Barchester Healthcare Homes Limited

Cherry Trees

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 and 22 April 2016 and was unannounced.

Cherry Trees is a nursing home which provides care to older people living with dementia, young adults and people with physical disabilities. Cherry Trees is registered to provide care for up to 81 people. At the time of our inspection there were 55 people living at the home. The home provides nursing and care support across two floors. On the ground floor were younger people with physical disabilities and older people. On the first floor, referred to as 'Memory Lane', staff supported people living with dementia.

There was no registered manager in post. The registered manager left the service in January 2016. 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. The home was being managed by a manager but had not yet submitted their application to become registered with us.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at Cherry Trees and relatives agreed their family members felt safe and protected from abuse or poor practice.

The provider assessed risks to people's health and welfare and wrote care plans that minimised the identified risks. However, some care records and risk assessments required updating to make sure staff provided consistent support that met people's needs.

There were enough staff on duty to meet people's health needs. The manager had recently reviewed people's needs and increased nursing support on both floors. The manager continued to reassess staffing levels to ensure people living at the home, continued to receive a responsive and effective service. The premises were regularly checked to ensure risks to people's safety were minimised.

People's medicines were managed, stored and administered safely in line with GP and pharmacist prescription instructions.

People were cared for by kind and compassionate staff, who knew their individual preferences for care and their likes and dislikes. Staff understood people's needs and abilities and they received updated information at shift handovers to ensure the care they provided, supported people's needs. Staff training had improved and staff felt they had the right skills and knowledge to support people safely and effectively.

Nursing staff and care staff supported and promoted people's choice, but they had limited understanding of mental capacity and their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed consideration had been made if a persons' liberty may be deprived, as the provider had made applications to the local authority.

People were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs, which minimised risks of malnutrition. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health, and when their health needs changed.

People and their representatives felt recent changes at the home were for the better and people received care from a more consistent staff team. People benefitted from this because staff knew people well and were responsive to their individual needs.

Care was planned to meet people's individual needs and abilities and care plans were reviewed although some information required updating to ensure staff had the necessary information to support people as their needs changed. People were supported to pursue their interests and hobbies and live their lives how they wished, and staff supported people to remain as independent as possible.

The quality monitoring system included reviews of people's care plans and checks on medicines management. Actions plans were followed to ensure identified actions were taken. Accidents, incidents and falls were investigated and actions taken to minimise the risks of a re-occurrence. Improvements were required in assessing risks to people and how staffing levels were determined to ensure safe levels of care were maintained to a standard that met people's welfare.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe and staff understood their responsibility to report any observed or suspected abuse. Staff supported people who had been identified at risk and they made sure people's current health needs were supported. Medicines were administered, recorded and stored safely and were given in line with their prescription or GP instruction.

Is the service effective?

Good

The service was effective.

People were involved in making day to day decisions about their care and support needs. Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards. People received support from a staff team that were trained and knowledgeable to meet people's needs. People were offered meals and drinks that met their dietary needs.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate towards people and people felt confident asking staff for support. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence, by encouraging them to make their own decisions.

Is the service responsive?

Good

The service was responsive.

People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People took part in a range of activities that kept them physically and mentally involved. The manager took action to resolve people's concerns and had not received any formal

complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

This home had experienced managerial instability and as a result, people's voice and feedback had not always been listened to or acted upon when people had raised their concerns. Systems that monitored the effectiveness and quality of service were inconsistent and identified actions did not always lead to improvements being made.

Cherry Trees

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.

At the last inspection in September 2014 the provider was compliant with the outcome areas we inspected against. This inspection took place on 21 and 22 April 2016. On 21 April 2016 this inspection was unannounced and consisted of three inspectors, one expert by experience and one specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our specialist advisor was a qualified nurse and specialist in end of life care.

One inspector returned on 22 April 2016 to speak with more people and staff about their experiences of living and working at the home.

Before the inspection visit, the provider completed 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. During the inspection, we gave the provider, manager and staff the opportunity to let us know what they do well, and what they have identified as areas to improve and focus upon.

