Mr Stephen Reid Gilmour

# Barton Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The inspection was carried out on 22 and 26 June 2017. The inspection was unannounced.

The home provided accommodation and personal care for up to 41 older people, some of whom were living with dementia. There were 33 people living in the home when we inspected. The provider had expanded the communal space in the home, which had reduced the number of bedrooms available. However, the provider had plans to develop the home and increase the number of bedrooms. The accommodation was provided over two floors, a lift was available to take people between floors.

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. The registered manager was not available during the inspection, but the deputy manager, the provider's area manager and the providers were on site to assist with the inspection.

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

People's care was delivered safely and staff understood their responsibilities to protect people who were frail and people living with dementia from potential abuse. Staff had received training about protecting people from abuse. The management team had access to, understood the safeguarding policies of the local authority, and when needed followed the safeguarding processes.

The premises and equipment in the home was clean, odour free and maintained to protect people from infection. Safety systems in the home, like fire alarms were serviced by an engineer and tested to maintain people's safety. Risks within the home had been assessed and maintenance issues were reported and dealt with in a planned and timely manner. The fire procedure was in date and was regularly practiced by staff.

The management team involved people in planning their care by assessing their needs prior to and after they moved into the service. People were asked if they were happy with the care they received on a regular basis.

When new staff started working at the home, they received an induction and followed a recognised pathway of basic training to gain the skills required to meet people's needs. We observed that staff knew people well, staff displayed a kind and caring attitude and people had been asked about who they were and about their life experiences.

We observed staff were welcoming and friendly. Staff provided friendly compassionate care and support. Staff were trained and understood the importance of respecting people's privacy and dignity.

People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

The activities in the home provided people with opportunities to get involved and participate in learning new skills and building new friendships. Community participation was encouraged and supported. People in the home benefited from links to a local Academy School and an art project. We have made a recommendation about this.

There were policies and a procedure in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs, community nurses and they accessed opticians, dentists and foot care professionals. People's health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. We have made a recommendation about this.

Incidents and accidents were recorded and checked by the management team to see what steps could be taken to prevent incidents happening again. The risks in the home were assessed and the steps to be taken to minimise them were understood by staff.

The providers had planned for foreseeable emergencies, so that should they happen people's care needs would continue to be met. There was an up to date procedure covering the actions to be taken in emergency situations.

Recruitment policies were in place. Safe recruitment practices had been followed. The management employed enough staff to meet people's assessed needs. Staffing levels were kept under review as people's needs changed.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink.

If people complained, they were listened to and the registered manager made changes or suggested solutions that people were happy with. The actions taken were fed back to people.

The provider and the management team consistently monitored the quality of the service and made changes to improve the service, taking account of people's needs and views. The registered manager and deputy manager of the home had provided good leadership to staff. The providers and registered manager implemented plans to improve the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staff knew what they should do to identify and raise safeguarding concerns.

There were sufficient staff to meet people's needs. Medicines were managed and administered safely.

Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained.

### Is the service effective?

Good

The service was effective.

People were cared for by staff who had induction and training and knew their needs well. Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance and staff had attained the skills they required to carry out their role.

The Mental Capacity Act and Deprivation of Liberty Safeguards were followed by staff.

### Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

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

### Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them.

Information about people was updated often and with their involvement.

People accessed urgent medical attention or referrals to health care specialists when needed.

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

## Is the service well-led?

Good

The service was well led.

The providers and registered manager promoted community links and person centred values within the home.

The management team had implemented development plans for the home to improve record keeping and the environment.

There were clear structures in place to monitor and review the risks that may present themselves as the care was delivered.

# Barton Court

**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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 22 and 26 June 2017. On 22 June the inspection was unannounced. We returned to complete the inspection on the 26 June 2017, this visit was announced. The inspection was carried out by one inspector.

Before the inspection, we reviewed the information we held about the home. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

Not all of the people at Barton Court were able to tell us about their experiences. Therefore, we spent time observing the care in communal areas. We observed how staff communicated with people so that we could understand people's experiences.

