Sussex Grange Limited

# Sussex Grange Residential Care Home

## Inspection report

14 Vincent Road
Selsey
Chichester
West Sussex
PO20 9DH

Tel: 01243606262
Website: www.sussexgrange.co.uk

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20 May 2016

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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 17 and 20 May 2016 and was unannounced.

Sussex Grange Residential Care Home provides care and accommodation for up to 20 people and there were 19 people living at the home when we inspected. These people were all aged over 65 years and some were living with dementia.

All bedrooms were single and each had an en-suite toilet. The home has a lounge and separate dining room which people were observed using. A passenger lift was provided so people could access the first floor.

The service had 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 CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the MCA and DoLS. We found the provider and registered manager needed to update their knowledge as well as the service's procedures where people did not have capacity to consent to their care or treatment and where DoLS were applicable.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

People received their medicines safely.

Staff were motivated and skilled to provide a good standard of care.

There was a choice of food and people said they liked the food. People were supported to receive adequate nutrition and fluids.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff demonstrated a caring attitude to people who they treated with kindness and respect. People were

able to exercise choice in how they spent their time.

Each person's needs were assessed and this included obtaining a background history of people. Care plans showed how people's needs were to be met and how staff should support people. Care was individualised to reflect people's preferences. Relatives and health care professional said the staff provided a very good standard of care.

Staff supported people with activities and social events were organised based on what people wanted.

The complaints procedure was provided to people and their relatives. People said they had opportunities to express their views or concerns, which were listened to and acted on. There was a record to show complaints were looked into and any actions taken as a result of the complaint.

The management of the service was open to suggestions on how improvements could be made. There was a culture which reflected a service based on meeting people's needs and obtaining the views of people regarding any improvements. Relatives commented that the staff and registered manager communicated well with them. Staff views were also sought and staff were able to contribute to decision making in the home.

A number of audits and checks were used to check on the effectiveness, safety and quality of the service which the provider used to make any improvements.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Appropriate action was not always taken when people did not have capacity to consent to their care or treatment.

Staff were trained in a number of relevant areas and had access to nationally recognised qualifications in care. Staff were supported by regular supervision.

People were supported to have a balanced and nutritious diet and there was a choice of food.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

### Is the service caring?

**Good**

The service was caring.

Staff had good working relationships with people who they treated with kindness. Staff demonstrated they had a caring attitude and were empathic about the needs of older people.

Care was individualised and based each person's preferences.

People's preferences and choices regarding their end of life care were acted on.

## Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

There was an activities programme for people.

People knew what to do if they wished to raise a concern.

## Is the service well-led?

Good

The service was well-led.

The provider sought the views of people and staff to check if improvements needed to be made.

Staff demonstrated they were aware of their responsibilities regarding the well- being and safety of people and the provider has systems to check staff treated people well.

There were a number of systems for checking and auditing the safety and quality of the service.

# Sussex Grange Residential 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.

This inspection was unannounced and took place on 17 and 20 May 2016 and was carried out by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with five people who lived at the home and to two relatives. We also spoke with four care staff, the registered manager and the provider of the service.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for seven people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

The service was last inspected on 13 August 2013 when no concerns were identified.

Good

# Is the service safe?

## Our findings

People told us they felt safe and secure at the home. Relatives said people received safe care. For example, one relative said staff supported people to safely use equipment to help them mobilise. Another relative said there were arrangements for safely evacuating people in the event of an emergency. People and their relatives said they received their medicines safely.

The service had policies and procedures regarding the protection of people from harm and what to do in the event of someone experiencing neglect or harm as well as local authority guidance on how to report concerns of this nature. Staff were aware of their responsibilities to report any concerns of a safeguarding nature to their manager and knew they could also make contact with the local authority safeguarding team. Staff confirmed they received training in safeguarding procedures and that this was part of the training considered mandatory to their role.

