Lifestyle Care UK Ltd

Glen Arun Care Home

Inspection report

9 Athelstan Way
Horsham
West Sussex
RH13 6HA

Tel: 01403253881
Website: www.glenarun.co.uk

Date of inspection visit:
19 December 2016

Date of publication:
21 February 2017

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Glen Arun Care Home provides accommodation for up to 35 older people, some of whom are living with dementia and diabetes and who need support with their nursing and personal care needs. On the day of our inspection there were 34 people living at the home. The home is a large property, spread over two floors, situated in Horsham, West Sussex. There is a communal lounge, a dining room and gardens.

We carried out an unannounced comprehensive inspection on 5 November 2014. Breaches of legal requirements were found and following the inspection the provider wrote to us to say what they would do in relation to the concerns found. On 23 June 2015 we carried out a focused inspection to check that they had followed their plan and to confirm that they were meeting legal requirements. At that inspection we found that significant improvements had been made and all previous areas of concern had been addressed.

This inspection took place on 19 December 2016 and was unannounced. It was brought forward following concerns that had been raised with us in relation to staffing levels and timely access to care to meet peoples' needs. At the inspection we spoke to people, relatives and staff. Following the inspection we spoke to a healthcare professional. All of whom told us that there was sometimes insufficient staffing to meet peoples' care needs and some of our observations confirmed this. Comments from people included, "Well you have to accept that with so many people to be seen you have to wait your turn", "They do tell you that if two of them are doing something for someone else you have to wait" and " I have to wait to get up in the morning, you have to fit into their rota".

People received their medicines from registered nurses and were happy with the support they received, one person told us, "They asked me if I wanted to be in charge of my own medication but I was happy for them to do all that for me so I don't have to worry about forgetting it and yes I get my tablets regularly". There were good systems in place to inform staff of when to offer people medicines on an 'as and when required' basis and systems ensured that the storage, administration and disposal of medicines were safe. However, there were concerns regarding peoples' access to prescribed medicines. A healthcare professional told us about several occasions when medicines had been prescribed but people had not received their medicines for several days. Measures had been taken to ensure that this was less likely to occur in the future as the manager had changed the pharmacy that delivered the medicines, however, there were still concerns regarding staffs' intervention to ensure medicines were provided to people in a timely manner.

Staff had demonstrated good practice by identifying and acting on concerns in relation to a pressure wound for one person. However, there were a lack of notifications to CQC about the deterioration of this and in relation to safeguarding investigations that had been conducted by the local authority. Notifications enable us to have oversight and to ensure that appropriate actions had been taken to ensure peoples' safety and well-being. Although this had improved since the new manager had been in post, this needed to be fully embedded in practice. Quality assurance audits were in place, however these were not always sufficient and although there were plans to improve these, the current provision did not ensure that the systems and processes used within the home were effective to ensure people received safe and effective care at all times.

Records, to document peoples' care and nursing needs, as well as the monitoring of the care they received on a day-to-day basis, were not always in place or completed sufficiently. When this was fed back to the manager immediate action was taken to address this, however this needs to be fully embedded in practice.

The home had been without a registered manager for over a year, however, there had been a number of managers that had managed the home during that time who had started the process of applying for registration before leaving. The management team consisted of two providers and a manager, who had been in post for several months and who was applying to be the 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. There was a warm, homely and relaxed atmosphere and people told us that they were comfortable and felt at home. People were complimentary about the home and told us they would happily recommend it to others. A relative told us, "As soon as we walked in I knew my relative would be happy here".

People were protected from harm and abuse. Staff had undertaken the necessary training to meet peoples' needs as well as to enable them to recognise concerns and respond appropriately. People were able to take risks in accordance with risk assessments that had been devised and implemented. People told us that they felt safe. Infection prevention and control was maintained, the environment was clean and people told us that they were happy with the cleanliness of the home.

