Barchester Healthcare Homes Limited

Mount Tryon

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Mount Tryon is registered to provide accommodation and personal and nursing care for up to 59 people. Care is provided to older people, people with a physical disability, people with dementia and younger adults. There is a dementia care unit situated at first floor level and has two areas, Memory Lane and Penny Lane. People needing more general nursing or personal care live on the ground floor. Mount Tryon is part of the Barchester group of homes.

The inspection took place on 20 and 22 January 2015 and was unannounced. Mount Tryon was last inspected by the Care Quality Commission (CQC) on 05 June 2014 when the provider met the regulations we inspected against.

A registered manager was employed at Mount Tryon. It is a condition of the home's registration that a registered manager is employed at 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.

Prior to this inspection on 20 and 22 January 2015 we had received some concerns relating to the way people's needs were met. We had been told that staff did not have the skills necessary to meet the needs of people living with dementia. Also, at times there were not enough staff available on the dementia care unit to meet people's needs. We had asked the registered manager to investigate these matters and they had responded quickly and appropriately. During this inspection we found some evidence to support these concerns.

Whilst there were examples of good practice that kept people safe we found some practices that put people at risk of harm. For example, not all staff followed appropriate infection control measures which placed people at risk of cross infection. People at risk of choking were placed at greater risk because staff were not consistently following guidelines on how drinks were prepared.

Some visitors felt that staffing levels were low, whilst we found no evidence to support this in staff rotas, it was difficult to find staff at times during the day. We also found staff spent little time engaging with people unless they were carrying out a task. People spent long periods of time in the same position without contact with staff.

Not all staff had received training in caring for people with dementia, but staff were patient and kind repeating information and requests slowly in order to give people a chance to process the information. Not all staff had received specific training regarding protecting people's human and legal rights. However, we heard staff asking people for their consent before receiving personal care. Where people did not have the capacity to make significant decisions such as medical treatment, meetings were held to determine if the treatment would be in the person's best interest.

Some aspects of the environment needed improvement to make it more suitable for people living with dementia. For example, some signage was confusing and there was no use of symbols or colour-coding to help people find their way around the home.

Improvements were needed to the way people's privacy and dignity was maintained. People wandered into other people's rooms and often removed items.

People's records were not reviewed appropriately to make sure the information was up to date and appropriate and people or their representatives were not always involved in reviews.

Whilst there were many systems to review the quality of care for people, they were not always effective or efficient at identifying the areas of concern were found during this inspection.

People's needs were met by staff who knew them well. They received care that met their healthcare needs from staff and visiting professionals. One visitor we spoke with told us about how staff at the home "always go that extra mile" with their relative.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not completely safe

People's risks were not being managed well and people's personal possessions were not kept safe. People were not fully protected from the risks of choking and cross infection because of inconstant practices and inconsistent records.

There were occasions when people were left unsupervised which put them at risk

People's medicines were managed appropriately.

People were protected from the risks of abuse because staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not completely effective.

People did not always benefit from staff that were trained and knowledgeable in how to care and support them.

The environment needed improvement to make it more suitable for people living with dementia.

People were supported to access a range of healthcare services.

People were supported to maintain a balanced diet.

People were asked for their consent before staff provided personal care.

People were supported by staff who displayed a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards act, which had been put into practice.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected and many interactions between people and staff were purely task orientated.

People had limited involvement in planning their care.

People's needs were met by staff who knew them well.

Is the service responsive?

Requires Improvement

The service was not completely responsive

People who were more independent did not always receive the same levels of attention as people with higher care needs.

Summary of findings

People's care plans were not reviewed regularly, so staff did not always have up to date information about their needs.

People had limited opportunities for spontaneous interactions with staff or other people.

Where possible people were able to decide how they spent their day.

Is the service well-led?

The service was well not completely well led

Quality assurance systems and monitoring practices did not always identify areas that required improvement.

Not all visitors felt they were listened to.

Meetings for people and staff were held regularly and suggestions acted on.

Requires Improvement

Mount Tryon

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The inspection took place on 20 and 22 January 2015 and was unannounced.

The inspection team consisted of three Adult Social Care (ASC) inspectors, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had particular expertise in the field of dementia care.

