the service. There was no registered manager in post at the time of our inspection, however, a general manager was in post to oversee the day to day management of the service until a registered manager is appointed. 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.

At this inspection we found three breaches of regulations because the management of medicines within the home was not always safe or in line with best practice, staff were not always supported in their roles through regular appropriate training, supervision or appraisals of their practice and performance and systems and processes in place to monitor the quality and safety of the service were not always effective or well-led. We also found several areas that required some improvement including the monitoring of safeguarding, accidents and incidents and complaints, staff deployment within the home and the provider's nurse call system, areas of the environment and some improvement was required to enhance people's meal time experience. We will check on the progress of these areas at our next inspection of the service.

You can see what action we told the provider to take at the back of the full version of the report.

People were protected from the risk of abuse as staff we spoke with demonstrated a clear understanding of how to safeguard people from abuse, the signs they would look for and what they would do if they thought someone was at risk of abuse. Staff had identified concerns and recorded accidents and incidents appropriately seeking medical attention when required. Appropriate recruitment checks took place before staff started work. There were arrangements in place to deal with foreseeable emergencies and there were systems in place to manage infection, clinical waste, gas and electrical appliances and water safety. Risks to people were assessed to help keep them safe and the home environment was clean and appropriately maintained.

Staff completed an induction programme which included induction training when they started work. People's dietary needs, risks and personal preferences were met and respected. Staff were knowledgeable about people's dietary needs and advice from health care professionals was sought when required. The

home is newly built and suitably designed to meet some people's needs. Pre-admission assessments of people's individual care needs and preferences were completed before they moved into the home to ensure staff and the home environment could meet their needs safely and appropriately. People and their relatives told us staff supported them to access health and social care professionals when required and monitored their health to ensure their wellbeing. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff were aware of the importance of obtaining consent from people when offering support and worked within the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People and their relatives told us staff were friendly, supportive and caring and they were provided with information about the service when they moved into the home. During our inspection we observed positive and caring interactions between people and staff and people were supported to maintain relationships that were important to them. Relatives and visitors told us they were made to feel welcome when they visited the home.

There was a range of facilities and activities offered to people to support their need for social interaction and stimulation. People and their relatives told us they received care and support in response to their needs and they were involved in planning, managing and making decisions about their care. Care plans documented the support people required and contained guidance for staff to ensure support was offered to people appropriately. People's diverse needs were respected and care plans included details about people's needs in relation to age, disability, gender and religion. However, we noted that care plans lacked detail in areas other than religion such as race, sexual orientation and culture.

There were some systems in place to seek the views of people using the service and their relatives through residents and relative's meetings and surveys. However, surveys were yet to be implemented and sent to people and their relatives to complete. The home worked in partnership with health and social care professionals to ensure people received appropriate support to meet their needs.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe.

Medicines were not managed safely.

People were protected from the risk of abuse, however, safeguarding records and the monitoring of safeguarding concerns required improvement.

Accidents and incidents involving the safety of people were recorded, however, there were no systems in place to manage and monitor accidents and incidents to ensure they were acted on appropriately.

Staff were not always deployed around the home effectively to meet people's needs in a timely manner.

The home environment was clean and well maintained. However, some parts of the building required actions to ensure people's safety and we will check on these issues at our next inspection of the service.

Appropriate recruitment checks took place before staff started work.

Risks to people were assessed to help keep them safe.

**Requires Improvement** ●

### Is the service effective?

The service was not consistently effective.

Staff were not always supported in their roles through regular appropriate training, supervision or appraisals of their practice and performance.

Staff completed an induction programme which included induction training when they started work.

People's dietary needs, risks and personal preferences were met and respected. However, some improvement was required to enhance people's meal time experience.

**Requires Improvement** ●

The home is newly built and suitably designed to meet some people's needs.

Pre-admission assessments of people's needs and preferences were completed before they moved into the home.

People were supported to access health and social care professionals when required and staff monitored their health to ensure their wellbeing.

Staff were aware of the importance of obtaining consent from people when offering support and worked within the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

### **Is the service caring?**

**Good** ●

The service was caring.

People and their relatives told us staff were friendly, supportive and caring.

People were provided with information about the service when they moved into the home.

We observed positive and caring interactions between people and staff.

People were supported to maintain relationships that were important to them.

Relatives and visitors told us they were made to feel welcome when they visited the home.

### **Is the service responsive?**

**Requires Improvement** ●

The service was not consistently responsive.

Complaints were not always managed and organised appropriately and there were no systems in place to monitor and manage complaints and this required improvement.

People's diverse needs were respected and care plans included details about people's needs in relation to age, disability, gender and religion. However, care plans lacked detail in areas other than religion such as race, sexual orientation and culture.

There was a range of facilities and activities offered to people to support their need for social interaction and stimulation.

People and their relatives told us they received care and support in response to their needs including end of life care when required.

### **Is the service well-led?**

The service was not consistently well-led.

Systems and processes in place did not effectively assess, monitor and mitigate risks relating the health, safety and welfare of people using the service and others nor did they continually evaluate and seek to improve governance and auditing practice.

There were no effective lines of communication within the home to provide staff with the opportunity to meet and communicate on a regular basis.

There were some systems in place to seek the views of people using the service and their relatives through residents and relative's meetings and surveys. However, surveys were yet to be implemented and sent to people and their relatives to complete.

The home worked in partnership with health and social care professionals to ensure people received appropriate support to meet their needs.

