European Healthcare Group PLC

Bay Tree Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 28 and 29 September and 1 October 2016 and was unannounced.
During the last inspection on 29, 30 and 31 December 2015 we found the provider had not protected people against risks that may have an impact on their health and well-being, had not ensured staff received adequate training and support, had not ensured records relating to people's care and treatment were accurately maintained and had not ensured people received appropriate care to meet their individual needs. The provider told us when and how they would address this. During this inspection we found these breaches of regulation had been met. In some related areas further improvements were work in progress, such as improvements to the content of people's care plans, in order to help staff deliver more personalised care.

During this inspection we found the provider had not managed people's medicines safely. You can see what action we told the provider to take at the back of the full version of the report. We also recommended the provider takes advice, from an appropriate source, to ensure that all quality monitoring processes that are carried out within the care home are being carried out effectively.

A maximum of 59 people could receive care at Bay Tree Court. During the inspection there were 42 people receiving care. The building is set off the main road with care parking to the front. Inside consists of two floors with stair or passenger lift access to the first floor. People's private accommodation consists of single bedrooms with en suite facilities. Each floor also has lounge and dining room spaces, bathrooms and additional toilets. A safe inner courtyard can be accessed off some bedrooms and communal areas.

The registered manager has managed the care home since July 2015. 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.

In April 2016 the care home stopped employing nurses for the purpose of meeting people's nursing needs. This change had meant that some people had needed to find alternative accommodation. It also meant if people went on to require nursing care they would need to find an alternative care home and for others it had made no difference. Some health needs subsequently needed to be managed by community nurses. This change took some external health care professionals time to adjust to and at times there was still a need to monitor requests to them to ensure people's needs were met. People's medical needs were met by local GPs who visited the care home on a regular basis.

There were arrangements in place to keep people safe and improvements had been made to how risks to people were identified, managed and monitored. This included nutritional risks. Staff were aware of the risks of abuse and knew how to recognise this, report concerns and involve relevant agencies. People were not discriminated against and they were able to raise concerns without reprisal.

The care home had been and still was dependent on the use of agency staff to ensure there were enough staff on duty. At the time of the inspection there had been a successful period of recruitment. Managers were waiting for new staffs' recruitment checks to complete before they could start them. These checks protected people from those who may not be suitable. Changes in how staff were deployed, their roles and responsibilities had been made over the year to ensure the care home had the right staff available at the right time. Staff training and support had improved and some staff were also in the process of adding to their current skills. There had been resistance to these changes from staff which had slowed up progress on this but during the inspection some staff told us they felt the changes were beginning to work. These arrangements were helping staff to be in a position to be more responsive to people's individual needs. People told us staff were busy but very caring when they attended to them.

People were supported to make their own decisions and when they were unable to do this decisions were made on their behalf and in their best interests. People who lacked mental capacity were protected because relevant legislation was followed. People had access to other health and social care professionals when needed and were free to talk to them in private. People told us they were able to make choices about their care and treatment as well as other day to day choices. People were involved in choosing what activities took place and there was a good attendance at many of these.

Relatives and representatives were appropriately involved and able to speak on behalf of their relatives. Improvements had been made to the content of people's care records. This ensured staff and other professionals had up to date information about people's needs. Further improvements were being made to personalise people's care plans so care could be delivered more around people's individual preferences and wishes. People and relatives were able to raise complaints and concerns. Over the last year several complaints had been received but they had been investigated where necessary and responded to. There was evidence to show that the issues raised had been seriously considered and steps taken to resolve these and improve the service as a whole.

Improvements over the last year to the support the registered manager received and to the senior management team in the care home had enabled the necessary changes to be managed and subsequent improvements to start having a positive impact. Representatives of the provider had been supportive throughout these changes. They had also altered and improved how they monitored the service. On-going monitoring arrangements within the home itself had not successfully identified shortfalls related to the management of medicines. This needed a review to ensure all staff involved in quality monitoring processes understood what action they needed to take for this to be effective. This inspection found that many improvements had taken place but work was still in progress to ensure changes in practice and systems were embedded and sustained.

