Barty House Nursing Home Limited

Barty House Nursing Home

Inspection report

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Tel: 01622737025

Date of inspection visit:
14 April 2016

Date of publication:
03 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 14 April 2016 and was unannounced.

The service provided accommodation, personal and nursing care for up to 58 older people. There were 51 people living in the service when we inspected. People predominantly needed nursing care to assist them to manage chronic and longer term health issues associated with aging or after an accident or illness. This included compassionate end of life care.

People benefited from accommodation that was set in a picturesque rural location that had been adapted and modernised for the intended purpose. Accommodation was provided over two floors. A lift was available to take people between floors. 28 rooms had on-suite facilities and the remainder had a wash basin. People in rooms without on-suite facilities had access to nearby toilets and bathrooms.

There was a registered manager employed at the service. 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.

There were policies in place for the safe administration of medicines. Nursing staff were aware of these policies and had been trained to administer medicines safely. However, the processes in place to ensure people received their medicines as prescribed were not always effective. Nurses were not always signing the medicines administration sheets when they administered medicines and the registered manager was not chasing this up in a timely manner after the errors had been identified through the service's quality monitoring system.

People's rights were protected through their involvement in decision's about their care and included discussions and decisions about resuscitation if the circumstance's arose. However, we noted that the lead nurse completing the do not attempt cardio pulmonary resuscitation forms had not always recorded the involvement of appropriate health and social care professionals in the process. For example, the senior clinician involved in the care, like the GP. We have made a recommendation about this.

Nursing staff assessed people's needs and planned people's care. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed. Infection risks were assessed and control protocols were in place and understood by staff to ensure that infections were contained if they occurred. End of life care was delivered by consent and mutually agreed with people and their families. Additional specialist end of life nursing guidance and training was provided by staff from a hospice.

The provider and registered manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. Equipment in the service had

been tested and well maintained.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

The registered manager had ensured that they employed enough nursing and care staff to meet people's assessed needs. A robust agency back up system was in place. The provider had a system in place to assess people's needs and to work out the required staffing levels. Nursing staff had the skills and experience to lead care staff and to meet people's needs effectively and the registered manager provided nurses with clinical training and development.

People were supported to eat and drink enough to maintain their health and wellbeing. They had access to good quality foods and staff ensured people had access to food, snacks and drinks during the day and at night.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. Nursing staff understood their professional responsibility to safeguard people. The registered manager responded quickly to safeguarding concerns and learnt from these to prevent them happening again.

Staff received training that related to the needs of the people they were caring for and nurses were supported to develop their professional skills maintaining their registration with the Nursing and Midwifery Council. (NMC.)

Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. The risk was assessed and the steps to be taken to minimise them were understood by staff.

People had access to qualified nursing staff who monitored their general health, for example by testing people's blood pressure. Also, people had regular access to their GP to ensure their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. This included checking nurse's professional registration.

We observed staff that were welcoming and friendly. People and their relatives described staff that were friendly and compassionate. Staff delivered care and support calmly and confidently. People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

If people complained they were listened to and the registered manager made changes or suggested solutions that people were happy with.

The registered manager of the service, nurses and other senior managers were experienced and provided good leadership. They ensured that they followed their action plans to improve the quality of the service. This was reflected in the changes they had already made within the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. People experienced a service that made them feel safe. Staff knew what they should do to identify and raise safeguarding concerns. The registered manager acted on safeguarding concerns and notified the appropriate agencies.

There were sufficient staff to meet people's needs. The provider used safe recruitment procedures and risks were assessed.

Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained to protect people from harm and minimise the risk of accidents.

Is the service effective?

Good

The service was not always effective.

Staff received an induction and training and were supported to carry out their roles well. The Mental Capacity Act and Deprivation of Liberty Safeguards was followed by staff. However, do not attempt cardio pulmonary resuscitation (DNACPR) forms needed to clearly show they had been completed by the most appropriate clinician involved in a person care.

People were cared for by staff who knew their needs well. Staff understood their responsibility to help people maintain their health and wellbeing. Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role. Nurses were supported to continue their professional development.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People told us they were treated with dignity and respect by staff and we observed this happening.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them. Activities were organised to promote involvement and reduce social isolation.