People were asked their consent before being assisted and there were measures in place to ensure that relevant people had been involved in decisions about peoples' care needs. The management team were aware of the legislative requirements in relation to making decisions on behalf of people who lacked capacity and were in the process of seeking further advice and clarification from the local authority with regard to the deprivation of liberty safeguards (DoLS). People were involved in the running of the home as well as the care they received. Regular resident meetings as well as care plan reviews and regular surreys took place to enable people and relatives to make their opinions and wishes known. One person told us, "It's very friendly and they don't mind if you suggest trying something new. They listen to you and are happy to try it a new way". People were aware of their right to make a complaint and those that had been made had been dealt with appropriately.

People were cared for by staff that were kind and caring. One person told us, "They tell me, don't be afraid to tell me what you need. They are very helpful". Another person told us, "I call them angels, they do so much for us". Peoples' health needs were assessed and met by registered nurses who made referrals to external healthcare professionals when required. There were person-centred care plans in place, that on the whole, provided staff with information about peoples' needs, these were reviewed regularly and provided staff with guidance as to how to support people according to their preferences. Peoples' privacy and dignity was respected and maintained, observations showed staff knocking on peoples' doors before entering. People had a positive dining experience and told us that they were happy with the food. Comments included, "The food is great and there's always plenty. I've put on a bit of weight it's so tasty", " The food is first class, beautiful, fit for a Queen" and "The Sunday lunch is a proper Sunday lunch and you get a glass of sherry if you want one".

People were supported to stay at the home until the end of their lives. A relative told us that they were happy with the care their loved one had received, they told us, "It was a big decision as to where X should be and we were very nervous but they have come up to the mark and we are quite a demanding family. The whole staff group are patient-orientated. They always speak to X when they come in and they are making sure X is comfortable. They do it so nicely and provide everything X needs at this time".

People, relatives, staff and healthcare professionals were complimentary about the leadership and management of the home. One person told us, "Oh yes we can speak up and we do here. You could talk to anyone really and the manager is very helpful". A healthcare professional told us, 'The new manager has established good communication and appears keen to improve the service and establish good communication with us, the residents and relatives".

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

Requires Improvement

The home was not consistently safe.

People, relatives, staff and healthcare professionals consistently told us that there was sometimes insufficient staff to meet peoples' care needs in a timely manner.

Medicines were dispensed by registered nurses and there were safe systems in place for the storage and disposal of medicines. However, there were historical concerns with regard to the accessibility and timely intervention of medicines for some people.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety. Risk assessments were in place to ensure peoples' safety. The home was clean and systems were in place to reduce the spread of infection.

Is the service effective?

Good

The home was effective.

People were asked their consent before being supported. The management team and staff had a good awareness of the legislative requirements in relation to gaining consent for people who might lack capacity.

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.
People were cared for by staff that had received training and had the skills to meet their needs. People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and caring and who knew their preferences and needs well.

Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to make their feelings and needs known as well as being able to make decisions about their care and treatment.

Is the service responsive?

Good

The home was responsive.

Peoples' social and emotional needs were met and they had access to meaningful activities to occupy their time.

People received care that was in accordance with their needs and preferences and people were involved in their care.

There were mechanisms in place to enable people and their relatives to comment and complain about the care people received.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Quality assurance processes monitored some systems and processes to ensure the delivery of high quality care and to drive improvement. However, not all systems were monitored, and as a result, actions that should have taken place were not carried out. Records were not consistently maintained, There had been a lack of notifications sent to CQC about certain events that had occurred within the home.

People and staff were positive about the management and culture of the home.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Glen Arun 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.

The inspection took place on 19 December 2016 and was unannounced. The inspection was brought forward due to information of concern that we had received. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with nine people, five relatives, seven members of staff, the manager and the two providers. After the inspection we contacted a healthcare professional. We reviewed a range of records about peoples' care and how the home was managed. These included the care records for five people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the home. We spent time observing care and support in the communal lounge and dining room during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person told us, "You have to have a place that is safe for old people, we need that. I wouldn't be here if it wasn't and my daughter would see to it that I wasn't either". However, despite this positive comment we found an area of practice that is in need of improvement.

