Guild Care

Irene House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 31 May and 1 June 2016 and was unannounced.

Irene House is registered to provide nursing care and accommodation for up to 40 people with a range of needs, including people living with dementia. At the time of our inspection, 39 people were living at the home. Irene House is a large, older-style detached property with the addition of annexed accommodation surrounding an enclosed garden/courtyard area. Communal areas include a large dining room, sitting room and conservatory. Some rooms have en-suite facilities and all are of single occupancy. Irene House is situated close to Worthing town centre and seafront.

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 received regular supervision meetings or annual appraisals to assist them to carry out their role effectively. This had been already been identified as an area for improvement by the provider. Following the inspection, the registered manager had put a plan in place to ensure that outstanding staff supervisions were organised and completed in line with the provider's policy.

The home was uniformly decorated throughout and had not been specifically adapted to meet the needs of people living with dementia. This was discussed with the registered manager as an area for improvement.

Staff had completed all essential training and staff meetings were organised, although these were not always well attended by staff. New staff completed an induction programme and studied for the Care Certificate, a universally recognised qualification. Staff understood the requirements relating to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and put this into practice.

People had sufficient to eat and drink and were supported to maintain a balanced diet. They had access to a range of healthcare professionals and services.

People told us they felt safe living at Irene House. Staff had been trained to recognise the signs of potential abuse and knew what action to take. People's risks were identified, assessed and managed appropriately by staff. Accidents and incidents were reported and prompt action taken to prevent the risk of reoccurrence. Weekly checks were undertaken of equipment used to support people. Staffing levels were sufficient and robust recruitment systems were in place. Medicines were managed safely. Staff had a good understanding of their role in the prevention and control of infection.

People were looked after by kind and caring staff who knew them well. They were supported to express their views and to be involved in all aspects of their care. People were treated with dignity and respect. At

the end of their lives, people were supported to have a private, comfortable, dignified and pain-free death by staff who were sensitive to their needs. Records relating to people's end of life care had been completed appropriately.

People received personalised care that was responsive to their needs. Care plans included detailed, comprehensive information about people's care needs, their likes, dislikes and preferences. A range of activities was organised for people. Complaints were managed promptly in line with the provider's policy.

People were involved in developing the service and they were encouraged to be involved in meetings with their relatives to feedback their views about the service. The provider sent out annual surveys to people and their relatives. Staff felt supported by the management team at Irene House and that any concerns they had would be listened to. People and staff said the home was well managed and well led. A system of audits monitored the quality of the service overall and identified areas for improvement.

We found one breach of regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe and staff understood what action to take if they suspected people were at risk of abuse. People's risks had been identified, assessed and were managed appropriately.

Staffing levels were sufficient and medicines were managed safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective..

Not all staff had received regular supervisions in line with the provider's policy to enable them to carry out their roles and responsibilities effectively. They had completed all essential training.

The environment of the home had not been adapted specifically to support people living with dementia to orient them with their surroundings.

Consent to care and treatment was sought in line with legislation and guidance.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. They had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff who cared for them in a warm, caring and supportive way. Their privacy and dignity were respected.

People were encouraged to express their views and to be involved in all aspects of their care.

At the end of their lives, people were supported to have a private, comfortable, dignified and pain-free death.

Is the service responsive?

Good

The service was responsive.

A range of activities was planned for people.

Care plans provided comprehensive information about people and guidance for staff.

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

Is the service well-led?

Good

The service was well led.

People and their relatives were asked for their views about the service through meetings and surveys from the provider.

Staff felt the service was managed well and that they were supported by the management team at Irene House.

A range of audits monitored and identified areas for improvement.

Irene House

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 31 May and 1 June 2016 and was unannounced.

An inspector, nurse specialist and an expert by experience 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 expert by experience at this inspection had expertise in older people and dementia care.

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. 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 seven care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with six people living at the service and spoke with three relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the deputy manager, two registered nurses, four care staff, a volunteer who spent time at the home and the chef.