Information about people was updated often and with their involvement so that staff only provided care that was up to date. People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about and the registered manager listened to people's concerns. Complaints were resolved for people to their satisfaction.

Is the service well-led?

Good

The service was well led.

The registered manager was qualified with the appropriate skills and experience to lead staff in the service and drive through improvements to people's care.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered and actions were taken to keep people safe from harm.

The provider and registered manager promoted person centred

values within the service. They planned to continually improve people's experiences. People were asked their views about the quality of all aspects of the service.

Barty House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 April 2016 and was unannounced. The inspection team consisted of an inspector, a nurse specialist and an expert by experience. The expert-by-experience had a background in caring for elderly people and understood how this type of service worked.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. The provider completed a Provider Information Return (PIR). The PIR 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.

We observed the care provided for people. We spoke with six people and two relatives about their experience of the service. We spoke with eight staff including the registered manager, the deputy manager, the nurse clinical lead, three care workers, the maintenance lead and the administrator to gain their views about the service. We also spoke with the senior operations manager for the service. We asked four health and social care professionals and a member of the local authority safeguarding team for their views about the service.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at seven people's care files, ten staff record files, the staff training programme, the staff rota and medicine records.

At the previous inspection on 20 September 2013, the service had met the standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service safe?

Our findings

People felt safe at Barty House. They told us, "Feel safe here, oh yes I do. They (staff) are very good. I am quite happy, warm and quite contented, I have no problems. They keep the place spotless. They always keep your room clean." And, "It's nice living here. Nurses are very nice here. I feel very safe, I haven't any reason to worry."

Relatives told us that they felt that their family members were safe. They described a service that was also supportive to them. One commented, 'At the beginning they (staff) were supportive, I could ring day and night to ask how he was.'

An NHS Nurse told us they believe people were safe. Their experiences were that nurses and care staff had always taken on board any recommendations they had made in relation to people's care and safety. The team at Barty House enabled specialist nurses to access all the relevant notes and care-plans to ensure people got the best nursing care.

People's health and wellbeing may not be protected by their prescribed medicines. Medicine administration records (MAR) did not always show that people received their medicines at the right times or as prescribed by their GP. The system of MAR records should allow for the checking of medicines, so that people could be sure their medicine had been administered and signed for by the nurse on shift. However, in March and April 2016 we found 33 occasions where nurses had not signed to confirm they had administered people's medicines. We noted that some of these omissions had been identified in a medicines audit, but the errors had not been corrected or investigated. For example, a note had been put against the missed evening dose of Gabapentin on 8 April 2016 asking the nurse responsible for the administration to follow up the omission. This had still not been done when we inspected on 14 April 2016.

This was in breach of regulation 12 (1) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that medicines records were maintained to protect people's health and wellbeing in line with current legislation and guidance.

The provider's policy on the administration of medicines followed published guidance and best practice and had been reviewed annually. Nurses told us that their medicines administration competences were checked by the registered manager against the medicines policy and that they had no concerns about the management of medicines in the service. We saw there were robust supervision systems in operation and themed discussions about competency had been recorded in staff files. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended ranges and these were recorded. Nurses knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

Medicines were correctly booked in to the service by nurses and this was done in line with the service procedures and policy. Nurses administered medicines as prescribed by other health and social care

professionals. For example, medicines specific to end of life care were well managed. 'As and when' required medicines (PRN) were administered in line with the PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

Staffing levels were planned to meet people's needs. In addition to the registered manager and deputy manager, the nursing clinical lead and the care team leader there were 11 staff available to deliver care managed by an additional two qualified nurses between 7 am and 9 pm. At night there were five care staff managed by an additional two qualified nurses. The rota showed that time was given between shifts for staff to hand over. Staffing levels were consistent and any staff or nurse absences were covered by approved agency or internal staff. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

There were enough staff to ensure the care people received was safe and they were protected from foreseeable risks. People told us they did not have to wait long for staff to arrive when they asked for assistance. Our observation and discussion with staff showed that staffing deployment was based on an analysis of the levels of care people needed. One person sitting in the lounge said, "You feel safe, there is so many staff around. Even here in the open space." People's dependency levels were reviewed every day. How staff would be deployed was organised by the nurse in charge before shifts started so that the skills staff had could be matched to the people they would care for. Staff responded to people quickly when they needed care which reduced the risk of people falling or becoming upset. There were enough staff available to walk with people using their walking frames if they were at risks of falls.