Concerns had been raised with us, prior to the inspection, in relation to staffing levels and peoples' access to staff to meet their care needs in a timely manner. As a result of this information the inspection was brought forward. At the inspection we spoke to people, relatives and staff. Following the inspection we contacted a healthcare professional who visited the home. All of whom told us that they felt that there was sometimes not enough staff to meet peoples' needs and that they often had to wait for assistance and some of our observations confirmed this. For example, one person was sitting in their wheelchair in the lounge and continually asked staff to assist them back to their room as they were uncomfortable sitting in their wheelchair. Although staff acknowledged the person's request and offered reassurance they explained that they would only be able to assist the person once they had finished assisting other people to eat their lunch as they were busy assisting people. Although the person was eventually assisted to their room, staff were unable to do this until they had finished supporting other people and the person was left to sit in their wheelchair, despite showing signs of discomfort. Further observations showed that some people, who required assistance to eat and drink, had to wait for staff to finish assisting other people before they were assisted to have their lunch. This meant that people were assisted to eat cold food as their food had been left uncovered in front of them until staff were able to assist them.

Comments from people included, "I can get up myself but others who can't get frustrated sometimes when they have to wait", "It seems to be more noticeable at weekends when the staff are rushing about", "They do work hard and do their best but sometimes I have to wait if I want to go to the toilet. It's jolly hard when you can't just get up when you want to", "I have to wait to get up in the morning, you have to fit into their rota" and "I feel terrible asking for something because they are so rushed off their feet". A relative echoed these comments and told us, "When I arrive I like my relative to be popped into a wheelchair so we can go and chat privately, perhaps back to the room or outside, but I've noticed there often isn't any staff around to do this and recently I came with a friend and in the end we'd waited so long we just did it ourselves. If they're available they're willing but there just doesn't seem to be many carers around". Staff spoke about the need to increase the staffing levels to enable them to meet peoples' needs in a timely manner. One member of staff told us, "There isn't enough care staff I think. We could do with one more". Another member of staff told us, "We are a good team so we get through but we probably need more staff, especially in the mornings". A third member of staff told us, "We do need more staff in the afternoons, we have four carers working and if one person needs the assistance of two if they use a hoist, that only leaves two". A healthcare professional also shared these concerns and told us, "I have noted that over the last few months, the nursing home has become busier and the duty nurse can be under some time pressure. Some of the residents at Glen Arun nursing home have complex nursing and medical needs and I am concerned about the staffing levels with regards to carers and qualified nurses". A member of staff echoed this comment, when asked if there was enough nursing staff, they told us, "On a Wednesday no, this is when we have things like doctor's rounds and it can be busy, some days we just don't get five minutes. However, I know that there is a senior program

being started in the new year which will enable senior carers to be trained and then undertake basic observations like blood pressures and the administering of medicines, this will free up some of the nurses time".

