Care Quality Commission

Barchester Healthcare Homes Limited

Ritson Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 31 October 2017 and was unannounced.

Ritson Lodge provides accommodation, nursing and personal care for up to 60 people, some of whom were living with dementia. At the time of our inspection, there were 50 people living in the service.

Ritson Lodge accommodates up to 60 people across three separate units; Seabreeze (nursing care) Seashore (residential care) and Spindrift (memory lane).

Ritson Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager 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.

At our last inspection on 20 May 2015, we rated the service as Good.

During this inspection we found that the quality assurance and auditing mechanisms did not identify concerns we found during the inspection. Concerns regarding staffing levels had not been addressed promptly by the provider to ensure people were receiving responsive care. Some relatives told us that communication needed to improve between them and the management team. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for good governance. You can see what action we told the provider to take at the back of the full version of the report.

The culture in the service was welcoming, friendly, and person-centred. The management team presented as open and transparent throughout the inspection, seeking feedback to improve the care provision.

People did not always receive the time and attention they needed to fully meet their needs. At times staff were unable to respond to people as quickly as they would like or perform their role effectively. This impacted on staff's ability to provide care which was consistently dignified and respectful.

Appropriate arrangements were in place to ensure people's medicines were obtained, stored and administered safely. Documentation relating to 'as required' and variable dose medicines were not always clear and accurate.

Activity provision was delivered by two activity co-ordinators within the service. However, some feedback suggested that this did not always meet the individual needs of people, and we have asked the service to

review this to ensure it is effective.

People were referred to other health care professionals to maintain their health and well-being in a timely manner.

Staff interacted with people in a kind and caring manner. Staff were patient with people, and skilled in using different methods of communication which reassured people.

The service was meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). Staff understood the need to obtain consent when providing care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were able to recognise abuse and knew how to report concerns if they suspected a person was being abused. Systems were in place to discuss potential safeguarding issues so they were escalated appropriately.

There was a complaints procedure available in the service for people and relatives to raise concerns.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Staffing levels were not sufficient to ensure that they were meeting people's needs in a timely manner.

People received their medicines safely. However, where people were receiving medicines on an 'as required' basis, or as a variable dose, clear and accurate records were not always being kept.

The likelihood of harm had been reduced because risks had been assessed and guidance provided to staff on how to manage risks and keep people safe.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

Is the service effective?

The service was effective.

Staff received training relevant to their role and were encouraged to continue their learning.

The service was working within the principles of the Mental Capacity Act 2005. DoLS applications had been made where required.

People were supported to ensure they received adequate diet and fluids. The mealtime experience was positive, people interacted socially and staff facilitated this well.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

The service was caring.

The atmosphere in the service was relaxed and people were listened to.

Staff were observed to know people well, and positive relationships had been formed.

People were supported to see their relatives and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We observed that staff could not always be responsive to people's needs due to staffing levels.

Activity provision was provided by two activity co-ordinators working in the service. However, some feedback suggested that this was not always meeting the individual and specialist needs of all people.

Care plans guided care workers in the care that people required and preferred to meet their needs. The majority of care plans we reviewed were updated in line with people's changing needs.

There was a complaints procedure in place. People and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider and registered manager had not recognised the experience for people using the service, which was not meeting people's needs in a timely manner.

Quality assurance systems were in place, but had failed to identify some areas we found as requiring improvement.

Relatives felt they could raise concerns or issues to the management team, but did not always receive feedback. Several relatives thought that communication required improvement.

There was an open and transparent culture in the service. Staff felt they could raise concerns with the management team and be listened to.

Care Quality Commission

Ritson Lodge

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 checked 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 31 October 2017, was unannounced and undertaken by three inspectors, a specialist advisor in nursing care, and two experts 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law. We also received feedback from the local authority and safeguarding team.

During the inspection we spoke with 17 people who lived in the service. We also spoke with the relatives of eight people and 14 members of care and catering staff. We spoke with one healthcare professional. In addition, we spoke with the registered manager, deputy manager, and regional manager.

We reviewed 10 people's care plans and looked at people's medicine administration records (MAR) charts. We looked at three staff recruitment files as well as training, induction and supervision records. We also viewed a range of monitoring reports and audits undertaken by the registered manager and other senior members of staff.'

