

Russettings Care Limited

Russettings Care Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Good



Overall summary

We carried out an unannounced comprehensive inspection at Russettings Care Home on 10 & 12 February 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the management of pressure care, the recording of accidents, incidents and electrical equipment risk assessments; Issues with storage of medicines and gaps in Medicine Administration Record (MAR) charts; People not receiving appropriate nutrition; care plans not being up to date, people not being involved in the running of the service and audits not

identifying areas for improvement and consequent actions. At this comprehensive inspection, we found that improvements had been made and that breaches in regulations had now been all addressed.

Russettings Care Home is registered to accommodate up to 45 people with a range of needs, including those living with dementia and/or long-term health conditions. The service also provides a short-breaks and respite service. At the time of our inspection, there were 39 people living at the service. Russettings Care Home is a purpose built nursing home set in its own grounds and is situated on the edge of Balcombe village. People have their own

Summary of findings

rooms and some have en-suite facilities. There is a large communal lounge area, dining room and conservatory overlooking the grounds; a separate garden has been made accessible to wheelchair users.

The service has a registered manager. 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 service changed providers less than a year ago and the new registered manager started at the service in April 2014.

People were safe as they were supported by staff that were trained in safeguarding adults at risk procedures and knew how to recognise signs of abuse. There were systems in place that ensured this knowledge was checked and updated. Medicines were managed and administered safely. Accidents and incidents had been recorded and appropriate action had been taken and recorded by the manager

Information in recruitment files was difficult to find and not readily available. We have made a recommendation regarding this.

We observed lunch, people had enough to eat and drink. They were given choices of food from a menu. Drinks were available throughout the day. One person told us "The food is nice". They were encouraged and supported to eat and drink enough to maintain a balanced diet. The service monitored people's weights and recorded how much they ate and drank to keep them healthy. One person said "It's not bad here, staff are nice and the food is good".

Consent was sought from people with regard to the care that was delivered. Staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation, which they put into practice.

Staff had received all essential training and some were working toward an award in health and social Care. They received supervisions from their line managers.

People told us that staff were kind, caring and approachable. One person told us. "Staff are very caring". We observed staff treating people with dignity and respect and involving them in their care. Another person said of staff "They are so caring and the nurses are very good".

People's care plans were up to date and contained information about their individual preferences and needs. Some of these care records were difficult to follow and information was sometimes hard to find. Standardising care record for effectiveness and ease of use was an area that needs further improvement.

Staff were responsive to people's individual needs and demonstrated that they knew people well and knew the detail of their day to day lives, for example how people liked their tea and what topics of conversation people liked to chat about.

The registered manager responded to concerns and complaints in a timely manner. A positive culture was promoted and new staff had a good understanding of how to communicate with people in an accessible way. The management team were transparent with people and relatives about the improvements that had needed to be made and on-going improvements that were being implemented. There was a range of audit tools and processes in place to monitor the care that was delivered and the registered manager worked in partnership with visiting professionals to the home.

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 not always safe

Some information in recruitment records was not readily available and recorded appropriately.

There were enough staff on duty to provide care that was safe.

People were supported by staff that recognised the potential signs of abuse and knew what action to take. Staff had received safeguarding adults at risk training. Medicines were managed, stored and administered safely.

Requires improvement



Is the service effective?

The service was effective

People's consent to their care and treatment was obtained. Staff had followed the legislative requirements of the Mental Capacity Act 2005 (MCA).

People could choose what they wanted to eat and had sufficient to maintain a balanced diet. People had access to and visits from, a range of healthcare professionals.

Staff received essential training and new staff completed a comprehensive induction programme. Communication between staff and people was good.

Good



Is the service caring?

The service was caring.

Staff knew people well and friendly, caring relationships had been developed.

Staff treated people with dignity and respect. They encouraged people to be as independent as possible. People were asked for their views via questionnaires and meetings.

Good



Is the service responsive?

The service was not consistently responsive.

Care records were not standardised in format and information was sometimes difficult to find.

There were activities available for people to participate in and activities for people with dementia were being developed.

The registered manager responded to concerns and complaints and people felt able to express any concerns they had.

Requires improvement



Is the service well-led?

The service was well-led.

Good



Summary of findings

There were formal systems in place to monitor the quality of the service, highlight any shortfalls and identify actions necessary for improvement.