The provider's recruitment policy was followed by the registered manager. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants for jobs had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.
Before employment, all applicants for posts at this service were asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the registered manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded.

The provider had policies and guidance in place about protecting people from the risk of service failure due to foreseeable emergencies, like flood or fire. Contingency plans were detailed and professionally written to ensure people's care would continue in emergency situations. Each person had an emergency evacuation plan (PEEP). Staff told us they received training in how to respond to emergencies and fire practice drills were operating to keep people safe. The registered manager operated an out of hours on call system so that they could support staff if there were any emergencies.

People were protected from potential abuse by staff trained in how to safeguard adults. The provider had an up to date policy about protecting people from abuse. Staff told us how they followed the providers safeguarding policy and their training. They understood how abuse could occur and what they needed to do if they suspected or saw abuse was taking place. Staff explained to us their understanding of keeping people safe.

The registered manager had ensured that risks had been assessed and safe working practices were followed by staff. Risk assessments gave a score for levels of risk and severity, which was in line with recognised best practice. People had been assessed to see if they were at any risk from falls or not eating and drinking

enough.

People were protected from preventable harm and could call for help if needed. The registered manager checked for patterns of risk. Incidents and accidents were checked to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again.

Equipment was serviced and staff were trained how to use it. The premises environment was maintained to protect people's safety and to meet their needs. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. When staff needed to use equipment like a hoist to safely move people from bed to chair, this had been individually risk assessed. We saw comprehensive records that confirmed both portable and fixed equipment was serviced and maintained.

Good

Is the service effective?

Our findings

Staff were trained to meet people's needs and people told us their health and welfare needs were met. People said, "The GP comes on Tuesdays and Thursdays, It's reassuring you can get a doctor when you need." And, "I've got MS, (multiple sclerosis) they (staff) are very well aware of that, I have not been very well the last three months, they looked after me very well." Another person said, "I have a catheter, when it needs changing no trouble for them, staff know what they are doing."

People praised the quality of the food they were offered. Access to appetising food and a variety of drinks helped people maintain their health and prevent infection. One person said, "Really nice food, the chef he always obliges. For example, we got mashed parsnips, I don't like mashed parsnips, he roasts them instead for me. If you do like something special, he will do it." And, "Oh there's plenty to drink, water, juice, cups of tea throughout the day and there is water over there, it is always nice and fresh". Another person said, "Breakfast very good – everything seems fresh, making you feel comfortable. I have had a glass of red wine at home every evening, I still have it here now with my supper."

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

People can only be deprived of their liberty 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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Do not attempt cardio pulmonary resuscitation (DNACPR) forms were in place and evidenced people's involvement and relevant discussions with appropriate relatives. However, it was not clear from the (DNACPR) forms we viewed, that the most senior clinician involved in the person's care had signed the form. For example, a DNACPR form had been signed by the lead nurse in the service rather than the most senior clinician involved in the persons care. We discussed this with the registered manager and they told us that the clinical lead nurse always discussed the DNACPR's with the persons GP and the specialist nurses from the hospice support team. They told us they would review all of the forms to check this had been recorded.

We have recommended that the registered manager and provider research published guidance at both national and local level to ensure they are meeting the expected outcomes in relation to the completion of DNACPR forms.

People received nursing and personal care from staff who were supported and trained to meet their needs. We found that staff were provided with regular one to one supervision meetings as well as staff meetings and annual appraisal. These were planned by the registered manager and fully recorded. Training records confirmed staff had attended training courses after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

Training consistently provided staff with the knowledge and skills to understand people's needs and deliver safe care. Staff told us that the training was well planned and provided them with the skills to do their jobs well. The provider had systems in place to ensure staff received regular training, could achieve recognised qualifications and were supported to improve their practice. Clinical supervision for nurses was on-going and there were appointed professional leads in areas such as infection control and medical awareness. Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training in end of life care, wound care and gained knowledge of other conditions people may have such as diabetes.

