Barchester Healthcare Homes Limited

Mount Tryon

Inspection report

Higher Warberry Road
Torquay
Devon
TQ1 1RR
Tel: 01803 292077
Website: www.barchester.com

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Mount Tryon is registered to provide accommodation and personal and nursing care for up to 59 people. Care is provided to older people, people with a physical disability, people with dementia and younger adults. There is a dementia care unit situated at first floor level that has two areas, Memory Lane and Penny Lane. People needing more general nursing or personal care live on the ground floor. On the first day of inspection there were 41 people living at the home. Mount Tryon is part of the Barchester group of homes.

The inspection took place on 15 and 16 October 2015 and was unannounced. Mount Tryon was last inspected by the Care Quality Commission (CQC) on 20 and 22 January 2015 when it was rated as 'Requires improvement'. We identified the registered provider was not meeting the regulations in relation to infection control procedures, quality assurance systems and notifying CQC about specific incidents. Following the inspection in January 2015 the provider sent us an action plan telling us they would have made the required improvements by 30 June

Summary of findings

2015. At this inspection in October 2015 we looked to see if these improvements had been made. We saw that some improvements had been made, but further improvement was needed.

It is a condition of the service's registration that a manager is registered. The previous registered manager had left the service in July 2015. A new manager had started work at the service the week of our inspection. They had not yet applied to register, but planned to submit an application. An acting manager had been in post since the registered manager left and was still working at the home to help the new manager settle in. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The new manager outlined their plans for improving the service and described how they intended to ensure improvements were made. However, the impact of this had yet to be felt by people living at the home, their visitors and staff.

Prior to the inspection we had received concerns that several members of staff had left and this had resulted in low staffing levels and high numbers of agency staff being used resulting in people's needs not being met.

At this inspection in October 2015 relatives, staff and people living at the home told us their main concern was the low staffing levels and the high use of agency staff. We found this resulted in people receiving inconsistent care and at times their needs were not met satisfactorily. This was particularly apparent at tea time when staffing levels were reduced and people became more distressed.

People did not always receive care and support that was responsive to their needs. Individual staff were caring but they were often too busy to be able to meet people's needs in a kind and caring manner. Some staff knew the people they cared for well and were able to tell us about their individual needs and how they liked them met. However, one agency member of staff told us "I've not actually sat down and read the care plans, all I know is what people tell me."

Some staff were proactive in their approach to people's needs, they identified when people were becoming agitated and took action to prevent the agitation. However, not all staff worked in this way and we saw one agency member of staff who only engaged with people when they had become very distressed.

Quality assurance processes had recently been introduced but there was not yet evidence that these were effective. A dementia care specialist had visited the home and recommended improvements, it was acknowledged by the management that these were needed. However, there was no action plan to show how the improvements would be made.

People's privacy and dignity was respected and all personal care was provided in private. However, confidentiality was not always maintained and we heard one staff member discuss people's needs in front of other people.

There were systems in place to manage people's medicines and ensure people received them as prescribed. However, improvements were needed to ensure there were clear directions when people had been prescribed medicines to be taken 'when required'.

Risks to people's health and welfare were well managed. People were protected from the risks of abuse and the risks of unsuitable staff being employed were minimised.

People were asked for their consent before staff provided personal care and were supported by staff who displayed a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

People were supported to access a range of health and social care services. People had received visits from a variety of professionals including GPs, speech and language therapists and care managers.

Improvements had been made to the meal time experience. Lunchtime in the dining areas on both floors was unhurried and sociable and staff had time to chat with people. People were supported to maintain a healthy balanced diet, although this was not always well monitored.

People's care plans were comprehensive and reviewed regularly. People and their relatives were supported to be involved in making decisions about their care. Visitors told us they could visit at any time and were always made welcome.

Summary of findings

People were confident that if they raised individual concerns they would be dealt with quickly by staff. However, visitors were not confident their concerns about staffing levels and the use of agency staff were being addressed by Barchester.

We have made a recommendation that staffing levels are reviewed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

Aspects of the service were not safe.

People's needs were not always met. At some times during the day staff were very busy and we have asked that staffing levels be reviewed.

