Maria Mallaband Limited

Troutbeck Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Troutbeck Care Home took place on 4 October 2017 and was unannounced. At our last inspection in February 2017, we found breaches of legal requirements relating to person centred care, safe care and treatment and good governance and the service was rated 'Requires Improvement.' At this inspection we found sufficient improvements had been made in regards person centred care and good governance so that the service was no longer in breach of legal requirements. However, we found a repeated breach in relation to safe care and treatment, relating to the proper and safe management of medicines

Troutbeck Care Home is situated in Ilkley, West Yorkshire and provides nursing or residential care for up to 54 people. At the time of our inspection there were 28 people living at the home. A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Following the last inspection, we met with the provider and asked them to complete an action plan to show what they would do and by when to improve the key questions of 'is the service safe, effective, caring, responsive and well led' to at least 'good'. At this inspection, we saw steps had been taken to address these questions although the service was still on an improvement pathway and had not yet reached the standards of a 'good' service.

People told us they felt safe living at the service. Staff understood how to keep people safe and had received training in how to recognise and report signs of abuse. Appropriate safeguarding referrals had been as well as incidents and accidents recorded. Risk assessments were in place and plans of care formulated to mitigate risks to their safety.

Staff who administered medicines had received training in the safe administration of medicines and their competency checked. We found some shortfalls in the safe administration, recording and storage of medicines. For example, the room which contained boxed medicines was left open on a number of occasions with the medicines cupboard unlocked.

We looked round the premises and found it reasonably well maintained with equipment serviced and in working order.

Staff were safely recruited and there were sufficient staff deployed to offer safe care. The registered manager told us they would increase the staffing levels as the service's occupancy rose. Training was up to date or booked and regular supervisions took place. The registered manager had not yet commenced appraisals but had plans in place to do so.

The service was acting within the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation

of Liberty Safeguards (DoLS) although a more robust system for recording some best interest decisions such as for covert medicines needed to be put in place and consent forms were not always signed.

People were generally complimentary about the food and a healthy and nutritious diet was provided. People at nutritional risk were referred to the GP or dietician although people's fluid amounts did not always reach the level requested by the GP.

Most staff appeared caring and supportive and there was a positive atmosphere, with people treated with dignity and respect. However, some staff appeared disinterested when interacting or providing support to people. People were supported to maintain independence where possible.

Some people's care records contained good information although improvements were required in others, such as detailing information about how to support some people's moving and handling and medication needs and updating plans with the most relevant information.

Complaints were treated seriously and investigated, with outcomes communicated to all relevant parties. These were analysed with actions put in place to drive service improvements.

A range of activities were on offer and the activities co-ordinator was enthusiastic about their role. Activities were conducted on a group and a one to one basis, according to people's wishes.

Relatives told us the service had improved over the last few months and were complementary about staff and the registered manager. Staff felt supported by the management team and morale was good. Regular meetings were held to discuss concerns, issues and updates with staff, relatives and people living at the home. Annual satisfaction surveys were conducted although none had been sent out since our last inspection.

A range of quality audits were in place to monitor and drive service improvements. These had improved since the last inspection although further improvements were required to help ensure a consistent and high quality service.

During the inspection the registered manager was open and honest and we had confidence they would continue to improve the service.

We found one repeated breach of regulations in regards to the safe administration, recording and storage of medicines. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Documentation, administration and storage of medicines were not always safe.

People told us they felt safe and appropriate safeguarding referrals had been made. Staff had completed safeguarding training and understood how to recognise and report abuse.

Staffing levels were sufficient to keep people safe and staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Training was up to date or booked. Staff told us the training had equipped them with the skills needed to provide safe and effective care.

Consent forms were in place although these were not always signed by the person or their legal representative.

People's nutritional needs were met although improvements needed to be made with regards the completion of food and fluid charts.

Is the service caring?

Requires Improvement

The service was not always caring.

Although some staff engaged positively with people living at the service, other staff appeared disinterested and did not always interact.

Care records were not always kept securely to ensure confidentiality.

Staff respected people's privacy and dignity and encouraged independence where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care records were detailed and up to date although more information was required in others.

Turning charts needed improving to ensure the appropriate information was documented.

Two new activities co-ordinators were in place who were improving the service's activities provision.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some improvements were noted to quality monitoring processes although medicines audits needed to be more robust.

