Baytrees Homes Limited

Baytrees Nursing Home

Inspection report

Baytrees
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 11 January 2018 and was unannounced.

Baytrees Nursing Home is registered to provide nursing care and accommodation for up to 30 people with a variety of health care needs in one adapted building. At the time of the inspection 27 people were living at the home. Communal areas include a large sitting room which also serves as a dining room and a further lounge/conservatory area which has access to the rear garden. Baytrees Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we completed our previous inspection on 19 February 2016, we found concerns relating to staff understanding of the Mental Capacity Act and how this was implemented. We made a recommendation that the provider ensured staff had a good understanding on this topic and were able to put this into practice. At this inspection, we were told that there had been a delay in the delivery of capacity training, but staff completed this after the inspection took place. Care plans were inconsistent in the information provided in relation to consent and lacked clarity. However, people told us that staff did consult them in decisions and sought their consent appropriately.

Not all staff had completed training as needed to ensure they had the skills and knowledge needed to undertake their roles and responsibilities. Some staff had not completed safeguarding training and they were unable to demonstrate their understanding of safeguarding and the different types of abuse they might encounter. Some training had been completed by staff, but there was a lack of oversight in this area to ensure all staff had undertaken training as needed. The induction programme for new staff was not effective and the member of staff who delivered training to staff on a range of topics only had a training qualification in moving and handling. Some staff had received supervision with their line managers, but not all.

No account had been taken of the Accessible Information Standard and how information was presented to people in a way that met their communication needs and in a format which they could understand. Some records had not been kept confidentially. The medicines audit had failed to identify the issues which we found at inspection.

Medicines were not always managed safely. A blister pack was left loose in a locked cabinet with no means of identifying who the tablets belonged to. An ophthalmic solution that was no longer required had not

been disposed of as needed. People received their prescribed medicines as needed and Medication Administration Records confirmed this. Medicines were stored appropriately.

People said they were happy living at Baytrees Nursing Home and spoke positively about the registered manager. People were asked for their feedback about the service through surveys and at residents' meetings. Some systems had been established to monitor and measure the quality of care provided. Staff and visiting professionals were asked for their views on the home. The registered manager kept up to date with latest practice in a variety of ways, through local managers' meetings and updates from social care and health organisations. Staff felt supported by the registered manager and said there was an 'open door' policy so they could talk with the registered manager at any time. Staff thought their views and suggestions would be listened to and were aware of the provider's whistleblowing policy.

Care records provided detailed information about people's care and support needs. People and their relatives said they were involved in reviewing care plans, although this had not been recorded within the care records. A range of activities was on offer which were organised by a part-time activities co-ordinator. Outings into the community took place at least weekly. People enjoyed the activities on offer. People knew how to make a complaint and the complaints log evidenced that complaints were managed satisfactorily. Some people had made decisions in relation to their end of life care and some staff had completed end of life care training.

People said they felt safe living at the home. Their risks were identified and assessed safely. Staffing levels had been identified as a concern at night, when there would not have been sufficient staff to evacuate people safely in the event of an emergency. The provider had taken advice on this and proposed to increase the number of staff on duty at night by one additional staff member. After the inspection, further advice had been sought and there were plans to install a sprinkler system on the second floor to keep people safe in the event of a fire breaking out. Recruitment systems confirmed that new staff were vetted and appropriate checks made before they commenced employment. The home was clean and hygienic and there were no offensive odours. The registered manager understood their responsibilities under Duty of Candour and lessons were learned or improvements made when things went wrong.

People enjoyed the food on offer and felt supported by staff at mealtimes. Menus were planned over four weekly cycles and people had the choice of what they wanted to eat. Special diets were catered for. When people required the services of specialists and other healthcare professionals, referrals were made as needed. People had regular access to a range of healthcare professionals and services. With regard to the environment, staff commented on the lack of investment in the building and some people felt the place would benefit from redecoration.

People were looked after by kind and caring staff and felt they were treated with dignity and respect. People said they were involved in decisions relating to their care and were in control of their lives.

We found a number of issues of concern. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Medicines were managed well with the exception of some medicines which had not been stored or disposed of safely.