People's care records identified where there were risks to people's safety which were included in risk assessments for needs such as possible falls, mobility, the risk of pressure damage to skin and going out. There were corresponding care plans of the action staff needed to take to minimise these risks to keep people safe. For example, there was a risk assessment for one person when they went out from the home along with a risk enablement plan so the person was supported to complete this activity. There were risk assessments regarding possible falls to people and for the moving and handling of people. Care plans gave clear guidance for staff to follow to safely assist people to move. Care records showed staff had referred people for assessments from the falls prevention team who then provided advice and guidance on specialist equipment to help people mobilise safely. Specialist equipment was also used to reduce the risk of pressure areas developing on people's skin such as pressure relieving mattresses. Where people needed to be moved and turned to prevent pressure areas on skin developing from prolonged immobility a record of this was maintained for monitoring purposes. Risk assessments were carried out when bed rails were needed in order to minimise any risks to people. Where people experienced an accident such as a fall there was a record to show this was looked into and any changes made to try and prevent a reoccurrence.

The service provided sufficient staffing levels to meet people's needs. We based this judgement on observations of staff with people, what people, relatives and staff told us as well as the views of a health care professional we spoke to. For example, when we asked one relative about the staffing levels the reply was, "There are staff everywhere."

From 8am to 2pm Monday to Friday there were six care staff on duty and five care staff between the hours of 2pm and 8pm. At weekends there were five care staff on duty from 8am to 8pm. The hours worked by the registered manager were in addition to this. The service also employed an activities coordinator, a cook, a kitchen assistant and cleaning staff. Night time staffing consisted of two staff on a 'waking' duty. Staffing arrangements were organised on the staff rota and these reflected the above care staff hours. Staff told us staffing levels were flexible depending on the needs of people. A staff member said the provider took account of people's changing needs and what staff reported about staffing levels. An example, was given where staff considered additional staffing was needed because people's care needs had increased, which

the provider responded to by providing additional staff.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting. These checks ensured staff were safe to work with people.

We looked at how the service managed people's medicines. There were policies and procedures for the safe handling of medicines. Only those staff who were trained, assessed and observed as competent to handle and administer medicines did so. Medicines were supplied to the service in a monitored dosage system which meant the medicines were easier to handle as they were organised in a pack for each time the person needed the medicine. Staff completed a record each time they administered medicines to people. Stocks of medicines showed people received their medicines as prescribed. Where people had variable doses of medicines, records showed this followed the correct guidance. For example, records showed Warfarin medicine was administered according to the results of blood tests carried out by the local health services.

Checks were made by suitably qualified persons of equipment such as the passenger lift, gas heating, electrical wiring, hoists, wheelchairs, the call points, fire safety equipment and alarms and electrical appliances. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises. First floor windows had restrictors on them to prevent people from falling out. Temperature controls were in place to prevent any possible scalding from hot water, and the temperature of water was also checked each time someone was bathed. Water temperatures were checked regarding the prevention of Legionella. Radiators had covers on them to prevent any possible burns to people. Call points were installed in each person's room so they could summon help from staff.

Requires Improvement

# Is the service effective?

## Our findings

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). One person at the home was subject a DoLS.

We observed staff asked people how they wanted to be supported. Care records included consent forms for sharing information and for people agreeing to their photograph being taken. A recent survey carried out by the provider showed 100% of those who responded said they were involved in devising their care plan.

Whilst there were policies and procedures as well as staff training regarding the MCA, the provider and registered manager did not have an adequate knowledge of the MCA to ensure people's rights were upheld where people did not have capacity to consent to their care. The provider and registered manager had devised a policy regarding the MCA and staff were trained in the MCA. However, there was no system to assess the capacity of people regarding consent about specific decision making where people lacked capacity. The registered manager and provider were unaware they needed to do this and referred to completing what is called a 'mini mental state examination' used to check memory and mental state. Applications to deprive people of their liberty for safety reasons had been made and one person was subject to a DoLS. However, we identified one person who did not have capacity, who was not free to leave the premises, had a DoLS application but this was for some years ago and needed to be revisited due to changes in legislation by the Supreme Court. There was no assessment of capacity for this person. For another person who did not have capacity and received covert medicine in their food without their consent, there was no capacity assessment about this. There was also no best interests decision meeting to agree to this although the person's GP had agreed to this in writing. Therefore they had not ensured that care and treatment had been delivered with lawful consent and in line with the principles of the MCA.