We reviewed the information we held about the service. We looked at information received from other agencies involved in people's care. We also looked at the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also spoke with the local authority before this inspection but they did not share any information with us that we were not already aware of.

We spent time observing the care people received from staff in the lounge and communal areas of the home. Some people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess whether people's needs were appropriately met and identify if they experienced good

standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with 14 people who lived at Cherry Trees and six visiting relatives. We spoke with two nurses and 11 care staff. We also spoke with the manager, a deputy manager, a divisional clinical lead nurse, an assistant general manager and a regional director. We reviewed 12 people's care plans, medicine records and daily records to see how their care and treatment was planned and delivered. We checked whether staff were trained to deliver care and support appropriate to each person's needs. We reviewed the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at Cherry Trees and said they received the care and support they needed from staff. People said staff made them feel safe and at ease and were not worried when they asked staff for help. One person told us they felt safe because, "Staff go outside with me for my safety." Another person said they felt safe because, "Staff are lovely and they look after me."

Staff knew and understood their responsibilities to keep people safe and protect them from avoidable harm. Staff understood what abuse meant and what to do if they suspected someone was at risk. Comments from staff included, "I would report it straightaway to the nurse or the manager, and I would record what I had seen or heard," and, "I would tell the unit manager or whoever was in charge if I noticed anything unacceptable. I know they would deal with it." Staff had received training in safeguarding adults and told us their training had recently been refreshed to keep their skills and knowledge up to date. The manager was aware of safeguarding procedures and described to us the actions they would take in the event of concerns being raised with them. They said if any staff member had caused a person harm, "I would suspend immediately, call the police and tell the family." They told us, "I would not hesitate to act."

Staff understood how to manage identified risks associated with people's care, for example how to reduce the risks of people developing skin damage. Staff comments included, "If people are unable to move around themselves, we always check their skin to make sure it's not red or sore. If people are in bed we turn them regularly," and "We use equipment to help prevent pressure sores, there are air mattresses on people's beds and pressure relieving cushions for people to sit on." Staff told us if they noticed any changes to people's skin, this was reported to the nurse on duty.

We saw staff supported people with their mobility and encouraged independence where possible. Risk assessments had been completed where people who were at risk of falls and staff we spoke with knew how to manage the risk. For example if a hoist was used to transfer people in and out of bed, they knew what size sling to use to do this safely. Records in care plans supported what staff told us.

Before this inspection visit, we received concerning information from other health care professionals, staff and members of the public about the levels of staffing not meeting people's needs. During this inspection, we found there were enough staff on duty to meet people's needs. The manager told us, dependency tools were used and regularly reviewed, which meant when people's needs changed, staffing levels were reviewed to ensure they continued to meet people's needs. The manager told us this helped them make sure staffing was right, but they also used their own and staff 's experience and knowledge of people and planned to continually keep it under review. Recent increases in staffing numbers meant staff had more time to be more proactive in supporting people to meet their needs.

Because of recent changes in staffing levels, people had mixed opinions although people, relatives and staff agreed staffing had improved. For example, on Memory Lane, relatives thought there were enough staff to keep people safe and meet their personal care needs. A relative told us "Whenever I visit [relative] looks clean and well cared for. There are always staff about, they are busy but they always make time to speak

with you and to let me know how [person] is." Another relative told us, "Oh yes, I think there are enough staff, but they are sometimes short which makes their job even harder. They are really brilliant, nothing is too much trouble."

People living on the ground floor told us if they called for assistance, they did not wait long. People told us they received the help they needed from staff, when they needed it. We heard call bell alarms ringing during our inspection, but found the call alarms were answered and responded to in a timely manner. However, one relative told us if they wanted staff to assist their family member, they could not always find them. They said, "Where are they? I look but can't find anyone." They also said the home was supported by a high number of agency staff which meant, they or their relatives, were not always supported by the same staff. However, people said this had recently improved because the provider had completed a successful recruitment campaign. Staff across both floors confirmed this.