Before the inspection visit we gathered and reviewed information we held about the provider. This included information from previous inspections, notifications (about events and incidents in the home) sent to us by the provider and the Provider Information Return (PIR). The PIR asked the provider to tell us key information about the service, what the service does well and how the provider planned to improve the service. We looked at the document 'Choosing a dementia care home' produced by the Barchester group to help people identify the 'best dementia care'. We also spoke with two health and social care professionals and one person from the local authority who had commissioned placements for people living at the home.

During the inspection we spoke with 14 people using the service, ten visitors and 16 staff including the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We also looked at the care files for six people living at the home, three staff files and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found inconsistencies in the way risks were managed. We saw examples of good practice that kept people safe and some practices that put people at risk of harm. Improvements were also needed to infection control procedures.

Risks to people were not always well managed. For example, one person had clear recorded guidance on their care plan on how to help minimise the risk of them choking. However, during the inspection we saw they had been given a drink of a normal thickness. We also saw that another person had been given a drink that had had thickener put into it, but the staff had not ensured the drink was stirred thoroughly and the drink separated with normal thickness liquid at the top and a very thick jelly like drink at the bottom. This not only increased the risk of the person choking, but would not have been pleasant to drink. We spoke with this member of staff who then stirred the drink, and said a different type of thickener was now being used and they hadn't realised it needed more stirring. Other staff told us about another person whose fluids needed to be thickened and we saw this happened correctly. This told us that some staff understood what actions needed to be taken to help keep people safe from choking but that this was not consistent across the staff group. We discussed these matters with the registered manager who agreed to follow up with staff to ensure they all followed the recorded guidance.

While staff did not always follow the information in the risk assessment records regarding choking, other risk assessments contained good details of how to reduce risks. For example, risks relating to nutrition, pressure areas and behaviours that could be difficult for staff to manage had been assessed. Where risks had been identified measures were in place to reduce risks. For example, where people had been identified as being at risk from pressure sores, pressure relieving equipment was being used. Equipment in use at the home was well maintained and serviced in line with the manufacturer's instructions.

Where people had been highlighted as being at risk of poor nutrition or hydration, a food or fluid chart was available to use. However, fluid charts were not fully completed, and had not been completed for long periods during the day. Not all charts had been completed overnight or amounts totalled for a 24 hour period. This meant that it was not possible to check what fluids the person had taken in over that period and the person may have been at risk of dehydration.

Several visitors told us personal items of their relative's had gone missing. One visitor said "jewellery and all manner of items have gone missing and never found. Some are small like hair brushes etc. Occasionally items also appear". The registered manager told us that when staff saw people with items that were not their own, the items were returned to the owners. Where items could not be found they had investigated and in some cases replaced the items.

There were some concerns expressed by two relatives and one person living at the home about the level of staffing. The two relatives visited most days and said there were times when there were insufficient staff, for example at weekends. Staffing rotas that we saw showed no drop in staffing levels at weekends. However, there were times during the day when it was difficult to find staff. For example, when we first arrived on the dementia unit we could not initially find any care staff. People who were already up had been left unsupervised for a short period while other people were still being assisted to get up. It was unclear whether this was due to low staffing levels or the way staff were deployed during this time. At other times staff were busy but people's personal care needs were met, call bells were answered promptly and people received food and fluids regularly. Staffing levels did not provide for one to one supervision for everyone that walked freely around the unit. This meant there were times when staff could not prevent people entering other people's rooms.

We saw that two people who lived at the home walked around all the time when we were on the dementia care unit, including going in and out of other people's rooms. We discussed this issue with the registered manager. They told us it was difficult to manage where people wished to stay in their rooms and have their doors open. They had begun to address this by making changes to the whole dementia care area. One part would be for people with lower care needs and the other for people with higher care needs who needed more supervision. The use of assistive technology such as sensor beams to monitor people's movements was also being looked into. We discussed locks on bedroom doors and how this might help minimise

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Is the service safe?

people entering other people's rooms. Before the end of inspection the registered manager had been authorised by Barchester to find suitable locks to be fitted to bedroom doors.

Staff told us there were enough staff on duty to support people. However, one commented on the large amount of paperwork that kept them away from caring for people directly. One told us "We are not perfect and we are all learning all our lives about how to care for people". There appeared to be plenty of staff available during the time of our observations in the dementia care lounge. The atmosphere was relaxed and unhurried, with staff having time to attend to people's needs. The registered manager told us that staffing levels were based on the level of people's needs and the number of people living at the service.