The registered manager was fully involved in the day to day running of the home and had created a culture where there was open communication.

People were asked for their views about the service. Relatives were also asked for their feedback.

Russettings Care Home

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.

We undertook a further comprehensive inspection of Russettings Care Home on 20 August 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in February 2015 had been made. The team inspected against all five questions we ask about services: is the service safe, effective, caring, responsive and well led. This is because the previous concerns spanned across all of these key questions.

Two inspectors, a nurse specialist and an expert by experience with an understanding of older people undertook this inspection. 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 provider had sent us an action plan following the last inspection and we used this to guide our inspection. We

also checked the information that we held about the service and the service provider. 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, relatives and staff. 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. We also spent time looking at records including 10 care records, six staff files, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. We contacted local health and social care professionals, including a GP, social worker and a community nurse who have involvement with the service, to ask for their views. They gave us permission to quote them in our report.

On the day of our inspection, we spoke with 18 people using the service and seven relatives. We spoke with the provider, the registered manager, a clinical lead, a registered nurse and six care assistants.

Is the service safe?

Our findings

At the last inspection a breach of regulation was identified in relation to regulation 9 and 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider had not ensured at all times people had the appropriate care for pressure sores. The provider had not ensured accidents and incidents were recorded properly and premises and equipment were not managed to ensure people's safety. People were also not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place for the safe management of medicines.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 June 2015. Improvements had been made, and the provider has now addressed the previous breaches.

People told us they felt safe living at Russettings. One person said "I feel safe and happy, I have been here a long time, I am 96". Relatives told us they thought their family members were safe at Russettings as they were cared for by skilled staff who knew their family members well.

The care records we looked at showed us that people's pressure care was being assessed and reviewed on a regular basis. On the day of our visit there was one person with a pressure sore and this person received the appropriate care. They had a pressure relieving mattress on the bed. Turning/repositioning charts were in place and were being completed. They were being filled in every two hours. These records also contained information on continence and personal care that had been delivered. Nursing staff we spoke with were able to tell us about the importance of following advice from the Tissue Viability Nurse, the importance of nutrition and hydration played in assisting healing and the importance of good hygiene to provide a good healing environment along with regular repositioning, the use of pressure relieving cushions and air mattresses. In the care records of the person with a pressure sore there was a clear record of input from the tissue viability specialist and we could see that the care plan had been updated as a result of this. If people were at risk of developing a pressure sore this was identified by the completion of a waterlow risk assessment tool. The appropriate treatment was then recorded in the care plan. For someone else who had been identified as at risk of

getting a pressure sore we could see that the appropriate equipment and treatment had been provided. A family member who had a nursing background told us that staff were "Looking after [the person's] pressure areas very well. We saw that a risk assessment had been carried out and specialist equipment had been provided for this person regarding their bed and commode.

Regular audits had been carried out in relation to monitoring people with pressure sores and those at risk of developing pressure sores. These records advised taken and actions implemented. We could see the progress of these from looking at the audits.

People's medicines were administered safely. We observed medicines administered by one of the nurses on duty. The trolley was locked whilst administering medicines to different people. The nurse was wearing a tabard that alerted people to the fact that they were administering medicines. This was to ensure interruptions were kept to a minimum and therefore the risk of making errors was minimised. A drink was given to each person with their medicine and each person was told what their medicine was for. One person refused pain relief and this was appropriately documented on the Medication Administration Record (MAR) charts. When the nurse had completed giving people medicines the trolley was taken to a secure clinical room and locked in. We looked at all the MAR charts and noted that no medicines had been missed and if people had refused this was clearly recorded and documented. Where there had been a medicines error previously this had been picked up quickly by the clinical lead. The error had been investigated and the GP contacted. It was documented that there had been no adverse effects. The agency that had supplied the worker responsible for the error was contacted.

The registered manager told us that medicines are dispensed from the doctor's surgery but that there had been delays in getting medicines. The registered manager had taken steps to address this. This showed us that the registered manager was considering what would work best for the home and would improve the experience of staff and people in relation to receiving medicines in a timely way. The registered manager had contracted a new pharmacy to carry out an audit of medicines management

Is the service safe?

in July 2015. This date was cancelled and a new date had been scheduled for September 2015. This audit would offer an objective assessment of medicines management at the home.