We spoke with five people and four relatives about their experience of the home. We spoke with 11 staff including the providers, the area manager, the deputy manager, two care team leaders, three care workers, the cook and the activities coordinator. We spoke with two visiting community nurses. We asked for feedback about the home from two other external health and social care professionals. We received feedback from the head of a local Academy School, a project officer from Kent County Council Dementia Friendly Communities Support and the lead for a Dementia Art Project.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at five people's computerised care records, six staff records, the staff training programme, the staff rota and medicines records. After the inspection the provider sent us more information about community links and involvement.

The service had been registered with us since 07 January 2016. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Good

# Is the service safe?

## Our findings

Some people in the home were able to speak with us about their experiences of living in the home. Other people living with dementia were not always able to verbally tell us how safe they felt. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered, or by talking to us about things that were important to them.

People described and we observed a service that was safe. We saw people were relaxed and smiling when staff spoke with them. One person said, "The staff are very good, yes I feel safe." When asked other person said, "I feel safe here." Relatives told us their family members were safe and secure. A relative said, "I visit every day, if I did not think my husband was safe he would not be here."

The premises were maintained to protect people's safety. Risk within the home were assessed, recorded and regularly reviewed. Actions to reduce risk was understood by staff. There were adaptations to the premises internally and externally. For example, ramps to reduce the risk of people falling or tripping. A mobile hoist was available for emergencies if people fell and needed help to get up. Other environmental matters were monitored to protect people's health and wellbeing. Firefighting equipment and systems were tested, as were hoists, the lift and gas systems, there was also an annual legionella water test. The management team kept records of the premises checks they made so that these areas could be audited. Maintenance records showed that faults were recorded, reported and repaired in a timely manner.

Staff received training in how to respond to emergencies and had a good understanding of the fire procedure in place. Fire practice drills had been completed and where necessary improvements had been made to improve evacuation effectiveness. Personal emergency evacuation plans were in place (PEEP's). The responses to fire drills were timed and lessons learnt to improve evacuation effectiveness were considered.

The provider had policies in place about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. This meant that if the home could not be used, people's care could continue safely in other places. The registered manager had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time.

The home environment had been designed for people living with dementia in mind. Signage was appropriately used to identify toilets, communal areas and the lounge areas. Different colours of décor assisted people to know where they were in the home. The premises were maintained to protect people's safety. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping, steps were clearly marked, and hand rails were provided. A sensory garden was accessible and flat.

Staff followed the provider's policy about safeguarding people and this was up to date with current practice. Staff were trained and had access to information so they understood how abuse could occur. Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. Staff said, "We always document and report any concerns we may have about

people."

People had been assessed to see if they were at any risk from falls or not eating and drinking enough. If they were at risk, the steps staff needed to follow to keep people safe were documented in people's care plan files. Additional risks assessments instructed staff how to promote people's safety. For example, if people may need bed rails or soft floor protection at night or if they needed to wear protective equipment like hip protectors.

Guidance about any action staff needed to take to make sure people were protected from harm were included in the risk assessments. Incidents and accidents records were checked by the manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. For example, if people had falls, this was fully recorded so that patterns and frequency could be monitored with actions taken to minimise the risks. Where needed protective equipment was provided for people. Movement sensors were provided that alerted staff if people at risk of falls got out of bed. We observed staff ensuing people used walking aids as part of their falls prevention plans.

Staff were deployed in appropriate numbers within the service to keep people safe. The provider had introduced a computerised care needs system which staff accessed through a smart device. In addition to the registered manager and deputy manager there were up to five staff available, including a senior staff member to deliver care between 07.30 and 22:00. Day time staffing numbers were flexible and more staff were available at busy times. For example, more staff were on shift during the busy morning period. At night there were four staff delivering care, including a senior staff member. Staff told us there were enough staff to meet people's needs. Back up staff had been recruited to cover staff absences, for example staff holiday. This gave people consistency of care. In addition to the care staff, there was a cleaner, cook and maintenance person employed in the home. This meant care staff could concentrate on meeting people's care needs.