Staffing levels were within safe limits. Arrangements were being made to install a sprinkler system on the second floor to ensure people's safety at night.

There were systems in place to protect people from abuse and people said they felt safe living at the home.

People's risks were identified, assessed and managed safely.

The home was clean and hygienic.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Care plans were inconsistent in relation to consent to treatment. People felt they were listened to and their consent was sought appropriately.

There were significant gaps in the training staff received. The staff member who delivered the majority of the training was not qualified and did not have the expertise to deliver training effectively. The induction programme for new staff was not thorough. Staff did not receive regular supervision meetings.

People enjoyed the food on offer and had choices in what they would like to eat.

People had access to a range of healthcare professionals and services and referrals were made as needed.

People and staff felt the home had lacked investment and some parts were in need of redecoration.

Is the service caring?

Good

The service was caring.

People spoke of the kind, friendly and caring nature of staff.

People were involved in decisions relating to their care and they were treated by staff with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People and relatives were involved in reviewing care plans, although this was not always recorded within care records. Care plans provided detailed information and guidance to staff.

A range of activities was available to people, either in house or as outings into the community.

People were supported at the end of their lives to have a dignified, comfortable and pain-free death.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Systems were not effective in identifying the issues that we found at inspection in relation to the disposal of medicines and staff training and supervisions.

People were positive about Baytrees Nursing Home and were asked for their views about the service.

Staff felt supported by the registered manager and said there was an open door policy.

Baytrees 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.

The inspection took place on 9 and 11 January 2018 and was unannounced. The inspection team comprised two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had experience of older people, including people living with dementia.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events that the provider is required to tell us about by law. The provider was unable to complete the Provider Information Return (PIR) as a request to do this was not sent to them by the Commission. The PIR is usually completed at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 people who lived at the home and two relatives. We spoke with the provider, the registered manager, the deputy manager, two housekeeping staff, four care staff and a cook. We spent time observing the care and support that people received during the time of the inspection. We reviewed a range of records relating to people's care and how the home was managed. These included 11 care plans and associated risk assessments and medicines records. We looked at staff training, support and employment records, audits, minutes of meetings with people and staff, complaints, policies and procedures and accident and incident reports.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place to protect people from abuse and staff training in relation to safeguarding. We were told the deputy manager delivered training on safeguarding within 12 weeks of new staff commencing employment and new staff also had a brief introduction to safeguarding as part of the induction process. Some staff had not completed safeguarding training and they were unable to demonstrate their understanding of safeguarding and the different types of abuse they might encounter. Risks to people's safety had been considered in relation to safe moving and handling techniques and new staff were only allowed to use hoists when they had completed moving and handling training.

We asked the registered manager how they managed any issues of concern in relation to potential abuse and they told us they would interview the staff involved, gather as much information as possible and look at people's care records. The registered manager told us they would work closely with the investigating officer at the local safeguarding authority when an incident was reported. Accidents and incidents were logged and included information on the action taken following each occurrence.

People confirmed they felt safe living at Baytrees Nursing Home. A relative said, "I'm very happy that [named person] is safe here; the fact that I know he has round the clock care means so much to me. It's the care that keeps him safe. If I had any concerns at all I would have no hesitation in speaking with the manager". One person told us, "I like the routine of it. That's my safety net. I need routine and I get it here. I like to know things will happen when they should and then I feel safe. If I was unhappy I'd probably speak to the nurse first, but if it wasn't something for her, I'd speak with the manager". A second person said, "Lots of things make me feel safe here. The care, my own room someone to talk to, having people around mainly though I think". People also told us about their experiences of being transferred by using a hoist. One person explained, "I can't get about by myself and need help. Because there's plenty of carers here, there's always two who are happy to hoist me up. They're very good at it and I feel very safe". A relative said, "There are sides on the bed so [named person] won't fall out and hoists to make life easier for him; that's what makes it safe".