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. People had not always received their prescribed medicines as they should have. Records held about people's medicines were not always accurate and in places necessary guidance to ensure some medicines were administered safely was not in place.

People were protected against risks that may affect their health and environmental risks were also monitored, identified and managed.

Improvements to staffing numbers had made sure there were enough staff to meet people's needs. Appropriate recruitment checks carried out before staff started work ensured people were protected from those who may not be suitable.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

Is the service effective?

Good

The service was effective. People had access to health care professionals and some new arrangements had been needed to ensure people's health needs were assessed and met.

People received care and treatment from staff who had been provided with training and support. Staff had required new knowledge and skills and had been supported to acquire this.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed. Not all appropriate records were in place but staff were aware of this and had started to address this.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind to them.

People's preferences and wishes were explored and staff aimed to meet these wherever possible.

Staff aimed to ensure people's dignity and privacy at all times.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires Improvement

The service was being responsive but new systems and arrangements which were enabling this needed to be embedded and sustained.

People's records gave accurate information and guidance to staff which enabled them to be aware of what people's needs were. Added detail in the care plans was beginning to give staff the information they needed to personalise people's care.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

People had opportunities to socialise and partake in activities which they enjoyed. Equally so if people did not wish to do this their wish was respected.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider's quality monitoring systems had been strengthened and had been effective. However, one area of quality monitoring (medicines) had not been effective in order to fully protect people from inappropriate or unsafe treatment.

People had been able to communicate with managers regarding the changes to the service and their individual circumstances. Arrangements for seeking more specific feedback on the service provided had been planned and were due to be implemented in the near future.

There were new leadership arrangements in place which had promoted and supported improvement which now needed to be embedded and sustained.

Bay Tree Court Care Centre

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.

The inspection took place on 28 and 29 September and 1 October 2016 and was unannounced. One inspector carried out this inspection.

We reviewed the information we held about the service which included information gathered from commissioners of the service and health care practitioners who visit the care home. We reviewed statutory notifications since the last inspection on 29, 30 and 31 December 2015. Statutory notifications are information the provider is legally required to send us about significant events.

During our visit to the care home we spoke with eight people who lived at Bay Tree Court and three relatives. We spoke with five members of staff including the registered manager and a representative of the provider. We reviewed six people's care records and two staff recruitment files. We reviewed a selection of people's medication administration records. We reviewed all the complaints and compliments received by the care home since the last inspection. We observed how staff interacted with people and how they provided support to people.

Requires Improvement

Is the service safe?

Our findings

People had not always received their medicine/s as prescribed. Some people's medicine administration records (MARs) were not accurately maintained and additional guidance for staff relating to medicines prescribed for use "when required" was not in place. We reviewed the MARs of seven people. In the case of four people it was not possible to confirm they had received some of their medicines. This was because there were staff signature gaps on the MARs. Safe administration practice includes staff signing people's MARs to demonstrate they have successfully administered the person's medicine/s. There were no additional recorded explanations as to why the person may not have received their medicine/s. One medicine for one person had been signed as administered only once during the time frame we reviewed. The MAR recorded the medicine as needing to be administered four times a day. Another medicine for this person had been out of stock for a longer period of time than would have been expected by the registered manager without any specific explanation. The required protocols for medicines prescribed for use "when required" were not in place for two of the seven people. This guidance, in addition to the MAR states exactly what a medicine was prescribed for, under what circumstances it should be used and the maximum dose that can be administered over a 24 hour period. These shortfalls were discussed with the registered manager as soon as they were identified and they told us they would address these immediately. This puts people at risk of unsafe care and treatment with regard to their medicines.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely and other records had been maintained well. We observed the administration of one person's particular medicine. The checks on this medicine were completed by two staff, an appropriate record completed and it was safely administered.

During our last inspection in December 2015 we found the provider had not fully protected people against risks that may have an impact on their health and well-being. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider forwarded an action plan which told us how they would meet this breach of regulation. During this inspection we found this had been met.

