Mr Ian Bradley

# Greystoke Manor

## Inspection report

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## Ratings

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

| | |
|---|---|
| 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? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 27 September 2017 and was unannounced. Greystoke Manor provides accommodation and personal care for up to 37 older people. At the time of our inspection there were 32 people living at the home.

The home was clean and tidy and maintained to a high standard. Hallways were decorated with ornate paintings and mirrors. People's bedrooms had been personalised and were complete with en-suite facilities. The home was spacious and light and offered a choice of communal areas.
Hairdressing facilities were available and people had access to a garden with an outside seating area.

As the provider is registered as an individual they are not required to appoint a registered manager. They may choose to accept responsibility for the day to day management of the service themselves. The provider was present during the inspection. 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 provider had also employed a manager as part of the management structure and they were also present throughout the inspection.

At the last inspection on 1 and 2 October 2015 we identified a breach of Regulations. We found the provider had failed to maintain an accurate and complete record on behalf of a person who required support with moving safely and their fluid intake. The provider wrote to us shortly after the inspection to inform us the action they were taking. At this inspection we found the records in place for the same person were satisfactory to ensure they received safe and effective care therefore, the legal requirement had been met.

At the last inspection we found medicines were mostly managed safely yet we found gaps on Medication Administration Records (MARs). This was related to a lack of entries on MARs made by staff to inform their colleagues the reason as to why they had administered PRN 'when required' pain relief to people. We made a recommendation to the provider to review and support staff to ensure the MARs were completed accurately following the administration of such medicines. At this inspection we found staff completed the MARs in line with current best practice.

Staff knew how to identify the signs of possible abuse and knew how to report any allegations of bullying or abuse to their managers. Prior to the inspection we reviewed statutory notifications sent to us by the manager about events that had occurred at the home. A notification is information about important events which the provider is required to tell us about by law. At this inspection we identified the manager had failed to notify us about an allegation made by a visiting district nurse about the care and treatment of one person. We discussed this issue during the inspection.

Health and safety quality assurance systems were in place and enabled the manager to implement changes to improve the quality of care provided to people. However, they had not consistently identified issues

raised by people and which were shared with us during this inspection.

People and their relatives said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. They told us that the manager and the provider were approachable. Staff knew people well and kind, caring relationships had been developed. People were treated with dignity and respect.

There were sufficient competent staff available to meet the needs of people living at the home safely. Staff received training and supervision to ensure they were able to meet people's specific needs. Staff were happy with the support they received from the management team. Most people had the capacity to consent to their care and were encouraged to maintain their independence. We observed people engaged in conversations with other people, staff and visitors. If people did not have the capacity to consent, the manager was aware of the arrangements that were required to ensure decisions would be made in their best interests.

People said that the food at the home was of good quality and particularly enjoyed the puddings offered. People had access to health and social care professionals such as district nurses and GP's when they needed additional medical guidance and attention.

A programme of activities had been provided for people to enjoy. People told us the care they received was person centred and met their needs. Each person had a care plan which contained information about their care needs.

The manager and provider offered a 'hands-on' approach and offered a family run management structure within the home. The management team all knew people well especially people who had been living at the home for a lengthy period of time. They told us their aim was to maintain a homely environment which respected the choices and wishes of people living there.

Due to the delay in the report being published we remained in contact with the provider and manager. They were able to provide the inspectors with information on how the home was progressing including areas we had discussed at the inspection. This included actions they had taken after a recent medicine audit.

## 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

Staff were trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were sufficient staff to meet people's needs safely.

Medicines were managed safely. The provider was improving their written guidance available for staff for PRN 'when required' medicine.

### Is the service effective?

Good

Staff had completed training in a range of areas which supported them to care for people effectively.

The manager was working within the principles of the Mental Capacity Act 2005.

People were provided support to maintain a nutritional balanced diet and had access to a range of healthcare professionals and services.

### Is the service caring?

Good

The service was caring.