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt there were sufficient staff to meet their needs. One person said, "Probably not, no. They [staff] get busy and I certainly have to wait for help at mealtimes." Another said, "Sometimes there are enough [staff]. It all depends on the time of day and what's going on." And, "They could do with more [staff], if they're passing they'll say, 'Are you ok for a minute?' The most I wait is twenty minutes. I was waiting for a [bed pan] but by the time they [staff] got here I'd done it. I'm upset for them [staff] because they're busy enough without me causing any problems."
A third said, "Yes probably [enough staff], but I'm mostly independent. They help me with a bath which I would like daily, but I know it can't happen as they're [staff] so busy."

Staff told us, "Staffing is ok generally but there are certain times of the day, after lunch and supper, where people may want to go to bed. If staff call in sick that can be hard, trying to find cover, so we borrow from the other units which isn't ideal". Another said, "You always need more staff wherever you are. If it was up to me I'd have one to one staffing for each person; for real person centred care that's what you need. We work well as part of a team though."

On one of the units, we observed a calm atmosphere, and saw that staff were available to people who required assistance. On two of the other units, we observed staff to be pressured and rushed. For example, at 2pm we observed one person calling out, "Will you answer me please", and they sounded distressed. We saw staff were busy attending to other people. At 2.15pm, we saw that staff had not responded, so went into the person's room and located their call bell which was not within their reach. We activated the call bell and observed that the care staff arrived 27 minutes later.

One staff member told us that one person had very complex needs, and at times required more than two care staff to support them with their care needs. This often necessitated 'borrowing' staff from other units which had the potential to shift the adequacy of staffing levels on the other units. We were concerned that there had been no consideration of the impact on people who may need assistance at the same time.

Relatives also raised concerns. One relative said, "A lack of staff. I've spoken to carers about this and I've mentioned this at every relative's meeting. After the evening meal most of the people on the nursing wing are taken to bed, but it does leave those who don't necessarily want to go to bed, they have needs too." Another said, "I've had to change and wash my [relative], and have changed the bedding three times. I looked around the home for a member of staff but there was no one to assist. You can't find anybody for about two hours after tea. [Registered manager] did say they'll try and introduce a twilight shift."

The registered manager told us they calculated staffing levels using a dependency tool, but in addition to this, increased staffing levels as needed. However, they had not recognised the experience for people using the service was not effective in meeting people's needs in a timely manner.

Following the inspection, the registered manager informed us that they had implemented a twilight shift from 6pm to 8pm on two units (ground floor) and this will be reviewed in six weeks to look at the

effectiveness of this.

The registered manager told us they had recently changed their systems for medicines, as advised by the supplying pharmacy, and they were reviewing the effectiveness of this on a monthly basis. Each person had a lockable cabinet in their room which stored their individual medicines.

We reviewed the systems in place for managing people's medicines, and found some improvements were needed where people were receiving medicines on an 'as required' basis, such as for pain relief. There was not always sufficient information on when to administer these types of medicines. For example, we saw that there was a protocol in place for one person who experienced pain, and it explained what medicines to give. It did not however describe the location of the pain so staff could ask relevant questions. Another said to give an allergy medicine every four to six hours, but not what symptoms they might display if they needed this. Other protocols in place gave detailed information, particularly in relation to periods of anxiety or distress. One staff member told us, "We [staff] get people off of sedation, we like people to have a quality of life where they know what's going on around them." Following the inspection, the registered manager informed us that protocols had been updated and implemented where needed.

Where people were receiving a variable dose of medicine (one or two tablets), we found that not all staff were recording on the MAR chart whether one or two tablets were given, therefore making stock checks incorrect. It also meant we could not determine what medicines had been administered in accordance with the prescriber's instructions. Staff acknowledged that they needed to improve this so they could ensure all medicines were accounted for and carried over to the following cycle.

People were supported to take their prescribed medicines. We saw that medicines were stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medicines. However, on one unit we found that the fridge temperature had been out of range since April 2017. Fortunately, there were no medications stored in the fridge at the time. On another unit we found that the room where medicines were stored had not been checked for seven days. This meant the effectiveness of some medicines could be compromised if the temperature was not monitored daily and was allowed to go above 25 degrees. We reported these concerns to the deputy manager.

People told us they received their medicines safely. One person said, "Yes I get my tablets all okay. They [staff] usually stay with me to make sure I take them." Another said, "Oh yes, medication's okay." One member of staff was observed asking a person if they would like their medication. They explained what one tablet was for and said, "Do you want me to get your [description of medicine]?" Upon which they both agreed that this was not needed.

Risk assessments provided staff with guidance on how risks to people are minimised. Risk assessments were completed in relation to the risk of developing pressure ulcers, nutritional risks, choking, falls, and moving and handling. Risks were regularly reviewed and updated to reflect changing needs.