Staff provided us with mixed opinions and said staffing at the home had begun to improve. One staff member said, "The YPD (young physically disabled) unit is for people with more highly dependent needs and they have one to one funding. When we first merged the two units (young physical disabilities and older people) it was hard, but it changes when the number of people changes. We have five staff and two nurses. The nurses are always hands-on." They told us the extra nurse made a difference to the shift. They said, "They (nurses) assist with eating, drinking and personal care." Another staff member explained to us the difficulties they had faced in recent months. They said, "It was awful while the contractors were here. We had walls out, doors out. The disruption, the noise and the smells were very stressful. People were stressed. Relatives were upset. We should have had extra staff on for people, to reassure them." They said, "There was no strategy to manage the impact of the work." Another staff member spoke with us and shared their views which matched other staff we spoke with. They said, "If they added extra care staff to each floor it would make all the difference, at the moment the work is like a conveyor belt just to get through it all." Staff wanted to spend more time with people and felt recent improvements in staffing numbers would provide further opportunities where they could spend more time with people.

Some members of staff told us it was busy, especially mornings, but because morale was improving, the team pulled together to ensure people's needs were met. The manager was confident staffing levels met people's needs and said, "I have put an extra nurse on duty, we have recruited to all posts, we have made a real improvement." They told us they had reduced agency use and were hopeful, this would be reduced further as new staff were recruited to posts. Staff said the additional recruitment had a positive impact and as a result, staff were keen to take on additional shifts. The manager used a monthly dependency tool to calculate people's support levels. They said, "This is a guide, but it tells us what people need and we staff to it." They said it was reviewed monthly, but if people's needs changed, it would be reviewed again to ensure people's changing needs continued to be met.

Records showed staff recorded incidents, accidents and falls in people's daily records and kept an ongoing log for analysis. The provider and manager analysed falls by the person, the location, time, outcome and action taken. The manager they had analysed the falls for March 2016 and found there was no underlying pattern or trend they needed to act on. They told us they would take any action to keep people safe, such as arranging for the GP to visit to check whether an underlying change in the person's health had caused the falls, or ask the GP to consider a medicines review.

People received their medicines safely from trained staff. To minimise potential risk for medicines errors, only nursing staff administered medicines to people. The clinical lead nurse told us they had assessed nursing staff to ensure they remained competent to support people with their medicines. Records seen of recently completed competency assessments confirmed this. Each medicine record had a photo of the

person to confirm their identity which staff said helped ensure they were given to the right person. Medicines delivered in boxes and liquid form were kept in a locked cupboard and liquids were marked with the date the medicine was first opened; to ensure they were administered or disposed of within their expiry date.

We looked at six people's medicines administration records (MAR). These records were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. Staff recorded when medicines were not administered and the reason why not. For example, if a person declined to take them.

All six medication records had PRN (as and when required) medicines prescribed for example as analgesia. MAR records showed these medicines were given, but there was no information that told staff when and why these medicines were to be given, and the safe doses. Both nurses agreed that nurses should be documenting on the back of the PRN form, why PRN drugs were being given. All six were prescribed PRN analgesia, but did not have pain assessments completed. The nurse and deputy manager agreed this made it difficult to establish what pain was experienced, and it made it difficult to look for patterns in episodes of pain, or to monitor effects of analgesia. They assured us improvements would be made but they were confident people received these medicines safely.

Good

Is the service effective?

Our findings

People told us they were pleased with the support they received from staff and they felt staff had the skills and experience to care for them. One person said they felt confident with staff's abilities because in their opinion, "They seem to know what they are doing" and, "Yes, they are very professional and understand dementia and how the illness affects each person." This person also explained staff knew them and others well. They said, "You can tell this from how they interact with people. They are skilled in what they do."

Staff told us they received an induction when they started work at the home, and completed training to meet the needs of people who lived at the home. The induction was linked to the Care Certificate which provides care staff with the fundamental skills they need to provide quality care.