**Requires Improvement** ●

# Baycroft Grays Farm Road

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 29 June and 3 July 2018. The inspection was unannounced and carried out by two inspectors, a specialist nurse advisor and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day two inspectors returned to the service. Prior to our inspection we reviewed the information we held about the provider. This included notifications received from the provider about deaths, accidents and safeguarding. A notification is information about important events that the provider is required to send us by law. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We contacted the local authority and clinical commissioning groups who commission the service to obtain their views. We used this information to help inform our inspection planning.

During our inspection we spent time observing the support provided to people in communal areas and at meal times. Due to their needs, some people were unable to directly share their views and experiences with us so we therefore 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 also spoke with five people using the service, nine visiting relatives and two visiting health and social care professionals. We spoke with 12 members of staff including the provider's general manager, associate head of CQC compliance, health and safety officer, customer relations manager, clinical lead, nursing staff, care staff, activity coordinators, chef and domestic and maintenance staff. We looked at six people's care plans and care records, eight staff recruitment records, staff training and supervision records and records relating to the management of the service such as audits and policies and procedures. We also looked at areas of the building including communal areas and external grounds.

Following our inspection, the provider's associate head of CQC compliance sent us information we requested and information on actions taken and planned improvements.

## Is the service safe?

### Our findings

People and their relatives told us they received their medicines from staff when required and as prescribed by health care professionals. Comments included, "Staff make sure I take my tablets when I should", "Yes they [staff] give them to my loved one and make sure she takes them", "Absolutely, my loved one wouldn't remember", "Yes, nursing staff do that well and supervise." Despite these positive comments we found medicines management within the home was not always safe and in line with best practice.

Medicines were not always managed, stored and administered safely. The provider had a medicines policy in place which was last reviewed by the provider on 1 July 2016. The general manager told us the medicines policy was under review by the provider. We found that the medicines policy was not service specific. For example, the medicines policy detailed the usage of methadone in a supported housing scheme environment and this required improvement to ensure safe best practice within the home. There was no up to date medicines reference guide for staff to refer to and the provider's medicines policy stated this must be updated on an annual basis. However, best practice recommends that medicines reference guides such as British National Formulary (BNF) are updated every 6 months to ensure new medicines information such as side effects and contraindications of medicines is referred to. Relying on an out of date BNF is potentially unsafe practice.

The provider's medicines policy and the local medication protocol did not detail the requirement of a mental capacity assessment or best interests meeting when covert medicines needed to be administered. Covert medicine is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. One person required their medicines to be administered covertly and a record of decision to administer medicines covertly form had been signed by the general practitioner in June 2018. However, no mental capacity assessment had been conducted or best interests meeting held in line with Mental Capacity Act 2005 and best practice. We discussed this with the manager and they agreed that this should have been in place. When we returned for the second day of our inspection we found that these assessments had been completed.

We looked at 10 people's medicines administration records (MARs.) Photographs were kept on people's MAR's to identify them to new staff to help ensure medicines would be administered to the right person. Records of allergies were also recorded on people's MAR's to prevent the risk people could receive medicines they were allergic or have had an adverse reaction to. However, three out of five people's PRN protocols we looked at had not been completed appropriately in line with best practice. A visiting GP had not signed the PRN protocols in place and one protocol did not have either the GP nor clinical staff signature as required. We drew this omission to the attention of the clinical lead who told us they would address these concerns.

Not all staff who administered medicines had evidence they had received medicines training on an annual basis in line with the provider's training policy and best practice. Four out of seven permanently employed nurses did not have training certificates for medicines retained despite them completing medicines competency assessments. One nurse last received medicine training in March 2016 and another was unable

to access evidence. The provider failed to retain evidence and ensure that agency nurses who administered medicines had completed up to date medicines training. One agency nurse told us they had received medicines training in January 2018 from the nursing agency. However, this had not been monitored nor documented by the provider. The provider had failed to monitor and review staff medicine training requirements in line with their medicine's policy and best practice. This meant there was a potential risk that some staff administering medicines may not be suitably trained and competent to do so.

There were systems in place to monitor the management of medicines and Controlled Drugs (CD), however, these were not always robust to ensure people's health and well-being. Regular medicines audits were completed, but they had not identified issues regarding the management of medicines errors. We spoke with the regional clinical manager and two nurses about medicine error management. They told us there had been no medicine errors since the service opened in August 2017. However, we saw that two medicine errors had occurred, which had been identified before people's medicines had been administered. These had been documented on the provider's incident alert form and were incorrectly retained within the incident and accident folder undetected or monitored. The provider's medicine policy in the event of a medicine error had not been followed as neither error had been recorded or managed appropriately on a medication errors record form to ensure learning and best practice.

These issues are in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt safe within the home and with staff that supported them. Comments included, "Yes, very well cared for, never fallen since being here but picks up infections very quickly", "Absolutely, I come in and out all the time. I can see how they treat mum", "Yes, because of the care and attention my loved ones getting", and, "Our loved one generally seems happy but has had a few accidents."

People were protected from the risk of abuse, however safeguarding records and the monitoring of safeguarding concerns required improvement. There were policies and procedures in place for safeguarding adults from abuse, however these required reviewing and updating which the general manager told us was being completed. Staff we spoke with demonstrated a clear understanding of how to safeguard people from abuse, the signs they would look for and what they would do if they thought someone was at risk of abuse. They said they would report any concerns they had to the nurse in charge or the homes manager. One member of staff said, "If a resident was being abused I would report it right away to the nurse in charge or the manager. I would tell social services and the CQC if I thought nothing had been done." All staff had received training on safeguarding adults from abuse. Staff were aware of the provider's whistleblowing procedure and told us they would use it if they needed to report issues of poor practice.