Where people required support, personal emergency evacuation plans were in place which outlined the support people would need in an emergency situation. These could be improved further by including information on people's sensory impairments and where people might display signs of distress. We discussed this with the registered manager.

Manual handling equipment, such as hoists, had been serviced, and there were systems in place to monitor the safety of water systems and the prevention of legionella bacteria.

We asked people if they felt safe. One person said, "Yes, well I'm warm and comfortable and fed three times a day." Another told us, "Yes I feel quite safe. I haven't been here long but I think the whole organisation makes me feel safe."

Staff were able to tell us about the principles of safeguarding, the different types of abuse they may come across in their work, and were aware of how to access the organisations safeguarding policies. The deputy manager told us that learning and actions are discussed as well as sharing of safeguarding alerts at team meetings. One staff member said, "I made a safeguarding referral in connection with a person's medicines before. I know who to go to, who to report to outside of the organisation." Another said, "We get to know people very well, and we [staff] would notice if they [people] were behaving differently. We [staff] would talk to them and find out if anything was worrying them."

The service followed safe recruitment practices. Disclosure and Barring Service (DBS) checks, which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, had been undertaken before new staff started work. This ensured that new staff coming to work in the service were suitable for their role.

Good

Is the service effective?

Our findings

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 decision 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). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

DoLS applications had been made to the local authority as required to ensure that any restrictions on people were lawful. Applications contained detailed information on why authorisation was required. Assessments of capacity were well completed and considered important information, such as, choosing the most suitable time and venue for the assessment, taking into account any language or communication difficulties a person may have, and providing all the information to enable the person to make an informed decision. When determining a person's best interests, relevant factors to consider were listed, such as past and present wishes, any beliefs or values, any other relevant circumstances, and the existence of any advanced directive. This upheld the principles of the MCA 2005.

We did however see that in one case a formal mental capacity assessment and best interests assessment had not been carried out prior to the DoLS authorisation being applied for. This meant the MCA was not followed consistently. We spoke to a senior member of staff who told us they were aware of this (and two others) and were in the process of updating records with a new form that was being implemented.

People's records made reference to their mental health and cognition, and how staff should support people. For example, one person was showing symptoms of short term memory loss and could sometimes get lost and walk into other people's rooms. This had been addressed by putting items on the person's door so they knew which room was theirs. Another plan described how one person could become distressed when being supported with a specific activity. The plan described how staff should intervene and how they should allow the person to have some 'time out' to allow them to feel calmer.

Staff demonstrated regard for people's choices and were observed always seeking permission before acting for them. For example, we observed a staff member assisting a person to have their breakfast in their room. They asked the person, "Shall I open the curtains for you?" They patiently waited by the curtains until the person had answered the question. We saw during the lunchtime period, very respectful and patient interactions with people. We saw a staff member interacting with one person who said, "Can I just move your chair forward for you a bit?" Another staff member was observed offering people clothes protectors to wear whilst eating, and said to one person, "[Person's name] would you like to wear one of these? Is that alright for you"?

People were supported to eat sufficient amounts and maintain a balanced diet. We asked people their views about the food. One person said, "I have all my meals in my room. The food's alright, pretty much what you'd expect when there's a lot to feed. There's always a choice at lunchtime and they'd [kitchen staff] do you something else if you wanted it. The staff are very good; they always ask if I want my food cut up. I can't use this hand you see." Another said, "The food's brilliant, like a five star hotel here, oh yes [enough choice]". A relative told us, "They [kitchen staff] have adapted to [person's] needs; food very soft, drinks thickened, we've been kept informed."

We observed the lunchtime meal on each of the units. Whilst the number of people who attended the dining area on each unit varied, we observed an enjoyable mealtime experience on each. Staff members were observed showing the menu to people and talking about the choices. They were shown food choices plated up and staff were heard to politely ask people which option they preferred. Small dinner plates with raised edges were used for some people in order to promote people's independence.

Staff appeared vigilant, and when one person was walking around they were careful to steer them away from the serving area (heated trolley). All staff members appeared to know everyone by their preferred name, all spoke clearly and appropriately to people, and assisted people without appearing overbearing. Staff members interacted with people freely, conversed openly and achieved a good balance between organisation and a relaxed atmosphere.