There were systems in place to manage people's medicines.

People were protected from the risks of abuse.

People were protected by robust recruitment procedures.

Is the service effective?

Requires improvement

Aspects of the service were not effective.

The environment needed improvement to make it more suitable for people

living with dementia.

People were supported to receive the healthcare they needed.

People were supported to maintain a healthy balanced diet, although this was not always well monitored.

People were asked for their consent before staff provided personal care.

People were supported by staff who displayed a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires improvement

Aspects of the service were not caring.

Individual staff were caring but they were often too busy to be able to meet people's needs in a kind and caring manner.

People's privacy and dignity was respected and all personal care was provided in private. However, confidentiality was not always maintained.

People and their relatives were supported to be involved in making decisions about their care.

Is the service responsive?

Requires improvement

Aspects of the service were not responsive.

People did not always receive care and support that was responsive to their needs.

People's care plans were comprehensive and reviewed regularly.

Visitors told us they could visit at any time and were always made welcome.

Summary of findings

People were confident that if they raised individual concerns they would be dealt with quickly by staff.

Is the service well-led?

Requires improvement

The service was not well led.

There was no manager registered for the service.

There was no effective system in place to regularly monitor and improve the quality of care provided.

There was no action plan that detailed how the identified improvements were to be made.

Mount Tryon

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 was 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 15 and 16 October 2015 and was unannounced.

The inspection was carried out by two adult social care inspectors on the first day and by one adult social care inspector on the second day.

Before the inspection visit we gathered and reviewed information we held about the provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. We looked at the action plan the provider had sent to us following the inspection on 20 and 22 January 2015.

We spoke with or spent time with 27 of the people living in the home and eleven visitors. We spoke with three health and social care professionals, the manager, acting manager and 16 staff. We also spoke with three members of senior staff visiting from head office.

We observed the interaction between staff and people living at the home and reviewed a number of records. The records we looked at included four people's care records, the provider's quality assurance system, accident and incident reports, three staff records, records relating to medicine administration and staffing rotas.

Following the inspection we contacted the local authority who had commissioned placements for people living at the home, to obtain their views of the service.

Requires improvement

Is the service safe?

Our findings

At our inspection in January 2015 we found improvements were needed to managing people's food and fluid intake, staffing levels, infection control procedures, protecting people's personal items, and managing people's risk of choking.

At this inspection in October 2015 we found that although some progress had been made, improvements were still needed in some areas.

Improvements were still needed where people had been highlighted as being at risk of poor nutrition or hydration. Food and fluid charts were available to use but the charts had not been fully completed. Poor record keeping in relation to the person's food and fluid intake meant staff could not judge if the care and treatment they were providing was safe.

Where accidents and incidents had taken place, these were recorded and a report was produced that identified any issues within the home that needed improvement. However, this report did not look at the number of falls or accidents sustained by an individual. This meant that times and places individuals fell were not identified and risks were not identified and minimised.

This was a breach of Regulation 12 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people were well managed. For example, moving and transferring and pressure area risk assessments were in place and had been updated when risks had changed.

People's risk of choking had been minimised. A fork mashable diet was provided to those that required it. There was some confusion as to how meat should be presented to people who required a fork mashable diet. The information available to staff in the dining room said that meat should be pureed. As meat given to people was not pureed we queried this with staff who assured us mashing the meat was sufficient. This was later confirmed as acceptable by a healthcare professional. The manager agreed to change the information available to staff on the unit, in order to avoid further confusion.

People, their visitors and staff were concerned about the number of agency staff being used. They felt that staffing levels appeared to have got worse because of the high level of agency staff being used while permanent staff were being recruited. We also saw that staffing numbers reduced by one at tea time. Where possible the same agency staff were used to aid continuity of care. However, on two occasions an agency nurse had not turned up and staff who had already worked one shift, had to cover the next one.

Some staff also told us there were not enough staff to meet people's needs, especially at mealtimes when so many people needed help to eat. They said that often agency staff took up their time, as they needed to be shown how to do things. However, other staff told us they felt that there were enough staff to be able to meet people's needs.