Positive, caring relationships had been developed between people and staff.

People were encouraged to be independent, to express their views and to be involved in decisions relating to their care.

People were treated with dignity and respect.

### Is the service responsive?

Good

The service was responsive.

People received personalised care from a staff team who responded to their needs. Care records included advice and guidance to staff about people's care and support needs.

People were stimulated and offered opportunities to attend activities.

Complaints were managed in line with the provider's policy.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

One incident regarding an allegation of abuse had not been reported to the Commission for their review without delay in line with health and social care regulations.

Audits and checks were in place to measure the quality of care provided to people. However, these had not addressed all the issues we highlighted at this inspection.

Staff understood their role and responsibilities. The culture of the home was open and the aim to provide a 'homely' environment where visitors and relatives were free to visit at any time.

# Greystoke Manor

**Detailed findings**

## Background to this inspection

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

This inspection took place on 27 September 2017 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience in the care of older people and people living with dementia.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service including complaints and how these were managed. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted stakeholders, including health and social care professionals involved in the service for their feedback.

We spoke with seven people who lived at the home, one relative and one visitor to gain their views on the care received. We observed how staff interacted with people in the communal areas within the home. This included the lounge, dining area and in people's individual rooms when invited. We also spoke with three care staff and the manager separately. The provider made himself available throughout the inspection. We observed the lunch time meal being served and spoke with the chef about their role.

We reviewed three staff files, staff rotas, policies and procedures, health and safety files, complaint records, incident and accident records, training records, activity plans and surveys undertaken by the provider. We observed medicines being administered to people and checked the corresponding medicine records. We looked at care records related to three people; these included care plans, risk assessments and daily notes.

Good

# Is the service safe?

## Our findings

At the last inspection the home was found in breach of a Regulation regarding safe care and treatment. There was a lack of complete and accurate records maintained for a person with risks associated with pressure wounds and hydration. The provider wrote to us after the inspection to tell us the action they were taking to minimise the potential risk of harm. We found at this inspection risks to people were managed so that they were protected from harm. Risk assessments provided sufficient information, advice and guidance to staff on how to manage and mitigate people's risks. Risk assessments covered areas such as how to support people to move safely and how to manage people with skin integrity issues. When potential risks had been highlighted for people, the necessary guidance for staff was provided in the person's care record. We found risk assessments were updated and captured any changes of care needs when they were reviewed. The provider had been developing a computerised care record system, although some care records remained in a hard copy format. The manager and the staff team confirmed they had access to both systems.

People told us they felt safe living in the home and we observed people were relaxed and comfortable. One person said, "Yes I feel safe here, this is my home now and it suits me. I've been here around three years and it's good to know there are other people around". Another person said, "Yes I feel safe here, there is only people we know, we are well looked after". A third person said, "This is a beautiful place, family run and I like that. I've lived all over the world and I feel very safe here". A fourth person said, "Let me tell you, if I didn't feel safe I'd move".

We observed that the Medication Administration Records (MARs) were completed on behalf of each person by the staff member on duty each time someone was supported to take their medicine. This evidenced that people received their medicines as prescribed. People told us they were happy and felt confident with how they received their medicines. They also told us if they were in pain they would be given the appropriate medicine and a GP would be called if necessary. People received varying levels of support with their medicines depending on their needs. This included people who stored their own medicines and administered them without staff support. One person told us," My tablets are brought to me and left with me to take". They added, "If I needed something else I know they'd give it to me". Another person said, "I take my own medicine". Care records confirmed the provider had assessed the risks associated with people managing their own medicines safely. We observed a staff member administering medicines during the lunchtime period using a personalised approach. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Medicines were dispensed from monitored dosage boxes and from bottles or boxes which were stored and labelled correctly.

