Mr & Mrs H Rajabali

Barons Down Nursing Home

Inspection report

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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?	Good
Is the service well-led?	Requires improvement

Overall summary

Barons Down Nursing Home is located on the outskirts of Lewes, with some parking on site. The original building has been extended and there are communal rooms on the ground floor, including a conservatory area to the side of the lounge. A lift enables people to access all parts of the home and there are accessible gardens to the rear and side of the building.

The home provides support and care for up to 30 people with nursing and personal care needs. There were 19 people living at the home during the inspection. No new admissions had been accepted while repair work had been carried out on the lift. Some people had complex needs and required continual nursing care and support, including end of life care. Other people needed support with personal care and assistance moving around the home, due to physical frailty or medical conditions, and some people were living with dementia.

A registered manager was responsible for the day to day management of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

This inspection took place on the 25 November 2015 and was unannounced.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The management and staff had attended training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, but they were not up to date with current guidance to ensure people were protected. Additional training had been arranged and advice was being sought from healthcare professionals.

People were assessed before they moved into the home to ensure staff could meet their needs, and care plans, including risk assessments to ensure their safety, were developed from this information. However, there was no evidence to show that people, or their representatives if appropriate, were involved in developing the care plans and people's daily records did not reflect the support and care we observed.

People said there were enough staff working in the home and that staff provided the support and care they needed. New staff were required to complete an induction programme in line with the Care Certificate, and the on-going training programme supported staff to meet people's needs. The registered nurses attended fundamental training and additional training to ensure their nursing competencies were up to date.

Systems were in place to ensure people were protected and support was provided safely. This included safeguarding training, staff had a good understanding of abuse and how to raise concerns if they had any. Staff were trained in the safe administration of medicines. Staff followed relevant policies, they gave out medicines safely and signed the administration records after they had been taken.

People, relatives and staff said the management were very approachable, and were involved in decisions about how the service developed with on-going discussion on a day by day basis and during residents meetings. In addition feedback was sought from people, their relatives, healthcare professionals and other visitors to the home, through satisfaction questionnaires.

People told us the food was very good. Staff asked people what they wanted to eat, choices were available for each meal, and people enjoyed the food provided. People told us they decided what they wanted to do, some joined in activities while others chose to sit quietly in their room or communal areas. One person said, "There is a programme of activities, but I don't go down every time. I went to the Halloween party and that was very good, I have photos of my family with me."

People had access to health professionals as and when they required it. The visits were recorded in the care plans with details of any changes to support provided as guidance for staff to follow when planning care.

A complaints procedure was in place. This was displayed on the notice board near the entrance to the building, and given to people, and relatives, when they moved into the home. People said they did not have anything to complain about, and relatives said they were aware of the procedures and who to complain to, but had not needed to use them.

Summary of findings

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.

Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

Risk to people had been assessed and managed as part of the care planning process. There was guidance for staff to follow.

People were cared for by a sufficient number of staff and recruitment procedures were robust to ensure only suitable people worked at the home.

Medicines were administered safely and administration records were up to date.

The premises were well maintained and people had access to all parts of the home.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had attended training of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, but were not clear how these should be used.

Staff had received fundamental training and provided appropriate support.

People were provided with food and drink which supported them to maintain a healthy diet.

Staff ensured people had access to healthcare professionals when they needed it.

Is the service caring?

Good

The service was caring.

The registered manager and staff approach was to promote independence and encourage people to make their own decisions.

Staff communicated effectively with people and treated them with kindness and respect.

People were encouraged to maintain relationships with relatives and friends. Visitors were made to feel very welcome.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved into the home.

Summary of findings

People's support was personalised and care plans were reviewed and updated when people's needs changed.

People decided how they spent their time, and a range of activities were provided depending on people's preferences.

People and visitors were given information about how to raise concerns or to make a complaint.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

There was no evidence to show that people were involved in developing their care plan, and daily records did not reflect the support provided.

There were clear lines of accountability and staff were aware of their roles and responsibilities.

People, relatives and staff were encouraged to provide feedback about the support and care provided.

Quality assurance audits were carried out to ensure the safe running of the home.

Barons Down Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 25 November 2015 and was unannounced. The inspection was carried out by two inspectors.