The provider had not ensured care and treatment was always provided with the consent of people and where people were unable to consent had not acted in accordance with the Mental Capacity Act 2005 and its Code of Practice. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives said staff provided effective care. For example, one relative said, "The care is wonderful. The staff are brilliant." People and their relatives said the staff supported people to get the right health care. People said they liked the food and people said how important the lunch was to their daily routine. We observed people enjoyed the lunch where they ate together and could have wine with their meal. Relatives said healthy foods were promoted and that there was a choice of food.

Staff received training, supervision and appraisal of their work in order that they had the skills and knowledge to look after people well. Newly appointed staff received an induction training programme to prepare for work at the service and enrolled on the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. A member of staff who recently started work at the service described how their induction consisted of working with experienced staff in a 'shadowing' role to observe how to look after people. Staff confirmed their induction included training in areas considered mandatory to their role followed by an assessment of their ability to work unsupervised.

Staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. The registered manager confirmed all care staff were trained to NVQ level 2, 3 or 4. These 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. Staff described the training as of a good standard and covered all the areas they needed in order to provide effective care as training was provided in areas such as Parkinson's disease, dementia, oral care and diabetes.

The service had links with local training forums where the provider attended meetings to discuss and plan developments in training for care staff. The registered manager had completed 'train the trainer' courses which qualified her to train staff in areas such moving and handling. The registered manager demonstrated a tool used to assess staff training needs and for recording how she delivered the training to individual staff.

Staff told us they received regular supervision and appraisal of their work. We saw records of staff supervision sessions and appraisals which showed staff performance was monitored. As well as one to one meetings with their manager staff told us their work was regularly assessed by observation by the registered manager. For example, one staff member said how their performance in hoisting people and in providing eye and oral care was checked by observation. Staff said they were able to discuss their training needs at supervision and each had a personal development plan. Staff said they felt supported in their work. Staff were motivated to enhance their skills and knowledge by completing training.

The service had a menu plan which showed varied, nutritious and balanced meals. People were offered a choice of food and were asked in advance what they wanted to eat which was recorded for the kitchen staff to follow. We observed the lunch when it was noted people had different meals according to their choice. Where people wanted something different staff supplied this and people were offered additional portions if they wanted. The cook showed us the food stocks which included fresh produce, such as fruit and vegetables.

People's nutritional needs were assessed using a malnutrition universal screening tool (MUST). This is an assessment tool which identifies if people are at risk of malnutrition and if a referral is needed for specialist assessment by a GP, dietician or speech and language therapist (SALT). Care records showed referrals were made where people had nutritional or swallowing needs and the advice of the SALT was recorded. The cook was aware which people needed soft or pureed food. We saw people had access to drinks including in their rooms and in communal areas. A relative commented that the staff provided good support to ensure people received enough fluids. Food and fluid intake was monitored where this was needed and people's weight was monitored so any action could be taken regarding weight loss or gain.

Care records showed people's health care needs were monitored by staff and arrangements made for health care checks and treatment. People told us staff accompanied them to hospital appointments. Records

showed the service liaised with people's GPs regarding health care needs as well as specialist heath care services such as the community psychiatric nursing team and nurses specialising in the care and treatment of Parkinson's disease.

Good

# Is the service caring?

## Our findings

People and staff had positive working relationships. People described the staff as "lovely" and said they treated them with respect and dignity. People also commented that staff provided emotional support when they were upset or low in mood. People and their relatives described the staff as cheerful and approachable. A relative contacted the Commission and gave the following feedback in 2015: 'The staff are exceptional. Their care and compassion to both the residents and the families is outstanding." A recent survey of people's views about the home showed 100% of people who responded said they treated with dignity and respect. The service used a company to survey the views of people and their relative's about the standard of care provided; this showed the service obtained a high score of satisfaction and the highest in West Sussex of those who took part in the survey. Similar responses to being very satisfied with the standard of care were made in other surveys by the provider and national website where the people could add their comments and give a score out ten; Sussex Grange Residential Care Home scored 9.4/10. Relatives also commented that they felt supported by the staff and management of the service.

