Guild Care

Caer Gwent

Inspection report

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Date of inspection visit: 30 December 2015
Date of publication: 19/02/2016

Ratings

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

Overall summary

The inspection took place on 30 December 2015 and was unannounced.

Caer Gwent provides nursing care and accommodation for up to 61 older people with a variety of health needs. At the time of our inspection, 45 people were living at the home. The home was under capacity due to extensive refurbishment and redevelopment taking place. It is estimated that full occupancy will be achieved by February 2016. Caer Gwent is a large home, situated away from the road and close to Worthing town centre. The home is divided into several units or suites comprising: Amberley, Goodwood, Arundel, Petworh and Parham.

Each suite contains bathrooms, communal sitting and dining areas. All bedrooms have en-suite facilities. The home has gardens at the rear which are accessible to residents and off-road parking.

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

Not all staff had a thorough understanding of the Mental Capacity Act 2005 and the requirements of this and

Summary of findings

associated legislation. A minority of staff had completed training on this topic. The registered manager was aware of their responsibility under the Deprivation of Liberty Safeguards legislation and had applied to the local authority for authorisations where people were deprived of their liberty. Staff followed an induction programme and completed all essential training and there were additional training opportunities available to some staff. All staff had received regular supervision or annual appraisals. People were supported to have sufficient to eat, drink and maintain a healthy lifestyle; they had access to a range of healthcare professionals and services. The home was in the process of being updated and a refurbishment programme was due to be completed in early 2016.

People felt safe living at the home and staff were trained to recognise the signs of potential abuse; they knew what action to take and who to contact if they suspected abuse was taking place. Risks to people were identified, assessed and managed safely. Risk assessments provided detailed information and guidance to staff about how to support people. The service followed safe recruitment practices and appropriate checks were in place. People and staff had mixed views about staffing levels at the home. Some people felt that staff did not always have time to stop and chat. Staffing levels were not always consistent. The provider was in the process of recruiting additional staff. People's medicines were managed safely.

People were looked after by kind and caring staff and positive, friendly relationships had been developed. Staff knew how to support people in line with their personal preferences and there was information about people's lives contained within care records. People were treated with dignity and respect and were supported to express their views and to be involved as much as possible in decisions about their care.

In the main, people received personalised care that met their needs. Care plans provided detailed information to staff about people's needs and the support they required. However, two care plans contained conflicting information which could have been confusing and was inaccurate. The home employed the services of an activities co-ordinator who organised a programme of events and activities took place every day. The majority of people did not or chose not to participate in these activities. The provider managed complaints appropriately. Complaints were responded to in line with the provider's policy and to the satisfaction of the complainant.

People, their relatives and staff felt the service was well led and that the registered manager was approachable. Residents' meetings were organised and people were asked for their views of the service through a survey from the provider. The registered manager also met with people to obtain their feedback. Staff felt supported by the registered manager, that they could raise any issues and that these would be dealt with appropriately. There were systems in place to measure the quality of the service provided overall. The provider was in the process of developing a robust, consistent quality audit system which would be rolled out across the provider's other homes.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People felt safe living at the home and staff were trained to recognise the signs of potential abuse and knew what action to take. Risks to people were identified, assessed and managed appropriately.

People and staff felt that staffing levels were inconsistent and the provider was in the process of recruiting additional staff.

People's medicines were managed so they received them safely.

Good

Is the service effective?
Not all aspects of the service were effective.

Some staff did not have a good or thorough understanding of their responsibilities under the Mental Capacity Act 2005.

Staff had completed all essential training and there were opportunities to undertake additional training. They had regular supervisions and annual appraisals with management.

People were supported to have sufficient to eat and drink and had access to healthcare professionals and services as required.

Major refurbishment undertaken at the home was in progress and should be completed by February 2016.

Requires improvement

Is the service caring?
The service was caring.

Positive and caring relationships had been developed between people and staff. People were treated with dignity and respect and they were supported to express their views as much as possible.

People's personal histories, including their preferences, were recorded in their care plans.

Good

Is the service responsive?
Some aspects of the service were not responsive.

There was conflicting information about people's support needs within two care plans. Staff felt they did not always have time to deliver person centred care.

A range of activities was organised for people, but the majority of people living at the home chose not to always participate in these activates.