At the last inspection we found staff did not consistently record why a person was administered PRN 'when required' pain relief such as paracetamol. We recommended the provider reviewed this in line with best practice guidance. At this inspection we found staff had recorded the rationale when pain relief had been offered and administered to ensure accurate records were maintained. Topical creams such as to prevent skin integrity issues were administered by care staff whilst delivering personal care. A local pharmacy had

carried out a medicine audit on 12 September 2017. This was to check all aspects of the medicine system. The manager told us they had appreciated the detailed check carried out as it had informed and guided how they could improve their system further. It had highlighted the need for the home to develop their own guidance available for staff associated with PRN 'when required' medicines. We discussed this with the provider and manager who told us they were acting on this. Shortly after the inspection sent to us the written guidance they had implemented which was in line with current best practice.

Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the provider or manager for guidance. One staff member said they would, "Report it to management, go to [named manager] straight away or [named matron]" if they were concerned about a person.

Accidents and incidents were recorded appropriately and documents showed the action that had been taken afterwards by the staff team and the registered manager. This helped to minimise the risk of future incidents or injury.

People spoke positively about the support they received and told us there were sufficient staff to keep them safe. A relative described how their family member had experienced a fall and initially moved into the home to receive short term care over a six week period. They told us the person had enjoyed their experience and when they suffered another fall at home they returned. They said, "The staff all know me and I feel comfortable that my mum is here, it is a big relief mentally to know she is safe".

At this inspection we noted there were five care staff on in the morning and four in the afternoon and records we checked confirmed this was a routine day shift. The day shift commenced at 8am and finished at 8pm. A 'matron' (who had a background in nursing care) was employed to support staff and worked a two days in the week and on a Sunday. In addition, a member of the management team including the provider was always available in the home or at weekends on call to meet the needs of people and the staff team. The provider also employed domestic staff, kitchen staff and a receptionist. This meant care staff were able to respond to people and their requests in a timely manner. In addition, four members of the management team made themselves available for people and their relatives throughout the inspection and were 'hands-on' in their approach.

The provider used a dependency tool to establish how many care staff they needed to ensure there were safe staffing levels in place and they were able to meet people's needs. The manager explained the dependency tool included a 'traffic light' system to prompt them to review their staffing levels routinely. For example, at the time of this inspection 29 people living at the home were assessed in green and requiring minimal support, two in amber and one in red. The two people in amber required one staff member to provide support with personal care on occasions throughout the night and the person in red received all their care in bed.

There were two care staff available to meet people's needs at night time. We received mixed feedback from people as to whether there was enough staff on duty at night times. One person said, "I have a bell on my wall above my bed. If I ring they come quickly. I've never had to wait long". However, another person said, "I think they need an extra pair of hands at night". Whilst we received no comments to state staffing levels were unsafe at night time we discussed the feedback we were given with the provider and manager. They told us that nights remained very quiet however, in the past when a person's needs had increased they had also increased their staffing levels at night to three staff members. Since the inspection there have been further changes to the needs of people living at the home. This included there were no longer any people

living at the home in the red assessed area. The manager told us they would continue to assess staffing levels and increase them if people's needs changed.

Staff recruitment practices were robust and thorough. Staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; a satisfactory application form, two reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Recruitment checks helped to ensure that suitable staff were employed.

Good

# Is the service effective?

## Our findings

People received effective care from staff who had the skills and knowledge they needed to carry out their roles and responsibilities. People and relatives we spoke with were complimentary about the staff. They told us of the confidence they had in the abilities of staff and said they knew how to meet their needs. One person said, "The girls are lovely and would do anything for you". Another person said, "I'm very well looked after here. Most of the staff have been here a long time, they know me well". A third person said, "The staff are bloody marvellous. They know what they are doing they are very nice girls". A relative told us, "They are very professional staff here. Always been good to my [named person]". Another relative told us, My [named person] never complains. I know [named person] has a bath twice a week and hair done weekly and the laundry is beautifully done. They are very strict here about labelling and there is never others' washing mixed".