People were protected from the risk of receiving care from unsuitable staff. The management team followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Staff we spoke with and records confirmed the registered manager followed the recruitment policy. Staff had been through an interview and selection process. Applicants for jobs had completed application forms and been interviewed for roles within the home. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions, or if they were barred from working with people who needed safeguarding.

People were protected from the risks associated with the management of medicines. Appropriate assessments had been undertaken for people around their ability to take their medicines and whether they had capacity to make informed choices about medicines. Staff who administered medicines received regular training, and yearly updates. Staff understood how to keep people safe when administering medicines. There was an up to date medicines policy which staff followed. There was a policy about the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. There were systems in place so that medicines were available as prescribed. Medicines were stored securely within a safe, temperature controlled environment. Temperatures were monitored and recorded to protect the effectiveness of the medicines. The system of medicines administration records (MAR) allowed for the checking of medicines, which showed that the medicine had been administered at the right times and signed for by the trained staff on shift. We sampled the MAR records and these had been completed correctly. The senior care staff were responsible for administering medicines and we observed they were

doing this safely.

Good

# Is the service effective?

## Our findings

Some people in the home were able to speak with us about their experiences of living in the home. Other people living with dementia were not always able to verbally tell us their views. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered, or by talking to us about things that were important to them.

Staff were trained to meet people's needs and people told us their health and welfare needs were met. One person said, "The care is good, I get plenty of food and I get lots of choices, like what I wear." Relatives commented, "The care is very good, excellent." "My wife is now cared for in bed, the staff look after her well." And, "My husband gets the doctor if needed, this is a brilliant home."

The Mental Capacity Act 2005 (MCA 2005) 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 2005. The application procedures for this in care homes and hospitals are called, the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The management understood when a DoLS application should be made and how to submit them. Care plan records demonstrated appropriate DoLS applications had been made to the local authority supervisory body in line with agreed processes. We saw that two DoLS applications had been approved and these were being kept under review by the management. This protected people's rights.

Staff we spoke with were knowledgeable about people's needs. For example, they were aware of people who were at risk of choking and when people's needs had changed. The smart technology carried by staff assisted them to effectively manage the delivery of the planned care people needed.

People received care from staff that had received appropriate training to carry out their roles. A training plan was in place showing that ninety eight percent of staff were up to date with their training. Training course availability had been advertised for staff. This included statutory mandatory training such as infection prevention and control, first aid and moving and handling people. Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training and gained knowledge of other conditions people had been diagnosed with, such as diabetes and dementia. New staff inductions followed nationally recognised standards in social care. For example, the care certificate. With the training and induction staff delivered care and support to people appropriately.

Training consistently provided staff with the knowledge and skills to understand people's needs and deliver

safe care. Staff told us that the training was well planned and was a mix of hands on training and on line training. The deputy manager was qualified to train staff to move people safely. For example, using a hoist. Staff confirmed that the quality of the training enabled them to safely and competently deliver care. One member of staff said, "The moving and handling training is really hands-on, we get to try equipment which means we know how it feels to be hoisted in a sling." Training records confirmed staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular training updates and meetings with managers.

People received care from staff that were supported by their managers. Staff received consistent supervision and appraisal so that they understood their roles and could develop more knowledge. For example, eighty five percent of staff held a national vocational qualification (NVQ) in social care. This led to the promotion of good working practices within the home. Staff were provided with one to one supervision meetings as well as staff meetings and annual appraisal. Supervisions were planned in advance and recorded in staff files. Staff told us that in meetings or supervisions they could bring up any concerns they had.