We observed one staff member sitting and talking with one person about the people in their photo album. The conversation was relaxed and continued throughout the meal. The same member of staff was observed talking to one person in French. They told us, "We've [staff member and person] discovered we both speak French, [person] pulls me up on it". They opened a bottle of wine for one person, and other people were offered wine with their meal where they were known to prefer this. A staff member said, "[Residents] can have a glass of wine if they want one. Some just have a glass now and again, it's whatever they prefer and why not? We know people well, so we do act responsibly [with alcohol]."

One person became upset when there was no-one to share their glass of wine with, so a member of staff joined them with a glass of red juice. The same person again became very agitated, so staff continued to reassure the person and asked one person if they would join them, which impacted positively. When the same person complained about waiting, the staff member got down on their knees to talk with them, offered both starter options plated up, and enabled the person to make a decision.

The service had issued feedback cards for people to comment on the quality of the food following their meal. Information was passed to the kitchen staff to review and make changes where necessary.

Care plans made reference to people's dietary needs. This included where specialist support was in place, such as dieticians and speech and language therapy. They also listed foods people should avoid, and their favourite foods.

People commented on the care that staff provided. One person said, "They [staff] know what they're doing. Because I can't walk I have to have two staff come and hoist me. They're [staff] very good, I feel safe with them." Another said, "They [staff] seem ok. Like they have had training of some sort." A relative told us, "It's the way they know them [relative], understand their needs, they're very good, know their personality, jolly them in the right direction". Another said, "They [staff] sit with [relative] and pacify them. I can't see that they could do any more than they are doing".

Systems were in place to ensure that staff were provided with training and support, and the opportunity to

achieve qualifications relevant to their role. Staff received training in areas such as safeguarding, moving and handling, Mental Capacity Act and Deprivation of liberty safeguards, dementia, medicines, and infection control. Some staff were overdue an update in areas of training such as fire training and cardio pulmonary resuscitation (CPR). The organisation had recently changed how training was being delivered to ensure staff training remained up to date. There were regional trainers in place who came in to deliver certain training courses. We spoke to one of the regional trainers who told us, "This month I'm delivering training in CPR and choking." We identify training which is slipping and arrange the courses. This new system will ensure that staff have regular refresher training." We also observed a group of new starters receiving their induction training.

Staff received supervision sessions every two months which provided staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. One staff member said, "I get regular supervision from [head of unit]." Another said, "Yes, I have had supervision recently. I discuss my training needs."

Staff were encouraged and given opportunities to develop; the Care Practitioner role had been developed within the service to assist the registered nurses with basic nursing tasks, such as non-complex dressings. One staff member said, "The care practitioner role is good, it bridges the gap and helps the nurses."

Further dementia training had been booked for November 2017 and 'distress reaction' training booked for December 2017. The organisation had created a bespoke 'distress reaction' training package, designed to enhance the dementia care environment and improve interactions between staff, people living with dementia, relatives and health professionals. It is expected to work towards reducing distress, increasing well-being and improving quality of life. The plan is to introduce the training, in manageable stages, across all Barchester 'Memory Lane' communities, adapting it to increase its effectiveness for individual homes.

As well as increasing staff knowledge in supporting people living with dementia, the training also aims to change attitudes and the use of more respectful terminology from the currently used term of 'challenging behaviour', to 'signs of distress'. Staff working on the memory lane (Spindrift) unit told us, "Saying someone is showing signs of distress is more respectful than saying they have 'challenging behaviour'."

People had access to a range of health care services and received on-going health care support where required. This included health professionals, dieticians, falls teams, podiatry, opticians and speech and language therapy. One person said, "I'm seen to quickly if I'm ill. Staff organise all that, they get the doctor in." A relative told us, "I'm happy with GP response, [relatives] nails and hair are done, and they've seen the chiropodist recently". Another said, "The staff have called ambulances and doctors. The optometrist has checked [relative's] eyes." A health professional told us, "They [staff] always phone ahead if someone needs to be seen, they follow recommendations and are well organised."

Good

Is the service caring?

Our findings

People told us they liked living in the service and that staff were respectful towards them. One person said, "The staff are very good. Caring, I feel respected. Very good." A relative said, "Overall the care is really good, I feel that the people that work here really care".

We saw that some staff had developed close relationships with people and knew them well. We observed the way people interacted with the staff. This included how people responded to their environment and the staff who were supporting and communicating with them. Several people were seen smiling, laughing and enjoying friendly banter with the staff as they were getting ready to eat their lunch time meal.

Staff demonstrated patience and kindness with people. We saw a member of staff explaining to people that the fire alarm was about to be tested. During the sounding of the alarm the staff member was observed to stay with one person who was anxious, and gave them a hug to reassure them. Another member of staff became aware of one person's confusion due to two people having the same first name. They went over to the person, reassured them and explained the confusion.