Although a number of improvements had been made to the service, these needed to be shown to be sustained. Some risks remained which needed to be addressed before we could be assured that the service had effective management and leadership.

We received positive feedback from staff, visitors and health care professionals about the registered manager.

Troutbeck Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 October 2017 and was unannounced.

The inspection team comprised three adult social care inspectors 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. On this occasion, the expert by experience had experience in older people and dementia care.

Prior to the inspection, we reviewed notifications received from the service and information from the local safeguarding and commissioning teams. We asked the service to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The service had returned this in a timely manner and we took the information in the PIR into consideration when making our judgements.

We used a variety of methods to gather information about people's experiences. We observed care and support and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with six people that used the service, five relatives and a health care professional. We looked at the way people's medicines were managed, looked in seven people's care records, some in detail and others to check specific information. We viewed other records relating to the management of the service such as maintenance records and meeting notes. We looked at staff files and training records. We looked around the home at a selection of people's bedrooms and the communal areas. We spoke with one registered nurse, two care staff, the cook, the activities co-ordinator, the deputy manager and the registered manager.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Troutbeck Care Home. Comments included, "I feel safe here because there is always someone around, I take my medication at breakfast, lunch and bed time, they wait until I've taken my tablets, if they do leave them they come back to check," and, "There are always staff on hand, if I press the buzzer they always come." A relative commented, "I think I would know if [relative] wasn't happy, I think [relative] is very comfy and secure."

Medicines were administered by nursing staff and advanced care practitioners who had received training in the safe administration of medicines. These staff had their competency assessed to ensure they retained the skills to administer medicines safely.

We observed part of the morning medication round and saw medicines administered carefully and patiently by the nurse on duty. They asked people's consent before administering medicines and waited to ensure people had taken their medicines before moving on. In most cases we saw people received their medicines safely with appropriate records kept which demonstrated this. Medicine Administration Records (MARs) were generally well completed which showed people had received their medicines as prescribed. We reviewed people's monitored dosage systems and saw tablets had been administered consistently as prescribed. However we identified one error made on the morning of the inspection, where the agency nurse working the night shift had not given a person a medicine required to help relieve the symptoms of Parkinson's disease. We informed the deputy manager of this who took action to investigate the incident.

Another person was prescribed a drug to slow the progress of dementia. To be effective it is important that this medicine is consistently taken, and the dose gradually increased over a period of weeks. However although the person had refused most of the initial lower dose, staff had still gradually increased the dose offered over a three week period. This showed a poor understanding of the medicine by staff administering the medicine. During the inspection immediate action was taken to rectify this, with the correct dosage being recommenced.

Where medicines were refused nursing staff told us these medicines were destroyed and records kept to provide an audit trail. However we were unable to match records of the medicines refused with those that had been disposed of meaning there was not a full audit trail of where these medicines had gone.

Where people were prescribed topical medicines such as creams, appropriate records were not kept to show the support staff had provided. MAR charts were not competed for these medicines with staff documenting on daily charts that they had 'applied creams.' However these were inconsistently completed and it was not always clear which creams staff had applied.

In most cases 'as required' protocols were in place instructing staff when to administer these type of medicines. This helped ensure consistent administration.

Stock balances were recorded on the MAR charts, to ensure all medicines were accounted for whilst in use.

Stock checks also took place as part of the auditing process.

Medicines were stored in locked medicines trollies when not in use and some boxed medicines were stored in the clinical room in a lockable cupboard. However, during our inspection we found this room unlocked on several occasions and the cupboards containing boxed medicines also unlocked in the morning. We saw this had been rectified in the afternoon. However, we were concerned medicines storage was not always safe. This room also contained confidential care records of people who lived at the home.

This was a breach of Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the premises. There were sufficient quantities of communal space for people to spend time. This included several lounges, two dining areas and a bar area. The communal areas of the building were very spaced out which made supervision by staff difficult. However we identified no safety concerns with the building, with it being maintained to a good standard. A maintenance worker was employed and a system was in place for staff to report faults so they could be promptly rectified. Checks on systems such as the gas, electric and fire systems took place and equipment such as hoists was subject to regular service. A fire risk assessment had been completed by an external contractor. Fire drills and 'table top exercises' took place although we saw there was a lack of recent fire exercises involving night staff. Key safety features were installed on the building for example radiator guards and valves on the hot water taps to protect against burns. The building was kept in a clean and hygienic state and we identified no odours.