People received support from staff who had been taken through an induction process and attended training which enabled them to carry out their care worker role. New staff were provided with opportunities to shadow experienced staff members until they felt confident themselves. The mandatory training schedule for all staff covered core topic areas including moving and handling, first aid, dementia and safeguarding. The manager accessed face to face sessions training for all the staff team and retained evidence of training attended within their staff files. Refresher training was provided to ensure staff routinely updated their knowledge on particular subjects. Staff told us they were happy with the level of training they received. One member of staff who had been working at the home for six months told us they had already attended training sessions and on their induction they were shown, "How to use the fire alarms, shown around the home, had several shadow shifts and read the policies and procedures". Staff members were also given opportunities to complete additional vocational training such as a National Vocational Qualification (NVQ) or more recently a health and social care diploma. Another staff member had been working at the home for three years and said, "I absolutely love working here". They explained they had completed a level 2 health and social care diploma and were complimentary about the support and training they had received. They told us about the dementia training they had attended and said, "Everybody should do that. You saw how they (people living with dementia) feel".

Staff also received additional support in the form of supervisions, appraisals and opportunities to attend staff meetings. A system of supervision and appraisal is important in monitoring staff skills and knowledge. Whilst records we checked stated staff had received a recent supervision and an appraisal in the last 12 months. One staff member we spoke with felt supervision and staff meeting opportunities could be increased further to allow them more time to discuss matters relating to people's care needs and other matters relating to the management of the home. We fed this back to the manager who informed us they had already identified the need to increase supervisions in an audit in August 2017. They told us they were in the process of reviewing the management structure of the home and this included who facilitated supervision and the frequency of them. During the inspection we noted one staff member was in the process of receiving training to enable them to facilitate supervision sessions to other support staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager demonstrated they understood current legislation regarding the MCA and explained they were able to assess a person's capacity at the initial assessment stage and had completed a DoLS application to the local authority when deemed necessary. There were no authorised DoLS in place at the time of this inspection. They continued to tell us how important it was that decisions were made in people's best interests and placed importance on letting the person choose for themselves where possible. They involved health and social care professionals and if appropriate relatives. Staff were able to share some knowledge on the topic and provided assurances they were aware of its relevance and importance. We observed staff gaining consent from people prior to supporting them with their personal care.

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs. A chef organised and provided freshly prepared meals seven days of the week, which left other staff to attend to people's personal care needs. The chef and other care staff were aware of any specialist diets including any allergies people had and adjusted the menu accordingly. This included if a person was diagnosed with diabetes or required a softer or pureed meal. People were able to choose the meals they wanted and this included whether they wanted a cooked breakfast. On the day of the inspection there was a choice of roast turkey or salmon en-croute for lunch. We observed people enjoying their lunch; it was a sociable experience for those involved and people talked to each other throughout. Condiments were positioned on each table such as cranberry sauce and salt and pepper. Some people chose to eat in the dining area. However some people, due to their needs or through choice, ate in their bedrooms and their lunch was delivered to them on a tray. One person told us, "I think the food is very nice and there are good portions". Another person said, "The puddings are wonderful. The rest of the food is what it is. It doesn't bother me, I get enough to eat". People were particularly complimentary about the puddings. However they said some of the names of the main meals left them confused as to what it actually was and told us the staff asking them didn't always know either. One person said, "Because of my iron deficiency I get a small glass of Guinness every day, that's very nice". They come round and ask us what we want for our meals. It's got fancy names and I ask what it is and they (staff) don't know. It would help if they put that in plain English or at least a translation". Another person said, "They use these foreign names and I don't know what they are talking about". We fed back people's comments and confusion with the menus to the provider and manager for their review.