We looked at information we hold about the home including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with all of the people living in the home, five relatives, six staff, the cook, housekeeping staff, the nurse on duty, registered manager and a visiting healthcare professional. We observed staff supporting people and reviewed documents; we looked at four care plans, medication records, four staff files, training information and some policies and procedures in relation to the running of the home.

Some people living in the home were unable to verbally share with us their experience of life at the home, because they were living with dementia. Therefore we spent a large amount of time observing the interaction between people and staff, and watched how people were cared for by staff in communal areas.

Good

Is the service safe?

Our findings

People and relatives said the home was a safe place to live. One person told us, “I don’t have any concerns at all.” A relative said, “It’s not something I really think about. That must be a good sign.” Another relative told us, “You hear all kinds of horror stories about care homes but I’m sure that wouldn’t happen here.” Staff told us they had a good understanding of safety and how to protect people from abuse. People, relatives and staff said there was enough staff working in home to make sure people had the support and care they needed and wanted.

Staff had a good understanding of enabling people to take risks in a safe way. Staff said, “If people can do things for themselves, we let them.” “People can take risks I know. We have to keep them as safe as possible” and, a member of staff explained the process, “We have a risk based assessment process. We look at people’s physical capabilities and their understanding of what they want to do. If it means they need the support of staff to be independent, like walk with a zimmer, then we make sure we are there to support them. We allow people to do things as much as possible, only when they are unable to do something safely do we make changes, like when we use the hoist because someone cannot stand up on their own. Even then we only do this when we have completed a risk assessment and sought additional advice from a physiotherapist or occupational therapist.” Risk assessments specific to each person were in place. These included assessment of people’s mobility, nutritional needs, communication and waterlow scores to ensure they were protected from pressure sores. Staff were knowledgeable about people’s assessment and these had been reviewed and updated as people’s needs had changed.

As far as possible people were protected from the risk of abuse or harm. Staff had undertaken adult safeguarding training within the last year and had an understanding of protecting people from abuse. They identified the correct safeguarding procedures should they suspect abuse and, were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider’s policy. Staff had read the whistleblowing policy and said they would have no problem raising issues if they thought people were at risk in the home. One member of staff told us, "I would report anything I thought suspicious to the manager.” Another member of staff said, “I’ve been in a situation before, at another home, where I’ve needed to ring the CQC (Care Quality Commission). I know what to do.” Staff said the manager operated an open door policy; they felt able to share any concerns they may have in confidence and were sure that appropriate action would be taken if they raised a concern. People, relatives, staff and a visiting health professional all said they had not seen anything they were concerned about.

People and relatives said there were enough staff working in the home. One person said, “We might have to wait a while because they are busy, like first thing in the morning, but not usually for long.” Another person told us, “No I don’t. I can wait half an hour for someone to come sometimes if I press my buzzer.” The registered manager said if people felt staff took too long to respond to call bells this was discussed with them and action taken to ensure this did not happen. They told us the person had not raised a concern about this. Relatives said, “Every time my relative calls the staff come within a minute. They are always asking us if we are happy.” “The staff are always around, I haven’t noticed anyone waiting when they ask for help” and, “I think there are plenty of staff. My relative remains in their room and they only have to ring the bell and staff are there quickly.” One person, who chose to stay in their room, said there were no problems, they rang the bell and it was answered within a couple of minutes. Staff told us, “I haven’t found a problem at all.” “Well I’ve not been here that long but I’ve had time to get to know the residents.” “If we are helping one resident and someone rings the bell we always see what they want, even if we have to get other staff to help them.” We saw that staff were not rushed, there was a relaxed atmosphere and staff provided the support and care people wanted.

Recruitment procedures were in place to ensure that only suitable staff worked at the home. We looked at the personnel files for four staff. There were relevant checks on prospective staff’s suitability, including completed application forms, two references, interview records, evidence of their residence in the UK. A Disclosure and Barring System (Police) check, which identify if prospective staff had a criminal record or were barred from working with children or adults, had been completed for all staff. Staff said the recruitment procedures were, “Fine, there were no problems.” “I was lucky in that my DBS (Disclosure and Barring Service) came through quite quickly. I didn’t

Good

Is the service safe?

work with residents until that happened" and, "It is a very good system, only people who have been checked out will be able to work with people who are vulnerable, which is how it should be."