In most cases, safeguarding incidents were recorded and investigated. We identified there had been a number of safeguarding incidents over recent months, 13 since May 2017. Following each incident we saw action had been taken, including investigating and measures put in place to learn from them. For example disciplinary action had been taken where appropriate with staff involved. Staff had received safeguarding training and understood how to keep people safe.

Incidents and accidents were recorded and investigated. These were subject to regular review. We looked at a selection of incident forms and saw appropriate detail was recorded. Clear actions were put in place to learn from incidents. Analysis took place on a monthly basis. This looked for any themes of trends such as the time, location or type of injury occurring.

We found risks to people's health, safety and welfare were identified and actions taken to mitigate the risk. For example, falls risk assessments were in place for people at risk of falls and 24 hour observation logs were completed post falls. However, we saw some conflicting information about one person whose moving and handling assessment stated 'independently mobile with Zimmer frame' and the mobility plan stated 'uses a wheelchair to transfer.' This could lead to staff confusion about which mobility aid to use. We discussed this with the deputy manager and registered manager and they told us they would take actions to address our concerns.

Staffing levels were sufficient to keep people safe although the registered manager was aware of the need to ensure appropriate numbers were maintained if people's needs increased or occupancy increased. A dependency tool was in place. We saw the usual staff levels during the day were for one registered nurse and five care staff and a registered nurse and three care staff at night time. The service had recently employed a registered nurse and two care staff for night time to reduce the number of agency staff used. The registered manager told us they had been given an allowance to recruit 15% above the levels stated by the dependency tool. We saw agency staff were used intermittently, particularly at night, although the same agency staff were deployed for consistency. We looked at the recent staff rotas which confirmed this.

Staff told us, "You can always improve staffing levels. We could do with extra staff. Thursday morning we have the ward round and the hairdresser and one [person] goes to the MS centre," and, "Staffing depends on the needs of the service users. One more staff member would be good. I know [registered manager] is fighting for staff. The staff that are here are doing the job properly."

We looked at four staff files and saw safe recruitment processes had been followed. These included attending an interview, providing references and waiting for a Disclosure and Baring Service (DBS) check to be undertaken before starting work. Additional checks were made on qualified staff's current registration with the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had a good understanding of the DoLS process and had made a number of appropriate applications for people who lacked capacity that they suspected were being deprived of their liberty. All of these were awaiting assessment or reassessment by the supervisory body, with no authorisations in place at the time of the inspection. We saw where previous applications had expired, the registered manager had made re-applications to the supervisory body within appropriate timescales.

The registered manager understood their responsibilities in relation to obtaining information where relatives claimed to have power of attorney. Documentation was copied by the home to provide assurance that relatives had the necessary authorisation to act on people's behalf. This helped reduce the risk of abuse.

One person was receiving a medicine covertly. Care records demonstrated that this had been done as part of a best interest decision involving the GP and pharmacist. However the decision making process could have been made clearer by documenting on the provider's dedicated form for best interest decisions. We saw people's care records contained consent forms in key areas such as use of photography and personal care. However, some of the consent forms were not signed by the person or their legal representative.

Staff training was up to date or booked. We saw staff had received key training such as manual handling, food hygiene, first aid and infection control during induction and this was updated annually. The registered manager told us a big emphasis had been placed on end of life training since the last inspection and we saw training had been carried out and further workshops were planned for the next few weeks. We saw other specific training had been booked such as pressure ulcer prevention and nutrition. Staff told us the training they received was good and had given them the necessary skills to provide safe and effective care. Staff new to care were registered to complete the Care Certificate. This is a government recognised qualification for care staff to gain the required skills for the role.

Supervisions were in place and we saw these covered a range of topics including personal development,

concerns and service specific information such as safeguarding, care records and service improvements. The registered manager told us they were recommencing the annual appraisal system and completed supervisions would feed into these.

We saw staff were kept informed and updated about people's care needs through regular handover and a staff meeting at 11am daily where any concerns about people and their additional needs were discussed. Staff told us this was an effective way of communicating up to date information.