Safeguarding records included local and regional safeguarding policies and procedures and reporting and investigating forms. However, there was no safeguarding log or monitoring tool in place to monitor and learn from any on-going or completed safeguarding concerns. For example, we saw one concern relating to staff misconduct referenced that nursing staff needed to check staff entries on the care planning system to ensure safe practice, however, no evidence of actions taken were recorded or monitored. Another reported concerns relating to missing items but again there was no evidence of actions taken and no outcome or resolution had been documented. This required improvement. We drew these concerns to the general manager and the provider's associate head of CQC compliance attention who told us they would implement a safeguarding monitoring tool to ensure all concerns and safeguarding enquiries were monitored and managed safely and appropriately. We will check on the progress of this at our next inspection of the service.

Accidents and incidents involving the safety of people were recorded, however, there was no system in place to manage and monitor accidents and incidents to ensure they were acted on appropriately. When accidents or incidents occurred staff identified the concerns and recorded them appropriately on the provider's incident forms. However, further information on actions taken to address concerns, actions taken to reduce the risk of recurrence and referrals to health and social care professionals was not documented. For example, we saw that one person's care plan recorded that they had suffered from seven falls since March 2018 and no analysis of the incidents to minimise the risk of further falls had been conducted. We drew these concerns to the general manager and the provider's associate head of CQC compliance attention. The general manager showed us a spreadsheet they were using which documented minimum information such as the incident type for example, a trip or fall and brief notes on the incident such as 'fell in flat' but failed to contain detailed information on actions taken, analysis of any trends, or reflective practice to evidence lessons learnt and practices changed as a result. This required improvement. The provider's associate head of CQC compliance told us a provider accident and incident monitoring tool was in place however, this had not been used. They advised they would ensure the tool was implemented to safeguard people's well-being and to monitor accidents and incidents appropriately. We will check on the progress of this at our next inspection of the service.

People and their relatives had mixed views about staffing levels within the home and how promptly staff responded to their requests. Comments included, "In the week there seems to be enough but at the weekends it's not well staffed. Recently I went around looking for staff as there is not many on at the weekends", "Last night I pressed this button thing [call bell] must have been 20 or 30 times and no one came. Eventually I had an accident", "Yes, always been people around, a mixture of the senior staff", "Yes, seems to be an abundance of staff", and, "I think by what I've seen there's enough. Sometimes they're pushed, it's much better here at night."

There was a dependency tool in place to calculate the numbers of staff required to meet people's care and support needs. The general manager told us that staffing levels were arranged according to people's needs. They showed us a staffing rota and said there was always five care staff and a nurse on duty on each floor during the day and three care staff and a nurse on duty on each floor during the night. However, throughout our inspection we observed and found that staff were not always deployed around the home effectively to meet people's needs in a timely manner particularly at meal times.

The home used an electronic call bell system. When call bells were activated staff were alerted by vibrating handheld devices. The silent system meant that people using the service were not unduly disturbed with alarms sounding throughout the day and at night. We asked the general manager how they monitored the system to make sure calls were responded to in a reasonable period of time. They showed us the homes call monitoring system however, they told us the WIFI system sometimes dropped out causing issues. They said they had checked where the system recorded long delays however, they could not always rely on the monitoring system data as being accurate. For example, on the 29 June 2018 we saw there was a delay of 74 minutes for one call and a delay of 61 minutes for another. The general manager told us they had not recorded what they had found to be the reason for these long delays. They said they observed and checked on the nurse call monitor screen throughout the day and if there was an issue they followed it up. This required improvement. We observed one occasion when an alarm had been activated for around fourteen minutes without a response. Eventually a nurse went to the persons room, we saw them turning off the alarm and checking the room for the person. The person was not in the room. We asked the nurse where the person was and we located the person in the lounge. They said that they had activated the alarm because they required assistance with personal care. The nurse told us the alarm system sometimes had 'glitches'. On the day of the inspection the general manager told us, and this was confirmed in an email, that following feedback from the home over recent months, the managing director had been liaising with another

company about fitting a new call bell system. The company had been to the home and the managing director had agreed to complete the installation within 6-8 weeks. They also advised the general manager to ensure the home was over-staffed where necessary to provide a manual solution to the areas where the current call bell system was failing. We will check on the progress of this at our next inspection of the service.

The general manager told us the home currently relied on the use of regular agency care and nursing staff. The home's administrator showed us records confirming that the agencies they used had carried out robust recruitment checks and that agency staff had completed training that reflected the needs of people living at the home and that agency nurses were registered with the Nursing and Midwifery Council (NMC). The general manager said they used the same staff whenever they could to maintain continuity, many of whom had worked at the home since it opened in August 2017. Agency staff we observed and spoke with appeared to know people well. The general manager told us that nineteen new permanent members of staff, including care and nursing staff had been recruited and were due to commence an induction period in July 2018 before starting work at the home in August 2018. They said the introduction of new staff would lead to a decrease in the number of agency staff working at the home. They said they would continue to recruit new staff as and when the numbers of people residing at the home increased.

Appropriate recruitment checks took place before staff started work. Completed application forms included staff member's full employment history and explanations for any gaps in employment, two employment references, health declarations, proof of identification and evidence that criminal record checks had been carried out. The home's administrator told us that they monitored each nurse's NMC registration to make sure they were able to practice as nurses.