We looked at how people's risks were assessed and their safety was monitored and managed. Risk assessments identified potential risks to people and provided information and guidance to staff on how to support people safely. Risk assessments had been drawn up for people in relation to their mobility, catheter care, wound management, skin integrity, nutrition, personal hygiene and included personal emergency evacuation plans (PEEP). PEEPs were in place to guide staff on how to evacuate people safely in the event of an emergency. Risk assessments were detailed and clear and gave staff the guidance they needed. In addition to risks relating to people, we looked at a completed fire risk assessment and environmental audits in relation to safe management of the premises; these were satisfactory. Staff had completed fire safety training. Where people had or were at risk of developing pressure areas, pressure relieving equipment was in use such as mattresses, which helped to prevent the risk of skin breakdown. Where needed, people were repositioned in bed to prevent or manage pressure areas and daily records confirmed this. Where people had developed pressure ulcers, records had been kept to show how these were treated and managed. People's risks relating to skin integrity were assessed using Waterlow, a tool specifically designed for this

purpose.

Staffing rotas showed that 10 care staff were on duty during the morning, with a minimum of five care staff in the afternoon and three care staff at night. One person was funded to receive 1:1 support which had been accounted for within the staff rotas. A registered nurse was on duty at all times and occasionally two registered nurses during the day. One member of the day care staff started work at 7am to assist night staff to get people up. We asked the registered manager and provider how staffing levels were assessed. We were concerned that, with only three staff on duty at night, there were insufficient numbers of staff to evacuate people safely in the event of an emergency. After the inspection, the provider informed us that a sprinkler system would be installed on the second floor of the home. This would be effective with regard to evacuating people in the event of an emergency.

Staffing levels were assessed based on people's dependencies and additional staff could be made available for people who required support with their healthcare appointments or on outings. We asked the registered manager whether there were any staff vacancies and about the use of agency staff. They told us that recruitment was, "Ongoing" and that potential staff were being interviewed.

We asked people for their views about the number of staff available and whether they felt they received the care they expected and needed. People we spoke with felt the staffing levels were appropriate and that their call bells were answered quickly. We asked people if they felt there were enough staff on duty during the night and feedback was positive, although one person felt it would be beneficial to have an additional member of staff on duty at night. A relative said, "Earlier on in the year there seemed to be a lot of agency people around, but the staff levels seem to be back up and it's much better. I've been called in a couple of times during the night when there's been a down turn with [named person], so I know they never try to hide anything from me". One person told us, "I think there's enough staff. I like to be up early. There is the odd occasion when I have to wait until later than I'd like, but I understand why that happens. Some people here need much more attention than me". Another person told us, "I think there are enough staff, but they could do with one more at night. Do you know you can't get directly from one side of the house to the other on this floor? You have to go down one side to get to the other. I've wondered what would happen if staff were all over the other side and I needed help. I've not had a problem though and when I've used my bell staff come pretty quickly".

We looked at some staff files to check on the recruitment systems when new staff came to work at the home. Potential staff had their employment histories checked, two references were obtained and checks made with the Disclosure and Barring Service to ensure staff were safe to work in a health and social care setting. Registered nurses pin numbers were checked to ensure they had current validation from the Nursing and Midwifery Council.

We observed medicines being administered to people at lunchtime by a registered nurse. Medicines were stored and administered from a medicines trolley. Each time the nurse left the trolley unattended they made sure the doors were locked. Explanations as to why each medicine was prescribed for people were recorded in their care plans. We looked at the storage of medicines in a room dedicated for this purpose and that temperatures in the room were recorded to ensure medicines were stored at a safe temperature. We saw that some medicine had been left loose in locked cabinet and it was not clear who the medicines had been prescribed for as they were not in the original packaging. However, the registered nurse knew who the medicines had belonged to and told us they should have been removed. We discussed this issue with the registered manager who agreed it was an oversight and that the medicine would be disposed of safely. In addition, we found an ophthalmic solution prescribed in November 2017 for one person had been stored in the refrigerator, but no date of opening had been recorded on the bottle. We were told by a registered

nurse that this medicine was no longer in use, but it had not been disposed of as needed. Medicines audits had not identified these concerns which we found at inspection. Actions were taken to address these issues at the time of the inspection. We recommend that systems are reviewed to ensure medicines are stored safely.

We asked people about their medicines and if they felt these were administered correctly and on time. We also asked people if they were offered painkillers when these were required. One person said, "The nurse gives me my medicine and yes it's on time. The distribution of drugs is important and they do that properly here". Another person told us, "They bring the medicine round and give it to you in little pots and ensure that you take it". A relative said, "If [named person] needs painkillers during the day, he or I will ask the nurse and she will give them to him".