We saw people were involved in making decisions about their meals and were offered a choice of food and drink. At breakfast time people were offered a choice of cereals, porridge, toast with jam or marmalade and hot and cold drinks. The main meal was served at lunchtime with a light menu served in an evening. We tasted the lunch time menu and found this was tasty and well cooked. Snacks were available throughout the day such as fruit tea cakes, crumpets, biscuits and cakes. We saw fruit smoothies with cream and syrup were prepared for people requiring a soft diet. People's daily food intake was recorded in their care records.

People had differing opinions of the food offered and told us they were offered a choice of meals. Comments included, "I don't like the food here, I don't like pasta or food cooked in sauces, I'm into omelettes at the moment; they cook them for me", "The food is not bad, it could be different," and, "I get plenty of drinks I just ask for them."

We spoke with the cook who knew about each person's specific dietary requirements, likes and dislikes which was stored in a file in the kitchen. They explained all meals were freshly cooked and they used cream, butter and cheese to fortify meals and always used full fat milk. The cook said staff ensured they were kept up to date with any changes with people's dietary requirements.

There was a four week rolling meal plan in place. People were given a choice of food at each meal, together with a vegetarian option. If people didn't want the food offered, additional choices such as jacket potato, fish, omelette or sandwiches were offered.

We saw people's nutritional needs were assessed and people's weights were regularly monitored. If people's weights were seen to be reducing, the GP was consulted and dietician referrals made. The completion of food and fluid monitoring charts had improved since the last inspection although some of these needed to be more specific to include how much of the meal had been consumed or how much fluid had been drunk rather than a general summary. We saw the GP recommended an annual daily fluid intake for some people. This was not always achieved despite the guidance stating to encourage more fluids the following day if the achieved amount had not been met that day. We spoke with the registered manager about this who told us this was not always achievable due to the person's condition but agreed staff needed to be clearer on the charts if fluids had been offered and refused.

The home worked closely with the local GP practice who reviewed people's healthcare needs during a weekly ward round. We saw they had input into a range of people's care needs. In addition, people had access to a range of other health professionals for example chiropodists and psychiatric nurses.
When medical practitioners visited a separate log sheet was completed which made relevant information easy to track. We spoke with a health professional who visited the home to provide treatment. They told us, "There is always staff around, notes are always up to date and the staff are caring."

People's needs were assessed and resulting actions taken. For example, assessments were carried out to determine whether people were at risk of developing pressure sores and relevant equipment was put in place.

Requires Improvement

Is the service caring?

Our findings

Most people who lived at the home told us they liked it and staff were kind. Comments included, "I love it here, I've been here for 5 years, the staff are lovely and they come and talk to me", "The staff always explain what they are doing," and, "It's friendly here, we have everything we want." Some people who remained in their rooms told us they sometimes felt isolated due to the lay out of the building.

Most relatives were complimentary about the care at the home and told us they had seen improvements over the last few months. One relative commented, "[Relative] was on end of life care and the staff were dedicated; they cared and nursed [relative] back to health. We are very grateful for the love and 24 hour care [relative] was given." They went on to tell us, "This team are now working well together; the staff were always miserable, now they are smiling."

We saw when staff were providing personal care to people they closed doors to protect people's privacy and dignity. We also saw staff knocking on bedroom doors before entering, giving people time to respond. Through conversations with staff they demonstrated a good knowledge and understanding of people's needs and were able to explain how they maintain an individual's dignity whilst delivering care. This showed staff understood and respected people's rights to privacy and dignity.

We found a mostly positive and caring attitude within the home. During observations of care and support we saw some positive interactions. Staff talked slowly and patiently to people and gave them time to respond. For example, we saw the nurse provided people with friendly support and encouragement to take their medicines during the morning medicine round. We also observed the activity co-ordinator engaged with people in the bar area prior to lunch and chatted with them about a variety of topics. We also saw the domestic staff asked someone's permission for them to vacuum close by prior to commencement. They chatted with the person, asking them if they wanted a drink and bought them a cup of coffee. We saw people congregated in the bar area before lunch and enjoyed a pre-lunch drink.