People were not protected from the risks of cross infection. A member of staff was mopping the floor of a bedroom that had faeces on it. The staff member was wearing a cotton, domestic style apron and no protective gloves. They then showed us in to the office without washing their hands or removing their apron. After this they went to the kitchenette area and prepared drinks for people without removing their apron. We discussed this with the registered manager who agreed to raise the matter with the member of staff.

We saw other staff wearing disposable aprons and gloves and washing their hands appropriately. A new carpet cleaning system had been introduced. This used a substance that absorbed moisture and smells with it. A new odour system had been fitted to some areas of the home to improve the flow of air and reduce smells. Generally the home was clean and well maintained, but we noticed three bedrooms where there was a persistent malodour, which we told the registered manager about.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of abuse because staff had the knowledge of how to identify and report suspicions of abuse. Staff were aware of different types of abuse and how to recognise any changes in people's behaviour that may indicate abuse was occurring. Staff told us they would feel free to go to the registered manager or deputy manager with any concerns or worries about abuse or the care they witnessed. Staff knew the home's safeguarding policy was available in the nurses' stations for them to access if they wanted to check on anything. One told us "I have worked here for two and half years and have never had to report anything. But I would if I needed to". Another staff member told us "There is always room for improvement ….but I would never question people's motivation or philosophy here". One person confirmed they felt safe because "all staff are so friendly".

People were protected by robust recruitment procedures. The provider had a policy which ensured all employees and volunteers were subject to the necessary checks which determined that they were suitable to work with vulnerable people.

People were protected from the risks of unsafe medicine administration. All medicines had been stored safely and appropriately. Medicines had been stored in a locked medicines trolley which was bolted to a wall in the clinical room when not in use. Medicines that required refrigeration were being stored appropriately and fridge temperatures were recorded appropriately. A list of signatures of staff who administered medicines was kept so that in case of errors it was possible to identify who administered or missed the dose. Information was available on people's allergies and any administrative difficulties, for example, any swallowing difficulties. Charts used to record the application of creams had been completed. Medicines were administered safely. There was an audit trail of medicines received and administered for each person. Hand written entries on Medicine Administration Record (MAR) charts had been double signed which meant a double check had been made to ensure the correct information had been recorded.

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Is the service effective?

Our findings

Improvements were needed to some areas of the home to ensure it met the needs of people living with dementia. Improvements were needed to the way mealtimes were managed as not everyone had a positive experience.

The registered provider had given some thought to providing a suitable environment for people living with dementia, but further improvements were needed. On the Penny Lane area of the dementia unit the environment had things of interest and texture on the walls and shelves. On the Memory Lane there were few such objects on show. There was no use of symbols or colour-coding to enable people find their way around. Bedroom doors had people's names on them but only a few had pictures that might enable people to find their own room. Rooms on the dementia unit were very bare compared to rooms downstairs. A few had a limited number of personal possessions. The registered manager told us that this was because some people's rooms needed to be easily cleaned.

There were some confusing aspects to the dementia unit environment. Signage was confusing, immediately we walked from the Memory Lane area to the Penny Lane area there was a sign saying "Memory Lane". In the kitchenette area a menu was displayed that related to the previous Saturday. A notice board in a corridor displayed the date, pictorially and events taking place in the morning and afternoon also invitations to "Let's talk" sessions and "arts and crafts". However, it was not clear whether these were to take place in the Penny Lane or Memory Lane area.

We completed the King's Fund environmental assessment tool 'Is your care home dementia friendly?' The Kings Fund is an organisation that provides advice on health and social care matters. We found that improvements could be made. For example, the level of lighting could not be adjusted, toilet doors were not 'painted in a single distinctive colour with clear signage' and there was no independent access to outdoor space for people. However, toilet seats were of a different colour as suggested by the King's Fund tool.

At lunch time in the dementia care unit two people were being supported to eat lunch at the same table. One person was supported by staff sitting next to them, making good eye contact end engaging with the person, making the mealtime an enjoyable experience. However, we saw another person supported by staff standing next to them. In this instance there was much less engagement or eye contact between the two people. This person's meal was finished more quickly and the staff went off to assist someone else. This inconsistency meant that two people had a very different experience of the mealtime. During lunchtime in the main dining room people were served food which was hot, nutritious and appetising. There was waitress service and a friendly atmosphere with relatives as well as staff assisting those who needed help. Adapted cutlery and crockery was available to help people eat independently.