There were arrangements in place to deal with foreseeable emergencies. People had individual personal emergency evacuation plans which highlighted the level of support they required to evacuate the building safely. Staff said they knew what to do in the event of a fire and had received regular training on fire safety. The home had a fire risk assessment in place, the fire alarm was tested on a weekly basis and regular fire drills were carried out. There were also systems in place to manage infection, clinical waste, gas and electrical appliances and water safety. Equipment such as hoists, mobility aids and lifts were also serviced regularly to ensure they were functioning correctly and safe for use.

On the top floor of the home we observed that the plant room door was unlocked. This room housed the boiler and electrical system to the home. Although the door from where people resided had a keypad to restrict them from moving to this part of the building there was a risk that someone could access this area. On the second day of our inspection we discussed this with the maintenance person and the provider's health and safety officer who was carrying out a health and safety check at the home. The provider's health and safety officer told us they had identified the issue during their visit and they had instructed the maintenance person to put a lock on the door and appropriate warning signage advising that only maintenance staff should enter the plant room. All communal bathrooms did not have toilet paper holders in place and toilet paper was kept in a basket either on the floor or on the toilet system. We drew this to the health and safety officer's attention as this posed an infection control risk and or a falls risk. We will check on the progress of these issues at our next inspection of the service.

We found that the home was comfortable in temperature due to the installation of air conditioning, was clean and tidy and free from any unpleasant odour. The home retained an external team of domestic staff. We observed them cleaning the home during our inspection. A member of the domestic team told us they had completed training on infection control, health and safety and the control of substances hazardous to health. We saw hand wash was available in bathrooms and toilets and was being used by staff throughout

the home. Staff had received training on infection control and food hygiene. We saw and domestic staff told us that personal protective equipment was always available to them when they needed it.

Risks to people were assessed to help keep them safe. Assessments were conducted to assess levels of risk to people's physical and mental well-being. Electronic care plans contained risk assessments which documented areas of risk to people, such as nutrition and hydration, falls, mobility, skin care and pressure relief, personal hygiene and behaviour amongst others. Risk assessments included guidance for staff and the actions they should take to support people safely and to promote their well-being. For example, we saw that where people were at risk through eating, drinking and weight loss or gain staff monitored people's food and fluids intake to ensure they maintained a healthy balanced diet and weight. Risk assessments were also completed for individuals specialised medical needs. For example, where people were at risk of breathing and respiration problems guidance for staff on monitoring people's conditions such as asthma was documented with actions for staff to take in the event of a medical emergency.

## Is the service effective?

### Our findings

Most people and their relatives spoke encouragingly about the knowledge, skills and competence of staff that supported them. Comments included, "I think some of them [staff] are okay. I've seen that some are better than others at handling my loved one", "Yes, I think most staff are good and know what they are doing", "It seems like they [staff] are on the ball", "Some of them are very good and others appear to still be learning", and, "Yes I think they [staff] are probably trained well." Despite these encouraging comments we saw that some staff were not always supported in their roles through regular appropriate training, supervision or appraisals of their practice and performance.

We spoke with the providers CQC compliance manager who told and showed us that a training needs analyses had been conducted to assess clinical training for nursing staff. We saw that training identified as required for nursing staff included medication management, phlebotomy, catheterisation, wound care, stoma care, end of life care, diabetes, dysphagia, continence care, venepuncture, cardio pulmonary resuscitation and supervision and appraisal. We saw an email dated 21 June 2018 from the clinical lead nurse advising the providers CQC compliance manager that they would seek training providers and request quotations for clinical staff training. During the inspection the clinical lead nurse told us they were planning clinical training for nursing staff and provided us with catheterisation training registration sheets for which five nurses had signed to say they would attend the training in July 2018. However, we looked at the staff training matrix which included a section for recording the eight clinical nurse training and noted that this section of the matrix was blank. We asked the general manager to update the clinical training matrix. We received a final copy of the matrix following our inspection. We saw it recorded that one nurse had completed catheterisation training and another had completed training on Huntington's disease which was conducted in 2016. No further clinical training had been recorded as completed by nursing staff employed at the home and this required improvement.

Staff were not always supported appropriately through regular supervision in line with the provider's policy and best practice. We spoke with the general manager who provided us with a copy of the provider's supervision policy dated 1 September 2014 which we noted was overdue for reviewing. The supervision policy stated that "Managers were responsible for scheduling one to one supervision meetings with the staff they managed. One to one supervisions should be held on a four to six-week basis." The general manager provided us with a matrix of supervisions completed with staff, however this was out of date. On the second day of our inspection we were provided with an updated matrix that also included staff start dates. Out of 49 staff, 24 had not yet received supervision support in line with the provider's policy. 21 members of staff had not received supervision in the entire time they had been working at the home, some dating back over a year. The updated matrix included some newly planned dates for staff supervision and other supervisions were to be confirmed. Therefore, we could not be assured, that if we had not brought these concerns to the attention of the general manager staff would have received supervision to support them in their roles. This required improvement.

These issues were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had completed an induction programme which included induction training when they started work. They also told us they shadowed experienced staff as part of their induction, enabling them to become familiar with the home and people's needs. The provider's induction programme was in line with the Care Certificate. The Care Certificate is a set of standards that social and health care workers are required to follow in their daily working life. The general manager provided us with a training matrix which confirmed that all staff had completed an induction when they started work. The matrix indicated that staff had completed induction training on infection control, safeguarding, equality and diversity, food hygiene, fire safety, health and safety, moving and handling, first aid, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), dementia awareness and responding to behaviour that challenges.