People told us and records confirmed people living at the home had routine access to health care professionals. This included chiropodists, dentists, opticians, district nurses and GPs. Some people were able to attend health appointments independently and either walked or travelled to various surgeries such as to see a GP. One person said, "I am diabetic but I inject myself. The nurse prepares my injection and then it gives it to me. I have been doing it for so long I just prefer to do it". Another person said, "My GP is only down the road, in fact [named provider] walked me to the doctor the other day, which was very nice. Nurses come in every day I think there's no problem getting to see anyone. Better than being at home". A third person told us, "I go to my own doctor, if I needed to I'd go out to the dentist or optician". A relative told us, "The GP has been out to my [named person] and a physio also visits. I'm confident her health needs are being met". Staff told us they would go to the matron or manager and/or the provider immediately if a

person had any health issues and they would then contact a GP for advice and guidance. We asked for district nurses' views on their observations of the care provided to people. One district nurse was extremely positive about their experiences and said staff were, "Always on the ball" and added, "Can't speak highly enough of them". However, another district nurse told us they felt the communication between staff could be improved as they had experienced a lack of consistency in how staff were informed about people's diabetes needs when attending to people on visits.

Good

# Is the service caring?

## Our findings

Positive, caring relationships had been developed between people and staff. We observed that people looked at ease in the company of staff and were comfortable when anyone in the staff team approached them. People confirmed their positive experiences of the staff team including the manager and the provider and the approaches they used. One person said, "They're very good at adapting to situations and very caring". Another person said, "We can do whatever we like, the staff don't impose or make suggestions that we get up or go to bed, but the simple truth is most of us want to go to our rooms after dinner". A third person said, "They're very kind". A visitor told us, "I visit regularly and my friend is so well looked after. This is such a lovely place to be. It's very grand. The staff are welcoming and there is no problem what time I get here. I would move here myself!"

Staff encouraged people to express their views and they were actively involved in making decisions about their care. People were provided with opportunities to talk with staff including the manager and provider about how they felt on a daily basis. We observed people felt comfortable approaching the manager's office and their queries were responded to by the manager, the receptionist or other care staff. We were told there were few formal resident meeting opportunities and the last one had taken place approximately six months prior to the inspection. One person told us, "There have been meetings but the last one was so long ago I can't remember when or what was said. I do put suggestions in the suggestion box or speak with [named one of the providers]; they have a very good listening ear". Another person said, "It was probably well over six months ago". We were unable to review minutes to the meetings to confirm the agenda items discussed. However, we fed this back to the manager and both providers for their review. They told us there had been a lack of attendance at previous meetings. However, due to the ability level of most of the people living at the home they were finalising the setup of a 'residents council'. They told us the aim would be for the management team to liaise with a representative of the resident council over any aspects which impacted their day to day living such as activities and menu choices.

People were encouraged to be as independent as possible by the staff. Staff described to us how they encouraged people to take part in their own personal care, enabled them to make choices and decisions about what they wore each day, how and where they wanted to spend their day, what time they wanted to get up and what time they wanted to go to bed. One person told us, "I can get up when I want, I go to bed when I want, which is exactly what I want. I can make my own choices how I spend my day and whether I want to go out or not. I can wash myself and have the en-suite so not restricted to what I do". A staff member told us, "Let them (people) do what they what they can do themselves. I let people do their back and legs as not all can reach".

People were treated with dignity and respect. We observed numerous occasions of positive support provided by staff to people. Staff bent down to address people at their own eye level and maintained good eye contact. Staff spoke with people calmly and warmly and ensured they had everything they needed such as a drink of their choice. We observed how staff interacted with people, engaging in conversations important to the person such as about their family members that were dear to them. People told us staff knocked on their bedroom doors before entering and we observed when bedroom doors were shut staff

knocked, waited for a response and entered. One person said, "They knock before they come in and close the curtains before they change my pad during the day". Another person said, "I have two assisted baths a week, the girls are very good and respectful, they always make sure my door is closed and the curtains are closed before I am undressed, they're very kind".

We asked staff how they promoted privacy, dignity and respect. One staff member said their role was to, "Support the residents, keep them happy, making sure they are comfortable". Staff told us how they made sure curtains were drawn and blinds closed within bedrooms before starting supporting a person to wash or undress. The same staff member told us, "I always get a towel over them to keep them dignified". Another staff member said, "We genuinely do care, we have empathy".