People's risks were managed. A risk register had been introduced which was updated each month and monitored by the provider. Risks included falls, the development of or risk of the development of pressure ulcers and nutritional risks. It also recorded people's dependency levels which was a considered factor when the provider agreed staffing numbers. One member of staff showed us how they updated this record, how they reviewed people's risk assessment and then how they followed up the actions taken by staff to reduce the levels of risk. This was a working document referred to on a regular basis. What was on the risk register was also reflected in six people's recorded risk assessments which we reviewed against the risk register. Information about people's risks was being consistently updated to keep it relevant for staff guidance. We discussed in detail with one member of staff the risk management plans in place for two people. These arrangements confirmed people's risks were being identified, monitored and actions were being taken to

address these.

Environmental risks were also managed and we observed maintenance staff carrying out various health and safety checks. People's individual levels of risk in the event of a fire had been assessed since our last inspection. Information on this, both for staff and the emergency services, was current and available. Specialist companies carried out monitoring checks and serviced for example, all lifting equipment, the nurse call system, fire prevention systems and emergency lighting. People lived in an environment which was suitably cleaned and where infection control arrangements were in place and followed.

Prior to the inspection we had received information relating to a lack of staff to meet people's needs. During the inspection there were mixed views about whether there were enough staff. One member of staff told us there had been a period of time earlier in the year when there had not been. They told us since agency staff had been used, on a regular basis, staffing numbers had improved. Another member of staff told us staffing levels were improving although they explained the care home used a lot of agency staff and more of their own staff were needed. They told us agency staff helped to make up the numbers but it made it difficult to delegate various responsibilities and tasks because these staff were not permanent.

Comments from people about whether there were enough staff available varied. When asking one person about this they said, "I find it very good here, but the staff are very busy. They seem to be rushing about so I try not to ask for things, not at mealtimes for example, when I know they are particularly busy". Another person said, "When you ring your bell they are a bit slow at responding". Two other people confirmed staff were always available when they rang their call bell but they also told us they sometimes needed to wait a "little while until they were free." These people confirmed that when they had needed to wait it had not been for too long and it had not had a negative effect on them.

Since the last inspection there had been significant changes in how the care home was staffed. There had been some staff losses but new staff had been recruited. We spoke to one senior member of staff about how staffing numbers were determined. They explained the provider used a tool which assessed people's levels of dependency but they also explained the care home's occupancy numbers changed frequently. This was due to a high number of people being admitted for short periods of care and then returning to their homes. The numbers of staff on duty, during the day, had just been reduced in the last week. This was because some of these people had been discharged and therefore numbers and dependency levels had dropped. The member of staff also confirmed that staffing numbers were increased when numbers and dependency levels went back up. Apart from the numbers of care staff on duty, the registered manager and deputy manager were also available to help provide support and did so when the care staff required this.

There were care staff vacancies and the registered manager had already successfully recruited just over two thirds of the hours the care home required. The benefit of this had not yet been felt as new staff were unable to start work until their recruitment checks had been completed. Once they had started this would reduce the level of agency staff being used. To help ensure people's needs were met a new way of deploying the staff had been introduced. This involved staff providing care to people across the care homes two floors. Before staff had worked in separate teams on their designated floor. The management staff told us this had enabled them to more evenly distribute the staff and their skills in order to be more responsive to people's needs. Staff told us they had found this change a challenge but two members of staff told us they personally felt it was beginning to work.

Previously poor response times to call bells had also been addressed. The registered manager explained that answering call bells was every member of staff's responsibility. The registered manager told us staff needed to answer a call bell immediately to establish if the person was safe. Their expectation was, if the

person was safe but the member of staff who answered the call was not free at that point to help, they either agreed with the person, a time frame for them to return or they found another member of staff who could help sooner. Walkie-talkies had been introduced to help staff communicate with each other to help speed up this process. Staff had also been allocated, on an hourly basis, to be responsible for following up call bells that were not immediately answered. The registered manager had continued to audit call bell response times over the period of time these arrangements were established. Audits showed there had been a marked improvement in the time call bells were responded to. During the inspection we saw call bells being responded to and people's needs being met when people wanted them met. We did not observe people's needs not being met due to a lack of staff or a lack of response.