There were mixed views from people and their relatives about the food and menus on offer at the home. Comments included, "The food is reasonably good but choice is limited. it's quite nicely presented", "It's okay. My loved one has problems with his fingers so cutting food is a problem and the glasses they use are difficult for him to hold. If you don't want what's on the menu they will do something else for you", "I believe they have a menu and give it to my loved one to choose. They are diabetic and staff are aware of that and are monitoring her", "I enjoy most things but there are some that I don't like", "They [staff] come around with a menu before every meal and we are given two options every course. There is more than enough to eat", and, "If my loved one doesn't like what's on the menu she just pokes the food about. She's quite confused and needs support."

We visited the kitchen and observed it was clean and well organised. We spoke with the chef who showed us documents which alerted kitchen staff to people's dietary needs and risks, and personal preferences. The chef was knowledgeable about people's dietary needs and was kept updated by staff with advice from speech and language therapists (SALT) and requests from people relating to their preferences. For example, they told us about one person who required their meat to be cut into small pieces and another person that required a soft diet to ensure the risk from choking was minimised. We also spoke with a member of staff whose role within the home was the nutritional lead. They showed us nutritional requirement sheets located within the kitchen, the bistro area and in dining rooms that described each person's dietary and meal time needs, including if they required, soft or low sugar diets and drinks. The chef told us they had held a taster day recently where people were offered different food options. They said people really liked the barbequed chicken and chicken tikka masala and these had been added to the menu as a result. The chef also told us they planned to facilitate residents and chef's meetings so that people could express their opinion about the food on offer and make suggestions for the menu.

There were no picture menus or sample plates of food for people to choose from at meal times. There was a menu displayed in the hallway on the ground floor indicating what was on offer during the week, however this was in small print so may not be suitable for some people to read. A member of staff told us people's menu choices were sought each morning and kitchen staff delivered meals pre-plated to people on each floor of the home at meal times. The chef showed us pictures of food that were shown to people for them to choose, however we did not see these being used during the inspection. They told us that up until recently they had used sample plates to show people what was on offer that day so that they could choose the meal they wanted, however this practice had stopped but they were planning to reinstate this again. A member of staff and the chef told us the home was in the process of developing picture menus so that people could see what was on offer each day and for people whose memory was poor this would aid decision making. We will check on the progress of this at our next inspection of the service.

We observed the lunchtime meal in two dining rooms within the home. People's experience at mealtimes varied depending on which floor they lived on. On the ground floor we saw that most people were able eat

their meals independently and required little support from staff. The atmosphere was relaxed and unhurried, people chatted together at their tables and joked with staff. They were offered a choice of meals and drinks and staff explained to people what was on offer for dessert. However, we saw that people living on the top floor of the home had a less positive meal time experience. We saw that there was not enough staff available to support people appropriately when required and little time for pleasantries as interactions were task-based and focused on the job in hand. For example, one person required support to eat their meal safely, however, there was not enough staff to support the person to eat their meal when food was served and so had to wait to be supported to feed later than others. Another person was seated in a lounge chair and staff advised they were going to support them to transfer to the dining table to eat with others, however, after several minutes staff reported that all staff were busy and so they remained seated in the lounge chair to eat their meal. We noted that tables were not set and cutlery and napkins were provided once food had already been served. Food was pre-plated in the kitchen and served from a hot hostess trolley delivering food to each floor. Meals were placed in front of people with minimal explanation or interactions from staff serving and people were served a choice of drink toward the end of the main course. Staff did not wear any personal protective equipment (PPE) such as aprons and hair nets whilst serving food to prevent the risk of cross infection until halfway through the meal when it was noted by a member of staff. This required improvement. We drew these concerns to the general managers attention. We will check on people's meal time experience again at our next inspection of the service to ensure improvements are made.

The home is newly built and suitably designed to meet some people's needs. There were accessible toilets and bathrooms throughout the home and equipment was readily available for people who required it such as walking frames, wheel chairs, hoists, hand rails and lift access to all floors. However, the top floor of the home which housed people living with dementia was not suitably decorated, adapted or dementia friendly to meet people's needs. For example, the design and placement of dining rooms and lounges did not promote engagement, sensory equipment and room, although in place was located at the end of a long corridor and unused on both days of our inspection, appropriate picture signage to aid orientation was not in use and colour schemes and entrance doors to people's rooms were unidentifiable. People had access to outside terrace areas, however, these were small and limited movement. We discussed our findings with the general manager and customer relations manager who told us they would discuss these findings with the designer.

Pre-admission assessments of people's individual care needs and preferences were completed before they moved into the home to ensure staff and the home environment could meet their needs safely and appropriately. Assessments incorporated details about peoples' personal history to help develop care plans. Assessments covered areas such as personal contact information, physical and mental health needs, communication needs, mobility and medicines amongst others. Assessments documented the involvement from people and their relatives where appropriate and any health and social care professionals involved to ensure all individual needs were identified and addressed.

People and their relatives told us staff supported them to access health and social care professionals when required and monitored their health to ensure their wellbeing. Comments included, "Yes, and I still take my loved one to visit the dentist and chiropodist", "The doctor comes twice a week and she's put on the list if needed. The opticians do home visits", and, "Oh yes, if I'm feeling unwell the staff make sure I see the doctor." Care plans documented that people were referred to health and social care professionals when required and records from visiting GP's and other health professionals were retained.