People's health was protected by proper health assessments and the involvement of health and social care professionals. People had access to GPs and other health care professionals such as occupational therapist and community nurses. We asked staff about their awareness of people's recorded needs and they were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered specific risk in relation to older people and the condition of their skin referred to as tissue viability. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and reduce risk to people, including from the development of pressure ulcers). Equipment was provided to minimise pressure ulcers developing; for example, air flow mattresses. People at risk had regular visits from the community nursing team and staff moved people's positions (Turning in bed) at the frequencies recommended by community nurses. Turns were recorded on the care plans in real time. The actions of staff reduced the risk of pressure ulcers developing.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. The food served to people looked appetising and the portions sizes were good. Kitchen staff confirmed that people were offered at least two choices at every meal and we observed this on the day of our inspection. People who changed their minds about the food were offered alternatives. Where people's health was at risk from dehydration or malnutrition, staff recorded their fluid and food intake. These records were used to assist staff and other health care professionals to intervene early to prevent people becoming unwell.

People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place. Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it. For example, if they needed their food cut up into smaller portions.

Good

# Is the service caring?

## Our findings

People living with dementia were not always able to verbally tell us about their experiences of the home. However, some people were able to communicate with us. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. People commented, "The staff are so nice and friendly" And "The staff are very good, they are kind and helpful."

People described their care positively. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. Staff said, "We meet people's needs to a good standard" And, "I just love coming into work, I feel I make a real positive impact on people's lives."

Relatives commented, "The care staff are brilliant, they make my husband laugh"; "The care given to Mum was so kind and compassionate" and "We are made to feel part of the family when we visit."

Community nurses visited the home almost daily. Two community nurses we spoke with told us that staff were caring and that in their view people in the home were happy.

People described staff who were attentive to their needs. There were a number of areas people could go to if they wished to sit away from others. For example, some people chose to sit in the friends café lounge, others were using the sitting rooms. People told us staff came quickly when they called them. People were able to see information about the time, date, year and weather forecast in the dining room. This meant that people could orientate themselves with the here and now.

Staff told us they tried to build good relationships with the people they cared for. We observed that staff were polite and cheerful, staff created a lively, jovial atmosphere. We saw staff listening to people, answering questions and taking an interest in what people were saying. When speaking to people staff got down to eye level with the person and used proximity and non-verbal's (good eye contact, caring gestures like a gentle touch, smiles and nods). Staff used people's preferred names when addressing them. The records we reviewed contained detailed information about people's likes and dislikes. Staff were aware of people's preferences when providing care.

Staff took the time to understand how dementia or other conditions affected people. People were able to personalise their rooms as they wished. They were able to choose the décor for their rooms and could bring personal items with them. People had personalised signage on the outside of their bedroom doors or memory reminders to help them identify their room.

We observed that staff knocked on people's doors before entering to give care. Staff described the steps they took to preserve people's privacy and dignity in the home. People were able to state whether they preferred to be cared for by all male or all female staff and this was recorded in their care plans and respected by staff.

Staff operated a key worker system. Each member of staff was key worker for three people. (This was a

member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their care.) They took responsibility for ensuring that people for whom they were key worker had sufficient toiletries, clothes and other supplies and liaised with their families if necessary. This enabled people to build relationships and trust with familiar staff.

People had choices in relation to their care. People indicated that, where appropriate, staff encouraged them to do things for themselves and stay independent. Staff closed curtains and bedroom doors before giving personal care to protect people's privacy. People told us that staff were good at respecting their privacy and dignity. Staff we spoke with understood their responsibilities for preserving people's independence, privacy and dignity and could describe the steps they would take to do this. Access to information about people was restricted to staff.

Good

# Is the service responsive?

## Our findings

People living with dementia were not always able to verbally tell us about their experiences of the home. However, people were able to communicate with us, either by us observing how they responded to staff when care was delivered or by talking to us about things that were important to them. People described and we observed a home that was responsive.

People said, "Going to the garden party (Armed forces day event) at the weekend was a dream come true for me" And, "I like going out on the day trips, I especially liked the one where we went on a river boat trip."

People were encouraged to participate in activities to keep them both mentally and physically active. Resources were made available to facilitate a range of activities. The activities covered one to one sessions in people's bedrooms, exercise groups, visits to places of interest and leisure, monthly visits from outside entertainers and craft groups. This promoted an enhanced sense of wellbeing, with staff responding to people's social needs. Activity planners were displayed within the home.