There were processes in place to help prevent the risk of abuse. Staff had been trained to recognise abuse, manage allegations of abuse and how to report relevant concerns. The provider's policy on safeguarding people was in line with the local county council's safeguarding policy and protocol. Safeguarding concerns were therefore appropriately shared with agencies that also had a responsibility to protect people. We had not received any statutory notifications relating to the safeguarding of people since the last inspection so we followed this up. The registered manager confirmed there had not been any safeguarding concerns to report.

People were protected from those who may not be suitable to care for them because appropriate staff recruitment processes took place. The recruitment files showed that appropriate checks had been carried out before the staff had started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought and in particular sought from previous care providers. Employment histories were requested and the reasons for any gaps had been explored.

Good

Is the service effective?

Our findings

During our last inspection in December 2015 we found the provider had not fully protected people by ensuring staff had received adequate training and support to safely meet people's needs. This was breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider forwarded an action plan which told us how they would meet this breach of regulation. During this inspection we found this had been met. The registered manager told us since the last inspection a review of staffs' competencies and knowledge had been completed. The care home's training record recorded when existing staff had received update training, since the last inspection, in subjects which the provider considered necessary to carry out their jobs safely. This included for example, safe moving and handling, infection control, safeguarding people, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff had also received training on equality and diversity in care. Staff had all received supervision from the registered manager and the support manager was providing additional monthly supervision to senior care staff.

As there had been changes in staff roles and new staff had been recruited basic training sessions were on-going. We saw reminders for staff to attend training sessions which had already been booked prior to our inspection. This was face to face training by an external trainer. As care staff had needed to acquire new knowledge and new skills senior staff were also providing additional training which they referred to as "flash training" and "bite size training sessions". This for example, was "on the job" training. It included how to write care plans and complete and understand the nutritional assessment tool when these documents were being reviewed. Some additional training in dementia care had been booked for all staff as very few staff had received this. The training record also showed that very few staff had received specific training in end of life care. There were however, very experienced staff who had completed relevant care qualifications/training modules, as well as new senior staff who had studied at an appropriate level, to be able to support these knowledge gaps.

All staff completed an induction training when they started work for the provider. This included an introduction to the provider's policies and procedures and then basic awareness training in subjects which the provider considered necessary for staff to carry out their jobs safely. This training included the subjects which are reported on above as being provided as update training but also health and safety related training for example, fire safety, food hygiene and the control of substances hazardous to health (COSHH). There were arrangements in place to provide some staff with support to complete the care certificate. This provides a framework of training and support for staff who are new to care. It's aim is for new care staff to be able to deliver safe and effective care to a recognisably acceptable level before they then go on to receive further on-going training.

People had access to health care professionals. The change in not employing nurses for the purpose of attending to people's nursing needs had meant some people had needed to find alternative care and others were now reliant on community nurses for some of their needs. It had taken the service some time to get this required support recognised by external health care professionals. At times it had been necessary for senior staff to be very proactive in sourcing this support so that people's health need was met in a timely manner.

We were told this was improving but still needed monitoring. The local GP practice provided regular visits to the care home. People's medical needs were therefore reviewed on a regular basis. Other GPs from different practices also visited as requested. Throughout the inspection we observed staff liaising with people's GPs over the telephone. One planned GP review visit took place during the inspection and several people's medical care was reviewed.

People's records showed they had been assessed by other specialist professionals when needed. For example, a physiotherapist when their mobility had altered, a continence advisor when they had required equipment to manage their incontinence and a speech and language therapist when there had been concerns about a person's swallowing. Staff had also been proactive in chasing up these referrals where needed. Mental health practitioners had also been involved when people required support to live with dementia or when their mood or behaviour had altered.

Where people were able to provide consent for their care and treatment this was sought by staff. Consent was also sought by external health care professionals before they provided treatment. An example of which was seen in one person's care records when they had required urgent treatment which had been delivered in the care home. Staff understood that some people were able to provide consent for their care on some occasions and not others. For one person who lived with dementia their care records stated when they had been able to provide this. When they had not been staff returned later to try and offer the support needed. This person was supported to make day to day decisions where they were able to do so. One other person had made decisions which did not always have a good result on their health. Senior staff explained the person had the mental capacity to make decisions. Staff recognised that although they had discussed the associated risks to some of these decisions the person still had a right to make what staff may consider to be unwise decisions.