Improvements had been made to the environment and the hot water machine that had been identified as a risk to residents at the last inspection no longer dispensed hot water and was not accessible to people at the home. New heating has been installed in the left wing of the building which will minimise the need for free standing heaters. Handrails had been fitted along the corridors. These were painted blue in contrast with the cream walls which would enable people living with dementia to distinguish them more easily. Alarm cords were in place in the bathrooms for people to access. People also wore pendant alarms if it was identified that this was a safer way to alert staff for help. The provider showed us a copy of a premises action plan that detailed work that had been taking place and planned works over the next six months. We saw that it had been identified that there was a need for new furniture in the conservatory and that this had been provided in July 2015.

On the day of our inspection there were enough staff on duty. On the day of our inspection there were two nurses on duty including a clinical lead, furthermore there were two senior carers and six carers in addition to a chef, three ancillary staff and the registered manager. Two clinical leads had recently been recruited to have oversight of nursing practice within the home. A dependency tool, which is a tool that identifies the levels of need for people living at the service and indicates the number of staff required to meet those needs, was in place. The registered manager told us that the service now had a stable group of staff in place and that included two clinical leads with a focus on nursing practice. If needed the service used staff from an agency. Where possible they tried to use the same agency staff that knew the needs of the people at the service. We observed staff had enough time to spend talking with people in a meaningful way for short periods. We saw staff checking people were ok as they went about their other tasks. People told us there were enough staff on duty. A member of staff said there were enough staff on duty and that they had enough time to carry out their duties. We observed that staff came promptly when call bells were rung.

We looked at accidents and incidents and saw that these were recorded in detail along with actions taken. These were checked monthly by the registered manager and signed off as part of the auditing process. Where patterns were identified such as a pattern of falling these were analysed and appropriate action taken for example using different equipment or a referral to the falls prevention team.

We looked at staff recruitment records and identified some gaps in these records. We could not see on the records that all nurses had an up to date PIN number from The Nursing and Midwifery Council (NMC). The NMC is the professional regulatory body for nurses in the UK. The PIN number indicate whether a nurse is fit to practice. The registered manager showed us evidence on the day of our visit that all the nurses had up to date PIN numbers and was aware of the dates that these needed to be reviewed. Where there was a missing written reference the provider told us that a verbal reference had been received and this was documented in the file. We could not see where the verbal reference information was stored. We discussed this with the provider who agreed that this was an area that needs improvement and was included as part of their ongoing action plan.

We recommend that the provider seek guidance around good practice systems for recording recruitment information.

All staff, including the kitchen and domestic staff had received training in safeguarding adults. Staff knew how to protect people from abuse and could identify potential signs in a person such as someone becoming more withdrawn or more agitated. Staff were aware that they needed to report any concern immediately to a manager in order for them to assess the situation and act accordingly. Where there had been concerns of a safeguarding nature these had been referred to the local authority. The registered manager knew who to contact in the local authority. They had access to the local authority's multi-agency policy and procedure. Where there had been whistleblowing concerns raised the registered manager had dealt with these in a timely and detailed way.

Is the service effective?

Our findings

At the last inspection a breach of regulation was identified in relation to regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider had not ensured people had enough to eat and drink and this was not adequately monitored.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 June 2015. At this inspection improvements had been made, and the provider has now addressed the breach.

People told us they liked the food and that they had enough to eat. People told us that the food had improved greatly over the past six months. One person said “The food is lovely”. Another person said “The food is very nice, I enjoy it”. Relatives told us that they could eat with their family members and that the food was good. One relative said “I phoned beforehand and pay for my lunch so I can eat with [the person], it is very nice”. Another relative said “We have been very impressed with dad’s care, he has a cooked breakfast, he likes prawns and he has a beer”. We observed people having their lunch in communal areas and in their rooms. In the communal areas tables were laid with colourful tablecloths, flowers and coloured beakers for drinks. Contrasting colours make it easier for people living with dementia to distinguish items of crockery, cutlery and their food. We observed staff assisting people calmly and encouraging people to eat. There was a choice of lamb curry and prawn cocktail salad for lunch. If people did not like either of these choices they were offered an alternative. People were offered a choice of puddings from a trolley with a variety of options including fruit, rice pudding and ice cream. A choice of drinks was available for people including shandy, orangeade, lemonade, water and juice. People were offered teas and coffees at the end of the meal. The drinks trolley was stocked and available throughout the day and people were supported to access this as and when they wanted. The registered manager told us that managing the lunchtime period and ensuring that people had enough to eat and drink was a priority. Nursing staff and a member of the management team were involved in assisting people and observing practice at lunchtime. We observed that this was the case on the day of our visit.