Requires improvement

Summary of findings

Complaints were managed appropriately and to the satisfaction of the complainant.	
Is the service well-led? The service was well led. People and their relatives felt the service was well led and that the registered manager was approachable. Staff felt well supported and spoke highly of the registered manager. There were systems in place to measure the quality of the service overall.	**Good** 

Caer Gwent

Detailed findings

Background to this inspection

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

The inspection took place on 30 December 2015 and was unannounced. Two inspectors undertook this inspection.

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 the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider, including previous inspection reports and notifications. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

On the day of our inspection, we met with three people living at the service and one relative. We spoke with the registered manager, the deputy manager, a registered nurse and three care assistants.

The service was last inspected in January 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe living at Caer Gwent. One person said, "I feel safe most of the time" and a relative confirmed that they felt their family member was safe, secure and well looked after at the home. The registered manager told us, "As long as the residents are happy and safe, they're content with their care and we're actually listening to them. It's all about the residents – this is their home".

Staff members had undertaken safeguarding in adults at risk training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse was taking place. They were aware that a referral to an agency, such as the local Adults Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let my manager know if I suspected abuse was happening. If nothing happened, I would go up the line. If that didn't work, I would let you (Care Quality Commission) know". Another staff member said, "The manager is very good like that and will always listen to anything I had to say".

Risks to people were managed so that they were protected and their freedom was supported and respected. People's risks were identified, assessed and managed appropriately and were reviewed monthly. Risk assessments in people's care plans provided information and guidance to staff on how to manage and mitigate risk. There were risk assessments in a wide range of areas, for example, general safety included risks relating to the environment, call bell, fire, equipment, eating and drinking, out in the community, medical conditions, illness and the use of bed rails. People also had risk assessments relating to falls, nutrition and hydration and personal emergency evacuation plans (PEEP) were in place. Accidents and incidents were recorded, together with action taken by staff, as a result of people sustaining a fall, for example. There was information about how a re-occurrence would be prevented, what follow-up action was required and whether the incident was reportable under the regulations relating to the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR). Where needed, care plans were updated so that people's risks were managed safely and updated information shared with staff.

People's risk of developing pressure ulcers had been assessed using a tool designed specifically for this purpose - Waterlow. Waterlow uses a range of factors to assess people's overall risk of developing pressure ulcers. One person with a pressure ulcer had been referred to a vascular consultant following a referral from their GP. Wound management plans were in place for people who had developed pressure ulcers or who had been identified as having a pressure area. Where needed, an onward referral was made to a GP or tissue viability nurse for advice on wound management and dressings.

We asked staff about their understanding of risk management and keeping people safe, whilst not restricting their freedom. One staff member said, "We let people decide what they want to do if they can make decisions for themselves". Although another staff member told us, "It really annoys me. We have some staff here who don't give people choice. I know one lady here who doesn't want to go to bed at eight o'clock, but I've heard a staff member say they were going to put them to bed anyway". However, people told us that they could choose what time they wanted to get up and what time they preferred to go to bed and that staff acted in accordance with their wishes.

Safe recruitment practices were in place. Appropriate checks were undertaken before staff began work. Staff files contained recruitment information relating to criminal records checks through the Disclosure and Barring Service (DBS). This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with adults at risk. There were also copies of other relevant documentation, including character references, job descriptions and Nursing and Midwifery Council registration details in staff files.

There were mixed views relating to whether there were sufficient numbers of staff to keep people safe and meet their needs. One person said, "The bell is very slowly answered and nearly always longer than it should be". Whilst another person said, "Generally staff are all right. Sometimes they come promptly, sometimes not". We asked a relative about the staffing levels and they told us, "I've never had to worry about that" saying that, in their experience, the call bell was responded to promptly.

We asked staff the question, "Do you think there are enough staff on duty to consistently care for people safely?" One staff member said, "No there aren't. We don't have enough time. Sometimes the care is very rushed and people can miss out on baths when they want them for example. We use agency staff quite a lot too". Another staff

Good

Is the service safe?

member told us, “We can cover the basics so people are safe, but the other things, like cutting people’s nails and reading Christmas cards to residents doesn’t get done”. A third staff member said, “It’s very stressful sometimes when we don’t have the time to give people what they need”. A fourth staff member told us, “We are short of nurses sometimes and are run ragged then”. We discussed these concerns with the registered manager who explained that it had been difficult to maintain consistent staffing levels over the Christmas period and that there had been a high level usage of agency staff. They explained that this was a challenge and said, “Getting staff to work to routine and completing all tasks” had been a difficulty. However, there were plans to recruit new staff from January 2016 and a new staff role had been created, that of hotel services assistant. It was hoped that new staff in this role would be the main point of contact between people and families and would also ensure the environment was managed to a high standard. At the time of our inspection, there were 12 care staff, four domestic staff, a housekeeper, two registered nurses, the deputy manager, administrator, activities co-ordinator and registered manager on duty.