The service was last inspected on 18 June 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "The staff are wonderful. I feel safe and happy and if there was something wrong I would speak to someone". A member of care staff said, "We work in their home. I always go and sit with them, tell them my name and job role. I make them feel secure and reassure them", adding, "A big part is the reassurance. Being confident in what I do reassures people too". Staff had been trained to recognise the signs of potential abuse and knew what action to take if they suspected a person was at risk. One member of staff described safeguarding as, "Making sure residents are safe and reporting any incidents, reporting concerns". They went on to explain they would report any concerns to the registered manager or registered nurse on duty and then complete an incident form. Another member of staff said, "Being aware of the different kinds of abuse and where they might occur, like physical or financial, being alert". Where safeguarding alerts had been notified by the provider to the local authority, appropriate action had been taken to prevent the risk of reoccurrence.

Risks to people and the service were managed safely. People wore call pendants so they could summon staff quickly when required. People's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for the purpose. Pressure ulcers were managed appropriately and pressures areas were monitored, with any improvements documented. Where necessary, advice and guidance had been sought from healthcare professionals such as a tissue viability nurse. Body maps kept in care records showed that people's skin integrity was monitored and managed appropriately. Profiling beds were provided, together with pressure relieving mattresses, to reduce people's risk of developing pressure ulcers.

Risk assessments recorded that people's risks had been identified and assessed and provided advice and guidance to staff on how to mitigate people's risks. We saw risk assessments had been drawn up in relation to falls, medicines, bed rails, moving and handling and eating and drinking. There was evidence within care records that people's relatives had been consulted, for example, family members had been involved in a decision for one person to have bed rails. Risk assessments were reviewed monthly and care plans updated if required. We asked a member of care staff if they had any involvement in drawing up people's risk assessments. They told us, "No, but the registered nurses do ask us if there are any changes, is 'this' or 'that' happening. We've got really good communication with the nurses, they're like our backbone".

Accidents and incidents were reported and action taken as needed. For example, one person had suffered a series of falls in recent months. Appropriate action had been taken and was recorded to show that this person's footwear had been checked, they were transferred to a ground floor room, the provider had sought advice from the local authority's falls team, a sensor mat was put in place to detect when the person tried to get out of bed and the person was reminded to use their call bell if they required assistance from staff. Staff told us that any incidents that had occurred during the day were reviewed at handover meetings when staff changed shifts. The outcomes of any incidents were also shared and discussed amongst staff, for example, any changes to people's care plans.

Equipment checks were undertaken in line with Lifting Operations and Lifting Equipment Regulations (LOLER) legislation. Weekly checks were undertaken for stand aids, mobile aids, ceiling hoists, baths and

bath chairs, slings and lifts. We observed one piece of equipment that was in a very poor state of repair; this was a chair that was used to aid posture and provide safe support for a person who had little or no mobility. We discussed our concern with the deputy manager who stated that they had already asked the provider for a replacement chair, however, at the time of our inspection, the chair was still in use. Following the inspection, the registered manager confirmed that the chair had been disposed of and a replacement was awaited. In the interim, alternative seating provision had been provided for the person concerned. We also observed that hoists were stored in bathrooms due to a shortage of space. The registered manager told us that when the bathroom was in use, the hoists were moved out into the corridor. After the inspection, the registered manager informed us that the lack of storage space had been fed back to the senior management team for discussion.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. Two registered nurses were on duty during the day and one at night. Up to eight care staff were on duty during the day, reducing to six care staff after lunch and three care staff at night. We checked the staffing rotas which confirmed these staffing levels were consistent. Staffing levels were assessed based on people's care and support needs. The registered manager told us, "People are assessed at admission, then people's needs are re-assessed and staffing levels are reviewed as needed". One member of staff told us that care staff worked flexibly in different parts of the home and generally in pairs. The registered manager told us that sometimes it could be difficult to provide registered nurses for night-time duties from existing staff and they occasionally used agency staff. They said, "We have to maintain occupancy and staffing can be a challenge. We have a good, strong nursing team". Safe recruitment practices were in place. Before new staff commenced employment, checks were made with the Disclosure and Barring Service. At least two references were obtained from previous employers and new staff were vetted to ensure they were safe to work with adults at risk.