Many people were not offered a choice of lunch in the dementia unit, and staff chose the meal for them. This was because some people needed to have a softer or fork mashable diet to eat independently. One person required a low sugar diet and we heard staff consult with the nurse in charge to check the person's blood sugar levels before making a decision about the dessert the person was able to enjoy.

People received sufficient amounts of food and drink. A choice of drinks and snacks were offered at regular intervals. Three visitors said that the food was really good and had witnessed people being encouraged to eat and offered alternatives. One person had two breakfasts, the first being porridge and the second a full cooked breakfast around half an hour later. The person told us "I have a good appetite". A 'nutrition report' was produced monthly for each person. This highlighted anyone who was at risk of malnutrition and plans were put in place to minimise the risks.

One person's relative told us they thought their relative did not receive adequate amounts of fluid and that fluid record charts were not kept for them. They said 'I worry that [relative] doesn't get enough fluids but when asked if [relative] suffered from urine infections they said "actually they have far fewer since they have lived here". This was discussed with the registered manager and senior staff. We were told charts were only completed when concerns had been identified, and there were no concerns about this person's intake. They told us this was because the person had no urinary infections or dry skin problems.

One visitor told us "I'm confident in the staff but they need a lot more training……sometimes [relative] can be angry but they don't tell him what they are going to do when they come into his room". A new member of staff had not received dementia care training but had training in dealing

Is the service effective?

non-confrontationally with behaviour which could be challenging. They also understood the Barchester values of promoting individuality and personalisation. The deputy manager for the service was responsible for providing much of the training to staff. They told us that Barchester were implementing dementia care training for all staff which was due to start at the service soon. However, we saw staff had the skills to meet people's dementia care needs. Staff were patient and kind repeating information and requests slowly in order to give people a chance to process the information.

The deputy manager used a training matrix to identify what training staff had received and when updates were needed. They told us this helped them ensure staff had the training they needed. Training was provided to staff in a variety of formats, including e-learning and face to face sessions. Staff had received training in a variety of subjects including, moving and handling, health and safety and safeguarding vulnerable adults.

New staff received a comprehensive induction before they worked with people unsupervised. Staff told us they received supervision from one of the registered nurses, which was regular and supportive for them. They described supervision as a time when they could talk in private about anything that was upsetting them in their work, plan training and receive feedback on their performance.

None of the staff we spoke with had undertaken Mental Capacity Act 2005 (MCA) training recently. One told us it was "On the cards soon" and that it had been talked about in the dementia training they had received. Staff understood the principles of the MCA and that people should always consent to their care. They told us how they would keep offering care if it was refused initially.

Staff asked for people's consent to having their blood and temperature taken. Staff were patient, kind and understanding in their approach. Throughout our inspection we heard choices being offered to people. For example, we heard staff offering one person several different types of biscuits. The person chose one which was wrapped and refused an offer of help to unwrap it. After several unsuccessful attempts the staff member suggested they start to unwrap the biscuit and the person finish it. The person accepted this help and eventually enjoyed their biscuit. This showed us that staff respected the person's independence, but was on hand to help when required. One person told us "It's brilliant…I choose my own clothes and get up when I like".

The MCA provides a statutory framework for acting and making decisions on behalf of people who lack the mental capacity to do so for themselves. It introduced a number of laws to protect these individuals and ensure that they are given every chance to make decisions for themselves. The deprivation of liberty safeguards provide legal protection for people who are, or may become, deprived of their liberty in a care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interests.

There has been a recent change to the interpretation of the deprivation of liberty safeguards and the registered manager told us they had made the appropriate applications to the local authority in order to comply with the changes.

Where staff thought people may not be able to make significant decisions for themselves an assessment of the person's capacity to make the decision had been undertaken. If the person was assessed as not having the capacity to make the decision, other people were involved to determine what decision would be in the person's best interest. This procedure had been followed where it had been decided that people needed to take specific medicines and some people had their medicines administered without their knowledge. All other alternatives had been tried and it was decided it was in the person's best interest to receive their medicine. The decision making process had involved the person's GPs, family members and staff at the service.