We spent time observing staff with people in the lounge and dining room. Staff were observed to treat people politely and with respect. Staff offered people support and it was clear the staff and people got on well sharing jokes and stories. Staff were aware of people's needs and preferences and spoke to people calmly.

Staff demonstrated values of compassion and empathy. For example, one staff member said it was important to treat people in the same way they would treat a family member or how they would like to be treated themselves. One staff member said a caring attitude was the most important approach to how they supported people. Another staff member said they tried to put themselves in the place of the person they were supporting to understand what the person experienced, such as loss of independence. This staff member said how important it was for staff to support people to maintain their independence.

The provider told us how the caring values of staff were checked as part of staff recruitment and that all staff underwent training in treating people with compassion, dignity and respect.

People said how they were able to make choices in their daily lives. Care plans were personalised to reflect people's preferred routines and choices.

There was a document for each person called 'My Life, My Wishes, My Future- Wishes and Preferences For My Future,' which set out how people wished to be treated including arrangements for any end of life care. Where relevant, people's care plans detailed any arrangements for end of life care as well as how people were to be supported. Staff also received training in end of life care. The service had links with a local hospice for support and advice regarding end of life care. The hospice had provided positive feedback to a person's GP regarding the end of life care for someone.

People's privacy was promoted by the staff. We observed staff knocking and waiting for an answer before entering people's bedrooms. Each person had a sign in their room which could be displayed on the door to

say 'Please do not enter. Care in progress,' so people had privacy. We observed these signs being used. Staff were aware of the need to ensure people's privacy.

Good

# Is the service responsive?

## Our findings

People and their relatives told us staff provided a good standard of care which was responsive to people's needs. For example, one relative said the service was, "Everything we could want for mum and more." People said staff responded to their wishes. For example, one person said, "Night staff are good as well, I can ask for a cup of tea at any time, it's no trouble."

People said they were consulted about their care and that any issues they raised were addressed to their satisfaction.

Each person's needs were comprehensively assessed prior to their admission to the service in order to ascertain if the person's needs could be met. Corresponding care plans outlined how each of the person's needs should be met by staff. Details about people's preferences, lifestyle and hobbies were included. Any guidance from specialist health care providers was recorded such as for supporting people to eat safely. There was guidance from a GP regarding the specific procedures to support someone to avoid unnecessary admissions to hospital. These details had not been transferred onto the home's own care plan so staff had clear guidance on what to do. However, the registered manager said this was discussed with the staff so they knew what to do. We asked staff about this and they said they knew what to do in these circumstances. Staff also told us they used the care plans for guidance and recording any care or changes to people's needs.

Staff completed a daily record of personal care tasks with each person which enabled a check to be made that these care needs were being met.

The service employed an activities coordinator for 18 hours per week and one activity session per week was also provided by an external provider. A range of activities were provided for people which included trips out to the seaside, quizzes, games and reminiscence sessions. People said they enjoyed the activities, which they could choose to get involved in if they wished. For example, one person said, "Plenty to do, Xmas, Easter, Harvest there's always something going on." Staff said people benefited from "lots of quizzes and entertainment" as well as outings.

The staff informed us of plans to screen a wedding of a resident's relative via the internet onto the television as the wedding was taking place abroad and the person was unable to attend. This would also involve other people and staff taking part in a wedding party at the service.
The provider confirmed people's needs were regularly reviewed and that the service's management encouraged people and their relatives to discuss any issues or concerns they had. People and their relatives said they felt able to raise any matters and that they were addressed. For example, one person told us they reported a problem with their radiator which was fixed immediately.