Medicines were managed so people received them safely. We observed a registered nurse administering medicines to people at lunchtime. They explained to each person what their medicine was for and waited patiently with people whilst they took their prescribed medicines. Medicine trolleys were locked when not in use and the keys kept with the registered nurse in line with Nursing and Midwifery Council (NMC) guidelines. Nursing staff informed us that medicine reviews for people were held every fortnight with the GP in attendance. On the day of our inspection, we witnessed a call to the GP surgery because one person had difficulty in retaining their medicine which had made them sick and an alternative format to their medicine was discussed. Weekly medicines' audits were completed by the deputy manager to ensure that Medication Administration Records (MAR) sheets had been completed appropriately and that people received their medicines as needed. The registered manager had completed a trend analysis to identify any common issues in the management of medicines. In addition, any medication errors were identified and acted upon. For example, one person had not taken their medicine as a tablet was later found in their bed. The registered manager had discussed this with the GP who then prescribed the medicine in an oral solution, to ensure the person took their medicine.

Staff demonstrated a good understanding of their role in relation to the prevention and control of infection. We observed staff wore personal protective equipment when they assisted people with their personal care. Clinical waste was disposed of in yellow bins and staff were observed to follow good handwashing techniques.

Requires Improvement

Is the service effective?

Our findings

Not all staff received regular supervisions or had annual appraisals. We asked staff how often they had supervision meetings and whether they had received annual appraisals. One member of staff, when asked about supervisions, stated, "At the moment, every six months". Another member of staff could not remember when they had their last supervision. We looked at the records relating to the planning of supervisions and appraisals of 37 care staff who were in permanent employment. Records stated that staff should receive supervision meetings every two or three months. There were significant gaps in the frequency of supervisions. For example, at least nine staff had not had a supervision meeting at all this year. At least two staff had not received annual appraisals to measure their performance. In a statement from the provider, the Operations Director had written, 'All staff members working in the care homes will have at least four one-to-one meetings per year, one of which will be an annual appraisal'. Supervisions and appraisals had not been undertaken in line with this statement. Staff should receive appropriate ongoing supervision in their role to ensure their competence to undertake their role to support people effectively is monitored and maintained.

The above evidence shows that staff did not always receive appropriate supervision and appraisals necessary to enable them to carry out their duties. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the registered manager sent us a list of all outstanding supervisions and appraisals that needed to take place and stated, 'Supervision allocation lists to be revisited and revised as necessary'. An internal audit by the provider had already identified this as an area for improvement in April 2016.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Staff appeared experienced and demonstrated the confidence and skills required to provide people with effective care. We sat in on a handover meeting where staff coming off shift shared information about people's care needs with staff coming on shift. Staff were informed of any outstanding personal care tasks that needed completing for people. We observed that staff were informed about the incident relating to the person who had difficulty with their medicine and the resulting conversation with the GP.

Staff told us they completed a planned induction programme and were paired up with an experienced staff member. In general, new staff shadowed six shifts until they were confident to work more independently. Staff said they used their induction period to get to know people and read their care plans. New staff completed the Care Certificate covering 15 standards of health and social care topics. 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. A member of staff said, "If they don't think you're good enough, they could extend the training". Staff were also supported to study for additional qualifications, for example, vocational qualifications or diplomas in health and social care. One member of staff described their training as 'constant' and they had recently completed

training in infection control and moving and handling. They told us, "They have excellent training programmes. I do love learning".

Registered nurses completed mandatory training in health and safety, fire safety, working at height, Control of Substances Hazardous to Health (CoSHH), basic first aid, safeguarding, mental capacity, record keeping, moving and handling, dementia care, mental health and learning disabilities and person-centred care. Care staff completed a similar training programme. Annual updates to training were provided to staff in moving and handling, safeguarding, infection control, food hygiene and health and safety which included first aid. Records confirmed that staff had completed all essential training as required.

Staff meetings were generally held on a monthly basis, with separate meetings for registered nurses, care staff, night staff, care supervisors and domestic staff and we looked at the minutes of meetings. The last meeting for care staff had taken place in May 2016 and various topics were discussed such as a reward scheme for attendance at work, the rota team, residents' care, mental capacity and inspection. Records showed that attendance levels were not consistently high. For example only five care staff had attended the meeting, plus management. The meeting held in April 2016 had been attended by 11 care staff and the lowest turnout recorded was in January, when six care staff had attended. After the inspection, the registered manager stated that meetings were held on a different day each month in order to encourage the attendance of different staff each time. A discussion had taken place with staff about the importance of attending staff meetings and they were to be encouraged to participate in relevant topics and to make suggestions.