People's care records held information on spiritual and social values which were important to people. Where people had suffered the loss of a loved one, records described the effect this had had on the person, and how staff should support them with the emotional and social effects of this. There were notes about people's interests, for example, one person wanted to be busy and help around the home. The importance of maintaining a level of independence was also reflected in people's care plans. This included guidance for staff on the areas of personal care people were still able to manage, and how they should encourage people to have control over their lives. One person said, "They [staff] talk to me as if I can do everything for myself, normal. You're not made to feel ill, that I can't do anything".

People were encouraged to move independently around the service. We observed one member of staff telling one person about an organised activity that was taking place. They said, "Are you coming downstairs to see the animals?" We observed the person entering the lift (supervised at a distance by staff), getting out of the lift and making their way to their preferred chair near a window. The person appeared content and familiar with their surroundings.

There was personal memorabilia and memory boxes outside people's rooms, so they were able to identify which room was theirs, and to help people with navigating around the units.

People's privacy and dignity was respected, and we saw that staff attending to people's personal care, ensured that doors were closed and when speaking about people, this was done so in a discreet manner so others close by were not able to hear. On several occasions we were asked to move into a room by staff so they could speak about people privately. People were asked their preference for the gender of their care worker. One person told us, "I was asked at the beginning if I minded a male carer, but I don't mind".

Resident meetings were held in the service, and we saw the minutes of the last meeting in September 2017.

The provision of activity was discussed, and that there was a new activity co-ordinator working in the service. One person said they would like more activity at the weekend, and the registered manager said they would like to see more physical activity provided.

There was a resident/relative meeting taking place during our inspection which we attended. The registered and deputy manager were there, as well as the chef. However, only one person and two relatives attended the meeting. A relative told us, "The relative meetings can be changed often without notice. Communication needs to improve with this. Sometimes a 'resident meeting' turns into a 'relative meeting', and you don't know what's happening." The registered manager told us that they were aware of the concerns which had been raised and would address this to ensure better communication and attendance.

There were no restrictions on visiting. A family member told us, "Unlimited visiting, you can stay for as long as you want, people are here all day and all evening".

Requires Improvement

Is the service responsive?

Our findings

The staffing arrangements in the service did not always promote opportunities for staff to ensure that the time and interactions with people was responsive. This had an impact on staff's ability to provide care which was consistently dignified. People told us of occasions when they had waited so long for staff to assist them to move to the toilet, that they had been incontinent. One relative said, "I've found [relative] sitting in underwear that's soiled, how can they know if they need the toilet if there's no staff to monitor them?" One person told us, "It's not the staff's fault, they are lovely, but too busy to see to everyone in time."

The service benefited from a full-time, and recently appointed, part time activity coordinator. There was a full programme of activities to cater for a variety of interests and needs. During the inspection we observed an animal petting activity, and there was music in the form of a live band taking place in the main reception.

However, we received mixed feedback regarding the provision of activity. One person said, "I sit in a chair most of the time. There's not much going on at the moment. I like to knit. There used to be a small knitting group but one person is in hospital at the moment, so that isn't on. I do feel bored and isolated at times." Another said, "There is plenty to do if you want to. Sometimes I join in, sometimes not". A third said, "I like the bigger events that go on here, I also like time to myself, so it works for me." A relative told us, "The home needs to be more inventive and proactive. There are too many [people] here that do nothing. There should be more physical activity and mental stimulation every day. There are too many people asleep in chairs." Another said, "There are not enough staff meaning people have to wait. If you go along to the reception lounge you will find five or six [people] asleep in chairs and no staff around."

Following the inspection we received information from a family member who was concerned that their relative was not getting the specific activity sessions which were agreed prior to the person moving into the service. The family member told us that it was this particular activity that kept them mentally well. We spoke with the registered manager who had followed this up with the head of unit, to ensure the activity was regularly offered. They also told us that the two activity co-ordinators were planning to develop the provision of activity further by speaking with people about what they would like to include in addition to the activity already provided, and this should help to meet people's needs. The registered manager also wanted to see more physical activity provided. However, whilst there were two activity co-ordinators working in the service, care staff would have little opportunity to support with an activity due to their caring duties, and this is therefore an area which requires review to ensure it is meeting the individual and specialist needs of all people using the service.