From our observations, the home was kept clean and hygienic. We were told that housekeeping staff were on duty every day except Sundays. The laundry was completed every day. Clinical waste was disposed of safely and we observed staff wearing personal protective equipment when they were carrying out personal care and when carrying bags of clinical waste which were sealed. Where catheters were in use, we saw the urine bag stands had been placed in plastic washing-up type bowls. The nurse on duty told us this was to collect any leakage of urine as occasionally the taps to the urine bags were not closed off properly. The nurse told us the bowls were kept separately for this purpose and not used for any other function. We looked at the kitchen checks and cleaning schedules and these confirmed that regular cleaning had taken place around the home. The home had achieved a Food Standards Hygiene Rating of 4, which is satisfactory.

We asked people if they thought the home was clean and whether there were ever any offensive odours. A relative said, "The home is very clean. There is absolutely no smell of urine which is one of the main reasons I like it here. It's a bit worn around the edges, but the care outweighs all of that". One person told us, "Oh yes, it's kept nice and clean and fresh. I think it could do with a lick of paint though". Another relative said, "Despite having so many people here that need a lot of nursing, it never smells. The housekeeping staff are very good".

We looked at the provider's policy on whistleblowing and asked staff whether they felt protected if they made complaints about aspects of the service. One staff member said, "I think that none of us would tolerate poor practice. I would certainly be confident to report it. We are confident in our work and in the support we receive from everyone to be as good as we can be". We discussed an issue that the registered manager had reported to us and of the action they had taken in relation to this. The registered manager had taken appropriate steps to deal with the issue and had shared her concerns with the Commission at the time. The registered manager understood their responsibilities under the Duty of Candour regarding people's care and treatment and the need for open and honest communication when things went wrong.

Requires Improvement

Is the service effective?

Our findings

We followed up concerns found at our previous inspection In February 2016. These were in relation to staff understanding about consent and mental capacity. Whilst staff had undertaken recent training in this area, many were unable to tell us the implication of depriving a person of their liberty or about the nature and types of consent. We made a recommendation that the provider put measures in place to ensure staff had a good understanding in this area and were able to put this into practice. At this inspection, according to the training matrix, not all staff who required it had completed training on mental capacity. Following the inspection, the provider submitted evidence that staff completed mental capacity training on 15 March 2018. The training had been delayed due to adverse weather conditions which resulted in the postponement of training scheduled earlier.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Care plans we looked at were inconsistent in relation to how consent was gained and how people's capacity was assessed. For example, one statement talked about if a person did not have a DoLS he would be free to go out whenever he wanted and might put himself in danger. Another statement referred to the person having a DoLS because they wanted to go home. Some care plans provided accurate information. For example, a person who had capacity and had given their consent to have bed rails. The registered manager had a good understanding about the relevant legislation and explained, "We looked at all the care plans. We need to include at the beginning whether the service user has the capacity to make decisions for any particular aspect of their care". Where required, applications for DoLS had been submitted to the local authority when a person was deemed to lack capacity. Notifications of when DoLS had been authorised or refused had been sent to the Commission as required.

We asked people whether staff listened to them and if their consent was sought. People confirmed they were involved in making decisions and felt that staff were skilled and experienced in meeting their needs. People we spoke with were extremely complimentary about the staff.

We looked at staff training records. Eight staff who were regarded as new starters had not completed safeguarding training but were working regular shifts in the home. When we spoke with staff, it was clear that their knowledge about safeguarding was unclear, with a few staff unable to identify all the different types of abuse. Training had taken place in other subject areas such as moving and handling, infection control, first aid and challenging behaviour. However, there was no oversight to identify training needs and

their implementation. The home accommodates people with complex medical conditions such as Parkinson's disease, schizophrenia, diabetes and dementia, but staff had not received training specific to these conditions, despite it being identified as a training need on the matrix. Despite the significant gaps in training, there was no evidence to suggest that this had an impact on people's health and welfare.