The registered manager said they had advertised for care staff and nurses so that they were enough staff working in the home before they offered rooms to people. The registered manager said they had not admitted anyone to the home while the lift was being repaired, as most people would be unable to use the stairs. The lift was out of use for several weeks and one of the rooms on the first floor was used as a lounge and staff spent time with people to ensure they were not isolated. One person said, "It is nice that the lift works now, we can sit in the lounge downstairs if we want." Another person told us, "They sorted things out so that we weren't left on our own. I can't use the stairs so I need the lift. It took some time to fix but we were well looked after."

Environmental risk assessments had been completed to ensure the home was safe for people living there. The home was clean and well maintained with pictures and homely touches throughout, people had personalised their rooms with their own furniture, ornaments and pictures. Staff reported any repairs and the administrative staff recorded these in the maintenance book and the maintenance staff were available every Monday and, these were dealt with these as soon as possible with the book signed and dated as these were completed. If the repairs could not wait the maintenance staff could be contacted for repairs on the day. There were records to show relevant checks had been completed, including lighting, hot water, call bells and electrical equipment. The fire alarms system was checked weekly and fire training was provided for all staff and the records showed they had all attended. External contractors maintained the lift, electricity supply and kitchen equipment, and if there were any problems staff were able to access their contact details.

People and their relatives were happy that medicines were dispensed in a safe, timely and appropriate manner and, the administration and management of medicines followed guidance from the Royal Pharmaceutical Society. Medicines were delivered and disposed of by an external provider and the management of this was safe and effective. People had been risk assessed with regard to managing their own medicines, no-one at the home managed their own medicines and no-one received their medication covertly, that is, without their knowledge or permission. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medicines were safely stored in trollies in a lockable, dedicated room. Medicines requiring refrigeration were stored in a fridge, which was not used for any other purpose. The temperature of the fridge and the room which housed it were monitored daily to ensure the safety of medicines. Staff told us regular training would be provided by a new external provider and they had conducted regular direct observation of staff administering medicines, there were documents to support this. The registered manager said they had observed all newly employed nurses when they had given out medicines and, discussed their knowledge and understanding of the medicines before they were allowed to give them to people on their own.

We examined the Medicines Administration Records (MAR) for eight people, we observed the dispensing of medicines at lunch time and examined the provider's medicine management policy. The MAR contained photographs of people for identification purposes and guidance for staff with regard to people taking medicines on an 'as needed' basis and those taking medicines that required regular blood test checks. Staff locked the medicine trolley when leaving it unattended and did not sign MAR until medicines had been taken by the person. There were no gaps in the MAR and staff were knowledgeable about the medicines they were giving. The provider did not undertake regular audits of medicines management. However, they did frequently check stock balances and told us the new medicines provider would offer a regular medicines audit.

Accidents and incidents were recorded; the registered manager monitored these and audited them monthly. Staff said if an accident or incident occurred they would inform the nurse on duty and an accident form would be completed. Information about what happened was recorded and staff discussed what happened and how they could reduce the risk of it happening again. For example, one person tried to stand up without assistance and were at risk of falls. Staff observed the person discretely to ensure support was provided when they stand up.

There were systems in place to deal with unforeseen emergencies. Emergency evacuation plans were in place

Good

Is the service safe?

for each person with clear information about how much support people needed and what action staff should take. Staff were aware of the emergency evacuation plans and felt they could follow them. Staff told us a senior member of staff was always on call and they were confident that people would be able to support people if there was an emergency.

Requires improvement

Is the service effective?

Our findings

People said the staff looked after them and understood their needs. One person told us, “They look after us very well, they know how much support I need and how to do it.” Relatives told us staff had the skills to look after people. One relative said, “Everyone is very well cared for.” People said the food was very good. One person told us, “There is a choice for each meal, we can have cooked breakfast if we want it.” Relatives said their family members liked the food, “They enjoy the meals, which is very good” and, “It smells lovely, makes me feel peckish when I visit.” Staff told us relevant training was provided and they were required to do this. They felt supported to develop their knowledge, “To ensure we understand the support each person needs, because everyone is different, like us.” Despite people sharing positive views, we found that improvements were needed to make sure people were safe at all times.