People's care records included care plans which guided staff in the care that people required and preferred to meet their needs. This included personal care, falls, nutrition, skin integrity, mental health and cognition, spiritual and social values, and hopes and concerns. There was also a 'getting to know me' quick reference guide at the front of people's care plans, which staff or other professionals not familiar with a person could refer to. They listed people's likes and dislikes, their mobility, and key information about a person's care. Care plans were person-centred and reviewed when people's needs changed.

There was a complaints procedure in the service should people wish to raise concerns. We asked people if they knew how to complain. One person told us, "My [relatives] visit me regularly and always help me, but I'd speak up if I had to, yes." A relative said, "The staff are 'on it', they're happy for you to express your opinion, they act upon it straight away" Another said, "I personally feel that [registered manager] would attempt to resolve any issues".

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who had been in post for six months. They told us they were supported in their role by a deputy manager and that the regional manager regularly visited the service to offer support. Throughout the inspection the management team demonstrated an open and transparent manner, assisting the inspection team to gather information required. Following the inspection they contacted us to confirm that changes were already being implemented in response to our feedback.

There was a programme of audits which were set by Barchester. This ensured there were quality assurance systems in place for assessing, monitoring and reviewing the service. Audits were being carried out by the management team and also by the regional managers. These included observation of practice, care plans, nutrition, dining experience, home environment, infection control, and, medicines. However, these had not always been wholly effective at identifying areas requiring improvement. For example, we found a medicines audit which said that 'as required' medicines had a corresponding protocol. We found that this was not always the case. Additionally, where people were having 'as required' medicines, more information was required to ensure staff could ask relevant questions to determine if the medicine was required. The audits had also failed to identify that one fridge temperature had been out of range since April 2017. Audit tools were long and not always worded effectively to enable specific issues to be identified. For example, multiple answers could be given within one question, and many audits were consistently scored as 100%, which we considered may not be accurate, given our findings. Some audits presented more as a 'tick box' exercise than an opportunity to record detailed findings.

Several relatives told us that communication within the home needed improvement. One relative said, "I sent an email concerning [relative]. I received no response. It was clear the email had been received and action had been taken, but no communication with me at all." Another relative told us that they didn't know that there were relatives meetings held in the service. We observed that there was a notice board close to the registered manager's office showing events and programme posters, but this was not immediately obvious unless visitors were entering/exiting the Seabreeze unit. A relative/residents meeting held in September 2017, also highlighted the need for improved communication in relation to activity provision. A third relative told us, "Communication could be better. Group emails are cheap and not difficult to organise."

The staffing arrangements in the service did not always promote opportunities for staff to ensure that the time and interactions with people was of good quality and responsive to people's needs. The registered manager and provider had not recognised the experience for people using the service was not effective in meeting their needs in a timely way. Relatives told us they had raised their concerns on several occasions regarding the staffing levels on specific units within the home. However, the provider had not implemented additional staffing in response to these concerns.

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

We saw that surveys had been issued to people and relatives for their feedback. In 2017, The majority of

feedback was complimentary, often praising the kindness of staff. However, in June and August 2017, we saw that three relatives had made reference to staffing levels not always being sufficient. Additionally, the views of visiting professionals were not currently being sought.

We spoke to the registered manager about the feedback from relatives, and following the inspection they informed us that they were planning to improve communication by introducing 'relative surgery's' with booked time slots and 1-1 opportunities for discussion.

Health and safety assessments were carried out by the organisation's health and safety manager, which showed the service was meeting all key areas. Quality reviews were undertaken by the regional directors of the organisation to identify areas requiring improvement. The review carried out in August 2017, had been effective in identifying areas for improvement, which included medicines documentation, the environment, training, and care plans.

Technology was in place to enhance care delivery. For example, the provider had responded to people, relatives, and staff about the intrusive nature of loud call bells constantly ringing. They had installed a system where all staff now carry 'bleeps' which vibrate and light up with the room number when a person requests assistance.

The culture in the service was welcoming, friendly, and person-centred. Staff showed a good understanding of their individual roles and spoke with each other throughout the day as to what was happening and what needed to be done. One staff member said, "We have 'head of unit' meetings so we all know what's going on." Another said, "It's [Barchester] a good company to work for. Staff leave, but usually come back to Ritson when they realise its actually ok here compared to some [services]." A third said, "I think [registered manager] is approachable. I feel I could just ask them anything and they would listen."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems and processes had not been wholly effective in identifying where improvement was required. The provider had not recognised that staffing levels were not sufficient to meet the needs of people in a timely manner, or recognised the experience for people using the service. Regulation 17 (2) (a) (e)