New staff inductions followed nationally recognised standards in social care. For example, the new care certificate. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

People's health was protected by proper health assessments and the involvement of health and social care professionals. A GP visited the service every week, and people had access to occupational therapist and other specialist services. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. We asked staff about their awareness of people's recorded needs and they were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file that covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and prevent risk to people, including from the development of pressure ulcers.) Care plans included eating and drinking assessments and gave clear instructions to staff on how to assist people with eating. People at risk of dehydration or malnutrition were appropriately assessed. People who were at risk of choking had also been assessed. Daily records showed food and fluid intake was monitored and recorded.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and that foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place. Nursing staff could tell us what action they would take if a person was choking to clear their airway. Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

We observed lunch being served in the dining rooms and to people in their bedrooms. Food was presented and served in a way that promoted the social aspect of the occasion. People were not rushed. Staff were on hand to supervise and provide support to those people that needed it. People could choose what they

wanted to eat and if they did not like the main meal an alternative would be provided. We saw staff chatting and laughing with people as they assisted them. People were then given a choice of drinks with their lunch. This encouraged people to stay healthy and reduced the risk of infections.

Good

Is the service caring?

Our findings

We observed friendly and compassionate care in the service. The staff were happy and up-beat, they enjoyed their work and this was reflected in the care we observed them providing. We noted the enthusiasm of the activity co-ordinators and the encouragement and welcoming of relative's involvement in the running of the home. This created a vibrant and engaging atmosphere for people.

Staff operated a key worker and named nurse system. This enabled people to build relationships and trust with familiar staff. People and their relatives knew the names of staff and the registered manager. One person we spoke with said, "They (staff) are all very nice, we have a giggle. There is always somebody about, it's comforting that people are around." A relative said, "There is fantastic staff. They do not sit around and do nothing; I think they are very good. Always busy. It starts with the reception staff, friendly and welcoming."

A visiting nurse from the local hospice said, "There are a brilliant set of staff here, the nursing staff discuss people's care needs openly and with transparency, if I ever needed care I would love the nurses and staff here to look after me."

Staff built good relationships with the people they cared for. Staff promoted a non-discriminatory atmosphere and a belief that all people were valued. This resulted in people feeling comfortable, relaxed and 'at home'. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We saw staff listening to people, answering questions and taking an interest in what people were saying. Two staff who needed to move a person using a hoist put the person at ease by talking her through the process and confirming with her if it was okay. When speaking to people staff got down to eye level with the person and used proximity and non-verbal gestures (good eye contact, smiles and nods). People responded well to the quality of their engagement with staff. People could choose to stay in their rooms, chat to others in the main lounge and dining room or use the separate lounge to sit quietly and read or meet friends and relatives. This promoted a relaxed and homely atmosphere for people to enjoy.

Care plans described people's communication needs on a day to day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for. Reference was made to hearing / visual aids people had and the support they needed to use these.

Compassionate end of life care was at the heart of the service. Nurses led as named champions in end of life care, which was planned and arranged to be as collaborative and individualised as possible. Staff at Barty House were the providers ambassadors for high quality end of life care. Weekly end of life care meetings encouraged people and staff to discuss the issues and challenges they may face and needed to face. Inclusive emergency health care plans were in place to enable people to record their views and wishes as their health deteriorated. Bereavement booklets were informative and assisted people with information about the choices they may need to make.

People told us that staff respected their privacy. Staff we spoke with described the steps they took to preserve people's privacy and dignity in the service. People were able to state whether they preferred to be cared for by male or female staff and this was recorded in their care plans and respected by staff. People were able to personalise their rooms as they wished. They were able to choose the décor for their rooms and could bring personal items with them. People told us that their care plans were followed and they could say what they wanted staff to help them with.

People's rights to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. For example, people had maintained their religious links., One person said, "The local Priest comes in." Others kept in touch with the world by having newspapers delivered every day. This enabled then to remain independent in areas they chose. People or their representative had signed to agree their consent to the care being provided whenever possible. Staff confirmed they sought people's consent before they provided care for people. This meant that staff understood how to maintain people's individuality and respect choice.