People who were no longer able to make specific decisions about where they lived and what care and treatment they required were protected under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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 as reported on above. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The recording of mental capacity assessments and best interest decisions needed to be better included in people's care planning but this was work in progress. 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 the DoLS. Several DoLS applications had been made to the County Council (the supervisory body). Where required appropriate applications had been made or advice sought from the local MCA team.

People's nutritional risks were monitored and acted on. A nutritional risk assessment tool was used to determine levels of risk and what actions to take next. Staff were receiving on-going support from senior staff on how to use this tool. One person's nutritional assessment showed they were at risk of not maintaining a healthy nutritional status and concerns about this were due to be discussed with their GP on the day of the inspection. Where people required support to eat and drink they were provided with this. People's weight was monitored and any concerns were discussed with their GP. Another person who had been losing weight had been prescribed dietary supplements by their GP. Staff had also commenced a food and drink monitoring chart so what they actually ate and drank was recorded so staff and the GP could get a more accurate record of what was actually being consumed. Another person who lived with dementia required support to maintain their calories intake. They were often awake at night and wanted to eat so snacks were provided at this time for them. Specific dietary needs were responded to and one person had

been advised on what foods would be better for them as they had diabetes. Another person had continued to lose weight despite interventions and therefore a referral had been completed for assessment by a dietician.

People made choices about where they wanted eat. One person said, "The food is very good" and two other people made similar comments. Some people preferred to eat in their bedrooms and others in the lounge area or dining rooms. The dining room tables were laid with table cloths, napkins, condiments and flowers to help provide an inviting place to eat. People had a choice of food at each meal and the kitchen provided a range of alternatives as well. People could help themselves to tea and coffee in one of the small lounge areas but one person expressed frustration at the arrangements for maintaining the hot water flask. They told us this was not always replenished. We spoke with staff about this and it had been something that had not been consistently carried out by the kitchen staff. This frustration was fed back to the registered manager during the inspection because it had an impact on people's abilities to get a hot drink when they chose to. The registered manager told us she would resolve this. Regular hot drinks were provided by staff at other times of the day and evening and people had access to fresh cold drinks each day. We had also received some feedback that meals had been late and the food had been cold. The registered manager explained that this had been the case but a review of kitchen and care staff roles and responsibilities had resolved this.

Good

Is the service caring?

Our findings

People told us they considered staff to be caring. One person said, "I like it here, it's a relaxing place and the staff are very kind." Another said, "The staff are always kind and very caring when they visit me." One person said, "They [staff] are always polite." We observed staff being kind and attentive when they were with people. We observed two staff ask a person if they wished to use the toilet. The person declined and the staff made it clear in a very kind way that they just had to call them if they changed their mind. One person spoke of staff making them laugh when they visited them, they said, "This cheers me up." Another person confirmed the staff always maintained their dignity and treated them with respect when delivering their personal care. In this respect they said, "The staff are lovely." Another person was not happy with the care staff provided, although they said, "Staff are caring and kind 'when' they come."

People's records stated whether they had a preference or not in which gender of staff carried out their personal care. People's preferences and wishes were explored on admission and more information about these were added to people's care plans as staff became more aware of them. People's life histories had been explored, often with the help of family members. This information helped staff to know and understand people better. This all helped to personalise a person's care and was used to make social activities in the care home more meaningful for people.

People's personal care was delivered behind closed doors and in private. Staff had not long been issued with walkie – talkies to help with the organisation of their work. They had been reminded that what they said on these could be heard by others and to be aware of maintaining confidentiality. We heard these in use throughout the inspection and did not hear any inappropriate comments or breaches of confidentiality. On two occasions we observed a cupboard containing people's personal care records to be open. This was in an office which was unsecured at the time with no staff present. At these times confidential information about people's care and treatment had not been appropriately secured. All entry to computers was password protected.

People's dignity was maintained apart from one occasion when we observed one person's dignity to be compromised. We spoke with the member of staff involved who told us they would never knowingly have compromised the person's dignity. We spoke to the registered manager about this and they told us they would speak further with the member of staff. Staff were observed to be respectful towards people addressing them in their preferred way. People told us they had been included in making decisions about their care and that generally their care was delivered in a way which they were happy with.