We observed people being supported to have their meals in their rooms and people received the meals and support

they required. We observed a staff member supporting someone to eat. The staff member did this with respect and patience in an unhurried way to allow the person time to enjoy their food. The staff member interacted with the person making the occasion a sociable one. This person told us “They are very good to me here. I have no complaints”

Staff heated food up for people who preferred to eat their lunch at a different time. One relative told us “Staff got my father ready for a trip out in the car and because he was back last they kept lunch for him”.

Care records had Malnutrition Universal Screening Tool (MUST) in place and calculations regarding Body Mass Index (BMI). A MUST tool was used to monitor people’s nourishment and weight. It is a five-step screening tool that identifies adults who are malnourished or at risk of malnutrition. The tool included guidelines which can be used to develop people’s care plans. Food and fluid charts were completed for each person and these were reviewed by senior staff on a weekly basis to monitor the amounts that people ate and drank. Details of what people had eaten and drunk was recorded. Nursing staff monitored if someone had lost weight and instigated a care plan to address this including a referral to the GP. Nursing staff had a clear overview of the nutritional needs of people living at the home. Where people needed special diets this was documented. Where people needed referrals to a speech and language therapist (SALT) this was actioned. We observed nursing staff discussing a referral to SALT on the day of our visit and requested that this be actioned as soon as possible. This showed us that staff worked in partnership with other professionals and advocated for the needs of people at the home to ensure they received the appropriate healthcare.

People and their relatives felt that staff were sufficiently skilled to meet the needs of people and spoke positively about the care and support. One person told us about staff “I have treatment and they are very nice and kind”. Relatives said that they thought staff had the right skills for the job. One relative said “Staff are very skilled and they have managed to calm [the person] down”.

Staff told us that they received an induction when they started working at the home which involved shadowing other staff to gain an understanding of the role. A new staff member we spoke with told us that they were starting the care certificate, a nationally agreed set of care standards

Is the service effective?

which should be met to ensure safe and effective care is delivered. The care certificate was being implemented for all new staff and we saw one that had been completed that the registered manager was due to check and sign off. Staff received training in areas such as moving and handling, safeguarding adults, infection control, fire safety, first aid, food hygiene and dementia care. Staff told us that they received enough training to support them to carry out their roles. Staff were able to carry out additional training such as diplomas in health and social care which gave them additional skills and knowledge for carrying out their roles. Nurses told us that if they requested training in particular areas this was responded to promptly. They gave examples of courses they were due to attend at Crawley hospital and these included phlebotomy and tissue viability. The clinical leads provided supervision for the nurses and an external agency was being sourced to provide clinical supervision for the clinical leads. Staff received regular supervisions and appraisals and felt supported to carry out their roles.

Consent to people's care and treatment was sought in line with legislation and guidance. Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and demonstrated their knowledge of this. We observed staff offered people choices and asked them if they were happy for example to take medicines. Staff told us that they gained people's consent where they could and always explained what they were doing. One staff member said "I always tell someone exactly what I am doing". People's capacity to consent to care or treatment was recorded in their care records. People were assessed on their capacity to consent in a range of areas and capacity assessments had been completed and best interest decisions recorded

where needed. These were evident where people required covert medicines to be administered. People were supported to make day-to-day choices and decisions about their care.

Two people were subject to a Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Sixteen further referrals had been sent to the local authority and these people were awaiting assessments. The registered manager had received advice on this from the local authority to ensure legal guidelines were followed and people's rights were protected in the meantime while their applications were being considered.

People and their relatives told us that they were supported to access healthcare. The GP was visiting people on the day of our visit and we observed nursing staff discuss in detail people's health needs. They took notes from the consultations and updated care plans, daily recording sheets and handover records accordingly. People had access to a variety of health professionals including SALT, dieticians and the dementia in-reach team. People's records demonstrated that external professionals were contacted in a timely way. We spoke with three different professionals who all told us that they were contacted in a timely way and that staff knew the healthcare needs of their residents and when to refer. Professionals told us that staff implemented advice and treatment that had been advised. The GP told us staff were "Very co-operative and helpful".