Staff told us they received the training and support they needed to carry out their roles effectively, which included training in dementia awareness. They told us, "We hadn't had any training for a while but we have a new trainer, she is great. I have had an update in safeguarding and infection control recently." Another said, "The training I'd had until recently wasn't great but the new trainer knows her job and the training I've had with her, moving and handling and fire safety has been pretty good." Throughout the day we saw staff competently undertake tasks that demonstrated their knowledge and understanding of the training completed. For example, we saw staff understood people's needs related to their dementia, wore disposable gloves and aprons when providing personal care and used equipment safely to move people who were unable to move independently.

We spoke with the training co-ordinator who told us they were prioritising essential training and arranging training sessions to update all staff. They told us they completed training observations on staff which assured them, staff had the knowledge to support people effectively. If improvements were required, further training was arranged for staff to improve their skills and knowledge. For example, one staff member was observed supporting a person to eat but did not fully understand the risks associated with supporting someone with food. From observed practice, the trainer subsequently booked the staff member on a course to help support people with eating and drinking, to help minimise risk of choking. We saw planned dates for training in the coming months for care staff and nurses which included fire safety, first aid and moving and handling.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

Mental capacity assessments were completed for people who lacked capacity to make certain decisions. People, their family and appropriate healthcare professionals were involved in best interest meetings and

records and decisions were kept. Staff had received training in the Mental Capacity Act 2005 (MCA), however, speaking with staff, we found they had limited understanding, especially for those people who had limited capacity to make decisions. The training co-ordinator recognised further training was needed, which was being arranged. Some staff were supporting people on 'Memory Lane' who had not worked there for some time, and did not know everyone's individual capacity, however, understood the need to support people to encourage them to make their own choices where possible. People we spoke with told us staff recognised they wanted to remain independent, which included making their own day to day decisions. Staff gave us examples of how they sought consent and how they made sure people had consented before any care was provided.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The previous and current manager understood their responsibilities under the legislation. Records showed people's capacity to make decisions had been assessed and where needed DoLS had been authorised where restrictions on people's freedom were needed to keep people safe from harm.

Some people's mealtime experience was not as good as it could have been, however people were supported to eat and drink according to their needs and abilities. People who required their food pureed due to risks associated with swallowing were served food that met their needs that was presented in an appetising way. Throughout the day we saw staff offered people a choice of hot or cold drinks. Staff knew which people required their drinks thickened to reduce the risk of choking.

People on both floors of the home were supported to be as independent as possible regarding food and drinks. People had access to kitchenette areas on the ground floor and the 'cupcake café' on Memory Lane, to make their own drinks if they preferred. People who had risks associated with poor fluid and food intake had 'food and fluid' charts completed to monitor their daily intake. These records supported people at risk, and staff told us they used these to check people remained hydrated and nourished. We discussed with the nurse on duty that people's 'ideal' fluid intake should be recorded. We were told everyone had an ideal fluid intake, but records did not record what people had consumed. The manager agreed to look into the use of fluid records and decide whether they should only be completed, for people at risk, rather than everyone. Staff said where people were identified at risk, people were weighed more regularly and if their weight caused concern, support from dieticians or other health professionals had been requested. Records seen confirmed this and staff followed the advice provided.

We spent time seeing how staff supported people's lunch time experience on Memory Lane. Nine people chose to eat their meal in the dining room, while others chose to eat in their rooms. The food served looked nutritious, appetising and well presented. People were shown the different choices available so they could select the meal they preferred.

Staff sat with people who required assistance to eat their meal, they supported people to eat at their pace, and checked with them before offering more food. Staff offered support to people who struggled to cut food up or required encouragement to eat their meal. The meal time was unhurried and people were given time to enjoy their food. People who required it, were supported to eat their meals in their room, assisted by staff. We saw one staff member assisting someone to eat their meal in their bedroom. There was lovely interaction and ongoing conversation from the nurse who sat by the person's bed. The nurse was patient and supported them to eat at a pace comfortable to them.