People's care plans showed evidence that their health care needs were met by a range of visiting health care professionals, including GPs, speech and language therapists and chiropodists. People's day to day health care needs were met by nursing staff employed by the service.

Requires Improvement

Is the service caring?

Our findings

Improvements were needed to the way people's privacy and dignity were maintained. People or their representatives were not routinely involved in planning people's care. Interaction between people and staff was mostly task related.

People's privacy and dignity was not always respected. Prior to the inspection we had received concerns about people going into other people's bedrooms and removing items of significance to them. We saw that people did go into other people's bedrooms, the doors of which were open for much of the day. We followed one person who spent much of their time walking around the unit, picking up and moving items of interest to them. We saw one person enter the room of a person who was in bed. We saw them enter the person's en-suite bathroom and then leave without saying anything to the person in the room. We asked them if this bothered or upset them. They told us "Sometimes they do, they are in and out. People here don't bother me – it's a laugh sometimes". One person told us "People frighten me if they walk about quickly" and looked worried when people came close to them. For some people it would not have been possible to preserve their privacy without shutting the door to their room which would have potentially isolated them. We discussed this with the manager who was rearranging the units and this meant some people moving rooms. People and their representatives had been consulted about the moves. Staff used measures to try to prevent people entering other people's rooms. Items that provided comfort for people were found for them and staff reassured people in a calm manner. This meant that while staff was around to distract and engage people they were not always able to prevent people entering other people's rooms.

There was some evidence that people and their representatives were involved in planning their care. For example, people's care plans recorded that they or their representatives had attended review meetings and agreed with the plans to care for them. However, some visitors told us they had limited involvement in this area and would like more. We saw that the service's quality assurance processes had highlighted the issue of lack of people's involvement in planning their care. The registered manager had plans to ensure all relatives were invited to all future reviews.

We spent over four hours observing the care that was delivered to people over a morning, lunchtime and afternoon period in one of the dementia units. For around one and a half hours we recorded all the interactions we saw using the SOFI tool. For much of this period people were engaged with activities and tasks such as eating. Staff interacted with people well, and that there were very few interactions that had a negative impact upon people. However, we also identified that around half of the interactions were task based or giving factual information to people, such as "It is lunchtime now". This told us that staff were missing communication opportunities to engage better with people with dementia in ways that supported the person's individuality or wellbeing. This was also in contradiction to the Barchester document 'Choosing a dementia care home', that suggested people looking for a dementia care home should, 'consider how people are being individually occupied'. It goes on further to state 'A care home that knows the importance of the word occupy will demonstrate that they know how to help individuals living with dementia to feel busy, useful, occupied and successful'.

One person told us they would not call the staff kind and said "they don't really care about us, want to look after us old things". The interactions between staff and people were mostly positive. However, the interactions between one staff and one person at lunch time was not positive. Staff appeared caring and concerned for the people in their care and demonstrated patience and understanding. Staff responded to people kindly, bent down or kneeled to ensure they could make eye contact with those in wheelchairs or who were seated. Staff knew people and their needs well and spoke with them affectionately and with care. They used touch and hand-holding to provide reassurance and were kind in their interactions.

One visitor told us "I'm happy [relative] is safe and well-fed and all the girls are very kind'. Another said "I visited all the homes in the area and this outshone the others…I thought [relative] would be comfortable and happy here and without a doubt it has lived up to my expectations".

We spoke with people in the dementia care unit about their care. We saw that attention had been paid to co-ordinate people's clothing choices and preserve their dignity. We saw people's nails were clean and hair was groomed. One person had had their hair done on the day of the inspection and another person told us they had been supported to

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have a shave that morning "but not a good one", and they laughed and rubbed their chin. When one person returned from the hairdressers they received compliments on their hair from the staff which clearly pleased them.

One visitor told us about how staff at the home "always go that extra mile" with their relative. This included making sure the person was wearing lipstick and well dressed in clothing of their choice. They told us they had been very pleased with their care and showed us photographs of how they had improved since being at the home. Other relatives told us they visited the home every day and were able to feel a part of the care being delivered, for example by helping their relative to eat their evening meal.