The registered manager and staff had completed training and had an understanding of the Mental Capacity Act 2005 (MCA). The MCA aims to protect people who lack capacity, and enable them to make decisions or participate in decisions about the support they received. Most of the staff had a good understanding of the MCA, including the nature and types of consent, people’s right to take risks and the necessity to act in people’s best interests when required. Staff said most people living in the home were able to make decisions about all aspect of the support and care provided, but they had a clear understanding that some people were living with dementia. Staff said, “Some people have dementia, and they forget what we have offered and what they have asked for, but they can make decisions and we make sure we offer choices and encourage them to be independent.” “People make decisions about all the support we provide. We are here to make sure they live like they would if they were still at home.” “I think it’s really about protecting people and keeping them safe” and, “It’s all about protecting people if they need it but letting them make decisions for themselves if they can.” One person said, “I can make decisions for myself.” A relative told us, “My relative has trouble with speech but the staff take the time to find out what they need.” Staff asked people if they wanted to go to the lounge on the ground floor, people were offered a range of drinks when they sat down there and staff asked them if they needed anything else before they assisted other people.

Deprivation of Liberty Safeguards (DoLS), which is part of the MCA, is to ensure someone, in this case living in a care home, is deprived of their liberty in a safe and appropriate way. This is only done when people are unable to tell staff about their wishes and need support with aspects of their lives. Decisions about their support is made during best interest meetings and agreed by relatives, health and social care professionals and staff, when there is no other way of safely supporting them. One member of staff told us about the implications of DoLS for the people they were supporting. “This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them.” The registered manager said they had been given conflicting information about DoLS from healthcare professionals, but they were clear about their responsibilities.

In one care plan we found that a mental capacity assessment had been completed and stated the person was unable to make decisions themselves. A request for DoLS authorisation had been made on the basis of this on 9 November 2015, this stated the person was aphasic, that is unable to speak, and therefore unable to communicate verbally. However, we found that although aphasic they had full mental capacity and were able to communicate yes or no to questions posed. This was confirmed by a relative. Staff told us the person was able to tell them what support they needed and made decision about all aspects of the care provided. The registered manager told us further training had been arranged for MCA and DoLS; to ensure they all had a clear understanding of deprivation of liberty and that mental capacity assessments were completed appropriately.

Staff said they had completed induction training when they started working at the home. One staff member told us, “I had a really good induction. I shadowed staff before I worked on my own. It was the best thing, really. I learned so much.” The provider had introduced the Skills for Care Certificate training as part of staff induction. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life.

Staff were satisfied with the training opportunities on offer. One member of staff said, “We get training in all the usual things, like fire safety and manual handling." Another member of staff told us, “Yes, it’s great. If we need training in an area, we will definitely get it.” The training plan

Requires improvement

Is the service effective?

identified that staff had attended relevant training and they were required to attend updates to ensure their skills were appropriate. People were confident that staff understood their needs and, had the skills and experience to look after them. One person said, "They are great. They are so caring." A relative told us, "The improvement in the health of my relative since they came here is remarkable. I can't praise the staff enough."

Staff told us they had regular one to one supervision with the registered manager and they felt this gave them a chance to sit down and talk about anything, and find out if there were areas where they could improve. The supervision records showed staff attended regularly and appraisals took place yearly. Staff said they could talk to their colleagues, including the registered manager, at any time, and they were clear about the disciplinary procedures if the registered manager or their colleagues thought they were not providing the care and support people needed. One member of staff said, "I can say what I want really. It's a good time to talk about training and how I am doing". Another member of staff told us, "I find it a good thing and I can say what I want. But I know I can speak to my manager anytime anyway." All of the staff said the registered manager was very approachable and they were able to speak with them at any time.

People told us the food was very good and staff asked them what they wanted to have for each meal. The cook had a good understanding of people's needs and their likes and dislikes, and staff were aware of each person's preferences. The food was fresh and home cooked. People were chatting with each other and staff as the meals were served; staff asked people what they wanted and assisted people with their meals if required. People chose where they wanted to sit for meals, some people used the dining tables; others preferred to sit in armchairs with small tables in the lounge and some people remained in their rooms.