On the ground floor, people's mealtime experience was more task orientated than personalised. Menus on

tables were only available in word format and showed three courses, with alternatives. During service, the soup on the menu was not served to anyone at the tables and we were unsure if it was offered or served to anyone in their room. We saw staff brought people their meals, but there was no explanation as to what people had chosen. For example, staff brought [person] meal, put it down in front of them and said, "Here's your meal", but did not explain what it was. Staff did not offer this person any verbal or visual choice. Staff did not remind this person what they had chosen, which would of helped this person and others who had limited or impaired cognitive function. People enjoyed the food and some people said if they wanted alternatives, this was provided. One person said, "The food is a bit same-ish, but I can ask for something else (like a bacon sandwich). They will get it for me."

People's healthcare was monitored and health professionals involved where necessary, such as speech and language therapy and dieticians. People had access to a GP who visited the home every week. Staff told us the GP was readily available for advice and would visit the home on other days. Records showed that people were supported to attend routine health appointments to maintain their wellbeing such as, chiropodist and optician.

Good

Is the service caring?

Our findings

People were complimentary about staff. People and relatives spoke positively about the staff, their caring attitude and the care they provided. Their comments included, "The staff are lovely," "I think the staff are friendly and caring" and "I'd say this is one of the best places I've ever lived. I've lived in three or four. It's a combination of the place and the staff. They are good." A relative told us, "I can't fault the staff they are wonderful, they are so patient and considerate." Another said "[Family member] always seems happy and well cared for. Staff are fantastic. The nurse and his named carer know [family member] so well it's like they are caring for their own parent." People said staff supported them when they required assistance and they told us they received the support they needed, when they needed it. People said if it took them time to do certain things, staff were patient and attentive.

Staff knew people's preferred names and spoke with people in a positive and respectful way. Throughout the day staff and people on Memory Lane seemed relaxed and at ease with each other. Interactions between staff and people were sociable and friendly. On the ground floor, staff supported people to be as independent as possible and assisted people to do the things they wanted to do. For example, one person enjoyed arts and crafts and staff assisted them to move to their preferred area so they could spend time on their hobby. Most people on the ground floor spent time in their room, either through choice or because they were cared for in bed due to their health.

Throughout the day people were able to make choices about day to day living such as what they wore, what they ate and what they wanted to do. Where people had chosen to remain in their rooms or sit in a particular area, their choice was respected. When staff talked with people they did so respectfully and demonstrated they had a good knowledge and understanding of individual people. Staff supported people to maintain relationships with family members and those closest to them. For example, one person became quite upset because they had not seen their relative. Staff were patient and understanding with the person saying, "[Person's name] came today to see you today, and [person is coming at 10:00am tomorrow." Staff repeated this message many times to this person, without getting frustrated or raising their voices. Staff were kind, considerate and patient when confirming this message. This person told us, "The staff are wonderful, I love them."

Staff were busy on both floors, and our observations showed interactions with people were mainly based on tasks they were doing, rather than spending more time with people. There was little opportunities for staff to sit and chat with people. We spoke with the manager about this. They encouraged a caring culture but recognised this needed further improvement. They said over time, it would improve so staff felt comfortable and confident to spend time talking with people, without it having an effect on the delivery of care.

Staff understood professional boundaries, yet still cared for people in a supportive and nurturing way. Some staff told us they cared for people as if they were their own family. One person offered to kiss a staff member. The staff member remained professional, diverting the person to talk about their family member.

People and their relatives told us visitors were welcome at any time. A relative told us, "I enjoy visiting as

there is good camaraderie with the staff." Relatives said they were made to feel welcomed and were offered drinks and opportunities to eat with their family member.

Most people we spoke with were able to express their views and opinions so we asked them if they were involved in their care decisions. Some people and relatives we spoke with, felt involved in how their care plans were designed around their needs. People told us they were satisfied with the support they received and any help they required, staff provided. People told us they were supported with their personal appearance. During our inspection, people visited the hairdresser and people we spoke with, enjoyed this.

Staff respected people's privacy and dignity and they understood people's need for personal space and privacy. For example, we saw one person's bedroom door was marked, 'please knock and wait 10 seconds'. Staff told us they respected this persons' wishes, however we saw one staff member knock, then went straight in. Through the open door, we could see this person was receiving personal care which meant their privacy and dignity was comprised and not always respected.