People and their relatives told us they had been asked about their views and experiences of using the service. The provider's quality policy included gaining written feedback from people about the service. There were very high satisfaction rates from people who had experienced the service, either as a resident or relative. For example, the results of the 2015/2016 surveys/questionnaires were analysed by the provider and 96 percent of people would recommend Barty House to others. Information about people's comments and opinions of the service, plus the providers responses were made available to people and their relatives. This enabled people to stay involved with developments and events within the service and give them the opportunity to influence decisions the provider had made about changes in the service.

Information about people was kept securely in the office and the access was restricted to senior staff. When staff completed paperwork they kept this confidential.

Good

Is the service responsive?

Our findings

People's care was kept under review and changes were made to improve their experiences of the service. People told us they could go to a registered manager in the event of any problems. One person said, "I'm quite at ease talking to staff, night and day staff, very good." Another said, "The staff are very good, I never feel worried." Relatives told us about examples of staff responsiveness. One said, "If there is a problem you go straight to the manager she sorts it out." And, "I ask questions and my mum does too. The manager is very approachable."

People received care from staff who knew their needs, their individual likes and dislikes and their life stories, interest and preferences. People's needs had been fully assessed and care plans had been developed. Before people moved into the service an assessment of their needs had been completed to confirm that the nursing home was suited to the person's needs. Care plans were well written and easy to navigate. They focused on areas of care people needed, for example if their skin integrity needed monitoring to prevent pressure areas from developing. The care plans were person centred and individualised. For example, additional care plans were used when people were receiving end of life care. Information was constantly updated as people's health deteriorated. Information about people's life histories was in place, telling others who people were and about their lives and loves. Knowing about people's histories, hobbies and former life before they needed care could assist staff to help people to live fulfilled lives, especially if they were living with memory loss, dementia or chronic illness.

Changes in people's needs were recorded and the care plans had been updated. The registered manager used a 'Resident of the day' monitoring system to ensure that every person was regularly monitored. This also promoted a person centred approach. We checked how well the system worked against people's care file records and could see that these focused monitoring events meant that people's general health and care was formally checked at least monthly. These in depth health checks fed into the daily checks made on people's dependency levels by the lead nurses. This ensured that the care people received met their most up to date needs.

The registered manager and staff responded quickly to maintain people's health and wellbeing. Dependency assessments had an emphasis on weight and body mass indicators. Nurses had implemented weight management plans based on advice from a dietician and emergency health care plans in response to people's illnesses. We cross checked this against the care plans and found they were kept under review. This had resulted in the people maintaining their health through good hydration and nutrition and minimised the risk of infection. After people had been unwell, the progress to recovery was monitored by nursing staff and if necessary further advice had been sought from their GP. This ensured that people's health was protected.

Staff had arranged GP appointments to monitor people's health and involved other health and social care professionals when needed, like speech and language therapist or the mental health team. There was information about upcoming hospital/other appointments that people needed to attend. The nurse's in charge reviewed these regularly to ensure that arrangements were made so that people were able to attend

appointments.

Changes in people's needs had been responded to appropriately. Care plans and risks assessments evidenced monthly review. Referrals had been made when people had been assessed for specific equipment, which was in place. For example, people had beds that provided protection from pressure areas developing and enabled staff to move the height of the bed up or down to assist the delivery of care. Hospital outpatient and discharge letters were in people's care plans. These gave guidance to staff and ensured continuity of care.

People had opportunities to take part in activities and mental stimulation. One person said, "They do a lot of activities, the other day they had a mad hatter's tea party, even senior staff dressed up. It was just a nice atmosphere." Another person said, "Every afternoon there's always something different. Quizzes, word games, painting and drawing, not everyone needs to join in you can choose. You can always talk it over with the girls and they find you something else to do." Others said, "It's a nice place to be, activities oh yes makes you laugh." And, "I enjoy knitting, it's good for your hands and brain. I keep myself busy, keep my brain working. Staff help me if I need help, I knit squares to make a blanket."