Is the service caring?

Our findings

People and relatives spoke very highly of the caring nature of the staff at Russettings. One person said “Staff here are very good and the girls are lovely. My son and granddaughter enjoy visiting me here”. Relatives of one person said “Staff are very caring” and “Staff have been excellent”. Another relative said about staff “They are always respectful and compassionate. When we are upset if mum is not very good that day they help us and talk to us”. Another relative said “The girls are kind and good”.

We observed staff talking to people and having caring interactions with them. At lunch time we observed one person singing and a staff member started to dance and encouraged them to continue. Staff and people clapped at the end and they visibly enjoyed the experience. We observed one woman who had just had her hair done laughed and joked with staff and looked very pleased with her new hairdo. We observed staff reorienting people to time and place and reassuring them often with gentle touch. We heard a staff member reassuring someone who was moving into a wheelchair “Take it slowly and in your own time”. We observed someone who liked to walk around being supported to access the garden and the staff member was chatting away to them. They ensured the person was comfortably seated outside and offered to bring them refreshments to the garden.

People and relatives told us that staff were respectful of people’s dignity. One person said “They are respectful of me, staff pop in and offer me drinks and snacks”. People told us that personal care was provided that respected their dignity and which helped them feel well and looked after. There was a dignity champion who told us that her role was to promote people’s dignity through the care that was provided. They told us “I try to implement this ethos in day to day work and encourage independence and choice”. They saw their role to lead by example, they said “Staff learn a lot by seeing, people leading by example is informative”. Staff told us how they respected people’s privacy and people had do not disturb signs on their doors when they were receiving personal care. A staff member told us they would “Shut the door, use the do not disturb notice, shut the curtains and use towels to cover up parts of

people’s bodies”. Another staff member said “You put a do not disturb sign on the door and ensure you have familiar faces to support people”. We observed that these signs were also in place when the GP was seeing someone. Staff told us that it was important to communicate with people when supporting them. Another staff member said “I always tell people exactly what I am doing”. Staff told us that if people did not want support they would chat to them. Another staff member said “If they say no I explain to them what I am doing and they see”. They also said that they would respect people’s choices and return another time to support someone.

We observed people being involved in their care throughout the day of our visit. They were offered choices around food and activities and offered support. We heard staff asking “Do you want me to help you with that?”, “Where would you like to sit?” and “Would you like something else to eat?”.

People and relatives told us about meetings that were held and how they were included in discussions about the running of the home. The provider told us that these meetings happened six times a year and that both the provider and registered manager attended these. We saw minutes from the last three meetings. Items discussed included accessing a male barber for men living at the home, the option for swimming at the therapy pool, new staff and building works. Minutes we looked at documented feedback from people and their relatives. Questionnaires were also offered to people and relatives to provide an opportunity to feedback regarding the experience of living at Russettings.

People were supported at the end of their life to have a private, comfortable and dignified death. Some people had end of life plans in place and, where they were able, had been involved in decision-making. There was no one receiving end of life care on the day of our visit. Staff were committed to providing high quality care in this area. One staff member said “We want to be able to support the resident and their family through a difficult and distressing time”. Several relatives commented on the support they received from staff regarding difficult times for them in caring for their family member which showed us that staff cared for people and their relatives.

Is the service responsive?

Our findings

At the last inspection a breach of regulation was identified in relation to regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider had not ensured that care plans were up to date and consistently completed.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 June 2015. At this inspection improvements had been made, and the provider has now addressed the previous concerns.

People and relatives told us that they were involved in planning people's care. One relative said "When the person first came I sat and had a long chat with staff and we discussed how they would be cared for. I am impressed and think the staff are very good". People were assessed by the registered manager prior to being admitted to the home and were involved in planning their care. The care plans followed the activities of daily living such as communication, personal hygiene, continence, moving and mobility, nutrition and hydration, sleeping, medication and mental health needs. Care plans represented people's current needs. Care plans contained information about the person's life history and their likes, dislikes and preferences. For example we saw in one record clear guidance around how this person was to be supported when they became distressed the care plan contained phrases that required staff to 'remain positive and support [the person] by reaching out and comforting them' and 'engage in activities that provide pleasure and promote self-worth'. A list of activities the person enjoyed followed. We saw staff following this in practice.