We saw a record of induction which was completed before a new staff member started work. There was an induction folder which had two headings, 'feeding' and 'repositioning' which had a set of questions to be answered which looked at issues relating to assisting people to eat and the use of thickening agents. Questions asked how people should be repositioned and the do's and don'ts with catheter care. The questions were marked with a tick or a 'x' to signify a correct or incorrect answer. However, there was no further update or direction on what the correct answer was. It was difficult to see how staff achieved any learning from this method. The registered manager said that new staff would shadow a senior staff member, however, some senior staff had not completed all their training. There was confusion about the skill set of the in-house trainer in that this member of staff had achieved 'Train the Trainer' status with moving and handling, yet delivered training to staff on a wide range of areas for which they had received no specific training themselves, for example, in infection control and safeguarding. The provider had misunderstood about the training status of this staff member, believing that the Train the Trainer qualification enabled them to train with expertise on all subjects. Staff did not complete all the training they needed to carry out their roles effectively.

Staff we spoke with were unsure about how often they received supervision from their line managers. Records we looked at showed that 12 members of staff had supervisions by the same senior staff member during 2017. This meant that not all staff had the opportunity to discuss their progress, any issues or particular training needs.

Staff told us of the difficulties within the home about the retention of staff and recent high turnover. We looked at the home's records which showed that during 2017, 46 staff commenced employment, 18 stayed and 28 left. In 2016, 42 staff started, six stayed and 36 left. The home did not have any systems in place to audit why staff left. Staff we spoke with felt that new staff were not properly recruited for dealing with people with complex care needs or found staff new to care found it too much to deal with. The lack of detailed and specific training meant that some new staff may not have had the confidence to carry out their duties.

The above evidence demonstrates that the provider had failed to ensure staff had completed the necessary training, received appropriate support and supervision as was necessary to enable them to carry out their duties they were employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the issue of staff supervisions and the lack of regularity with which these took place. The registered manager told us they were in the process of completing a staff supervision plan and booking staff in to complete the supervisions needed. The registered manager told us they had also enrolled on the local authority's training link, West Sussex Learning Gateway, and that they were trying to ensure all staff completed full safeguarding training. We were told that new staff completed a Care Certificate workbook, a vocational qualification which is work based. Staff could also complete vocational qualifications at higher levels in health and social care. Some staff had achieved National Vocational Qualifications at level 2 and 3.

It was difficult to establish how people's care, support and social needs were holistically assessed since staff had not completed the training they needed.

We asked people what they thought about the food on offer and whether they had any dietary requirements, if these were met. We also asked people if they had any input in planning the menu or if they required support from staff with their eating and drinking. Everyone we spoke with was able to eat independently. One person said, "The food is very good, no complaints from me". Another person told us, "The food is excellent and there's lots of it. The best is when they do the all day breakfast". A third person explained, "Overall I would say the food is really good. Sometimes I go out and don't get back in time for lunch and they put it aside in the hot cabinet for me and I can have it later. I've put on a stone in four months – maybe the food is too good!" Choices were available to people and one person said, "You can make suggestions and you can always ask for more. I'm not allowed citrus fruit and they keep an eye on that for me to make sure I'm not given it". Another person told us, "The cook is brilliant. The food is great and if there's something on the menu I don't want, they'll give me a choice of something else. You can't fault it".

We observed the lunchtime meal from 12.30pm. Two tables were set up for lunch, but only two people chose to sit at the dining table, the rest sat in their chairs with overlap tables, which was their choice. Where needed, we saw that food was cut up for people so they could be independent in their eating. A member of staff was available to ensure that no-one was struggling with their meal. The choice on offer on the first day of inspection was an all day breakfast or mince with mashed potatoes and vegetables, followed by cherry pancakes and ice-cream. The meals smelled and looked appetising and we observed people were eating happily. Juice was served with the meal. We also walked around the home to observe people who had lunch served to them in their rooms. Doors were open and we saw that three people had eaten all their food and one person was being assisted by a staff member with their meal. We observed throughout our inspection that drinks and snacks were brought around and readily available to people. Whilst the majority of people were happy to sit and listen to music, watch the television or just immersed in their own thoughts, no-one was ignored. Staff regularly went around to ensure people had drinks and had drunk them, enquiring that all was well.