While people's needs were being met throughout the day it was evident at tea time that people became more distressed as there were fewer staff to meet their needs. Since the last inspection some staff had left. We discussed our concerns with the management team and the regional operations director for the Barchester group. They acknowledged all our concerns and told us they were working hard to rectify the situation and were recruiting more staff. They told us that while staff had been appointed, other staff had left. They were aware of the issues the low staffing levels were having on people living at the home and said that they had not admitted more people to live at the home because of this.

During our inspection there were 41 people living at the home with 22 people requiring help from two staff. Most people were older and the majority of people had mobility difficulties. All 20 people on the first floor were living with some level of dementia. The 21 people living on the ground floor had more general nursing needs. There was a registered nurse plus five carers on each of the floors in the morning and a registered nurse and 4 carers on each floor during the afternoon. At night, rotas showed there was to be one registered nurse and three carers on duty. As well as care and nursing staff there was a number of ancillary staff including kitchen and domestic staff as well as managers, domestics and laundry staff.

A system was used to assess people's dependency levels and this information was used to determine the numbers of staff required to meet their needs. Rotas showed the staff levels as determined by these calculations, were being maintained. Managers told us in order to maintain the staffing levels, agency staff had to be used. They said they

Requires improvement

Is the service safe?

had requested the agency send the same staff as agency staff could not be expected to know people living in the home as well as full time permanent staff. One agency worker confirmed they had been working at the home for 10 weeks. However another agency worker told us that they worked in many different homes, and that it had been several weeks since they were last allocated a shift at Mount Tryon.

At this inspection in October 2015 the issue of items going missing from rooms was not raised. Locks had been fitted to all bedroom doors so if people wanted to prevent other people going into their rooms, they could lock their door. Relatives raised concerns that people could get accidently locked in their rooms. However, the type of lock that had been fitted meant that people could not accidently lock any of the doors.

Relatives told us they felt their relatives were safe. One relative told us "No worries whatsoever. If I thought for one moment they were not safe I'd be shouting from the roof-tops".

People were protected from the risk of abuse as staff understood the signs of abuse, and how to report concerns within the service and to other agencies. Staff told us they felt confident senior staff would respond and take appropriate action if they raised concerns. Staff had also received training in safeguarding people.

Safe staff recruitment procedures were in place. Staff files showed the relevant checks had been completed. This helped reduce the risk of the provider employing staff who may be a risk to vulnerable people.

People were protected against the risks associated with medicines because there were arrangements in place to safely manage medicines. The nurse on duty gave people their medicines. Records of medicines administered confirmed people had received their medicines as they had been prescribed by their doctor to promote good health. However, some people had been prescribed medicine to be taken 'when required' to relieve their distress. In these instances the instructions for when staff should give the person the medicine was unclear. The staff member we spoke with was clear about when they would give the medicine and felt other staff would do the same. However, they recognised that there was a possibility staff may interpret signs of distress differently and therefore administer medicines at different times. The acting manager said they would ensure more detailed directions were added.

Procedures were in place to protect people in the event of an emergency. Staff had been trained in first aid and there were first aid boxes easily accessible around the home. Personal emergency evacuation plans were in place for people. These gave staff clear directions on how to safely evacuate people from the building should the need arise, such as a fire. Records showed that equipment such as hoists were regularly maintained and serviced to ensure they remained safe to use.

Infection control procedures had been improved and staff were seen wearing disposable gloves and aprons. However, several areas had a strong smell of urine and there were plans to replace these carpets.

We recommend that tea time staffing levels are reviewed. A copy of the review should be sent to CQC when it has been completed.

Requires improvement

Is the service effective?

Our findings

At our inspection in January 2015 we found improvements were needed to the environment and to the way mealtimes were managed as not everyone had a positive experience.

At this inspection in October 2015 we found that some improvements had been made to the environment, but improvements were still needed to the first floor, dementia care unit. The manager told us that areas for improvement had been highlighted and plans were in place to make the improvements. For example, the two units which are at present separate are to be merged into one. This was to enable everyone to use the whole of the first floor.