A healthcare professional told us, "I would appreciate if you could review the care staffing levels especially with regard to patients at end of life and those who are bedbound as those are at highest risk of not receiving enough attention if other residents are unwell or require more input". People and relatives' comments were fed back to the two providers and the manager who explained that they were in discussions about introducing a dependency tool to enable them to assess peoples' increased nursing needs and align these to the staffing levels. There were insufficient numbers of suitably qualified, skilled and experienced staff deployed to peoples' needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assisted to take their medicines by registered nurses. Safe procedures were followed when medicines were being dispensed and administered and peoples' consent was gained before being supported. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed this. One person told us, "They asked me if I wanted to be in charge of my own medication but I was happy for them to do all that for me so I don't have to worry about forgetting it and yes I get my tablets regularly". Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines and these had been completed correctly. Medicines were stored correctly and there were safe systems in place for the receiving and disposing of medicines. However, a comment from a healthcare professional raised concerns over the accessibility of medicines for some people. They told us that there had often been delays with regard to people receiving their prescribed medication, however, the manager had addressed this and had recently changed the pharmacy that supplied medicines. The healthcare professional explained that although measures had been taken to ensure this improved in the future, there were still some occasions when staff had not acted in a timely manner to ensure people received their prescribed medicines on time. For example, on one occasion a person had to wait to receive their pain relief medication as the staff had not recognised that this hadn't been delivered to the home until nine days after it had been prescribed. Another person had not received an anti-psychotic medicine which had been prescribed by the hospital and this was only identified when an urgent review of their care had been undertaken due to their mental health deteriorating. The healthcare professional told us, "This only became evident at an urgent review, which had been arranged in view of the resident's mental deterioration. The nursing staff and manager are aware of this incident. I was told, that this incident happened as the nurse in charge had not added the medication to the MAR chart". There were concerns with regard to the timely manner in which people received their prescribed medicines. This is an area of practice in need of improvement.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. One member of staff told us, "I would always go to the manager if I witnessed abuse going on. I know they would manage it but I could contact social services if I had to". Another member of staff told us, "We get training on this every year because it's so important. It's good to have it even if you know what to do". There were whistleblowing and

safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace. Records further confirmed that staff had an awareness of their responsibilities in relation to reporting concerns. Body map charts had been completed detailing any scratches, bruises or wounds on peoples' bodies so that these could be monitored to ensure their safety and well-being. People told us they felt safe in the presence of staff, one person told us, "You never hear anyone shouting they are all calm and pleasant". A relative told us, "I don't go home worrying about my relative and I've only ever seen people being spoken to in a kind and caring manner. I've never seen any rudeness or sharpness from any of the staff".

Suitable measures had been taken to ensure that people were safe. Most risk assessments recognised peoples' physical and clinical needs and were reviewed regularly. Observations showed that staff were aware of risk assessments and worked in accordance with them. For example, care records for one person stated that the person needed to be supported by two staff and that a hoist should be used. Observations showed staff assisted the person to safely transfer from their armchair to a wheelchair using the recommended hoist.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of a fire. Accidents and incidents were recorded and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in peoples' needs or support requirements.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and there were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices, they wore protective clothing and equipment, maintained hand hygiene and disposed of waste in appropriate clinical waste receptacles. One person told us, "I think since the new manager has been here the hygiene and cleanliness has improved".

Good

Is the service effective?

Our findings

People were cared for by staff that had the relevant experience, knowledge and skills to meet their needs. People and relatives told us that they felt staff were competent and well trained. When asked about the experience and competence of staff, one person told us, "I think since the manager has been here the training has got better. They seem to have spent more time giving them training and input. I think they brought some of their best staff with them".

Staffs' learning and development was encouraged from the outset of their employment. New staff were supported to learn about the providers' policies and procedures as well as peoples' needs. An induction was completed to ensure that all new staff received a consistent and thorough induction. Staff had undertaken inductions and completed the care certificate. The care certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standard that can be covered as part of the induction training of new care workers. Staff were also able to shadow existing staff to enable them to become familiar with the home and peoples' needs, as well as to have an awareness of the expectations of their role. Staff told us that the induction training they had received was effective and helpful. One member of staff told us, "It was very good. I have no complaints". Another member of staff told us, "I'm new to the home but not new to caring. Still, the induction was really good and I never felt unsafe or out of my depth". When asked about the induction training for staff, it was apparent that the manager had plans to develop this even further. They told us, "The induction of new staff is being reviewed, it is good, but not good enough, and I'm looking at that and making it more robust".