Visiting healthcare professionals told us "I have never had any cause for concern about the care provided for the people I have been to see", and "They [staff] are so helpful, nothing is ever a chore for them".

Requires Improvement

Is the service responsive?

Our findings

We found inconsistencies in the way staff responded to people's social care needs. Most activities were organised and there were limited opportunities for social interactions with staff other than the staff employed to provide activities. Improvements were needed to care plans to ensure staff had consistent up to date information about people's needs.

Staff did not spend time engaging with people. Staff spent a lot of time supporting two people who walked around the dementia care unit. This meant those who required less attention remained seated in the lounge for long periods without any staff interaction. We also found a significant number of people lacked independent mobility and a number of people remained in bed all day. Others were seated in the same chair all day, eating their lunch there. One person who remained in their room all day was mildly distressed and repeatedly got up and down from their chair. They spent most of the day alone in their room in silence.

Staff told us that as far as possible their routines were led by the people who lived at the service. They told us that most people were up and dressed by 11:00am, but that some wanted to be up at 7:30am. Some people chose to spend time in the downstairs unit during the day or in the adjacent dementia unit on the first floor. One person enjoyed contact with toys and soft animals which they carried with them throughout the day. Staff told us the person was very 'maternal' and that the dolls and toys gave them comfort. The person's care plan clearly detailed how the toys were important to the person, staff understood this and a staff member told us about how they helped the person to engage with them.

People's care plans contained much useful information for staff. The care plans were very large documents and contained some information that was not relevant, such as out of date moving and transferring assessments. Overall the plans were reviewed on a regular basis, but there were some areas of the plans that had not been reviewed for some time. For example, we found contradictory information about one person's need for laxatives. This showed us that the system for reviewing the whole document was not effective and meant staff may not always have the most up to date information available to them.

Staff told us how they responded to one person when their behaviour indicated they did not consent to receive care. This information was recorded on the person's care plan, but their communication plan stated the person was "unable to communicate any needs or wishes". This meant there was contradictory information recorded on this person's file which could lead to them receiving inconsistent care.

Only three people living on Memory Lane were able to use the toilet on their own. Staff did not know if the other people needed prompts to use the toilet. This may lead to people becoming incontinent because staff had not been reminded.

An activity organiser and a support worker were employed at the service to engage with people. People had been consulted on the type of activities they would like. There was evidence on care plans that people had been able to participate in hobbies such as gardening. A good range of activities was shown on the noticeboards and the activities coordinator told us that activities included regular visits from community members such as an art teacher, and musical entertainers. There were also quizzes and sing-alongs, cooking, shopping and minibus trips available. During the afternoon the activities organiser accompanied individuals on walks around the grounds. We observed an activities session held in the dementia care unit. This was targeted at an appropriate level to engage with and stimulate all of the people who participated. People enjoyed the singing and all joined in.

However, one visitor told us "Quite often activities on the notice boards don't happen which is not good for those who can read and expect them to happen…the activities coordinator loves to talk but often it's TV all the time for people". We saw eight people sat in front of a large TV with the sound muted for a large part of the day. The Barchester document 'Choosing a dementia care home', stated 'a care home that places an increased emphasis on comfort and well-being will have people living in the home who appear relaxed, engaged, looking after each other and involved in the environment – not sitting slumped, sleeping in a circle'.

Relatives and friends could visit at any time. They were able to use a visitors' room where coffee and cakes were available.

One person on the dementia unit told us the staff were kind on the whole and if they had any concerns they would

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Is the service responsive?

speak with their family. A relative we spoke with told us that they had only had three minor issues of concern since their relation had been at the home in the preceding five years. They had found it easy to raise the concerns and said they had been promptly addressed. They said this left them feeling they would have no concerns about raising any issues in future. We spoke with three other visitors who said when concerns were raised to the manager they were heard and responded to. One visitor told us "[registered manager] is obliging and lovely but not always here…the kitchen and laundry are great but the care staff let her down…weekends are poor because different, inexperienced staff are here and I come in and no-one has given [relative] a drink". They said they had put their concerns constantly to staff but still wasn't confident her relative won't get 'overlooked'. They felt they were listened to but there was inconsistency in carrying out their requests.