We looked at the staff duty rota for the previous six weeks. Staffing levels were lower at the early part of the time examined, with seven to eight care staff plus the registered manager, deputy manager and registered nurse on duty during the day. However, the registered manager and deputy manager may not always be available to work on the floor. This was due to the fact that the home was in the process of refurbishment and several people had been transferred temporarily into one of the provider’s other homes. On their return, staffing levels rose to between nine and 12 care staff on day duty, with one to three registered nurses and five or six care staff on night duty. The provider used existing staff, where possible, to cover vacant shifts left by sickness or annual leave. We noted there were high levels of sick leave on the rota, for example, within two of the weeks, there were 17 and 13 separate incidences of sick leave respectively. The provider used a formal tool in order to assess the changing care needs of individuals and calculated staffing levels accordingly. This was based on West Sussex County Council’s Continuing Healthcare Checklist. Staffing levels were sufficient to keep people safe, but staff did not always have time to sit and chat with people.

People’s medicines were managed so they received them safely. We observed medicines being administered by one of the nurses during the lunchtime period. The nurse checked the Medication Administration Record (MAR) sheet before administering each medicine to people. When people had taken their medicine, the nurse signed that this had been completed in the MAR. The registered nurse told us that if people refused their medicine, then this was recorded, the GP was consulted for advice and the person’s family informed. Generally, only registered nurses administered medicines, but senior staff would sometimes support this process. Staff had received training in the administration of medicines which had been updated as needed. Medicines were dispensed from a medicines trolley and stocks of medicines were stored in a dedicated, secure medicines room. Unwanted medicines were disposed of safely. There were sufficient stocks of medicines for people and medicines were ordered in a timely way.

Requires improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. We asked staff about issues of consent and about their understanding of the MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Most of the staff we spoke with had not undertaken training specifically in this area and the training plan confirmed this. Some staff did not have a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. However, staff involved people in day-to-day decisions and choices and we observed this at inspection. For example, people were consulted about the activity that was planned for the day and whether they wished to participate in this. People were also offered choices at lunchtime and were asked whether they wanted to wear a clothes protector. People were listened to and their choices implemented.

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). No staff could tell us the implications of DoLS for the people they were supporting. One staff member told us, "I think it's about making decisions for people" and another staff member said, "I don't know what DoLS is".

In the Provider Information Return (PIR), the registered manager had identified that staff understanding of the MCA and DoLS was an area for improvement. The registered manager stated, 'To increase staff awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards, an information sheet is to be made available to staff'.

We recommend that the provider sources specific training for staff on the Mental Capacity Act 2005 that enables them to understand their responsibilities under this legislation.

The registered manager was aware of their responsibilities under DoLS and had completed capacity assessments for people. Where people had been assessed as lacking capacity to make decisions, an application had been completed under DoLS and sent to the local authority for consideration and authorisation. The majority of applications submitted under DoLS were still awaiting a response from the local authority. After the inspection, the provider stated that mental capacity assessments were completed by the registered manager, deputy manager, registered nurses or senior care staff. These staff had attended an update of training in the MCA and DoLS.

Staff had the knowledge and skills they needed to carry out their roles and responsibilities. We spoke with staff about their experiences of induction following the commencement of employment. One staff member told us, "Yes, I had a good induction. I felt safe and didn't do anything I wasn't okay with". New staff followed a qualification leading to the Care Certificate covering 15 standards of health and social care. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

We asked staff about the training opportunities on offer. One staff member said, "Yes, it's quite good. I've just done some training on dementia and there's more coming up". Another staff member told us, "I've no complaints. The manager makes sure we get our mandatory training every year". After the inspection, the registered manager sent us a copy of the training plan for 2015. This showed that staff had received training in the following areas: moving and handling, health and safety, fire safety, food safety nutrition and hydration, infection prevention and control, basic first aid and safeguarding. Some staff had received specific training in dementia awareness, medication and mental capacity. After the inspection, the provider stated a ten week training programme in dementia awareness was being provided to all care staff at the home. Nursing staff had received training in areas such as catheterisation, defibrillator and venepuncture. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose and meant that the care given was of a consistently high standard.