Although information was current and represented people's needs the system for care planning was not consistent across care records and in some records it was hard to find the order information was presented in. The registered manager, provider and staff told us that the records had improved but that this remained a priority to streamline the records for ease of use and effectiveness. We saw a plan that was in place regarding this and that indicated care plans were to be standardised and in format by October 2015 and then the care plan audit system would be implemented. One of the new clinical leads

informed us that they would be carrying out some of this work as a dedicated task over the following months. This therefore remained an area that needed further improvement.

Staff knew people's individual needs and had a clear understanding of the particular things that people liked and disliked. We observed that staff knew the topics of conversation people liked and responded to. For example we saw staff members having conversations with people about the past particularly engaging them in conversations that interested them. "[The person] here used to have a pony when she was young didn't you [the person]". Another staff member said "What's that badge on your hat [the person]? Tell us about your time in the RAF", the person responded "I used to fly jets and we had to jump out and parachute over...". These conversations showed us that staff knew people's histories and how to interact with people living with dementia and involve them in stimulating social conversations.

At lunch time we observed someone who liked to walk around and didn't like to sit still for too long being encouraged to move from the dining room into the lounge to have their pudding. This enabled the person to sit for a while and eat a pudding. This showed us that staff were responding to the particular need of this person to be on the move. We also observed someone singing at lunchtime and a staff member started to dance and encouraged him to continue. Staff and people clapped him when he had finished. He visibly enjoyed the experience. Relatives told us that staff were supportive of them. One relative said that staff had supported them at difficult times when their family member had bad days. "Sometimes [my relative] is not so good and we get upset, staff are kind.

An activities co-ordinator had been recruited since the last inspection. Activities were on offer for people and these consisted of one to one activities and group activities. The schedule of activities was displayed in the lounge area on a large board with pictorial prompts. This was displayed alongside the weekly menu. Activities included bingo, exercise classes, fish and chip Fridays baking and beauty treatments for women and pamper mornings for men. Outings were arranged into the local village. Minutes from resident meetings documented the Easter and summer fetes that had taken place. An outing to Brighton had been enjoyed with people having a fish and chip supper on the beach. We saw that future activities were planned including

Is the service responsive?

an outing to Stanmer House in Brighton for lunch at the end of August and a tea dance at the winter gardens in Eastbourne in September. One to one time was provided for people who preferred this or who preferred to spend more time in their rooms. There was an activities file that documented what people had been doing over a week period. This showed us what activities people had participated in and what one to one support they had received.

The dementia in reach team had been working with the staff to develop strategies and methods to implement at the home to support people living with dementia. We saw that a wall in the dining room had been painted red to provide a more stimulating colour, there were puzzles, games and books available in the conservatory area and a doll in a moses basket which some people living with dementia found comforting to hold. There was also a summer house in the garden which was in the process of being turned into a beach hut with a shop in it for people to visit and take part in the activity of visiting and working in a shop. This would provide meaningful activity and

stimulation for some people living with dementia. The registered manager and activities co-ordinator were working on integrating these activities into what was on offer for people on a day to day basis.

We saw that staff and residents meetings were opportunities for people to express concerns and that the responses to these were documented in the minutes. For example concerns that the service was short staffed at weekends had been discussed. The provider had explained the staffing situation and reassured people and relatives of how staffing need was calculated. They reassured them that if there were staffing shortages this was covered with agency staff.

We saw that the complaints policy was available for people and relatives. Complaints had been responded to in a timely way. We looked at the last three concerns raised and noted that people's concerns had been addressed in a timely way and feedback gained to ensure that the person was happy with the response. The registered manager followed the procedure for addressing complaints raised with them.

Is the service well-led?

Our findings

At the last inspection a breach of regulation was identified in relation to regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider had not ensured people were involved in developing the service, audits were not being completed with regularity and actions from these were not being identified.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 June 2015. At this inspection improvements had been made and the provider has now addressed the previous breach.