Everywhere was to be re-carpeted to bring the two units together as one. At our inspection in January 2015 we had used the Kings Fund environmental tool to assess the environment. The Kings Fund is an organisation that provides advice on health and social care matters. We had found that improvements could be made. For example, the level of lighting could not be adjusted, toilet doors were not 'painted in a single distinctive colour with clear signage' and there was no independent access to outdoor space for people. At this inspection we found that lighting could still not be adjusted, toilet doors remained the same and there was still no independent access to outdoor space. Staff told us that they did take people into the garden when the weather permitted, but this was not on a regular basis.

Improvements had been made to the meal time experience. Lunchtime in the dining areas on both floors was unhurried and sociable and staff had time to chat with people. When people needed a soft diet each food item was prepared separately and presented attractively. People who needed support with their food were encouraged to eat in a relaxed manner. Several people in the ground floor dining area were helped with their meals by their relatives. Relatives told us they did this to help staff during the busy lunch time. When we asked the acting manager about staffing levels at lunch time they told us that all staff including activity staff helped out at lunch time and that there was no need for relatives to help unless they wished to.

People living at Mount Tryon had needs relating to living with dementia, mobility and general health. Staff had received a variety of training including moving and transferring, safeguarding people, infection control and dementia care. Staff working on the dementia care unit on the first floor were knowledgeable about various types of dementia and how these may affect a person's behaviour in differing ways.

Training was provided to staff either by the provider's 'in-house' trainer, by visiting specialists or by staff attending external courses. In order to ensure they maintained their knowledge to keep their registration, the nurses told us they had attended many specialist training courses.

There was a system to ensure all agency staff had a basic induction to the home. This was not always followed and there was no system to check it had been followed. The acting manager showed us the induction checklist that should have been completed for every agency worker's first shift at the home. However, one agency worker told us that on their first shift at the home (on the first floor) they were given no induction and no information whatsoever. However they were given an induction and shown around when they did their first shift downstairs.

Staff received regular supervision and an annual appraisal. Staff told us they could raise any concerns they had and the sessions helped them feel supported by senior staff.

Many people who lived at Mount Tryon did not have, or might not in the future, have the capacity to make some decisions. Although not all staff had received formal training, they all had a good understanding of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). This legislation is in place to ensure people's legal right to make a decision is upheld and that their liberty is not restricted without proper authorisation. Staff were aware that everyone is assumed to have capacity to make a decision unless it is proven otherwise. People's best interests were upheld when they had been assessed to not have capacity to make a specific decision at a specific time. For example, healthcare professionals, relatives and staff had been involved in deciding that as one person needed specific medicines to maintain their health, they should be given the medicines without their knowledge.

People's liberty was only restricted when there was no other means of keeping them safe. Staff were aware that any such restrictions should be properly authorised and always be the least restrictive option. Where necessary DoLS applications had been made to the local authority

Requires improvement

Is the service effective?

and people were being monitored to keep them safe whilst the DoLS applications were in progress. Where applications had been granted staff acted in accordance with the details contained within the authorisation.

Throughout our inspection people were offered choices about what they wanted to drink and eat and where they wanted to spend their day. Staff asked people for their consent before providing care. For example, staff asked people if they could assist them to move from chairs to wheelchairs and vice versa.

People were supported to receive a balanced diet. People were offered plenty of snacks and drinks through the day. Information regarding dietary needs and preferences were taken from people's care plans and passed to the kitchen so that the chefs knew what people's tastes and requirements were. The chef told us that a list was passed to them of people's choice for each meal. They said some people would change their minds so they always did extra portions to allow for this. However, we did not see people living with dementia being shown both options so they could chose, and there was no option for those who needed fork mashable food. One person told us "the standard of food went rock bottom in my opinion, but now the kitchen is back to its standard." They then told us what they normally chose for breakfast, but how on the day of our inspection they had chosen something different. Relatives told us staff always noticed when people had not eaten their meal and offered them an alternative.

Staff ensured they contacted healthcare services when people needed them. Records showed people had seen their GPs and other health and social care professionals as needed. We spoke with a visiting GP. They told us staff at the home contacted them when necessary and that they followed any medical advice given. They said that the information about people that was given to them was always up to date and thorough. A visiting social care professional told how the person they visited had lived at Mount Tryon for many years was very happy there. They said they found staff helpful and professional in their manner.