Best practice guidance was being followed in relation to adaptations for people living with dementia. There was lots of use of photographs displayed of people taking part in activities. The walls in parts of the home displayed pictures of films from the 1940 and 50's. These were memory prompts for people and aided reminiscence. Toilet doors had pictorial signs on them so that they could be identified easily by people and bedroom doors were painted different colours for the same reasons. The garden was well kept and accessible and included a world war two memorial garden. The staff in the home had links with a local Academy School and art groups and the art works produced were displayed for people to look at. The school had won an award for being dementia friendly and pupils learnt about dementia, met people from the home and participated in projects. Having plenty to do kept people mentally and physically active and enabled them to participate in activities they enjoyed.

People's needs had been fully assessed and care plans had been developed on an individual basis. Before people moved into the home an assessment of their needs had been completed to confirm that the home was suited to the person's needs. The provider had recently invested in a bespoke computerised care planning system. Each member of care staff carried a smart device which gave them access to the care plans from anywhere in the home. The system also tracked when care was due, when it had had been delivered, what care had taken place and enabled staff complete their log of care directly into the smart technology. This enabled management to monitor care delivery in real time and respond to any deficiencies.

Assessments and care plans were detailed and reflected people's choices. Care planning happened as a priority when someone moved in, so that staff understood people's care needs. Families were encouraged and participated in care planning, so that staff could meet people's needs.

The management and staff worked hard to respond to people's changing needs. Care plan reviews evidenced responsive input in people's care from health and social care professionals such as the falls team, and GP's. We saw that staff implemented changes recommended by people's GP's and this was recorded in

people's care plans. Community nurses visited the home every day to provide insulin injections and other nursing related care. As people's dementia or physical health deteriorated, they made changes to keep people comfortable. For example, by increasing the levels of staff input people received or by providing equipment such as pressure relieving mattresses. This reduced the risk of people developing pressure ulcers. Medicines were reviewed and changed by people's GP to maintain their health and wellbeing. Staff followed guidance and recommendations made by health and social care professionals. Needs to know care plans were in place for use if people left the home to use other services. For example, hospital admissions. This meant that there was continuity in the way people's health and wellbeing was managed.

Staff knew about the changes in people's needs straight away because the care plans were available to staff via the smart technology they carried with them. Management also verbally informed staff of key changes at hand over meeting. Staff spoken with were able to tell us about recent changes in people's care. This meant staff then adapted how they supported people to make sure they provided the most appropriate and up to date care.

The staff and management team took account of people's complaints, comments and suggestions. There was a policy about dealing with complaints that the staff and registered manager followed. The provider displayed lots of information for people in the home, which included how to make complaints. There had been three complaints since January 2016 and 17 compliments about the care people received. Complaints had been fully investigated and responded to by the management team. There were examples of how the registered manager and staff responded to complaints to resolve them. People had access to information about other places they could go with complaints, for example the Local Government Ombudsman (LGO). All people spoken with said they were happy to raise any concerns. People and their relatives said the management were approachable and felt they would listen to their concerns if they had any. There was a culture within the home where management always tried to improve people's experiences of the home by asking for and responding to feedback.

People and their relatives had been asked about their views and experiences of using the home. We found that the registered manager used a range of methods to collect feedback from people. For example, social media pages, e-mails and newsletters. From the feedback, changes had been made, for example about how information was given to people so that they would remember which staff were their key workers. There were monthly residents and relatives meetings at which people had been kept updated about new developments in the home. Meetings were also held monthly in the friends café. These meetings were supported by external organisations with an expertise in dementia. At the meetings, people and their relatives could learn more about dementia and how it affected people.

Good

# Is the service well-led?

## Our findings

The management and the providers were well known by people and were passionate about delivering high quality, person centred care. We observed them being greeted with smiles and they knew the names of people or their relatives when they spoke with them. The registered manager and deputy manager were both experienced in social care.

The home was led by a stable and consistent management team. New providers had taken over the home early in 2016. However, most of the staff and management team continued to work in the home for the new providers. This had led to a smooth transition and maintained consistency of care for people in the home.