Staff were aware of the importance of obtaining consent from people when offering support. They demonstrated good knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty

Safeguards (DoLS) including people's right to make informed decisions independently but where necessary to act in someone's best interests. People told us staff sought their consent and respected their wishes and independence. One person said, "My son and daughter have power of attorney and my son handles these things. I have a say in any decisions." Another person commented, "Staff are respectful. They always ask me how I want things to be done or how they can best help me."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Care plans showed that where people lacked capacity to make specific decisions for themselves, mental capacity assessments were conducted and decisions were made in their best interests, in line with the requirements of the MCA. Applications had been made to local authorities to deprive people of their liberty where this was assessed as required. Where these applications had been authorised, we saw that the appropriate documentation was in place and kept under review and any conditions of authorisations were appropriately followed by staff.

## Is the service caring?

### Our findings

People and their relatives told us staff were friendly, supportive and caring and they were provided with information about the service when they moved into the home. Comments included, "Yes, when there has been a problem and my loved one has an upsetting evening they [staff] check on her until she has settled down. They are very good at coming to talk to her", "Above and beyond they give them [residents] cuddles and kisses", "They [staff] are all willing to have a laugh and a joke", "We were given a welcome pack when my loved one moved in", "It's got a home from home feel rather than a hospital type", and, "Very kind and caring, just their [staff] general attitude. You treated as a person and they are very sympathetic to my loved ones needs."

We spoke with the general manager who told us that people received a copy of the provider's 'Resident Information Guide' on admission to the home. This provided them with an introduction to their new home and included information on accommodation, housekeeping, resident and family involvement, dining and drinking, activities and facilities, policies of note, transport and mobility, the organisational structure and care requirements amongst others.

People's diverse and spiritual needs were assessed and documented within their care plans. Staff we spoke with told us they were committed to supporting people to meet their needs with regard to their disability, race, religion, sexual orientation and gender. One member of staff said, "We speak with people and their relatives to ensure we know about people's diverse needs and how we can support them. It's important that people's needs are met in every area and care plans are tailored to meeting their needs." Staff told us and records we looked at confirmed that staff had received equality and diversity training. A visiting relative told us, "My relative is Christian. I know that someone from the church visits but I don't know if she participates in the services on a regular basis."

During our inspection we observed positive and caring interactions between people and staff. Staff treated people in a respectful manner addressing them by their preferred names and spent time talking and interacting with people during less busy periods. For example, we observed one member of staff actively engaging in conversation with one person discussing the last world war. The person had served in the Royal Engineers and was telling the member of staff about being in the war and where they stayed with their army colleagues. The member of staff was asking lots of questions and expressed their admiration for the person's experiences and achievements. Staff knew people they supported and had good knowledge of their personalities, behaviour and communication needs. They were aware of individual's preferences, life histories, family and the things that were important to them.

People were supported to maintain relationships that mattered to them and visitors told us they were made to feel welcomed when they visited. Comments included, "Yes I am made to feel welcome, there are some very nice people here", "Yes we are welcomed, anytime of the day", and, "Definitely, reception staff are lovely and very understanding when I feel low as my relative's condition is so up and down." Throughout the course of our inspection we observed people were free to come and go as they pleased with no restrictions placed upon them. A visiting social care professional told us, "I am always made to feel welcome. Everyone

asks me if I am okay and if I need anything. My client's family had a few issues with things going missing but they are sorting it all out. I would say the staff are very attentive. They put their heads in the door and say hello. A member of staff came into the room this morning with a menu to see what my client wanted for lunch. They were very friendly, patient and happy."

## Is the service responsive?

### Our findings

People and their relatives told us they were aware of the provider's complaints procedure and how to make a complaint but had mixed views on the confidence of issues raised being dealt with appropriately by management. Comments included, "I find its sometimes very difficult to complain. You go to the nurse when you want to have something done, it's as simple as that as its non-serious things", "I would certainly have a word if I had any complaints", "Yes, I am aware, I would go and see a member of staff or senior nurse", "I've had to complain about a few things, nothing serious. It usually gets sorted", "I would complain to the staff. They get things done", "You complain to the manager and he says yes and just goes off", and, "When I complained they made no comments as they knew it was constructive. It was resolved but they didn't involve my loved one."

The home had a complaints procedure in place. The complaints procedure was provided to people in the homes brochure and through a leaflet entitled 'how to complain and give feedback'. We spoke with the customer relations manager who showed us a complaints file that included records of individual complaints made to the home. The file included email correspondence from complainants and responses from the provider. When concerns had been raised they were responded to and discussions were held with complainants to help resolve their concerns. However, the complaints file was disorganised and we found it difficult to establish the origin and nature of the complaints as there was no complaints log in place to monitor and manage complaints appropriately and this required improvement. We brought this to the attention of the customer relations manager who told us they would implement a complaints log to check and ensure complaints were monitored on a regular basis. We will check on the progress of this at our next inspection of the service.

There was a range of facilities and activities offered to people to support their need for social interaction and stimulation. People and their relatives told us they enjoyed some of the activities on offer, comments included, "I know my loved one has gone out onto the patio in the good weather, he does take part in the activities", "Activities are good it depends on the day. My loved one likes doing sewing, flower arranging, gardening and quizzes dependent on what sort of day she has had", "I don't really know much about any of the activities. I know my relative has joined in with bits and pieces", "Some of the activities we have are quite good, it's really a day by day thing", and, "My loved one sleeps quite a lot but they get him up in his wheelchair and we go into the garden."