Good

# Is the service responsive?

## Our findings

People lived in a home where staff were responsive to their individual needs. We observed people receiving personalised care. People told us they were happy with the care they received and it met their needs. Bedrooms were personalised to suit people's preferences. Staff demonstrated they had a good understanding of people's personal histories and what they liked and disliked. One person said, "I had an iron deficiency when I first came here but they got me sorted and I feel so much better". Another person told us, "I can do as I please. No one tells me what I've got to do, only reminders when meal times are if I've nodded off in my chair. If you go late for supper, say, three quarters of an hour late, they will still get you a hot meal".

Each person had a care record which included a care plan, risk assessments and other information relevant to the person. The provider had installed an electronic system however we were told historical information also remained in a hard copy format which staff had access to. People and their relatives told us they were involved with planning their care. Care records included information provided at the point of assessment to present day needs. Staff told us the care plans provide sufficient guidance on how to manage people's physical and/or emotional needs. This included guidance on areas such as communication needs, continence needs and mobility needs. Staff had access to all care plans so could refer to the information they required at any point. Staff told us they found the care plan format easy to read and follow and an effective working tool. They also told us they could approach the matron and manager with any queries associated with how care should be given.

On occasions the computerised care plans did not capture the level of detail required which may have proved helpful for new staff supporting people. Also the dates the provider had planned to review each care plan had not been adhered to. For example, sections titled, 'All about me' were not always completed. However, despite this all staff we spoke with could provide details on how they supported people with their personal care and emotional needs. They knew how people liked things done for them. We discussed the gaps in care records with the manager and provider who were keen to add further details and review more routinely. They provided us with an example of an 'All about me' document which they had recently completed with a person. They told us they were in the process of doing this with all people living at the home then they would enter the specific details onto the computerised system.

Daily records were also completed about people by staff during and at the end of their shift. This included information on how a person had spent their day, what kind of mood they were in and any other health monitoring checks. These daily records were referred to by staff throughout their shift as they were accessible at all times.

People were provided with stimulation and were offered various group and 1:1 activities to be involved in at the home, however people could decline to join if they so wished. The manager told us how they were always introducing different external entertainment groups and based their decisions on whether people who lived at the home enjoyed them. On the day of our inspection we observed armchair exercises where nine people joined in. Later in the day, a historical interest session took place named, 'Creative castles' in

the lounge. The manager told us it was a popular session. Other sessions included reminiscence and music sessions. Some people joined in groups outside of the home such as Bridge or accessed the church of their choice. One person told us, "There's various entertainers come, singers and someone to give a talk, quite often the same people, the variety could be better but you can't please everyone". They added, "We have morning exercise three times a week". Another person told us, I don't join in much, I like to occupy myself. I've just given up my car which restricts me now but I keep myself busy knitting". They also told us they would prefer more day trips organised. During the inspection we established a further three people maintained their driving licences and parked their car in the home's car park. This meant they could access the community independently when they wished.

On 26 August 2017 Greystoke Manor held a garden party and opened up the home and gardens to guests of people living at the home. We were told alcoholic and non-alcoholic drinks were served, a 'hog roast' and many cakes and puddings were provided to all. A pianist and singing group were also provided to entertain the guests.

People told us staff responded to their concerns and queries promptly and addressed anything that was worrying them. One person said, "If I was unhappy I'd speak [named both providers] and would be happy to do so. They are good people who will listen and act upon anything reasonable. I had a little moan about leaving the window open and sitting in a draft and that was sorted immediately". Another person said, "Not long ago I complained there was not enough veg but this has changed. There's more choice now". There were no formal open complaints at the time of our inspection. The most recent complaint had been reviewed by the local ombudsmen. Whilst we were not investigating the specifics of the complaint we used the outcome to inform our inspection planning process. The manager told us they were disappointed it had got to that stage however also informed us they had learnt from what was discussed.