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 whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had a good understanding of the requirements of the MCA and their responsibilities under this legislation. One member of staff explained, "It's about protecting and encouraging people to make their own decisions". Referring to capacity, they said, "We speak to the family. I'd always encourage people to do what they want to do and support them with decisions". Another member of care staff said, "Residents should be given the right to make a choice. MCA gives them that freedom". A third member of staff said, "We have to assume that everyone has capacity to make decisions for themselves". They went on to explain their understanding of best interests and decisions taken on people's behalf when they lacked capacity. Referring to DoLS, they told us, "You're not allowed to impose restrictions on people's liberty until they've been assessed". Whilst only a minority of staff had completed formal training on MCA and DoLS, the registered manager had updated staff on these topics. In addition, we saw that the five statutory principles of the MCA had been written up and posted on the back of the staff toilet door, for easy and accessible reference by staff!

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. All the people we spoke with said the food was good and we observed people were offered choices at lunchtime. A member of staff spoke kindly to one person, asking them if they could help to cut up their food. Another person required 1:1 support from a member of staff during the meal and staff encouraged them to be as independent as possible, supporting them to hold their own spoon, whilst also informing them what

food was on the spoon. There was a relaxed atmosphere in the dining room, with music playing in the background and staff and the managers sitting and chatting with people. One person did not like the vegetables on offer and was offered an alternative. Staff told us that the chef was willing to change the menu if required so people's choice of food could be accommodated.

We spoke with the chef who showed us the menus which were arranged over a 7 week cycle. They told us that alternatives were always on offer to people, aside from the two main options, such as omelette or jacket potatoes. They told us that people particularly liked milk puddings, so that these were always available as a dessert choice on a daily basis. Meals were provided by staff who were employed by an external catering company under contract to the provider.

People's risk of malnourishment had been assessed using a tool designed for this purpose, the Malnutrition Universal Screening Tool (MUST). One person had been assessed as underweight with a low appetite; they were completely dependent on staff to help them with eating and drinking. We observed staff supporting them at lunchtime and that they offered the person small amounts of food in a patient and calm manner. Where required, people had also been assessed by a speech and language therapist or dietician and, where needed, their diets had been adapted, for example, a soft diet for people who had difficulty with chewing.

People were supported to maintain good health and had access to healthcare professionals and services. We observed a registered nurse make a call to the GP surgery to discuss one person's health needs and that a GP called back promptly. One person told us that a GP had been called when they had a recent infection and added that they were supported by staff to attend hospital appointments. GP visits were documented in people's care records and we saw evidence of changes to people's medicines when these had been reviewed. One person had suffered from ingrown toenails and had been seen by the chiropodist, with regular six weekly appointments. People also had access to their dentist. On the second day of our inspection, one person had visited their dentist and had been fitted with dentures. Staff complimented them on their 'new look'.

The home was uniformly decorated in tones of magnolia or cream throughout, with similar patterned and coloured carpeting. Opportunities had been missed to create an environment that aided people living with dementia to orient them with their surroundings and navigate their way around the home. For example, signage with symbols or pictures to show the location of bathrooms or toilets. We discussed this with the registered manager and the issue was later referred to the senior management team of the provider for advice. The use of pictorial menus was also to be discussed with the chef and external catering contractor. People's rooms were personalised and they had ornaments, pictures and photos on display. The registered manager told us, "We try and encourage families to personalise the rooms".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People spoke highly of the staff who supported them. One person said, "The staff always say 'hello' to me, they are like my friends and they listen if I am ever worried". Another person told us, "The staff are lovely. It doesn't matter what the question is, they will always help, nothing is too much for them". They went on to tell us that they liked to be as independent as possible and made their own bed adding, "And the staff respect my wish, but I know they will do it for me if I cannot". A relative said, "Staff are always willing to help, they make it very personalised for her". They gave an example of a recent wedding anniversary where the chef had made a special cake to mark the occasion. We observed a calm, relaxed atmosphere at the home and that staff communicated well with each other and with people. Staff were observed using people's preferred names and there was friendly joking between staff and residents. When staff communicated with people, they bent down and spoke with them maintaining eye contact.