Facilities within the home included a cinema, sensory room, library, spa, children's activity room, gardens and terraces and a gymnasium. However, during the course of our inspection we noted that none of these facilities were being used by people. We saw that on both days of the inspection the cinema located on the first floor of the home was showing a movie on the first day and Wimbledon on the second day but the room was empty. We were told that the cinema was left on in case anyone wanted to use it. Similarly, we were told that people could use the sensory room if they wanted to, however the room was in darkness and the sensory equipment was turned off. The home had two activity coordinators in post and offered a chauffeur service to people wishing to venture out.

We spoke with the activities coordinators who told us about the activities provided to people and showed us a weekly activity programme. Activities listed on the programme included a gardening club, sewing club, card games, aromatherapy, bingo, quizzes, visits from a therapy dog, board games, pampering sessions, movie shows and use of the sensory room with support from care staff. There was a well-used café located on the ground floor and on the first day of our inspection we observed children from a visiting local school making potpourri pouches with people. The activities coordinators told us that singers and musicians also visited the home to entertain people. There was a community coffee afternoon where people from the local community could attend the home and meet with people. A church service was held at the home once a month for people to attend and the activities coordinators told us that people also visited the church with support if they wished. They told us they provided activities and engagement for people who were nursed in bed or for those who wished not to join in group activities. They told us they read to people, played them music, painted, offered hand massages and took the dog to see them if they wished.

People and their relatives told us they received care and support in response to their needs and they were involved in planning, managing and making decisions about their care. Comments included, "Yes I'm involved", "Yes, definitely, staff involve me in my relative's care", "Yes, care is responsive to my loved ones needs. She likes to wake up early and gets dressed. They [staff] work around that", "I know I have a care plan but I tend to leave all that to my family", and, "Staff always ask me what I want."

We saw that people's diverse needs were respected and care plans included details about people's needs in relation to age, disability, gender and religion. However, we did note that care plans lacked detail in areas other than religion such as race, sexual orientation and culture. We spoke with the general manager and customer relations manager who told us that they would look into improving the care planning system to allow for equality and diversity issues to be further explored and assessed.

Care plans documented the support people required and contained guidance for staff to ensure support was offered to people appropriately. Care plans contained information in areas such as capacity and consent, communication, nutrition and hydration, emotional well-being, falls and mobility, mental health behaviours, personal hygiene, skin care and pressure relief, medicines and end of life care wishes amongst others. Care plans evidenced involvement with people and their relatives where appropriate documenting information in relation to people's likes and dislikes and life history. One relative commented, "They have gone into some detail asking me if my loved one goes back to her childhood home." Another relative commented, "They have life care books in the rooms which you fill in. There is room for photo's. The idea is when my mum gets upset they can go through it and talk with her." A third relative told us, "When my loved one first came here I had a long interview with the staff who wanted to know all about his history."

We saw that where people were not able to be fully involved in the planning of their care, relatives and professionals, where appropriate, contributed to ensure people's needs and wishes were met. We saw that people received appropriate care and support at the end of their lives and care plans documented discussions had with individuals and their relatives where appropriate. Any advanced directives and end of life care wishes and needs such as 'do not attempt resuscitation' forms and choice of funeral arrangements were documented. For example, we noted that one person's wish was not to be transferred to hospital as they wished to die within the home. Daily records were kept by staff about people's day to day well-being to ensure that people's planned care met their needs and care plans were reviewed on a regular basis to help ensure they remained reflective of people's current needs.

## Is the service well-led?

### Our findings

People and their relatives had mixed views on the management and running of the home. Comments included, "Not very keen on the management at all. All show and no go", "There is always someone available. I don't know the gentleman's position", "The manager is a big chap, he's been here about six months. The wellbeing man will come and get a cup of coffee and have a chat", "The clinical manager is the head and shows you around. They can tell that I'm happy, they would know if I'm not I would tell them", "It probably has its hiccups but its spotless and clean", "I think it's very good. There is plenty of people to ask advice it seems a nice place from what I've seen", and, "I want my loved one to stay here, there are some lovely care staff but they all need to be good. You can't live in fear, it's not hard to communicate." Despite some people's positive comments, we found that systems in place to monitor the quality and safety of the service were not always effective or well-led.

At the time of our inspection there was no registered manager in post. The provider had a general manager in post until a registered manager had been appointed. The general manager was knowledgeable about the requirements of a registered manager and their responsibilities with regard to the Health and Social Care Act 2014. Notifications were submitted to the CQC as required. Throughout our inspection we noted that the general manager and customer relations manager was visible within the home and available to people, their relatives and staff.

Staff told us that senior management were visible within the home and offered them support when required. They told us there was a sense of teamwork within the staffing team and they enjoyed their jobs. Comments included, "When I saw Baycroft I just knew I wanted to work here. It really is the best place to be in terms of the care people get. I am very happy working here. I work closely with my line manager and they check with me regularly. I feel that I am very well supported by them and we have lots of informal meetings. I attended a staff meeting the first week I started here but there's been none since", and, "There's a lovely atmosphere here and the team work is nice. I am very happy to be working here. We all get well supported by the nurses and the manager has an open-door policy. I have spoken with the manager when I thought things could be improved and I am sure they listen to what I have to say. Staffing levels sometimes can be a bit tight as it can get busy at certain times during the day for example, in the morning or at lunch times."