Relatives and friends were able to visit at any-time. One relative told us they were always made to feel welcome. They confirmed they felt able to ask staff about their relative's health and found staff to be helpful and informative. One person was having difficulty in staying in-touch with the outside world and could not make certain independent arrangements because the care home did not have Wi-Fi. The registered manager had recognised this as being something they needed to provide in the future and they told us they had spoken to the provider about this. They told us they would organise a temporary solution for this person whilst they were resident in the care home.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in December 2015 we found the provider had not fully protected people by ensuring records relating to their care and treatment were accurately maintained and kept relevant. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also not ensured people received appropriate care to meet their individual needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider forwarded an action plan which told us how they would meet these breaches of regulation. During this inspection we found work had been completed to ensure people's care records were accurate and up to date. Improvements had been made to the way people's care was delivered and the care delivered was more personalised. What was now needed was for these improvements to be fully embedded in everyday practice and then sustained.

Since the last inspection all care records had been reviewed to ensure staff and visiting health professionals had access to up to date information about people's care and treatment. We observed this to be the case when reviewing people's care plans and risk assessments. Work was also well underway to improve the detail of people's care plans and to put the person's wishes and preferences at the centre of the written plan. Where this had been completed the care plans told us more about what the person's wishes were in relation to their care and treatment. Where people had been admitted on a permanent basis and not just for a short period of care, we saw the care plans had developed over a period of time as more personalised information had been added.

Alterations to how staff planned their work had also enabling a more personalised approach to the delivery of people's care. Staff were also more available to people when they needed them to be.
One person spoke to us about how previously one of their needs had not been adequately met. This involved the support they required to use the toilet. This person was aware of some of the new arrangements designed to help staff to be more available and responsive to individual needs. The person explained that when they had previously called for assistance, by the time staff had initially responded, then gone away to find help, "it had been too late." Too late had meant they had been incontinent. They told us more recently, but not always, the time between ringing for assistance and getting the support they needed had improved. They also told us when their care was delivered it was now, more often than not, completed in a personalised way which met their particular needs. Relatives of one person told us their relative's care was not personalised to their specific needs. They attributed this to a lack of staff with the appropriate knowledge and skills. We discussed the issues with them but this was the subject of a complaint made to the registered manager which they were due to investigate.

People's needs were assessed prior to their admission so staff could be sure they were able to meet these. This process also identified the need for any necessary equipment so this could then be sourced. For example, pressure reducing equipment and for larger people (bariatric care) the right size equipment. Information from this assessment was transferred into people's care plans for staff guidance.

People and their visitors were able to raise complaints and discuss areas of concern with the senior staff.

Any complaint or area of dissatisfaction which had been raised had been recorded in the service's complaints log. We therefore reviewed eleven entries in the log recorded since January 2016. The records showed the date the complaint had been raised, the date of acknowledgement of the complainant, the investigation findings (if one was required), the final response to the complainant and the subsequent actions taken. Nine of these included issues which the service had focused on and made subsequent improvements these being: length of call bell response time, lack of staff available to meet needs and people's preferences and wishes not being met. Three of the complaints were completed outside of the provider's stated 28 days for responding and finalising a complaint. This was due to legitimate reasons such as more information required from either complainant or members of staff and holidays preventing further communication and progress.

Compliments in this time had also been received. Comments from relatives of a person receiving end of life care said, "We could not have asked for a better place, amazing staff" and from relatives of someone who received short-term care, "The month with you made [name] a lot stronger and able to go home."

People had access to social activities and other one to one or group activities that were meaningful to them and which they enjoyed. The activities co-ordinator worked closely with the volunteers co-ordinator to provide a programme of social events/activities which people told us they enjoyed. Recent events had included a special tea called "Tea at the Ritz" put on for people and their visitors and a cocktail evening where people enjoyed alcoholic and non-alcoholic cocktails prepared by a mixologist. One person said, "Yes, I join in the activities [name of activities co-ordinator] is very good." Another person told us they enjoyed the social interaction with staff but did not like joining in group activities. They said, "They tell me what's going on but it's my own choice not to." We did not observe any group activities taking place during the inspection but we did see photographs of recent activities and the work which had been produced from recent group work.