It was clear that staff knew people well, how they wished to be cared for and their needs and preferences. People told us they were asked whether they wished to be looked after by male or female staff. A member of staff explained that they knew every person very well and that when they first started working at the home, "We introduce ourselves and get to know people quite quickly". Another member of staff told us, "I like getting involved with people and hearing their stories. The residents are like friends I've known". Staff felt that recording and reading people's personal histories in their care records helped to build relationships with people and to gain their trust. A third member of staff said, "It's quite an intimate atmosphere between people and staff. We have a good bond and rapport with people. In the team we get along and help each other".

People were supported to express their views as much as they were able and were actively involved in making decisions about their care. One care plan recorded, '[Named person] would like to be involved in decisions about the care and assistance she receives'. Some people had signed their care plans to show their involvement and agreement. We asked staff whether people were involved in reviewing their care plans and one member of staff said, "I should think the nurses review it with the resident or their family". The majority of people were able to make day-to-day decisions, for example, with washing, dressing and what time they wished to get up and go to bed. A member of staff told us, "I listen to what people want and try and do the best I can for them. I do observations if people have had a fall. I think everyone is treated with dignity and respect".

We observed that people were treated with dignity and respect by staff and that their privacy was maintained. When people received personal care a 'Do Not Disturb' notice was hung on their door. Staff knocked on people's doors before entering. Staff confirmed to us that they treated people with dignity and respect. One staff member said, "I try and encourage people to be independent too" and another staff member told us, "I treat them how I would want to be treated". A third member of staff explained, "It's about respecting their individual habits, personalities and expectations".

People were supported at the end of their lives to have a private, comfortable, dignified and pain-free death.

Staff explained that families were with people as they reached the end of their lives and were supported to spend time with them. Care plans recorded some people's end of life wishes, for example, one person had requested their daughters to be with them. Everyone living at the home had 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms in place. These had been completed by medical professionals, with the involvement of the person (if possible) and their families. DNACPR forms record decisions relating to people's current quality of life and whether they should be resuscitated in the event they stop breathing. Registered nurses were trained and experienced in looking after people with life-limiting conditions and some care staff expressed a wish to know more about end of life care. One member of staff told us, "I've had to adjust to end of life care. I try and give them the best care I can, especially the family. I try and get the answers for people". After the inspection, the registered manager told us they planned for the registered nurses to deliver mini training sessions at team meetings for care staff and that end of life training would be discussed with the provider's training team.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person told us about improvements in their independence since they had moved to the home. They said, "The staff have done so much for me. When I was in hospital I was on a full hoist. The staff here supported me to use the stand-aid hoist which I prefer. It was the best thing I ever did. I feel more independent". We spoke with two relatives who were recently involved in meeting with the registered manager concerning recent changes in behaviour of their family member. Following this, the person's medicines had been reviewed and since the change in their medication, the family member's behaviour had settled. The relatives told us that they felt the home was, "Excellent" and that they had looked at several homes in the area, but felt that Irene House was the right home.

Care plans included comprehensive detailed information about people, their assessed needs and the care and support to be provided by staff. Assessments had been completed in a range of areas such as personal care, sleep, medication, behaviours, cognition and environment. For example a personal care assessment for one person recorded their hygiene preferences and assistance, dressing, grooming, facial hair, nail care, make up, hair preferences and included that they liked to wear lipstick and jewellery, perfume and used deodorant. Information for staff included advice on managing people's skin integrity, pain management, physical wellbeing, mental cognition and behaviour, continence and communication needs. A printed booklet entitled 'Our Life' had been developed by the provider to record people's personal histories, likes, dislikes and preferences. However, some care records did not include this document or include the relevant information. We discussed this with the registered manager at the end of the inspection and they explained that some people and their families had not wished to complete the 'Our Life' document. Care plans were reviewed monthly, together with people's risk assessments. A list on the wall of the nurses' office served as a guide and identified people who were 'Resident of the day' when all aspects of their care were reviewed. We were told that as part of the review, families were also contacted.

Activities were planned for people by an activities co-ordinator and volunteers supported people to engage in various activities on offer. We saw two people were enjoying their knitting and were making squares to make up babies' blankets. Another person said, "I am not keen on activities, I prefer my own company. I like spending time in my room. The staff will pop in and see me". A programme of activities was on display with pictures to aid people's understanding of what was on offer. People also had access to a daily newsletter which contained quizzes and crosswords and historical information so that people could reminisce about important events. On the first day of our inspection, a game of Scrabble had been organised for people in the dining room and people appeared to be enjoying this. Staff also supported people to participate in activities and told us they had time to spend and chat with people. One member of staff said, "Yes, that's part of our daily role, we get involved with activities". After the inspection, the registered manager told us about activities that were organised for people who were less able. These activities included personalised 1:1 sessions with people, Pets as Therapy (PAT) dogs visiting and monthly musical and poetry entertainment.