When people required assistance with their personal care, staff managed this discreetly and made sure all doors were closed. People's bedrooms were individually furnished. For example, people furnished their rooms with personal items such as furniture, pictures, photographs and other personal memorabilia.

Staff understood the importance of caring for people and they described to us the qualities staff had at Cherry Trees. Staff said morale had improved lately and there was a good team spirit that helped people and each other. Some of the staff said they had not enjoyed recent months at the home, but were pleased things were improving. One staff member said, "Staff morale has lifted. We can see new staff coming in, staff are caring. Staff told us they were proud of the care they provided and wanted to do their best for people they looked after.

We spoke with the manager and asked them how they were confident staff respected people's choices and supported people in a caring and dignified way. They told us they spent time observing staff practices because they worked shifts themselves. They said, "I walk around, I look, I see." They said this provided opportunities to talk with people and observe how staff supported people, as well as caring for people on a regular basis.

People were supported to maintain relationships with people important to them. Visitors were able to enjoy meals with their family member if they wanted. One relative told us they came most days and were always made to feel welcomed and offered drinks and food throughout their visit.

Good

Is the service responsive?

Our findings

People told us they were generally happy with the support they received from staff and were complimentary about the staff who provided their care and support. People told us they previously had some concerns, as staffing levels meant their needs were not always responded to in a timely way, although recently, this had improved. One person told us, "I like it here," A relative told us, "I am more than satisfied with the care [husband] receives." Throughout the day of our visit staff responded to people's needs, we saw appropriate, respectful interaction between staff and people who lived in the home. Call bells were answered promptly and people looked after in bed were repositioned as stated in their care plan to prevent their skin becoming sore.

Staff told us recent improvements had meant they were more responsive to support people and they had more flexibility to cover all areas of the home. Staff said the merge of four units into two had improved the care. One staff member said, "Staff panicked, now we have merged its better." They told us, "You can see the change in staff and people."

Staff had a handover meeting when they came on shift that informed them of any changes since they were last on duty. Information was written down so each member of staff could review the information when they started their shift. One staff member confirmed, "We always have a handover and read the sheet when we start our shift to check if there is anything we need to know." Another staff member said handover had improved.

Staff told us they worked across both units although some staff found this unsettling. For example, two staff on Memory Lane usually worked on the ground floor in the home. They said they had received a handover at the start of their shift but had not been provided with any information about the care and support needs of people on Memory Lane. They said whatever they needed to know they asked the regular staff. Regular staff said this added more pressure to an already busy shift as they had to explain everything which took time. Regular staff said this was the same if agency staff were used but said, things were improving as agency hours reduced. The manager agreed this had impacted on time, but said this would be reduced as they had reduced agency use.

Two activity co-ordinators supported people in the home to pursue their hobbies and interests. There was a planned activity programme each week which was displayed throughout the home so people and their relatives knew what was planned. The programme showed a morning and afternoon activity for people to become involved in. On the day of our visit there was a party in the morning to celebrate the Queen's 90th birthday. People enjoyed themselves singing along to music and having tea and sandwiches. People on the ground floor were supported to pursue their hobbies. Some people enjoyed gardening, going into the local town, going out with family members, or reading books and the newspapers. On both days of our visit, we saw a person involved in tapestry making. They told us they enjoyed doing this.

On Memory Lane, staff told us they were not always able to spend time with people getting to know more about them and their past histories. They told us, they had time to read people's personal care plans and

risk assessments but not to read about their hobbies, interests and backgrounds. Staff told us staffing levels meant they were not always as responsive to people's needs as they would like to be. A staff member told us, "People here have dementia and need a lot of supervision and support, not just help to wash, dress and eat but supervision with mobility. Several residents are unsteady on their feet but they forget this, and try to walk without any aids. You have to be vigilant all the time, which isn't easy with the staffing levels as a lot of people spend time in their rooms. When you are with them you can't see what's happening to people on the floor all the time." Another said, "I would like to be able to sit and talk with people instead of always having to be task orientated."