We asked staff how they were formally supervised and appraised by the provider. Staff said they had received

Requires improvement

Is the service effective?

recent, formal supervision or a yearly appraisal. One staff member said, "I do feel listened to and supported, the manager is very good". Another staff member told us, "This is the best manager I've had. They listen to me. The staff meetings are good too, they're very open and honest". The registered manager felt that listening to staff was important and went on to say, "They know the residents, what works and what doesn't". We looked at the 2015 supervision planner and five supervision and appraisal records. Supervision sessions and yearly staff appraisals for all staff had been undertaken or were planned in line with the provider's policy. There were also probation reviews for newer staff members, which had been completed appropriately. Regular staff meetings took place and records confirmed this. Supervisions, appraisals and staff meetings enabled the provider to measure staff performance and to deliver effective care to people.

People were supported to have sufficient to eat, drink and maintain a balanced diet. The provider had a contract with an external organisation who were responsible for catering at Caer Gwent. At the time of our inspection, food was being prepared in a temporary building due to the ongoing refurbishment at the home. People could choose whether to have their lunch upstairs or downstairs in the dining areas, in their room or in another communal area. We observed people were invited to sit in the dining area at tables that were tastefully and festively laid with red and white tablecloths. People were offered a choice of roast lamb or cheese and onion roly-poly pudding, with summer fruits cheesecake to follow. If people did not like the menu choices, they could opt to have an alternative. We observed one person had eaten half their lunch and appeared to be struggling. Staff asked them if they could interest them in an alternative meal. Staff asked people if they would like to wear some form of clothes protector and one member of staff asked a person humorously, "Do you want a pinny on?" People who were sat at the table appeared to be enjoying their meal, although there was little social interaction or conversation. Staff were chatting with people, especially where they were providing them with support to eat their meals.

There were mixed comments about the food at the home. One person said, "I'm not impressed with the food. It's less than 50% of what you would expect. It's not consistently good". Another person said, "I don't like it an awful lot" and then admitted that they did not have much of an appetite anyway. They added, "You can have anything you like to drink" and said how much they enjoyed breakfast. A relative felt the food was good and described their family member as a, "fussy eater". They went on to say, "They've made every effort to meet his needs. We're more than happy". People could arrange to eat meals with their families if they pre-booked these. Special diets were catered for. One person had been assessed as being at risk of choking and advice had been sought from a speech and language therapist. Their care plan advised that fluids should be thickened to prevent the risk of choking or aspiration. People's risk of malnourishment had been assessed and copies of these assessments were in their care plans. The provider used the Malnutrition Universal Screening Tool to assess people's risks using a combination of height, weight and body mass index. Drinks and snacks were freely available to people throughout the day.

People were supported to maintain good health and had access to healthcare professionals and services. The registered manager told us that a GP from a local medical practice made a routine visit to the home once a week. If people needed to see the GP more urgently, then this was arranged and care plans recorded this. Where necessary, staff would accompany people to their healthcare appointments. People also had access to the private services of a physiotherapist who visited the home and with a chiropodist and optician. A hairdresser also regularly visited the home.

The provider was in the process of completing major refurbishment work at Caer Gwent at the time of our inspection and occupancy levels had been reduced during this time. The registered manager told us that they hoped full capacity would be achieved by the end of February. The home had been extensively upgraded and modernised in recent months. As rooms became available, these had been refurbished and people were encouraged to bring their own furniture with them when they moved into the home. Rooms were personalised and people had their own photos and memorabilia on display.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed care in communal areas throughout the day and that people were dressed appropriately for the time of year. One person told us, "Some people [referring to staff] are lovely and some are really good workers here with talent". A relative said, "Staff are very friendly, very happy and willing to help – they're very patient". We observed excellent interaction between people and staff, who consistently took care to ask permission before intervening or assisting. For example, at lunchtime we observed staff asking people if they needed help with their lunch. We also observed that staff were attentive with supplying extra drinks and condiments if requested. There was a high level of engagement between people and staff. We overheard a conversation between one person and the registered manager concerning the refurbishment of the home and the registered manager answered their concerns reassuringly. Consequently people, where possible, were empowered to express their needs and receive appropriate care.