Requires improvement

Is the service caring?

Our findings

At our visit in January 2015 we found that some aspects of Mount Tryon were not caring. We found that improvements were needed to the way people's privacy and dignity were maintained. People or their representatives were not routinely involved in planning people's care and most interaction between people and staff was task related.

At this inspection in October 2015 we found that some improvements had been made. However, we identified improvement was needed to ensure confidentiality was maintained at all times and to the way some staff interacted with people.

Not all staff spoke about people confidentially. One member of staff told other staff about people's needs in the dining room in front of people living at the home. However, when other staff spoke with us about people, they checked it was alright for them to tell us about people's needs.

People and their visitors spoke highly of the care they received. We were told by all the people living at the home, and their visitors that the permanent staff who remained at the home were "wonderful" and "very hard working." One visitor told us " Can't fault the carers, they are wonderful, just not enough of them". One person living at Mount Tryon said " I think the staff are very friendly and very helpful, you can ask them any questions you like."

People's privacy and dignity was generally upheld. Although some people living with dementia did sometimes go into other people's rooms, staff were vigilant in redirecting them when they tried to do this. People told us they felt their privacy was respected. All personal care was provided in private. People were dressed appropriately and their clothes were clean and tidy which told us that staff had taken care to ensure people's personal needs were met. People were treated with respect and as individuals. Staff enabled people to maintain as much independence as possible and offered choices throughout the day. Staff listened to people and supported them to express their needs and wants. Any personal care that was offered was done so in a discreet manner.

Everyone we spoke with told us that although staff as individuals were caring, there were not enough on duty to make sure they could spend quality time with people. We were told that two years ago it was not unusual to walk into the home and see carers with their arms round someone and chatting with them, but "Now they can't do it at the moment as they do not get the time, there are just not enough staff." We saw some very caring interaction between staff and people. However, most of the interaction in the dementia care unit was still centered around tasks.

We were shown a report following a visit from a dementia care specialist. The report highlighted that although there were many positive and supportive interactions, staff were rushed and "care task orientated in their approaches to care delivery and interactions with residents". The regional operations director, managers and the head of the dementia care unit told us that they were working to change this. There were to be environmental changes to the unit and staff were to be supported to work in a different way. However, there was no action plan to show how this was to be achieved.

Staff were pleasant, friendly and open and spoke about the people in their care affectionately. One staff member told us "I work with my heart and with compassion, I always remember I am a guest in their home".

People's needs were reviewed regularly and where people were not able to be involved in making decisions about their care, we saw that their relatives had been. Relatives told us their relatives' needs were discussed with them and staff always let them know if there were any changes in their needs.

Relatives and friends were welcome at any time and were coming and going throughout our inspection. They could have privacy in individual rooms or in the lounge if they wished.

Requires improvement

Is the service responsive?

Our findings

At our inspection in January 2015 we found inconsistencies in the way staff responded to people's social care needs. Also some staff were unaware of people's specific care needs. At this visit in October 2015 we found some improvements had been made but that there were still improvements required.

People's needs had been assessed and care plans developed. People's care plans were reviewed monthly and updated when their needs changed. However, people's care plans gave limited instructions to staff on how to manage people's emotional care needs. For example, one person's care plan told staff to talk to the person to try to calm them down. However, there were no details on how to talk to the person or what to talk to them about. Although permanent staff knew how to meet people's needs, the lack of written information meant agency staff may approach the person in different ways and this could have an impact on the persons care.

Permanent staff knew the people they cared for well and were able to tell us about their individual needs and how they liked them met. However, one agency member of staff told us "I've not actually sat down and read the care plans, all I know is what people tell me."

Some staff were proactive in their approach to people's needs and identified when people were becoming agitated. They took action to prevent the agitation increasing by speaking with the person or walking with them and chatting about what they may want to do. However, not all staff worked in this way and we saw one agency member of staff who only engaged with people when they had become very distressed. We discussed this with the management team who agreed to address this with the agency staff member.