Requires Improvement

# Is the service well-led?

## Our findings

At the time of this inspection the provider was registered as an individual therefore they were not required to appoint a registered manager. They chose to accept responsibility for the day to day management of the service themselves. The management structure also included a matron and an additional manager role. The provider had legal responsibility to complete and send to the Commission statutory notifications. Notifications are changes, events or incidents that the service must inform us about. They give an opportunity to the provider to inform us of an incident and any actions they have taken to minimise any potential further risks to people. This includes any allegations of abuse. In August 2017 the West Sussex safeguarding team contacted the Commission. They informed us of a concern which had been raised by a visiting district nurse regarding a person living at the home and that the manager and provider had been made aware of the concerns raised. Whilst we did not investigate the specifics of this incident, we used the information to inform the inspection planning. Mostly, the provider had notified us about significant events regarding people yet on this occasion they had not. We discussed the incident with the manager, their views on the concerns raised and the need to notify the Commission accordingly in the future at the point an allegation is made.

Mostly, people, their relatives and staff were complimentary about the care and support they received. Our observations also concluded the care provided to people living at the home was carried out safely and effectively. People and their relatives spoke positively about the homely environment and that they were able to make choices and be involved with the care they received. Relatives and visitors were pleased they were able to visit when they wished to see their friends and family members. However, on occasions we identified areas which were not highlighted through the providers own checks and auditing. Whilst we found staffing levels to be sufficient and safe checks carried out by the provider had not identified how some people were feeling about how staff were deployed at night time. Checks had not identified people were struggling with the names used regarding some of the main meals which we discussed in the Effective section of this report. Whilst we appreciated the provider and manager were taking action regarding gaining the views of people by introducing a 'residents council' at the time of our inspection, this had yet to be embedded.

We spoke with the manager about the care records we had read during the inspection and the associated risk assessments they had devised. We had noted that some review dates set by the manager had not always been met. For example, one person had a risk assessment in place to review their mental health needs. The date for review stated August 2017 however this had yet to be addressed. Whilst we found this had not compromised the safety of the care provided to people, we discussed this with the manager who told us they were aware they needed to update some of the computerised care records.

Other checks were carried out regarding the health and safety of the quality of care provided to people. This included areas such as infection control, electrical audits and the cleanliness of the home. On 31 August 2017 an independent audit was carried out by a consultant. The manager and provider told us they had initiated this to have an objective person carry out checks to ensure all aspects of the home were running as they should. The audit had already highlighted some of the areas we had identified at this inspection, such

as an increase in supervision sessions offered to the staff team. The same consultant was also going to be providing monthly support to the manager with the aim of improving the quality of care provided to people living at the home.

Routine satisfaction surveys were sent to people and their relatives to gain their views on the care provided. The majority of surveys we read included positive comments. One we read said, 'Staff are kind and patient'. Another read, 'First class facilities'. Another stated, 'Gardens are lovely'. However, we also read, 'Initially was told there are many outings [named person] has been in the home two months and not been on one'.

Staff understood their role and their responsibilities when supporting people and told us they enjoyed working at the home. They told us they had developed close relationships with the people they supported and felt supported by the provider and the manager. They were asked to complete satisfaction surveys. The responses we read, were mostly positive, one comment out of the 19 returned said, 'I feel management are approachable and I am able to discuss my issues'. However, a comment made in May 2017 referred to, 'need for more staff meetings, supervisions and key worker time'. The manager had responded with, 'Supervisions, shadowing and appraisals are being reviewed at present'.

We spoke with the manager separately about how they felt the home was progressing, what were their challenges and positive experiences so far. They said, "Everybody here works their socks off to take care of the residents". The manager told us they had been busy undertaking two qualifications, a degree in health and social care and a level five health and social care diploma. Once completed they would be applying to become the registered manager of the home.

During the inspection we observed the staff, including the management team were driven towards providing homely environment where people's rights were exercised and respected.