There were four enthusiastic activity co-ordinators, working across the service to ensure they involved people. Activities also ran at weekends. We observed people getting one to one activities in their bedrooms which reduced isolation if people were cared for in bed. There was tea and biscuits and a generally cheerful atmosphere created by the staff who did their best to include everyone. A relative commented, "I suggested starting a relatives group, so we can support each other. This was welcomed. We are called Barty's Buddies. We meet once a month. Relatives take it in turns to help out around the home, with the gardening, other activities and trips out." This ensured people and their relatives had opportunities to get involved in the life of the service. Also, it kept people occupied and active if they chose to participate and offered opportunities for them to feel less isolated.

People experienced a service that enabled them to openly raise concerns or make suggestions about changes they would like. This increased their involvement in the running of the service. There was a policy about dealing with complaints that the staff and the registered manager followed. The registered manager responded well to informal complaints about the service people experienced. One person said, "I complained that the vegetables were not fresh, a few of us felt that way. The chef came to our residents meeting, now it is better. If you are unhappy the registered manager wants to know".

Information about how to make complaints was displayed in the service for people to see. Records showed there had been two formal complaints in the last 12 months. People were offered meetings with the registered manager to try and resolve complaints and these were recorded. These two complaints had been resolved to people's satisfaction. The registered manager ensured that complaints were discussed with other people in the organisation if needed. This showed there was a mechanism for people higher up in the organisation who were not based at the service to get involved to try and resolve complaints if needed. Everyone we spoke with was happy with the idea of raising any concerns. One relative stressed, "We are very happy, just a few niggles, but overall we are very happy." Another person said, "If I have a complaint I would go to the top, to the registered manager."

Good

Is the service well-led?

Our findings

The registered manager had been in post for more than six years and had worked hard to improve people's experiences of the service. They were supported to manage the service by the provider and a team of experienced and competent nurses. People spoke highly of the registered manager and staff team. People and their relatives told us that the registered manager and staff greeted them warmly and with respect. People's comments included, 'The care and kindness shown to our mother by staff was deeply appreciated.' And, 'First class staff and activities, I would highly recommend Barty House.'

People's positive experiences of the service were underpinned by consistent improvement. The registered manager carried out regular audits of health and safety risks within the service and of the quality of the service provided. The registered manager told us that the provider listened to, considered and acted on requests made for additional resources. For example, the dignity butterfly had been introduced as a symbol to represent positive end of life care. The symbol was used on end of life information produced for people in the service and their relatives and could also be used at funerals and on bedding. This underpinned the philosophy of care at Barty House in providing warm, compassionate and comforting care.

General risk assessments affecting everybody in the service were recorded and monitored by the registered manager. These covered everything, lawnmowers to wheelchairs. Service quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits covered every aspect of the service.

The registered manager reviewed the quality and performance of the service's staff. They checked that risk assessments, care plans and other systems in the service were reviewed and up to date. All of the areas of risk in the service were covered; staff told us they practiced fire evacuations. Each audit had an action plan. We could see that issues identified on audits were shared with staff and it had been recorded how and when they would make the improvements. For example, a new fridge had been purchased for the kitchen after an audit had identified the door seal had broken. These actions had been signed as completed by the registered manager on their action plan. This ensured that issues identified on audits were actioned and checked to improve service safety and quality.

Staff told us they felt supported by their registered manager. There were various meetings arranged for nursing and care staff. These included daily shift hand over meetings, weekly end of life care meetings, registered nurse meetings and heads of department meetings. These meeting were all recorded and shared. Staff said, "We get good access to training, I have just put my name own for dementia awareness and nutrition." And, "People's care is well organised, we never feel panicked and often get moments when we can spend more time with people just chatting." Information about how staff could blow the whistle was prominently displayed in staff areas. Staff told us they fully understood their responsibilities to share concerns with outside agencies when necessary. This meant that staff were fully involved in how the service was run.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service.

Maintenance staff ensured that repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. The maintenance team kept records of checks they made to ensure the safety of people's bedframes, other equipment and that people's mattresses were suitable. This ensured that people were protected from environmental risks and faulty equipment. The registered manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.

The provider's area manager was often on site. They had assisted the registered manager to develop the service systems and they were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints to the highest levels with the organisation so that they were dealt with to people's satisfaction.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines records were not always maintained to protect people's health and wellbeing in line with current legislation and guidance.