Staff had completed training which the manager considered essential and this was updated regularly. Registered nurses were also supported to keep their knowledge and skills up-to-date by undertaking essential training as well as courses such as wound management and catheter care. The manager had plans to develop links with external organisations to provide additional learning and development for staff, such as the local hospice and the tissue viability nurse. (TVN). Staff told us that the training they had undertaken was useful and enabled them to understand peoples' needs and offer appropriate care. One member of staff told us, "It's good I would say. There is quite a lot of training going on. I've been here a few months now and I'm doing something all the time". People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss peoples' needs. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive. When asked about the provision of clinical supervision for registered nurses we were told that clinical support and supervision was provided to registered nurses by the deputy manager who was also a registered nurse. The deputy manager in turn received clinical support and supervision from an NHS community matron. Clinical supervision enables registered nurses to reflect on their practice and think about their knowledge and skills to identify how they can be developed to improve the care provided.

Peoples' communication needs were assessed and met. People had access to relevant healthcare professionals to maintain or improve their communication, such as audiologists and opticians and we observed people wearing the spectacles that had been provided. One person told us, "I have a hearing aid

and they check the batteries for me I've some spare in there ready". Some people had limited communication, staff ensured that they took time to interpret peoples' needs and explained their actions when offering support. Effective communication also continued amongst the staff team. Regular handover and team meetings ensured that staff were provided with information to enable them to carry out their roles.

Peoples' health needs were met by registered nurses who made referrals to external healthcare professionals when required. These included GPs and TVNs. It was apparent that staff knew people well and staff told us that they were able to recognise any change in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. People told us that staff ensured that they had access to medicines or healthcare professionals when they were not well. One person told us, "The doctor comes in every Wednesday I think it is and so you always know you can speak to the doctor then". Another person told us, "Yes I see the chiropodist on a regular basis. They sort out all that for you". A third person told us, "I've had a knee operation and the 'physios' come to see me and here they encourage me to do my exercises". A relative told us, "There is a new scheme for oral care that X will have every two months".

People had a positive dining experience. Most people ate their meals in their rooms, with assistance from staff. However, other people chose to eat their meal in the main dining or lounge areas. People had a choice of meals and told us they were happy with the food available. Comments included, "The food is great and there is always plenty. I've put on a bit of weight it is so tasty", "The food is first class, beautiful, fit for a Queen" and " The Sunday lunch is a proper Sunday lunch and you get a glass of sherry if you want one". Relatives told us that they were also able to enjoy meals with their loved ones, one relative told us, "The chef is so accommodating. I emailed asking if we could have a meal in the conservatory with the family and they even accommodated another relative's preference of raw carrots in a little separate pot". Another relative told us, "I've been invited to have my Christmas dinner with my relative in their room so we can be together and the menu looks delicious". The dining room created a pleasant environment for people to have their meals; tables were laid with napkins, vases of flowers and condiments. People, who required support form staff, were assisted according to their needs. Staff respectfully sat alongside people and assisted them to have their meal, ensuring that they were enjoying their food and were ready for their next spoonful before offering assistance.

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 provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People were asked their consent for day-to-day decisions that affected their care. One person told us of their involvement in the use of bed rails, they told us, "They suggested I have the rails up and I don't mind, it makes me feel safer".

The management team and staff had a good awareness of the MCA and DoLS. One member of staff told us, "We know we have to assume the residents can do things for themselves unless they've been assessed as being unable". Another member of staff told us, "I think the main thing is that people can make decisions for themselves. If they can't, they might need help but if they can do it, they should do it". However, for one person who lacked capacity to make certain decisions an application to the local authority had been made due to them being unable to leave the home unaccompanied due to risks to their safety and welfare. Some

people had cognitive and physical disabilities and required support from staff to move around the home using mobility aids such as wheelchairs. Other people, due to their condition, spent their time in their beds. The management team explained that some people, due to their cognitive and physical abilities, would be unable to leave the home on their own and would require support from staff or be asked to return to the home if they were to leave unaccompanied. However, even though people were not asking to leave the home, they were still potentially being deprived of their liberty as they were not free to leave the home unaccompanied. This also related to the use of bed rails for people who lacked capacity to consent to their use. The management team explained that they had contacted the local DoLS team for advice and had been advised to ensure that regular checks, to ensure peoples' whereabouts were made, however, had not considered that some people might require DoLS authorisations. When this was raised with the management team they explained that they would seek advice and guidance from the local authority with regard to this.