We talked with kitchen staff about the menus which were planned over four weekly cycles. The main meal was served at lunchtime with a lighter meal at suppertime. A blackboard was on display in the dining room which stated what food choices were on offer that day. People's menu choices were taken during the morning by staff. We spoke with a member of staff who was cooking the meal on the first day of our inspection. She told us of the qualifications she had achieved in food hygiene and had a good knowledge of the special diets that people needed such as gluten-free, sugar-free, pureed and soft diets. Vegetarian options were also available.

The registered manager explained how people were referred to other services for specialised care and support when required. They had put in place a 'referrals book' which was completed by the registered nurse on shift to request when a person might need involvement from other healthcare professionals such as a speech and language therapist, tissue viability nurse or living well with dementia team. Requests for referrals were clearly recorded and followed-up to ensure people had the additional support they required.

We asked people whether they received input and had access to healthcare professionals such as their GP, dentist, optician and chiropodist. People told us there was a GP who visited regularly and a chiropodist, who was in attendance on the first day of our inspection. If people did not have their own dentist or optician an appointment could be arranged for them, if necessary at the home. Care records we looked at showed when people had been visited by various healthcare professionals and the outcome of these visits. Clear guidance was provided to staff on how to manage any identified healthcare need arising from the professional's visit. When people needed to be admitted to hospital, information relating to their personal and care needs was printed off and accompanied them. The registered manager told us that a member of staff would always go with a person when they had to go into hospital, to ensure the safe handover of

medicines.

Baytrees Nursing Home has been adapted from two semi-detached buildings to provide nursing and residential care. Two separate staircases allowed access on either side of the home and there was a lift for easy access. Staff we spoke with commented on the lack of investment on the exterior of the building and general upkeep of the maintenance and its contents. People had also commented feeling that parts of the home were in need of redecoration. People had access to gardens at the home and visitors were made to feel welcome. People told us that visitors were allowed to come in at any time and there were no restrictions in visiting the home.

Good

Is the service caring?

Our findings

We observed that all members of staff genuinely cared for people and treated them with respect and compassion. Staff were friendly and patient when offering or providing support to people. One person said, "The care and attention is very good. I was in a bad place before I came here, but the staff have brought me round. I've got nothing but respect for them". Another person told us, "Staff are gentle as can be and I think they are very kind. They always find time to speak to me and we get on very well". A third person commented, "The best bit about here is the staff. They are all so friendly and helpful. They really care and I never hear anyone moaning". A relative said, "The staff are all very kind and professional at what they do".

We asked people what staff were like, whether they spent time talking and getting to know them and if they were gentle when they assisted people. A relative said, "All the staff are very kind. They make me feel welcome as they always talk to me and offer me drinks. It takes very special people to do the job they do and they do it very well". One person commented, "Staff are very kind and have taken time to get to know me. I don't have to think for myself if I don't want to. I don't have to worry about washing or what to wear, they will do that for me and that is a relief". Another person told us, "Oh staff are as gentle as can be. They'll say to me, "Do you think we could do your legs today?" and then they do, lovely it is". It was clear that staff knew people well and that positive relationships had been developed. Staff knew people's personal histories, likes and dislikes; personal histories about people had been recorded within their care plans. We observed staff reassure people if they were anxious or upset.

People told us they made choices about their lives and felt in control of their lives. One person said, "There's give and take. I'm an early morning and early to bed person. Unless there's something going on, the routine is that they get me up around 7.30 and wash and dress me, then I'm happy to sit and watch tv, do whatever I feel like for the day and return to bed early evening. I've never felt rushed and I've certainly never bothered about who gives me personal care". Another person told us, "The staff are nice. I'm a good sleeper and don't mind fitting in with others. I'm easily contented. I can do whatever I please and that's exactly what I do. There's always someone for a chat if I want to". A third person said, "I can make my own decisions. I normally tell staff the day before what time I want to get up. I then watch telly, join in with the quizzes, bingo or whatever when I feel like and also like to go to the pub lunches".