People and staff told us that they were involved in the running of the home. They told us about the meetings that had taken place for people and their relatives where issues of importance were discussed. Relatives told us they could approach staff, the registered manager and the provider with any concerns. One relative said “The new owner’s heart is in the right place and the place has improved a lot. They look after [the person] and we can talk to him. We have raised a lot of points at the meeting. He always tries his best and we wouldn’t want [the person] anywhere else”.

We looked at the last three meetings minutes and saw that a range of issues had been discussed including the last inspection report and the improvements that were being made to the home.

People and relatives were consulted regarding activities and outings. They were informed about new staff and improvements being made to the premises. The registered manager gave updates following advice given by the dementia in reach team. The newly appointed activities co-ordinator was looking at increasing ways of resident’s participation in the meetings and was looking at alternative ways to involve people in contributing to the running of the home such as one to ones and in smaller group activities.

A quality survey had been carried out in May 2015 which had asked people and their families to comment on the service provided at Russettings Care Home. The survey had asked questions in five areas that addressed facilities, services, access to staff, resident’s rights and care. There were a small number of respondents. The feedback had been analysed and positive feedback included a statement ‘There has been significant improvement in standards over

the last year! Thank you’. Issues relating to staffing were addressed in the feedback and an explanation of how staffing levels calculated given. Comments relating to the conservatory and its use were raised. It was documented that new furniture has been purchased to brighten the environment.

Audits were in place to monitor the service provided. These included audits around medicines, wound management, health and safety and infection control. We saw that actions were identified as part of the auditing process. For example the infection control audit had identified that a member of staff had not worn protective clothing whilst supporting someone to eat. The date that this had been raised with the staff member was documented. Another action had been identified in relation to the need for coloured coded mops for different areas of the building. The date this had been done was recorded and we saw these were in use. The medication audit identified that two dated photographs of people were needed for their MAR chart records and these were to be put in place by the end of August. The provider had an ongoing action plan in place for areas of improvement needed within the home and it had been identified that when care records were standardised across the home a care planning audit would be implemented.

People, relatives and staff told us that there had been significant improvements in the running of the home over the last six months. People, relatives and staff felt that they could approach the management team and discuss any issues with them. A staff member told us “The manager is supportive, that’s what she’s good at”. Another staff member told us about the improvements “It’s a lot, lot better. [The provider] is brilliant, he always gives us what we need”. Staff and relatives said that the management team had been transparent with them regarding the previous inspection report and the areas that had been identified that required improvement. These had been discussed in staff and residents meetings. The action plan that the provider showed us contained ongoing issues regarding keeping records accurate and up to date. These included ensuring recruitment files held all the accurate up to date information and were accessible in the files. An audit system for this was being developed. Clinical supervisions were being arranged for the new clinical leads. This action plan showed us that the management team

Is the service well-led?

were addressing areas of practice that needed ongoing improvement. Staff were aware of the whistleblowing policy and knew how to raise a complaint and who they should contact.

The registered manager and provider discussed the challenges that they had faced over the last year in implementing improvements. They were committed to delivering a high quality service. They told us that creating a positive culture among staff had been a challenge for them along with recruiting a team of regular permanent staff. Staff commented that they felt they had a supportive team that worked well together. Staff told us they enjoyed working at Russettings. One staff member said “It’s a lovely home”. The registered manager told us that they felt supported by the provider and that they met regularly to discuss the running of the home. Management meetings were held every quarter and one provider visited the home every Friday and the other provider was visiting the home twice a week to facilitate the action plan. The registered manager told us that they were “Passionate about dementia care” and we could see that the service was developing practice in this area. We could see that staff and the management team were committed to providing good

quality care and that significant improvements had been made following the last inspection. There were ongoing improvements identified and a plan was in place for these. The management team had created a transparent culture that reflected this. They were clear with us about the areas that they were continuing to work on. These included standardising the care plans, introducing further audits, introducing more dementia focused activities and making environmental improvements.

The home was making links with the local community and keeping people integrated with what was happening in the local area. The home held fetes at Easter and in the summer. At the summer fete the mayor of Hayward’s Heath and the chairperson of the local parish council had attended. People from the local community had been invited. People from the home were regular visitors to the local village pub.

Visiting professionals we spoke with told us that the registered manager and staff worked in partnership with them and contacted them in a timely manner that ensured the welfare of people living at the home.