Staff spent some time with people on an individual basis. One person was encouraged to help fold a basket of clothes and another was encouraged to touch a series of locks and switches that were attached to plaque on a wall. One member of staff responsible for activities ran a musical session in the downstairs lounge. They put on a CD and tried to encourage people to sway in their chairs, by individually taking their hands and swinging their arms in time to the music. They later spent some time supporting people to complete a crossword puzzle. One person living at the home told us that sometimes trips out in the mini bus were arranged, to go to the beach and have tea and biscuits. Another person told us "there are ancillary staff, like activities, I think that is pretty good, they do sewing and music and they're baking donuts today and they try to keep everybody busy, not just in bed."

Relatives told us they felt stimulation for people was something that needed improving. They said that while there was a notice displaying a series of activities available, the notices were not dated and the activities often did not take place. They said that often the only stimulation was the TV. During our inspection two of the three TVs were on, showing subtitles, people were not watching one of them at all. The report from the visiting dementia care specialist recommended the provision of activity for people living with dementia was reviewed. There was no action plan to show how this was to be addressed.

People knew how to raise concerns or complaints. One relative told us "normally if something is not right I go to a carer and it can be sorted straight away, they are all very approachable and conscientious staff." Records showed complaints had been fully investigated and responded to.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in January 2015 we found there were quality assurance procedures in place for identifying areas for improvement, but these were not always followed through in a timely way. Care practices were not thoroughly monitored to identify shortfalls in performance and CQC was not always notified of occurrences within the home as required.

At this inspection in October 2015, there was no manager registered for the service. Since our inspection in January 2015 the registered manager, deputy manager, and many staff had left. A new manager had very recently been appointed, but had not yet applied to register and a deputy manager had been appointed, but had since left. Most of the concerns raised with us and many of the issues we identified related to the lack of permanent staff and the use of agency staff.

At this inspection in October 2015 we found that some improvements had been made, but the impact of this was yet to be felt by the people living at Mount Tryon and their relatives. The management team spoke of the improvements to be made including those to the dementia care unit. However, there were no firm action plans to show how the improvements were to be made as suggested by the specialist's visit.

The new manager outlined their plans for improving the service and told us of the need to ensure everyone believed in the same ethos and philosophy. They described their intention to make changes to ensure improvements were made. However, the impact of this had yet to be felt by people living at the home, their visitors and staff. A relative said that they had met the new manager very briefly they said "He does not seem to be communicating very much, but neither did the acting manager, I never had any communication with her. I wonder what they're doing." A staff member told us that they thought they had bumped into the new manager on the day of our visit, they said "at least I assume it was him, he has not introduced himself."

New quality assurance systems were in place to monitor the quality of care provided. Some of these checks had been newly introduced so it was not yet possible to evaluate their effectiveness. The manager recorded a series of daily observations around the home, including checking for any maintenance issues and checking people's charts recording their nutritional intake. However, this had failed to identify that charts were not being fully completed. There was no system in place to ensure staff working in the home were working in a way that Barchester required. For example, in relation to maintaining confidentiality. Also the system for ensuring agency staff had the information they needed when they first started work in the home was not robust.

This was a breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a monthly programme of in-depth audits which included medication and infection control. We met the newly appointed area clinical nurse lead who was visiting the home on the day of our inspection. She told us that her role was to provide support and advice to the nurses as well as to carry out quality audits of their work.

Relatives were concerned about the findings from our inspection in January 2015. They told us that following our last report they had requested a relatives meeting to discuss it. This had been arranged and a representative from Barchester had attended and told the relatives that it (CQC findings) was not acceptable. Another relative told us the management had agreed to hold a follow up meeting in October 2015, but that it was being postponed until November 2015, once the new manager had settled in. All relatives were concerned that although meetings were held and promises made by Barchester they had not yet seen improvement.

Staff told us they felt supported to do a good job and that there was a friendly atmosphere at the home. One staff member told us that management were approachable and that they had seen recent improvements. They said that mealtimes were now much more relaxed.

Improvements had been made following suggestions from relatives. A noticeboard was now in place to keep relatives informed of events and 'communication' diaries had been obtained for everyone living at the home. Staff and relatives could write in the diaries to improve communication between them.

The manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided to people in a safe way. Regulation 12 (1)(2)(a)(b)(c).**

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 **There was no system in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a).**