We saw most staff and the management team interacting appropriately with people and relatives and showing qualities such as compassion. Both staff and the management team comforted people who had become upset. However, on occasions we observed some staff providing care and support without speaking with the person or appearing disinterested with the task they were performing, such as when assisting people with their meals. We reported our findings to the registered manager who told us they were disappointed as this was an area they had worked to improve since the last inspection.

We found the room where the care records were stored to be unlocked on three separate occasions. Care records were stored on open shelves within this room which meant people's confidentiality was not always protected. However, we did not see anyone apart from staff in this room or attempting to access the room. We spoke with the registered manager who told us the room was normally kept locked and agreed to speak with staff about the importance of ensuring this room was kept secure. Following our inspection, the registered manager took action to ensure care records were stored securely within a separate locked area within the service.

Visitors were warmly welcomed by staff and we saw pets were encouraged to come to the service which people enjoyed seeing. Staff clearly knew people well and chatted freely, offering drinks to both the visitor and the person they were visiting.

We saw the service promoted people's independence where possible, such as ensuring appropriate mobility aids were available to assist people to walk around themselves. For example, we saw staff gently encouraged people to mobilise to the dining room, walking with them if they required assistance. We spoke with staff who were able to provide us with examples of how they promoted peoples independence. For example, they would sit people who sometimes required motivation to eat at tables with people who ate independently and then would only assist when required.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. Some people had religious needs, and the service had regular visits from local churches as well as some people's families taking them out to church occasionally. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Requires Improvement

Is the service responsive?

Our findings

We looked around the home and saw people had access to call bells. For example, these had been placed in people's lap or in their bed to assist them to summon assistance. Whilst the layout of the building was not fully conducive to staff supervising and responding quickly to requests, we did not find any evidence of calls for assistance going unanswered.

People's needs were assessed and plans of care drawn up to ensure individual needs were met. The registered manager was clear about the need to recognise when the service was unable to offer the required level of support for people. For example, they were waiting for a service user to be found alternative placement since the service was unable to fulfil their needs.

Some people's care records contained a good level of information and others needed some updating and further explanation of the required care. For example, we saw one person's care plans and risk assessments were up to date and reviewed. There was evidence of formal care plan review which involved the individual and family. There was useful information in place which enabled staff to get to know the person such as '[Person] likes to have a cup of tea before personal care takes place,' and, 'Staff need to give [person] time to express what needs are. Staff are not to finish [person's] sentences as this could lead to [person] becoming frustrated.' This showed a high degree of personalisation in the planning of the person's care.

Another person's care plan stated what time they like to go to bed and the type of drink and snack they liked to eat. This was useful information to show staff how to support the person. However, in another person's review of needs it stated '[Person] has fragile skin and is prone to tears and blisters, care should be taken when moving and handling.' We did not see any information recorded in the moving and handling care plan explaining how the activity should be carried out to prevent damage to the person's skin. Another person's care plan relating to use of antibiotics stated the person would not accept them. However, we could find no information about what staff should do about this or what interventions had been attempted.

We saw a number of people had regular turning charts in place. We saw most of these were better completed than at the previous inspection in February 2017. However, further details such as to what side the person was turned onto to ensure the person was not repositioned in the same way.

One person told us they had received a lack of care to a wound they had on their foot. Although daily records provided some evidence of interventions by nursing staff and the chiropodist, care planning and recording in this area could have been more robust. For example, the person's 'wound care record' had not been updated since 15 August despite the wound still regularly bleeding. In addition, the wound care plan to promote healing had not been updated since 15 August 2017.

We saw the registered manager had introduced a box in the reception area for people to put comments, compliments and complaints in. A formal complaints procedure was also in place and on display in the home. We saw complaints were logged individually with actions taken, outcome and date of conclusion. Where possible, meetings had been held to resolve any issues and outcomes communicated to all involved.

A monthly log was recorded of complaints to identify any trends with actions and analysis. This showed the service took complaints seriously and investigated appropriately. A number of compliments had also been received with positive comments about the service including, 'Extremely grateful and thank all those concerned in [person's] care this weekend,' and, 'superb care and attention to my [relative] over the last few weeks has been greatly appreciated by all the family.' One relative told us, "We would go and see [registered manager] if we had any complaints but not had any so far."