Throughout our inspection we observed staff worked as a team and offered each other support where needed. However, there were no effective lines of communication within the home to provide staff with the opportunity to meet and communicate on a regular basis. The general manager told us they used to hold daily 11 at 11 meetings with staff however, they had stopped because not all staff could attend at the same time. They told us they were going to reinstate these meetings to ensure communication within the staffing team was effective. There had only been two team meetings held at the home since it registered with the CQC in September 2017 and this required improvement. Records of meetings held showed recurrent themes and areas that required improvement but action plans had not been implemented to ensure action was taken to address them. For example, we saw the minutes from these meetings held in October 2017 and March 2018. At the October 2017 meeting the home manager had expressed their disappointment regarding the lack of staff attending the meeting which again was addressed at a seniors meeting held in June 2018.

Items also discussed at the October 2017 meeting included the instability of the WIFI system within the home and the impact that had on the care planning and the nurse call system. Again, this is an area of concern that we found during our inspection which had not been addressed nor actioned. Items discussed at the March 2018 meeting included additional training on the nurse call system, staff training and continued professional development training for nurses. Nurses that wanted to expand their development in certain areas were advised they could discuss this with the provider and the provider would be happy to pay for this training. This was also an area of concern that we found during our inspection and records showed that nurse training had not been actioned since the meeting in March 2018.

We spoke with the general manager and provider's associate head of CQC compliance about the systems in place to assess, monitor and help drive improvements in the quality and safety of the service provided. They showed us provider quarterly audits they had undertaken at the home. A provider compliance audit was conducted in April 2018 and which had identified many areas requiring improvement. For example, it was recorded that the recording and monitoring of falls was 'inconsistent in the audit sample' and the 'clinical governance tool for March could indicate a lack of managerial overview and structured approach to care provision'. It was also noted that there were gaps in auditing such as no infection control audit, no incident analysis and no analysis of key areas of clinical care conducted since February 2018. Furthermore, there were no full records of safeguarding's and incidents including investigation and follow up action records. Staff training certificates were noted to be missing and the provider's clinical governance tool had not been found. We looked at a clinical governance tool that had been completed in June 2018. This showed that there had been no care plan reviews, meetings or audits conducted that month. The general manager told us they conducted a 'resident of the day' system whereby one person's care plans and records were reviewed and audited every day, however this had not been conducted since March 2018.

We looked at the provider's service improvement plan that was first implemented in December 2017 but updated following the provider's last compliance audit conducted in April 2018. As of the last update on 20 June 2018 we saw that many areas requiring improvement were still either planned, outstanding or on-going. For example, we saw that the home's WIFI problems resulting in issues with the care planning and nurse call system were still outstanding, a review and update to the staff training matrix to fill training gaps was still planned, staff supervisions were still to be conducted in accordance with the provider's policy and procedure and incident and accident investigations were to be concluded with follow up actions and outcomes evidenced and lessons learnt following the incident management policy and procedure. It was noted that incident and accident records had a lack of detail and statements as evidence and the process was not at times followed through.

We also looked at the provider's 'quality and risk review report'. We noted that critical care indicators for the months of March, April and May 2018 stated there had been no medicine errors when in fact we had identified that there had been two in March 2018. We also saw the review went on to say, 'All medication errors have been graded green on the serious incident log, although use of the log for recording these errors remains inconsistent'. We also looked at the providers 'daily clinical walk round' audits and noted that this was last conducted on the 22 June 2018.

These issues demonstrated that systems and processes in place did not effectively assess, monitor and mitigate risks relating the health, safety and welfare of people using the service and others nor did they continually evaluate and seek to improve governance and auditing practice.

These issues were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some systems in place to seek the views of people using the service and their relatives through residents and relative's meetings and surveys. However, the customer relations manager told us and we saw that the surveys were yet to be implemented and sent to people and their relatives to complete. We also noted that a staff survey had been drafted and was also due to be sent to staff to complete. One relative told us, "Relatives and residents meetings are held but I haven't been able to go. They [staff] are keen to get people involved."

We looked at the minutes for the residents and relative's meetings held in October 2017, January 2018 and April 2018. We noted that four residents and their relatives attended the meeting held in October 2017. Issues discussed included staffing levels, the appointment of an activities coordinator, the delivery of a mini bus, medicines and technology to be used at the home. The manager provided families with life history forms to complete with their relatives. Other issues discussed included the high staff turnover, the number of residents, security and pets. We noted that the meeting held in January 2018 was well attended by 22 people, a mixture of residents and relatives. The meeting was called following the registered managers resignation. Issues raised by people included the number of agency staff at the home and shortage of staff on Christmas day. Other issues discussed included security, new residents, technology, out of hours contact and the call bell system as a relative expressed concern over call bell system not being responded to. We saw that they were advised there were technical issues as it relied on the WIFI.

The home worked in partnership with other professionals to ensure people received appropriate support to meet their needs. Records showed how the home engaged with other healthcare and social care specialists to respond to people's care needs and to maintain people's well-being. For example, a community mental health team 'care home project team' visited the home to work alongside staff and to deliver training in relation to working with people living with dementia. We also saw that palliative nurses visited the home to work with staff in relation to the provision of end of life care. The general manager told us they were working towards achieving the Gold Standards Framework which is a nationally recognised standard in the provision of end of life care.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  <b>Safe care and treatment</b>  The provider failed to ensure the proper and safe management of medicines.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance  <b>Good Governance</b>  The provider failed to ensure that systems or processes in place assessed, monitored and mitigated risks relating to the health, safety and welfare of service users and others who may be at risk and to improve the quality and safety of the service.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing  <b>Staffing</b>  The provider failed to ensure staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.