We observed that people were treated with dignity and respect by staff. For example, if a person required to be hoisted, this would be done in the top lounge to provide people with privacy. Similarly the chiropodist would provide treatment in a screened-off area to people. We asked people whether staff spoke to them in a respectful manner and in line with their preferences. Everyone we spoke with said staff were respectful and addressed them by their chosen name and no staff member entered their room without knocking first. People said they were always asked for their permission when staff carried out any interventions and felt their dignity was always preserved. Curtains were drawn when staff delivered personal care or when helping people to dress. A relative said, "I have never seen anyone treated with disregard". One person told us, "Staff all know who I am and call me by my name which I like. They always knock before coming into the room, even if I've pressed the bell to call for someone. The carers always ask permission if they need to do anything and wait to be given the 'go ahead' or will repeat if I've missed what they said".

Good

Is the service responsive?

Our findings

We looked at a range of care records. The provider was in the process of transitioning from paper-based records to an electronic care plan system. Care plans we looked at were person-centred and contained information in relation to people's care and support needs. For example, in relation to their physical and mental health, personal care needs, continence, night care, medicines, capacity and last wishes. People's religious preferences had been completed and any specific language needs. People's rights were acknowledged and included in the provider's Statement of Purpose, for example, the right to complain and to have support from an advocate if needed. Care plans were reviewed monthly although it was not clear from the care plans how people or their representatives were involved in care plan reviews. However, people we asked had been involved in their care plans and in the reviews. A relative said, "I have been fully involved in [named person] care plan and reviews. Recently I discussed end of life care with staff". One person told us, "I've got my care plan. My sons are involved with my care and I'm very happy about that. I don't think it has got to end of life care yet, but I think that conversation will have to be had at some point". A second person said, "I have been involved with my care plan but I've got nobody to sort things out for me if I can't make decisions later down the line, so I've appointed a solicitor, who will hold Power of Attorney for me. The paperwork is going through now". A second relative told us, "Yes I have been involved in [named person] care plan and everything is fine at the moment. I'm sure we will have a review at some point". We also asked people if they were able to practice their faith, but no-one we spoke with had religious beliefs. We were told, however, that there was a vicar who visited on a Friday morning and some people did attend their church.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. People had a good understanding of the content of their care plans and were, as much as they were able, fully involved with all aspects of their care. However, care plans had not always been signed by people to show their agreement nor were they written in a format that took account of their communication needs.

A part-time activities co-ordinator was employed at the home. Activities and outings were planned well ahead and notice given when these were due to take place so people could sign-up to go on them. Outings were arranged such as afternoon tea in Worthing, lunch at various pubs, ten-pin bowling and shopping. Activities within the home included bingo, quizzes, card games and musical entertainers also visited. When the weather was clement, activities were organised on the decking outside the conservatory. We asked people whether they liked to join in with the activities on offer and if there was something they particularly enjoyed. We also asked people if they managed to get out to activities in the community.

A relative said, "All the staff are absolutely wonderful and [named activities co-ordinator] who organises the entertainment and outings is brilliant. I've been invited many a time to join in with the outings. It's lovely to go out for lunch. They do parties here, games and have entertainers. There's plenty going on and they make me so welcome". One person told us, "We have a bus but can only get eight in it. The outings are put

on the board and we add our names. There's always a chance to get out as there's usually an outing twice a week".

We looked at the record of complaints that had been received at the home. Each complaint had been documented and included the actions taken to rectify any issues. The complaints policy was on display at the home. Complaints were acknowledged within three working days and completed within 28 working days. We asked people what steps they would take if they were unhappy about anything at the home. A relative said, "I know the complaints procedure, but have never had to use it. If I had to though, I would". One person told us, "The staff are very accessible and I'm pretty sure if I had to make a complaint, it would be resolved there and then". Another person said, "Yes, I know the procedure for complaints, I did make one when I first got here. Three windows in my room were blown and they quickly changed them, so I know the system works". A third person told us, "If I had to make a complaint I'd see the manager. She's around every day and I feel sure she would take me seriously and do something about it".

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. Some staff had completed end of life care training. When they wished to, people had discussed their end of life care wishes and these were recorded within their care plans. The home had signed up to an NHS initiative to improve co-ordinated end of life care. The service aims to improve the co-ordination and delivery of end of life care for people across coastal West Sussex by linking key service providers together via a 24/7 telephone co-ordination hub.