Staff respected people's choices. Condiments, napkins and juices were provided, and tea and coffee was available throughout the day when people wanted it. People were encouraged to have enough to eat and drink, and if people did not want to eat at the usual times staff said their meals were kept for when they were ready to eat them. Snacks and drinks were available at any time and people said they had enough to eat and drink. One person said, "The food is excellent." Another person said, "I don't like the food at all," although people ate the meals they had chosen. Relatives said their family members were able to have the food they liked and there were always choices. One relative said, "I usually ask what they have had for lunch, they don't remember but always say it was very nice." A relative told us, "My relative has put on weight since coming here so they must be doing something right." People's weights were monitored monthly and recorded in the care plans. Staff said they would notice if people were not eating and drinking as much as usual and would report this to the nurse or registered manager. The registered manager and nurse said it they had any concerns they would set up a food and fluid chart record and contact the person's GP, and they had done this for one person.

People had access to health care professionals and there was evidence of good communication in the management of people's care between the provider and external professionals, such as Speech and Language Therapists, dentists, opticians and chiropodist. We noted advice and guidance given by these professionals was followed and documented. GPs visited the home as required. Appointments and any outcomes were recorded in the care plans which included any changes to the support provided. One person said, "If I need a doctor, they will organise it before I could." A relative told us, "I have complete confidence in the staff to act if necessary and they always keep me informed."

Good

Is the service caring?

Our findings

People told us, “The staff are very kind. I think they are lovely” and, “They are very good. They know what we need and look after us so well.” A relative said, “I come visiting at any time and the staff are always welcoming and friendly. There’s such a caring atmosphere here.” Another relative told us, “There is a very good relationship between relatives and staff. Staff are interested in what the residents want to do” and, “They all look well cared for, staff make sure her hair is brushed and her personal appearance is very good. Residents all look like the staff care about them which is very comforting.” Staff said they provided the care and support people needed.

The home had a calm atmosphere. People were relaxed and comfortable sitting in the lounge area, dining are or their own rooms. The TV was on when people wanted to watch it. We heard people and staff talking about how they were going to spend their day and they discussed the activities people might want to do. Interaction was very relaxed and friendly, we heard laughing and joking as we sat in the lounge, staff had a good understanding of people’s needs. Staff talked to people quietly and respectfully. Some people chose to sit on their own and we observed the care and support to be safe and appropriate. Staff sat near people when they spoke to them; they used their preferred name and waited for a response when they asked if they were comfortable, if they wanted a drink or to do an activity

Communication between people, relatives and staff was excellent; staff consistently took care to ask permission before intervening or assisting. Staff said they always asked people if they needed assistance, they never made decisions for them and it was clear that staff respected people’s choices. People, where possible, were enabled to express their needs and receive appropriate care. It was evident throughout our observations that staff had the skills and experience to manage situations as they arose and meant that the care given was of a consistently high standard.

Staff respected people’s privacy and dignity, and they regarded information about them as confidential. One member of staff said, “We do not talk about people’s needs in front of other people and if relatives ask we refer them to the nurse or the manager.” We saw screens were used in communal areas when a person required attention, for example, when hoists were being used. Staff asked people if they needed assistance with personal care in a quiet and respectful way, and discretely asked if they needed assistance to use the bathroom. One person was asked if she wanted to return to her room for the flu injection from the district nurse. She said she wanted to remain in the lounge and a screen was used to ensure her privacy. Staff knocked on people’s bedroom doors before opening them and asked if they could enter. One person told us, “Yes, the staff always knock before they come in my room”. A relative said, “I think staff are quite sensitive about this. They will make sure people have their privacy.”

People said they were involved in making decisions about all aspects of the care they received. One person said, “I don’t think they would do anything without my permission.” People said they knew they had a care plan, although they did not really think they needed to be involved in writing it. People told us, “My relative talks to the staff about things like that. I don’t need to, I have everything I need” and, “My daughter and family deal with that. I haven’t seen it but I know they have.” Relatives said, “The manager is good like that. They don’t make decisions without asking us first” and, “The staff always let us know what is happening and if anything changes.”

Staff had not yet attended equality and diversity training, but they had a good understanding of the issues and their implications for the people they were supporting. People’s preferences were recorded in the care plans. There was information about each person’s life and these had been compiled with people and their families where possible. They contained information that staff could use to help build relationships, such as people’s previous occupations and hobbies. Staff said they had read the care plans and felt the information enabled them to provide support based on people’s preferences so that they could meet people’s diverse needs. One member of staff told us, “I think we need to make sure we understand each person’s back ground to make sure the care suits them.” They told us each person was different, they had their own personality and made their own choices, some liked music or watching TV, while others liked to sit quietly in their rooms, and they enabled people to do this as much as possible.