We reviewed 12 people's care plans across both floors of the home and found overall, care plans reflected people's needs and staff knew how to care for people. However, some care records required further information and better evaluation to ensure they remained relevant and supportive to people's needs. We found information in care plans on Memory Lane, were comprehensive but it would take time for staff to read through. We discussed this with the manager, who agreed a summary about each person's care and support would be useful for staff who did not work regularly on the unit. Care plans informed staff how they were to deliver care and support in a way each person preferred. Plans contained information about people's preferred routines and their likes and dislikes and past history. Care plans were reviewed and updated and information was shared during handovers. Staff had good knowledge and understanding of people's needs and preferences. The information staff told us matched the information in people's care records.

Most of the care plans on the ground floor reflected people's needs and staff were knowledgeable about people they supported. For example, there were clear and well written records that were descriptive provided staff with the information they needed. For example, we saw one care plan for a person who had seizures. Charts recorded frequency of seizures which meant other healthcare professionals had accurate information to support the person as required. However, another person had a health condition that needed regular monitoring and there was no clear evidence to show the person was being consistently supported. We spoke with the manager about the inconsistent records and they assured us improvements would be made and this was an area they had identified for improvement.

Some people and relatives gave us mixed opinions about the service they had received, especially in recent months. Some relatives told us they had raised concerns with previous managers and felt their concerns were not listened to. Other people said, if they raised concerns, the manager acted quickly. We asked the manager if they had received any complaints since they took up their post in February 2016. They said they had not, but had held a meeting with people and relatives to introduce themselves, and to invite feedback. The manager told us they would hold regular meetings for people so they had opportunity to raise issues.

We asked people what they would do if they were unhappy about anything. People told us they were happy with the care and support they received. Comments included: "I would speak to my niece, but I have no complaints." A relative told us, "I would speak to the nurse or [name] manager but I have never had a complaint." We asked staff what they would do if someone came to them with a complaint. A typical response was, "I would pass the complaint on straightaway to the nurse or manager. They would look into it."

Requires Improvement

Is the service well-led?

Our findings

Before this inspection visit, we received a number of concerns from relatives of people living at the home, the local authority and other healthcare professionals. Most of these concerns were about staffing and how this affected the quality of care. In January 2016, the registered manager resigned and temporary measures were in place to manage the service until a permanent manager was appointed. A manager had been recruited at the time of our visit and was in the process of registering with us.

We asked people and relatives what they thought about their home and the quality of the support they received. It was clear from what people told us there had been previous issues and concerns that had not always been addressed. Most of their concerns were around staffing levels, lack of familiar staff and how staffing had impacted on their daily routines. Comments included, "The doctor told me I should try and walk a bit more each day but staff haven't got the time to help me, they leave it to my daughter", "There are different staff all the time, they get moved around, the regular staff know about my needs but not the others, sometimes the night staff won't even take my towels to be washed ready for the morning." When we asked people about the service now, and recent managerial changes, people were optimistic. They told us the quality of care was good, and staff were more consistent and on hand to assist when needed

People had mixed views about communication within the home. Some people felt communication had not been good and if concerns were raised, actions were not taken. For example, one relative said they had repeatedly asked for their relative to be showered daily, but were told us this did not always happen. When they asked for reasons why, no information was given to them that explained why their relation had not received the personal care they needed. Other people said if they raised concerns, prompt action was taken. Since their appointment, the manager held a 'people and relatives' meeting and they planned to hold these regularly to encourage and invite feedback about the service.