Mental capacity assessments should be undertaken for any specific decisions that relate to peoples' care. Mental capacity assessments were in place for some decisions that affected peoples' lives, for example some people used bed rails to ensure their safety and wellbeing. Records, such as risk assessments for the use of bed rails, considered the least restrictive options, such as the use of low profile beds or crash mats, as well as the risks involved in their use, to ensure that bed rails were the most appropriate option. Measures to ensure that the relevant people had been involved in decisions that affected peoples' care had been made. Further records showed that for people who lacked capacity relevant people had been involved in the decision making process. For example, a letter had been sent to a person's Lasting Power of Attorney (LPoA) for health and welfare, informing them of the use of bed rails and seeking their permission for their use. A Lasting Power of Attorney is a way of giving someone people trust the legal authority to make decisions on their behalf if they lack mental capacity at some time in the future and can no longer make certain decisions themselves. The management team demonstrated good practice by ensuring that they held copies of peoples' LPoA documents to ensure that they had the correct information as to who had the legal right to make decisions on peoples' behalf. Further measures, for one person, showed that best interests decision meetings had taken place to ensure that any decisions, for a person that lacked capacity, were made collectively by relevant people, such as their next of kin, the deputy manager and a healthcare professional.

Good

Is the service caring?

Our findings

People and relatives consistently told us that people were supported by kind, caring and compassionate staff. Comments from people included, "I call them angels, they do so much for us" and "You can tell they all care by checking if I'm comfy or asking me regularly if need anything". One relative told us, "They give my relative hugs too", their loved one confirmed this and told us, "Yes I love my hugs, it means a lot".

There was a caring, friendly and relaxed atmosphere. Staff appeared to know people well and it was apparent that positive relationships had been developed. Observations showed staff were aware of peoples' needs and when one person showed signs of apparent anxiety they went to the person and offered them comfort and reassurance. Staff were overheard reassuring people, saying things such as, "Hello, are you alright there. Can I get you anything? Would it help if I put the light on for you it seems a bit dark in here? Let me know if you want anything won't you"? and "I'm here, I just need to pop along the corridor is that alright? I won't be long I haven't forgotten about you and I'm coming straight back". People and relatives told us that people liked staff. One person told us, "They say things like 'Don't be afraid to tell me what you need', they are very helpful". Another person told us, "I get nervous coming down in the lift and my legs start to shake. They talk very kindly to me and make me feel happier about it, it is just how I am and they know it and settle me". Whilst a third person told us, "You can talk to them about anything and if they are going to the shops they ask if you need anything fetching". People were encouraged to maintain relationships with their family and friends. Observations showed people enjoying visits from family and friends, who told us that visiting was not restricted and that they were welcomed at any time.

Peoples' differences were respected and staff adapted their approach to meet peoples' needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. People were involved in decisions that affected their lives. Records showed that people and their relatives had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to peoples' feedback or changes in their needs. People and relatives confirmed that they felt involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it. Regular joint relatives' and residents' meetings were held enabling people to be kept informed of information relating to the running of the home, as well as being able to share their feelings and opinions. Records showed that within the meeting people had been asked about food choices and activities they would like to participate in.