Good

Is the service caring?

End of life care had been discussed with some people and their relatives where appropriate and, this had been recorded in the care plans. Do not resuscitate forms had been discussed with healthcare professionals and completed by people or their relatives.

The registered manager said advocates were available to support people if they had no relatives or representatives and information was available in the office. They said this service was not needed at the time of the inspection.

Good

Is the service responsive?

Our findings

People were very positive about the care the staff provided and they said there were a number of activities they could take part in if they wanted to. One person said, "I like to make things and I am good at knitting, several people are waiting for me to finish things for them." Relatives felt the activities were good and kept people interested and active, if they wanted to be. One relative said, "The staff are always doing something with them and they spend time with everyone." People said staff always asked them what support and care they wanted. One person said, "We are always asked if we need any support and when we are ready to get up." Relatives said they had been involved in discussions about people's changing needs. One relative told us, "My father needs support to stand up and walk, he is unable to do this on his own so I know staff have recognised this and look after him." One member of staff said, "We look at the whole person when we plan and provide care and support, a holistic approach and this includes all aspects of their care."

People's needs had been assessed before they moved into the home. The registered manager said if people wanted to move into the home their needs were assessed, to ensure they could provide the care and support they needed. One person said, "My relatives found the home for me, they visited it and thought it was just what I needed, and they were right." Relatives said the registered manager had assessed their family member and one relative said they had been pleased there was a room available when they needed it. The information from the assessment was used as the basis of the care plans.

We looked at four care plans and daily records for these people. They were legible, person centred and up to date. They contained information about people's care needs, for example, in the management of the risks associated with environmental hazards and medicines management. The care plans also contained detailed information about personal histories and likes and dislikes. People's choices and preferences were also documented. Care planning and individual risk assessments were reviewed monthly and some contained detailed and relevant information if required. For example, one person's care plan described a high level of risk concerning the development of pressure sores. We noted action had been taken to minimise this risk through the use of equipment, regular assessment of dietary need and monitoring of the person's skin integrity. There was further information to assess and monitor the risk, for example the use of the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. The daily records showed that these were taken into account when people received care, for example, in their choices of food and drink.

Staff explained clearly people's support needs and what action they took if people's needs changed. One member of staff said, "Residents are like us really they have good and bad days, sometimes they are not in the mood to get up and that is fine. But we know if their needs have really changed and we talk to them about this if we can and, then the nurse or the manager." Staff told us the nurse and registered manager acted on any information they received and they said they could talk to them about people's needs, and make suggestions if they thought someone needed more or less support. Staff said they recorded the care and support in the daily records and thought these were a good way of showing how people had spent their day. However, we found they did not accurately reflect the care we saw staff provided, which meant there were no written records to evidence people received the support they needed.

People and their relatives felt their care was personalised to meet their needs. One person told us, "Yes, I suppose so. They are a jolly bunch." A relative said, "The manager and staff are wonderful. They treat people like family".

People and relatives told us social, educational and occupational opportunities were provided. One person said, "I think there's stuff going on but I don't really want to join in." A relative told us, "I think that's improved a lot recently." The activity co-ordinator told us what was on offer at the home. There were two part-time activity co-ordinators and activities were offered in either group settings or one-to-one, depending on the person's preference. There were regular visiting entertainers, inter-generational work with local schools and contact with local businesses who provided input, for example in flower arranging. The registered manager said they had introduced changes to ensure activities were provided. Staff were asked to pay for meals provided at the home and

Good

Is the service responsive?

this money was used to arrange and pay for activities and external entertainment. Staff said they thought this had been, “A really good idea” and, were pleased to be able to help people take part in activities.

A complaints procedure was in place; a copy was displayed on the notice board near the entrance to the home, and given to people and their relatives. Staff told us they rarely had any complaints, and the registered manager kept a record of complaints and the action taken to investigate them. The complaints folder contained details of the complaints procedure and the action staff should take if a concern is raised. People told us they did not have anything to complain about, and relatives said they had no concerns and if they did they would talk to the registered manager or the staff.

Requires improvement

Is the service well-led?