Requires Improvement

Is the service well-led?

Our findings

Since the last inspection at the end of December 2015 the registered manager had continued to manage the care home. In late spring 2016 necessary decisions were made by the provider which altered what services the care home provided to people (the specifics of which are reported on in: Is the service Effective? section of this report). During this inspection we evidenced that several necessary areas of improvement had either been completed or were in the process of being improved. The provider had successfully addressed the areas of shortfall identified in the last inspection which had put people at risk. In this inspection it was recognised that there had been improvements but some of these still needed to be embedded and then sustained.

Communication with people and their relatives about changes to the service had been carried out on an individual basis. The changes had a different impact on different people and it had been decided that this would be the most appropriate way of managing this. The same approach had been taken with the staff in relation to what the changes meant to some staffs' roles and their responsibilities. Further meetings had taken place with individual staff groups. There had been strong resistance to these changes and to any new plans and ideas spoken of by senior staff. Staff were encouraged to bring ideas forward and to feedback on the new systems and ways of working.

In order to ensure the registered manager had the much needed support she required and to ensure the service remained effectively monitored the provider made some internal changes. The registered manager told us support from the provider's representatives had and still was very good. We were provided with evidence which showed regular meetings were held with the registered manager and visits were made to the care home. The employment of a new deputy manager and support manager provided the much needed hands on help to provide staff with the direction and support they required. They had enabled the registered manager to be freed up to complete, for example, the extensive staff recruitment programme and respond to the ever growing need for pre-admission assessments on people who required care. During this inspection we met a senior team who were unified and worked to a shared plan of action. They were aware of what had improved, what was still work in progress and what needed to be fully embedded into practice. Their current challenge was to get more experienced care staff with the appropriate level of training into senior care positions to help lead the hands on care.

The provider and registered manager had factored in additional management time for the deputy manager and support manager. This enabled them to work along-side staff but to also coordinate staff and implement the new systems. People and staff told us these managers were very visible and approachable. They told us the registered manager was not as visible as they used to be but they knew they could speak to her when needed. The registered manager told us she still carried out regular walkabouts and visited people when she could. However, the additional staff support now allowed her to focus on managing the service as a whole. She confirmed she could not have sustained long-term the amount of work and number of roles she was completing before the employment of the deputy and support manager.

There was a quality monitoring system in place and new additions to this had already enabled the provider,

for example, to have better oversight of people's risks and how these were being managed. However, effective auditing of the medicine records and medicine stock had not happened, although we were told there were arrangements in place to do this. The shortfalls we found during this inspection had not been identified and therefore not addressed. The result had been that some people's medicines had not been administered correctly. Improvements had been completed on the infection control audit to ensure it was in line with current legislation.

A new quarterly monitoring cycle was due to be introduced by the provider. Although there was a full annual programme of audits the signing off of these audits had not always been consistent. We were informed that the new quarterly monitoring review would help with this. During the inspection we observed staff completing part of the health and safety/maintenance audit. Other areas were monitored frequently and more informally on a day to day basis such as care plans. In order to promote more rigorous auditing of care provision the provider was soon to introduce audits which would focus on dignity in care, nutrition and hydration.

We recommend the provider takes advice, from an appropriate source, to ensure that all quality monitoring carried out on their behalf is effective; meaning that it identifies shortfalls, leads onto actions being taken which result in people being protected and longer-term improvements.

Due to the individual communication with people and their relatives over the last year a formal exercise to seek people's views on the service had not been carried out as part of the provider quality assurance process. This had been done in the past on an annual basis and it was an action on the current action plan to do this in the near future. The registered manager however, clearly operated an open door policy and as evidenced when reviewing the complaints received by the service, people had been able to feed back their views and the registered manager had acknowledged these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines had not always been administered as prescribed; the required administration records had not been accurately maintained. Medicines had not always been available to administer when required and guidance to ensure people received their medicines safely was not always in place. Regulation 12 (1) and (2) (f) (g).