One of the community nurses we spoke with told us that sometimes they experienced issues with the effectiveness of joint working with the staff in the home. For example, they said that sometimes they could not see people in the home if they visited at lunchtime and that on occasion they had needed to speak to the management so that the records in the clinical room were left tidy in the files. We discussed this with the provider's area manager and the deputy manager. They explained that sometimes there were conflicts between the community nurses visit times and the protected lunch times and that they had responded to the nurses comments about the paperwork. We observed that paperwork had improved.

We have recommended that the registered manager researches person centred care best practice guidance and managing effective partnership/collaborative working with visiting health care professionals.

The aims and objectives of the home were set out in the provider's statement of purpose and the management team and staff in the home was able to follow these. For example, staff had a clear understanding of what they could provide to people in the way of care and meeting their dementia needs. The registered manager was working on resourcing more specialised training in dementia care and the Mental Capacity Act 2005 for staff. Records showed that either the registered manager or deputy manager carried out random spot checks and observations of staff. After the observations staff were debriefed and discussions were held to share what had gone well and what they could do better. Staff told us how their behaviours and attitude were discussed with their manager to promote and maintain the quality and standards of care.

People and staff in the home were actively involved in community projects about dementia. This included working with the Sheppey Lapwing arts project run to enhance people's involvement. The lead for this group commented, 'The work the young students from the Academy in joint art activities is invaluable in creating new social links. I know that these activities are helping to increase people's sense of belonging, creativity and well-being.' A project officer for a Kent County Council Dementia Friendly Communities project commented of Barton Court, 'I have worked with many care homes in Kent and do not often see the involvement and passion in community projects such as the dementia awards and awareness week.' The provider told us they aspire to develop their wellbeing projects to provide outstanding outcomes for people.

To further enhance people's experiences we have recommended that the provider researches strategies for

dementia that underpin or formalise the providers own plans and expected outcomes for people living at Barton Court, their relatives and staff.

Management were committed to making the home a good place for staff to work in. They promoted good communication within the team. Staff told us they enjoyed their jobs. New staff told us they were made to feel part of the team from the day they started. Staff felt they were listened to, they were positive about the management team in the home. Staff spoke about the importance of the support they got from senior staff. Different staff we spoke with told us their experiences were similar and they confirmed they attended team meetings and were able to give feedback at these meetings. One member of staff gave us an example of how they had raised an issue and it had been dealt with by the registered manager. The discussions and actions of meetings were minuted and shared with staff.

There were a range of policies and procedures governing how the home needed to be run. They had been reviewed by the new providers and a planned update was due to take place so that the policies were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the home. For example, whistleblowing.

Audits were effective and covered every aspect of the services provided at the home. Management carried out daily health and safety check walk rounds in the home and these were recorded. For example, audits had identified hazards, like equipment needing to be cleared from exits and fire safety advice was given to people living in the home if they used objects to hold back fire doors. These actions minimised risks in the home.

The providers and their area manager, who were often at the home, came in to review the quality and performance of the systems and staff. They checked that risk assessments, care plans and other systems in the home were reviewed and up to date. The providers were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints to the highest levels within the organisation so that they were dealt with to people's satisfaction. An independent pharmacist carried out audits of medicines. The maintenance team kept records of checks they made so that these areas could be audited. All of the areas of risk in the service were covered.

The providers produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises. For example, the addition of en-suite bedrooms. Records showed that the provider monitored their improvement plans to endure they were implemented. For example, eight bedrooms had been upgraded, they had made improvements to the fire safety in the home, new heating boilers had been installed and a new nurse call system had replaced an older model. The new nurse call system could be linked to the staff through their SMART devices. People were protected from risk within the environment and from faulty equipment. Staff reported maintenance issues promptly and these were recorded. Maintenance staff carried out repairs safely and signed off works after these had been completed. Records showed that repairs were carried out soon after the issues had been reported.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the home. This meant that there was transparency and openness and the risk of harm was reduced.