Our findings

From our discussions with people, relatives, staff and the registered manager, and our observations, we found the culture at the home was open and relaxed. Care and support focused on providing the support people living at Barons Down needed and wanted. People said the registered manager was always available and they could talk to them at any time. Relatives said the management of the home was very good, they could talk to the registered manager when they needed to and staff were always very helpful. One relative said, "The home is very well managed. People are safe and supported to make decisions about the care and support they have."

People, and their relatives if appropriate, told us they had been and continued to be involved in decisions about the care and support they received and, they were aware of their care plans. Staff told us people were always involved in decisions about the care and support provided, but this was not included in the care plans. We found there was no evidence that people and their representatives, if appropriate, had regular and formal involvement in developing their care plans. The records did not show that people's views had been sought, which meant people may not have had the opportunity to alter their care plan if they felt it had not reflected their care needs accurately. The registered manager was aware of this and had set up a system for nurses to take responsibility for reviewing and updating a number of care plans. They said this would offer nurses an opportunity to improve their record keeping and would evidence people's involvement in the care planning process. Record keeping training had been arranged to support staff and they had attended this. The registered manager said the training would be repeated and staff meetings would be used to discuss care plans and daily records, to ensure they evidenced people's involvement and reflected the support and care provided.

The registered manager had an understanding of 'duty of candour'; but staff were not aware of this and its relevance to the care and support of people living in the home. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with people they support and other 'relevant persons' (people acting lawfully on their behalf) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to the person in relation to the incident. The registered manager said not all staff had attended the relevant training and further training was planned to ensure all staff had a clear understanding of being, "open and transparent with people and their representatives."

The management team had changed since the last inspection. A senior nurse had taken on the role of manager and had registered with CQC as the registered manager. Staff said the home was well-led. One member of staff told us, "Yes, the manager is very good. Things are better than they used to be." Another member of staff said, "The manager really knows what they are doing. I think things have improved a lot." Staff said there were clear lines of accountability. They were aware of their own responsibilities and the role of their colleague's on each shift. Staff told us they worked well together as a team and there were systems in place to ensure staff provided the support and care people needed and wanted.

A system of quality assurance and monitoring was in place. The registered manager checked and analysed incidents, accidents and complaints. There were systems to audit care plans, including mental capacity assessments and these had identified where improvements were needed. Satisfaction surveys for people living at the home, their relatives and healthcare professionals, as well as staff surveys were used to collect feedback about the support and care provided and, the results were made available to people, relatives and staff. The responses included, 'Many thanks for all your hard work' from a doctor and 'I think the home is excellent and make me feel very confident in the care my mum receives', from a relative. Staff questionnaires were also very positive, and enabled them to suggest improvements for training times. People, relatives and staff said they were asked to put forward suggestions about improving the support provided and felt involved in developing the service.

The registered manager told us about their philosophy of care and said they had developed a system that was based on meeting the needs of each person, providing the care and support they needed in a way that they wanted it. Staff said this was a holistic approach to care. We observed if

Requires improvement

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people wanted to do an activity they could, there were no specific times for people getting up or going to bed, and meal times to a certain extent were flexible, so that people could have their meal when they wanted to. Staff provided care based on people's choices and preferences and involved them in decisions about all aspects of the support they received. A resident's charter stated that people were individuals, with each requiring different care and support and, this was based on staff supporting people to lead a full and independent life.

Staff said the monthly staff meetings were very good. They meant that management kept staff up to date with any changes and pointed out if things were not being done or where improvements were needed. One member of staff told us, "We can talk about anything really. The manager updates us if anything has changed and we can ask questions and point out things that we think are needed. It works very well usually." We looked at the minutes from the last meetings for care staff and nurses and found there had been discussions about training, new employees and holidays.

Residents' meetings were held regularly and, the views of people and their relatives were addressed and changes made where appropriate. For example, a relative was concerned that the call bell system was very loud and may have affected people's opportunity to relax throughout the day. The minutes stated that the volume was turned down after 8pm, but they would look at repositioning the bell so that its affect was minimal. People said they could attend these if they wanted to, but some preferred not to. One person said they were, "A good opportunity to sit down and talk about things that are going on in the home" and, "The minutes are around for us to read if we want to." The minutes from the meeting showed that people and relatives had been involved in discussions about activities, refurbishment of the home, staffing, the Christmas party and the involvement of local churches for carol singing.