Care plans contained documentation relating to people's past lives and personal histories. The provider had produced a document entitled, 'Our Life', which contained the following headings, 'About me, my family, friends and places, my hobbies, my day, eating and drinking, feelings and emotions, likes and beliefs, achievements and experiences, my appearance, my favourite memory and comfort and care'. Not all care plans that we looked at contained the completed 'Our Life' document, however, there was information about people's life history, including people's likes, dislikes and preferences. This information was useful for staff and meant that they could have meaningful conversations with people on topics that mattered to them.

People were supported to express their views as much as possible and care records showed that people were involved in decisions about their care, as were their relatives. People felt they were treated with dignity and respect. One person praised staff on this saying they thought the staff were, "A good set of people and very responsible". We asked staff how they maintained people's dignity. One staff member said, "We always knock when we go into someone's room" and we observed this was the case. Another staff member told us, "I think it's about giving people choice. That's hard when you're really busy though". We observed staff hung a 'Care in Progress' sign on people's closed doors when they were attending to people's personal care and to maintain people's privacy.

Requires improvement

Is the service responsive?

Our findings

In the main, people received personalised care that was responsive to their needs, although some people felt that staff did not have time to stop and have a chat. This issue was being addressed by the registered manager and additional staff were to be recruited. We asked staff what they understood by the term, 'person centred care'. One staff member told us, "It's providing people with the care they need when they need it". Another staff member said, "I think it means that the person is at the centre of things and we work round them". We asked staff if person centred care was provided at the home. One staff member said, "Not always. Sometimes we are so busy we can only do the basics". Another staff member told us, "I think that can be the first thing to go. If you're really busy you tend to see things as tasks to get through and you can lose sight of the person".

For the majority of people, care plans provided comprehensive information to staff about people's support needs and reflected how they wanted to be cared for. One care plan recorded information relating to the person's personal care, mobility and transfers, medication, pain management and communication. However, with regard to the communication section, the care plan stated, '[Named person] can express and communicate his wishes, but requires empathy and patience'. Later on in the care plan it was recorded, '[Named person] is unable to communicate verbally and will require aids and assistance'. This was discussed with the registered manager at the time of inspection and they agreed that this information was conflicting, inaccurate and confusing for staff. In another care plan we read, '[Named person] at times does not use her call bell for help and walks without aids'. Later on in the care plan it stated, [Named person] evaluated, requires a walking stick to be mobile' (dated October 2015). Then in November 2015, it stated, 'The resident is not fully mobile with or without aids'. Again, this conflicting information did not provide an accurate record of the person's care or support needs. The registered manager agreed with our findings and stated that the issues would be addressed and care plans reviewed to ensure such conflicting statements were corrected.

We recommend that the provider reviews the care needs of each person recorded in the care plans to ensure that the information and guidance provided is accurate and up to date.

Risk assessments were reviewed monthly and care plans were updated appropriately as required, so that people's most up to date care needs were met.

A range of activities was organised at the home by an activities co-ordinator. A programme of activities was made available to people and we were given a copy of the programme from 6 December 2015 to 2 January 2016. The programme showed a variety of activities that were on offer to people. For example, during the week that our inspection took place, the following activities were available: Sunday: Christmas songs and a glass of sherry and Sunday Service, Monday: 'Family Fortunes' and bowling, Tuesday: Pianist and board games, Wednesday: Famous Faces Bingo and New Year hangman, Thursday: Sing-a-long and New Year's Eve drinks and nibbles, Friday: New Year quiz and games afternoon, Saturday: Musical Bingo and New Year film. In the Provider Information Return, the registered manager stated, 'An activity programme in place. Feedback from the resident survey recently suggested the programme needs to be reviewed more regularly to ensure that it remains varied'. As a result, an activities programme was published. People were given a copy of the activities programme and could choose whether or not to participate in activities.

We observed activities in the ground floor lounge on the day of our inspection. Seven people were present and two people were reading newspapers. Before the activity commenced, the activities co-ordinator checked that everyone had a drink and classical music was playing in the background. On occasion, during the activity, the activities co-ordinator had to speak loudly so that people could hear them above the sound of the music. The majority of people were engaged with the quiz that was taking place and responded enthusiastically. However, one person said they could not hear the answers easily and the background music may have been intrusive. Some of the questions were challenging, but the activities co-ordinator supplied clues to people and encouraged them in their answers. People appeared to enjoy the activity and were encouraged to be involved in choosing activities so that the activities co-ordinator could put together a programme that appealed to the majority of people. One person felt

Requires improvement

Is the service responsive?

there could have been more activities and said, “Not many of the residents join in with the activities”. Another person said, “I’m not a lonely man, but at times I feel bored”. People said that either they attended some of the activities that appealed to them or preferred not to be involved at all. One person enjoyed a daily two mile run in the community and care staff would accompany them and run with them.