Speaking with people, relatives, staff and other healthcare professionals, we felt the provider had not been responsive and proactive to resolve some of the issues raised. Staff told us during this visit they raised their concerns regarding staffing and the quality of care, but they felt the provider did not listen or take action. We spoke with the senior management of Barchester that visited the home during our visit and asked them what the provider had done, to ensure people received a consistently good service. They acknowledged shortfalls in the quality of service and experiences some people had faced but said, they were, "All committed to making this home better and to improve the quality of care." The regional director said the new manager, "Was the right appointment". They told us, "We are getting the right support in." This viewpoint was shared by the divisional clinical lead. They told us recent improvements had been made, such as improving support mechanisms. They said the role of divisional clinical lead was a new appointment and they had additional support from four nurses, that could provide additional clinical support where needed. We were told this has increased nurse's knowledge and skills. They said, "In the past, the home was split into silo's (separate areas) but now, they all work as one." They explained this was vital by saying, "We need to sustain improvement, we are keeping people and relatives better informed."

Discussions with the new manager and new senior management team showed they had identified

improvements. The manager and senior management said they had reviewed people's dependency levels. They told us recent reviews were completed because, "We identified some people were high dependency and possibly, staffing was not right." They told us they had increased nursing cover to two nurses per floor. The manager said, "This is right, to go less than two nurses per floor is not safe." They also told us recent recruitment exercises had a positive effect in reducing agency hours from 700 hours per week, to 200 hours per week.

Staff said recent changes had begun to improve staff morale. Some staff told us they were so demoralised, they thought of leaving. However, they said they could see the provider was listening to them. One staff member said it, "Was horrible. Lots of agency staff, some didn't want to work here. Some gave 'Weetabix' as a main meal". They said they told the previous manager who did not use them again, but constant high turnover of staff meant existing staff were working harder than normal. They said, "We get better staff now, the same, it makes a big difference, morale has lifted." Staff also told us the merge of units destabilised the atmosphere in the home, "Causing some staff to panic." One senior staff member said, "Staff are stuck in their ways. It was difficult at first, but it's better now." They told us, "You can see the change, it does work." Another staff member said with the recent changes, "People get the highest levels of care. " They also said, "In the right hands this could be a great home." They felt confident it was.

The manager told us they were committed to making improvements and had plans to address some areas. For example, staff training, staff supervision meetings (one to one), staff morale, care plans, and documentation required improvement. We spoke with the staff member responsible for training. They said, "The schedule was outdated, so I am making sure all staff are trained." They said this was a work in progress but had held and planned to complete more essential training for staff. They had identified dementia training for some staff, especially as staff supported people living with dementia, who had not received training. They told us they felt supported by the provider and new management team.

We looked at systems that assured the provider people received a quality service. We saw systems that monitored, reviewed and updated care records required improvement to ensure people received the care and treatment they needed. We found some care records for people with complex care needs did not always demonstrate the support they needed, and staff knowledge was inconsistent. For example, one person had a tracheotomy (a tracheotomy is a surgical procedure in which a cut or opening is made in the windpipe to insert a tube into the opening to bypass an obstruction, allowing air to get to the lungs, or remove secretions), was not detailed and did not tell staff the care they required in how the tracheotomy site was treated. We found information about tracheotomy care, cleaning, suctioning and tube replacement had not been documented consistently since February 2016. It was unclear from the talking with staff and looking at records, how often this person's tracheotomy was suctioned, changed and cleaned, or if they experienced problems. We found this person had a history of admissions to hospital with aspiration pneumonia and a history of tracheostomy site infections.

Medicines checks were completed on a daily basis to ensure people received the right medicines at the right time. We were confident people received there medicines, but there was no effective monitoring of when people received 'as and when' medicines. People did not have pain assessment charts and when people received analgesia, this was not consistently documented. The nurse and deputy manager agreed this should be documented, but no checks had been made to check people received 'when required' medicines safely.

Staff were confident to raise any issues or concerns they had. Staff told us if they saw anything of concern, they would raise it. One staff member said they would raise concerns and if required, they would not hesitate to 'whistle blow'. They said, "I have done this before and if I had to again I would."

People's personal and sensitive information was managed appropriately and kept confidential. Records were kept securely in the staff office so only those staff who needed to, could access those records. Staff and nurses updated people's records every day, to make sure that all staff knew when people's needs changed. However some required closer scrutiny and checks, such as food and fluid charts and repositioning charts to ensure they remained accurate so people continued to receive consistent levels of support.