A range of activities was on offer and the service had employed two activities co-ordinators since the last inspection. We spoke with the activities co-ordinator on duty on the day of our inspection and found them enthusiastic about the role and plans they had for the future. We saw they had devised a weekly activities programme, depending on people's wishes and this was on a rolling basis. We saw activities such as chair exercises, sing a-longs, music sessions, games, arts and crafts and birthday activities had taken place, with the activities co-ordinator planning trips out every three weeks. The activities co-ordinator told us they spent time with people individually if they did not want to participate with group activities or were unable to leave their room. We saw this happened on the day of our inspection. One person told us, "It's friendly here, we have everything we want, we have good entertainment, good singers, we have board games, I like doing them, we have quizzes I like them, I like to go in the bar, I like my white wine."

Requires Improvement

Is the service well-led?

Our findings

The registered manager was supported by a new deputy manager who worked a combination of nursing shifts and had supernumerary time allocated. This provided a strong link between nursing and management staff. The deputy manager told us how it allowed them to appreciate as a manager how nursing staff operate and also maintain a close link with people who used the service. Nursing staff were supported by care practitioners who assisted nursing staff in areas such as medication to ensure nursing staff had enough time to complete core nursing duties.

We received positive feedback from staff about the registered manager and morale at the home. Staff told us they felt supported by the registered manager and they felt that could approach them for anything. Comments included, "Morale is better. Everyone is singing from the same hymn sheet and we're getting praise. [Registered manager] is brilliant. Since day one, [registered manager] has always wanted it to work right. She communicates well, for example in handovers", "Staff really do work hard here. If I want anything, all I do is ask [registered manager]. I am enjoying it," and, "They are hardworking individuals. I think care has improved. Feel supported by [registered manager]. Staff attitude is better. Morale is improving; we're generally happier. Lovely staff, lovely building and staff go above and beyond."

Positive feedback from relatives about the management of the service included, "In the last 3-4 months there has been a dramatic change for the better", "I have no grave concerns now, they have come a long way; it was full of problems before but they have got rid of the bad staff now," and, "I would recommend this place, [registered manager] has made a big difference. There is a nice atmosphere here and [relative] loves the singers that come. I think this is a positive place to be."

Systems were in place to assess and monitor the service. The registered manager had a good understanding of the topics we asked them about and provided us with assurance they had a good oversight of most areas of the home. They completed audits and checks in a number of areas to monitor and improve the service. For example audits of the medicine management system were regularly undertaken. We saw whilst these were effective in identifying areas for improvement, these systems could have been made more robust. For example a recent medicine audit on 2 September 2017 had identified that the administration of creams was not robustly documented, although action had not been taken to improve this by the date of inspection, 4 October 2017. Audits took place in other areas including care plans, infection control, equipment, health and safety, safeguarding and dignity. Action plans were produced following these to help drive improvement of the service.

At the previous inspection in February 2017, we were concerned about the support the service was receiving from the provider. At this inspection we found improvements had been made and the service was no longer in breach of regulations relating to good governance. The registered manager explained how they had received enhanced support from senior management in recent months to drive service improvements. This included regular visits from regional management. Audits were undertaken by these staff, with action plans sent to the registered manager to drive the necessary improvement.

Regular staff meetings were held where any concerns and service improvements and changes were discussed. Staff told us these were a forum where they felt able to discuss areas of concern openly.

Meetings were also held with people living at the home and relatives and we saw these had discussed the challenges facing the service following the previous inspection and addressed any concerns expressed. We saw minutes from the recent relative's meeting indicated a positive feeling about the home and improvements made. Annual satisfaction surveys were conducted although none had been sent out since our last inspection.

Staff told us they would recommend Troutbeck as a place to work and most relatives we spoke with said they would now recommend Troutbeck as a place to live.

Whilst we saw a number of improvements had been made to the service, some risks remained which required addressing before we could be assured that the service had effective management and leadership. In addition, improvements would need to be sustained as the service became more occupied. The registered manager agreed the service was on an improvement journey and further action was needed to bring it up to the standard they desired. We found the registered manager and the management team open and honest in their approach and passionate about making a positive difference to the lives of the people who lived at Troutbeck Care Home.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The proper and safe management of medicines; medicines were not always administered, recorded or stored safely or properly. Regulation 12 (1) (2) (g) Health and Social Care Act 2008 (Regulated Activity) Regulations 2014

The enforcement action we took:

Warning notice issued