Requires Improvement

Is the service well-led?

Our findings

Records relating to people's care had been left on a table in the dining area which meant that information was not kept confidentially. We drew this to the attention of a member of staff who then removed the records. They told us that the records were not care plans but were notes. Nevertheless, the records should not have been left in a communal area where anyone could have access to them. The medicines audit which we looked at had not identified the loose blister pack left in a secure cabinet or an ophthalmic solution left in the refrigerator, when these should have been disposed of. There was an inconsistent approach to training and the registered manager stated that when training was booked, some staff did not attend. Training had not been prioritised to ensure staff were skilled and competent to ensure the safety of the people they cared for. For example, according to the training matrix, not all staff had received safeguarding training. The registered manager told us that not all staff had completed safeguarding training as they did not come into contact with people living at the home. There was a lack of oversight from management in the implementation of staff training and supervision.

The above evidence demonstrates that the provider had failed to ensure systems were effective in mitigating risks because staff had not completed the training they required, nor did they receive regular supervisions. Medicines audits had failed to identify that some medicines needed to be disposed of. Records relating to people's care were not always kept confidentially. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture at Baytrees Nursing Home was positive, friendly and family orientated. We asked people what it was like living at the home. One person said, "It's very nice here, sometimes a little noisy, but plenty going on and if I want peace and quiet, there is always my room, which is very comfortable". Another person told us, "There's always someone here and the staff are always happy which makes this a happy place". A third person commented, "The people are friendly and [named activities co-ordinator] is especially good fun. I would say the atmosphere here is like one big family".

We asked people whether they felt the registered manager was effective and whether they had regular contact with her. One person said, "The manager is very accessible and she always says 'hello' and asks how I am when she sees me". Another person told us, "The manager is very good. The first meeting I had with her was over the 'phone and she immediately put me at ease. She sounded so confident and warm". A third person said, "She comes round every day. She's a good manager and doesn't stand any messing around. You can't pull the wool over her eyes. She's very approachable".

The Commission's rating of the home, awarded at the last inspection, was on display at the home as required.

Some systems had been established to monitor and measure the quality of the care delivered at the home and the service overall. Observations had been completed in relation to staff supporting people. Call bells had been audited to monitor how long people had to wait before they were assisted by staff. Questionnaires had been sent out to staff, healthcare professionals who visited the home and people who

lived at the home. However, the level of responses was low. Of the responses we looked at, the results were quite positive. We asked people if they were involved in decisions of how the service was run, if there were any residents' meetings or whether any surveys or feedback forms were handed out. Residents' meetings did take place, but people were vague in their responses and unable to say if they had seen any minutes of residents' meetings.

The registered manager explained how they kept up to date with latest practice by attending a managers' forum, worked closely with a local hospice and received updates from the National Institute for Care Excellence (NICE). Representatives from the local authority had provided input in relation to care plans and training suggestions. The provider told us, "We discuss regularly what we would like to do and what we're aiming for and have regular managers' meetings". When first aid training had been organised, staff from other homes had been invited to participate. The registered manager said, "It's not so competitive between nursing homes any more".

Staff felt supported at the home and told us they could see the registered manager at any time. The registered manager said, "We have an open door policy here and staff can talk to a nurse at any time. Staff have a named nurse who is responsible for a group of staff". The registered manager added, "I think we're very person-centred and have good communication. Staff feel confident in walking into the office if they have a problem. When there is a problem we take it and deal with it. We involve and take advice from staff". Staff confirmed they felt listened to if they had any concerns about the home and felt the registered manager respected their views. One staff member told us, "I have never had trouble speaking with the manager. We are encouraged to raise issues and they do listen". The same staff member explained the provider's whistleblowing procedures and we looked at the whistleblowing policy. Whilst the majority of staff felt supported by the registered manager, some felt they were not valued sufficiently by the provider. Some staff talked about their workloads and felt this had contributed to the high turnover of staff. Staff meetings took place and records confirmed this. Registered nurses had separate meetings and we looked at the recent minutes of all these meetings.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems and processes had not been established or operated effectively to assess and monitor the service. Records were not kept securely. Regulation 17 (2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider did not ensure that staff received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2)(a)