Complaints were listened to and managed in line with the provider's policy. We asked people what they

would do if they had a complaint or concern. One person told us that, although they had never had to raise a complaint, they would see the registered manager. They told us, "The management of the home is marvellous. They fall over backwards to keep everyone happy". A member of staff said, "Guild Care do listen to the residents". We looked at the complaints that had been recorded and saw that action had been taken in response to the issues raised. Complaints were investigated and usually resolved within 28 days in line with the provider's policy.

Good

Is the service well-led?

Our findings

People were actively involved in developing the service and they confirmed that monthly residents' meetings were held. People and their relatives were invited to attend meetings and minutes recorded what had been discussed. For example, minutes of a meeting held in May 2016 showed that 11 residents and four relatives had attended. The Summer Fayre had been discussed, as well as activities and catering. A newsletter was produced after each meeting and circulated to people and their families. People and their relatives were also asked for their feedback about the service through a customer survey which was sent out by the provider which covered all the homes and services operated by Guild Care. Relatives reported that they completed annual questionnaires and that if they had any concerns they would always report these to the registered manager or deputy manager.

Guild Care's vision is, 'An organisation at the heart of a thriving local community where people are able to choose and help shape the services they need to enjoy healthy, engaging and independent lives'. We asked the registered manager for her views and she said, "I want the residents to feel happy, safe, secure and to be looked after". They talked about the importance of being open with relatives and said, "I want them to feel I'm always approachable. We're here to support the residents and we feel very passionate about it". One person told is, "The manager is lovely, she's more like a friend".

Staff felt supported by the management at Irene House and that they would be listened to if they had any concerns. One staff member told us, "Any problems I had I could go to a senior and I'm listened to" and added, "I think this is one of the best care homes. If I've had any problems or grievances, they will listen". Another member of staff said, "It's a nice atmosphere. It's all about the people who live here". All staff we spoke with were not so positive about a system of staff rostering that the provider had recently introduced and which was administered from their central office in Worthing. Staff felt that this had presented a challenge to them personally and said they could now be allocated to work at the provider's other locations, where staffing shortages had been identified. This new system was in a pilot phase. One member of staff said, "I get texts [on my mobile] to ask me to work a morning shift when I'm already working! You get no thanks for doing it. Some texts are very rude. I don't always respond to them. Blanket texts are sent to everyone". Another member of staff felt that rotas were now 'depersonalised' and added, "Up until the staff rotas, we were all extremely happy, contented and motivated". The management team at Irene House were aware of the concerns raised by staff about the new rostering system and had raised these with the provider's senior management team.

People felt that the home was managed well and one person said, "It's well led and we always have activities". Staff had respect for the management team and spoke positively about them. One member of staff said, "It's a really good atmosphere and the people I work with are brilliant, trustworthy and reliable. Management are understanding and nurses are always there for us". The registered manager said, "We have residents and families that are happy and the staff are generally happy".

The home delivered high quality care and people and staff confirmed this. One person told us, "This is not a 5 star home, this is a 10 star home. I've come from home to home. Staff will do anything for you". A

member of staff told us, "I think it's busy and stressful, but it's a very good home". A range of audits was in place to monitor and measure the quality of the service overall. Audits had been completed under the headings of 'Safe' which included a trends analysis on accidents and incidents, medication and cleanliness and infection control. Other audits were completed relating to 'Effective', 'Caring', 'Responsive' and 'Well Led'. Audits identified areas for improvement and the action required. For example, one audit had identified that some bells were not responded to promptly by staff. Certain times of the day were busier than others and at these times, it had been identified that staff took a little longer to meet people's needs.

A number of compliments had been received from relatives regarding the care at Irene House. One letter recorded, '[Named family member] was looked after there with such good care under difficult times. I only wish you could have seen him when he enjoyed good health'. Another commendation stated, 'There are not enough words to express my feelings to you all. You all looked after my mum so well. You were all so kind. She was very happy with you all'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Staff did not receive supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a)