We saw a file in which the registered manager kept a record of all written complaints, we saw that these had been responded to in a timely manner and the outcomes had been recorded. The registered manager told us that when people raised concerns verbally, they were addressed at the time, and not always recorded. This meant there was no way for the registered manager to identify any trends or similarities in the concerns being raised, and therefore it was not possible to look for the root cause of the concerns.

Requires Improvement

Is the service well-led?

Our findings

There were quality assurance procedures in place for identifying area for improvement, but these were not always followed through in a timely way. Care practices were not thoroughly monitored to identify shortfalls in performance.

All accidents and incidents which occurred in the home had been recorded and analysed to identify patterns that could be used to minimise risks. However, one person's file showed five incidents that involved them being aggressive to other people. Neither CQC nor the local safeguarding team had been notified of all these incidents.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager told us they had contacted the local safeguarding team, but had been told it would not be looked at until there had been over three incidents. The registered manager had not contacted the team after the third incident, but they had sought professional advice on how to manage the person's behavioural needs. The registered manager contacted us following the inspection and told us they had contacted the safeguarding team about the incidents. At the time of the inspection the person was receiving care from one member of staff throughout the day. This had eliminated the aggressive incidents.

There was a variety of quality assurance systems being used. For example, representatives from the registered provider visited the service regularly to undertake an audit of the service. From these visits an action plan was produced and issues identified from the previous visit had been addressed. For example, protocols relating to the administration of medicines had been updated. A monthly 'Quality First' visit was also undertaken by the registered providers. These visits were a self-audit using the areas covered by the Care Quality Commission (CQC) when inspecting services. For example, Safe, Effective, Caring, Responsive and Well- led. However, these visits had not picked up on the issues identified at this inspection. For example, inconsistencies in care plans, the risks to people of choking, environmental aspects, lack of people's involvement in their care plans and not all complaints received being recorded had not been identified.

We also noted that some aspects of the Barchester document 'Choosing a dementia care home' were not being followed. Staff told us they knew the values of Barchester and were happy with their work. However, they were not always following these values in practice. For example, staff did not fully engage with people, mealtimes were not a positive experience for everyone and infection control procedures were not always followed. The registered manager told us that they watched and listened to staff to ensure the Barchester values were embedded in everything they did. They also told us they immediately addressed any concerns with staff if they witnessed poor practice. However, their monitoring practices had not identified the issues that we did during our visit.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they received regular supervision. These sessions were used as an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff told us that there was always a senior manager on call for advice or support at the weekends or out of hours.

The activities co-ordinator told us "I'm absolutely 100% supported by [registered manager]. I've progressed in seven years … I've got NVQ in activities... I attend meetings with the other Barchester co-ordinators. Another member of staff told us the home had "good management – nothing is too much trouble for them". A member of the nursing team told us they understood Barchester's philosophy and 'vision' for the home, which was about respecting Mount Tryon as people's own home and not having too many routines. One staff told us "I always remember this is their home, I am coming to work in someone else's home."

The registered manager and deputy were very open and approachable. The main office was located in a central position which enabled people to speak with them at any time. It also enabled the management team to observe care practices and carry out on-going monitoring. One visitor told us "[registered manager] is extremely pleasant, kind and went out of her way to keep me informed".

Requires Improvement

Is the service well-led?

Meetings were held for people to raise any concerns they may have and to make any suggestions. We saw that a meeting was held on 21 January 2015 when people discussed mealtimes, food, evening events and the possible provision of activities every day of the week. The registered manager told us that previous meetings had raised the issue of communicating with relatives who could not visit regularly. This had led to the purchase of a computer to enable people to email or 'Skype' their relatives on a regular basis. Wi-Fi internet access was also available for people who wished to use their own computers.

We attended a 'stand up' meeting for senior staff that was held each morning. The meeting was used to pass on important information such as changes to people's needs and what activities were planned for the day. Other staff meetings were held on a regular basis to pass on important information and for staff to make suggestions. The registered manager told us that a member of staff had visited another service and had seen that screens were used to protect people's privacy and dignity when they were being helped to move using a hoist. The registered manager was looking to adopt this practice for the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 18 CQC (Registration) Regulations 2009 Notification of other incidents **CQC had not been notified of incidents of abuse. Regulation 18 (2)(e)**

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 **People were not protected from the risks of cross infection. Regulation 12 (2)(h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was no effective process to assess and monitor the quality of service provision. Regulation 17**