People knew about the complaints procedures if they were dissatisfied with the standard of service they received. We noted the complaints procedure was contained in each person's terms and conditions, the residents' handbook and in the service's policies and procedures. This had the incorrect details of who any

complainant could contact if they felt their complaint was not dealt with to their satisfaction. The procedure identified this as the Care Quality Commission, when it should be the government ombudsman. This was rectified immediately following the inspection and a revised procedure sent to us. The service maintained a record of any complaints and how they were dealt with. The provider had worked with the local authority in designing a poster which for use in care homes about reporting their concerns, which was displayed in the service.

One complaint was made to the service in the 12 months preceding the inspection and records showed this was dealt with satisfactorily. The service also maintained a record of 19 written compliments about the service.

Good

# Is the service well-led?

## Our findings

Care providers are required to send notifications to the Commission when someone in their care dies as well as for other incidents such as specific accidents and incidents and when a DoLS application is authorised or rejected by the local authority. The Commission did not have a record of any notifications regarding any deaths to people and at the time of the inspection the provider was not able to provide evidence the notifications were submitted. Following the inspection the provider sent in details to confirm notifications were submitted to the Commission.

People and their relatives said the registered manager was approachable and communicated well with them. Residents' meetings were held where people said they could raise any issues or give feedback about the service.

People and relatives told us their views were sought about the standard of care either by being asked at care reviews or via a satisfaction survey questionnaire. Survey questionnaires had been completed by relatives and staff which were part of the provider's quality assurance process to plan for any improvements. Copies of the quality assurance questionnaires showed relatives were satisfied with the standard of care and considered people were always treated with dignity and respect.

Staff were aware of their responsibilities regarding the safety and rights of people and demonstrated they were committed to promoting people's welfare.

There was a registered manger and the staff team reported they were able to approach the service's management with any issues or concerns. Staff said they felt supported by the service's management team. For example, one staff member said, "The management team are absolutely brilliant," and that they listened and acted on what staff said whether it was training needs or staffing levels. Staff also described the management team as "kind, helpful and considerate," and said they looked forward to going to work.

Staff told us they felt supported in their work and they felt able to raise any issues they had with the registered manager. Regular staff meetings were held, which staff said allowed them to discuss people's care needs and any other issues they had. Records of staff meetings were maintained and these showed areas for improvement were raised which were then followed up at the following staff meeting. The provider had links with care service forums in order that any developments in training of staff could be implemented. This demonstrated there was support for staff and a culture which was open to learning and improvement.

The provider and registered manager checked on the quality and safety of the service in a number of ways. The registered manager checked staff performance including unannounced spot checks at 6am to observe staff were carrying out their duties. Checks and audits were carried out of the safety and cleanliness of equipment such as wheelchairs and walking aids, medicines procedures, call points in people's rooms, accidents and infection control. Records showed incidents were looked into and changes made so lessons were learned.

The registered manager had devised a method of compiling a record in people's care plans which identified how care was provided in line with the Commission's standards and regulations. We raised the fact the standards and regulations related to the previous legislation and guidance and needed to be updated, which the registered manager expressed a commitment to complete.

There was a system of governance where the provider held eight board meetings a year which involved the registered managers and directors of Sussex Grange Limited. These meetings looked at health and safety issues, staffing, contracts with the local authority and the service's IT system.

The provider is a member of the West Sussex Partners in Care which is a provider's forum which also meets with the local authority to discuss developments in care practices. The service was subject to an audit by the local authority who had a contract with Sussex Grange Home Care. The local authority staff member who completed the audit informed us they visited and assessed the service in January 2016 and found it was meeting people's needs and operating to an acceptable standard. The local authority gave the following feedback to the service following the audit, 'Each monitoring visit found the home to be operating at a level whereby it is clear that resident's needs are at the forefront of the minds of both the registered manager and provider.'

The service also had links with local health and social care provider regarding the care of people, which enable effective communication about people's needs.

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 | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had not ensured care and treatment was only provided with the consent of people and had not acted in accordance with the Mental Capacity Act 2005 where people were unable to give consent due to a lack of capacity.<br><br>Regulation 11(1) (2) (3) |