Complaints were managed appropriately. People could complete a ‘Talkback’ form for the provider, or they could raise a complaint verbally or in writing. When people visited the home, they were welcomed by a member of staff at reception, who was often the first point of contact when people wanted to raise an issue. This meant that any concerns could be dealt with or passed on promptly. One person told us that they would see the registered manager if they had a complaint and added, “She’s nice”. Another person told us that the registered manager was very approachable and would check with people individually if they had any concerns or issues. A relative told us, “We have a good all round view. If we do have a little issue, it is listened to, responded to and put right”. They told us that they had raised a complaint about the noise caused by the refurbishment and that this was disturbing for their family member. As a result, the family member was offered another room and the issue was resolved satisfactorily for all concerned. The registered manager said, “Residents don’t like change and refurbishment has been very difficult”. The complaints record described the complaint raised, the action taken to address the complaint and the action taken to prevent reoccurrence. According to the Provider Information Return which the registered manager had completed, 10 complaints had been made in the last 12 months, all of which had been resolved within 28 days to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

People told us that they felt the service was well led. One person said, "I think it's excellent here to be quite honest". Another person said, "If you've got to live somewhere, you might as well live here!" A relative spoke highly of the home and said, "We're very lucky to have this care home, close by to relatives". A compliment received by the registered manager from a relative said, 'Not everyone is cut out for your line of work, so I must commend Guild Care for putting together staff to be very proud of'. Residents' meetings were organised and the last meeting in July 2015 showed that discussions had taken place on the redevelopment of the home. The registered manager said that residents' meetings were not always effective in involving everyone and gathering people's views, so they made a point of having individual meetings with people to obtain their feedback. The provider had undertaken a survey in March/April 2015 to obtain feedback about the quality of the home overall. Responses showed that 65% of people were 'most satisfied' and 35% of people were 'quite satisfied' overall. Almost 50% of people questioned felt that more information was needed about activities and a programme. As a result, activities were now organised into a programme, a copy of which was circulated to everyone living at the home.

Staff felt supported by the registered manager and felt they would be able to discuss openly any concerns they might have. Staff confirmed to us that the registered manager operated an 'open door' policy and that they felt able to share any concerns they might have in confidence. The registered manager referred to staff and said, "You meet them and learn from them and implement change if you need to". The registered manager was fully involved in all aspects of the service and we observed them interacting with people and staff throughout the day of our inspection. The registered manager told us, "I try and work on the floor a lot with staff. I can see how they communicate and interact with residents".

We asked staff about the vision and values of the home. We asked the question, "What is the purpose of the home and what does it offer to people?" One staff member said, "It's to keep the residents safe". Another staff member told us, "I think it's about trying to make this place a 'home from home'". We asked staff if they thought the home was well led. One staff member told us, "Yes, the manager is great and you can tell them anything". Another staff member said, "I do think the manager does a great job, but there are some things that need looking at, like staffing levels. I'm not sure if the manager can do anything about that". (The registered manager was aware of this issue and additional staff were to be recruited.)

There were systems in place to measure the quality of the service provided at the home. Records showed that audits had been completed in care planning, environment, staffing, nutrition and hydration, cleanliness and infection control. No overall analysis was put in place to measure any trends or patterns relating to accidents and incidents over the year. However, monthly analyses were in place and the registered manager told us they planned to undertake a more in-depth analysis to measure the time of day and where accidents or incidents occurred. Whilst audits had taken place across a range of areas, these did not appear to be planned on a regular basis or in a consistent way. After the inspection, the registered manager sent us some templates which they were developing for future use, to ensure that all aspects of the service were audited. The provider was planning to develop a robust and consistent quality assurance system, for use across all their organisations. Trustees of the provider had also visited the home in June and July 2015. In the Provider Information Return, the registered manager stated, 'Guild Care's board of trustees have a group of trustees that complete unannounced visits to the home. They talk to staff, residents and relatives during their visits and make recommendations for improvements if concerns are noted'. The registered manager said, "We need to adapt to meet residents' needs, continuously changing. I'm very much 'hands-on'. We're constantly trying to improve".