People were asked their opinions and wishes and staff respected peoples' right to make decisions. Staff explained their actions before offering care and support and people felt that staff treated them with respect. The manager had recognised that people might need additional support to be involved in their care, they had involved peoples' relatives when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Peoples' privacy was respected and maintained. Information held about people was kept confidential, records were stored in locked cupboards and offices. People confirmed that they felt that staff respected their privacy and dignity. Staff were observed knocking on peoples' doors before entering, to maintain peoples' privacy and dignity. People were encouraged to be independent, as much as they were able to. Observations showed people independently eating and drinking and choosing how they spent their time. People told us that staff were there if they needed assistance but that they were encouraged and able to continue to do things for themselves and observations confirmed this.

People were able to stay at the home until the end of their life. Relatives told us that they were happy with the care their loved one received at the end of their lives. One relative told us, "It was a big decision as to where X should be and we were very nervous but they have come up to the mark and we are quite a demanding family. The whole staff group are patient-orientated. They always speak to X when they come in and they are making sure X is comfortable. They do it so nicely and provide everything X needs at this time". Compliment cards had been sent by relatives whose relatives had spent the last days of their lives at the home. They contained comments such as, 'Thank you for looking after their comfort, for the last few years and to the end of life care team. You have all done a wonderful job, they enjoyed their life at Glen Arun and you all made life very pleasant for them' and 'Your professionalism and kindness were appreciated by all. I know that my relatives stay was all the more pleasant for it'.

Good

Is the service responsive?

Our findings

People and relatives told us that they were involved in decisions that affected peoples' care and that staff were responsive to their needs. One person told us, "There was a review of the care plan with the social worker, the home and all of us. I think it will be re-done on a yearly basis".

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. The provider employed two activities co-coordinators, one of whom had recently been recruited, who both worked on a part-time basis. There was an activities timetable that showed people had access to activities every weekday, these included entertainment provided by the activities coordinators as well as external sources such as bible studies, quizzes, cooking and visits from a PAT dog (Pets as Therapy). People also had access to daily newspapers of their choice. Volunteers visited the home to spend time with people to ensure their social and emotional needs were met. One person told us, "Oh there's always something going on we have so much, Coco the dog comes regularly I love that and we have the local children coming in and we go to the pub". Another person told us, "You could never be bored here". A comment within a recent quality assurance survey sent to healthcare professionals that visited the home, stated, 'Staff were friendly and helpful and it was nice to see some residents sitting outside and participating in cooking'.

Some people chose to spend their time in their rooms, they told us that staff respected this and ensured that they were asked if they would like to join in with the activities or go to the lounge area. It had been recognised by the management team that people who spent time in their rooms required more support to meet their social and emotional needs. The recently recruited activity coordinator's main role was to offer more one to one style activities and interaction with people. People told us that they didn't feel isolated and could choose where they spent their time. One person told us, "They leave me to do what I want to do but every day they ask if I'm alright". Another person told us, "Even though I tend to stay in my room they always come and ask me if I want to join in and sometimes something takes my fancy".

Peoples' social, physical and health needs were assessed when they first moved into the home and care plans had been devised, these were person-centred and documented the person's preferences, needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. Records showed, and people and relatives confirmed, that they had been involved in the development and review of the care plans. There were regular reviews of peoples' care based on observations of their health and welfare and through feedback gained from people and relatives. These reviews took into consideration changes in peoples' needs and care was adapted accordingly. People were supported to make choices in their everyday life. Observations showed staff respecting peoples' wishes with regard to what time they wanted to get up or go to bed, what clothes they wanted to wear, what they had to eat and drink and what they needed support with.

Assessments in relation to peoples' healthcare needs were completed. Peoples' skin integrity and their risk of developing wounds were assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. This assessment was

used to identify which people were at risk of developing wounds. For people who had wounds, wound assessment charts had been completed providing details of the wound and the treatment plan recommended. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushion and mattress that was appropriate as well as the setting that the mattress was required to be on. Records showed that checks to ensure that settings for mattresses were correct had been carried out and were further confirmed by our observations. Peoples' risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk and they were weighed each month to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition and nutritional supplements were provided and food fortified to increase peoples' calorie intake.

There was a complaints policy in place, complaints that had been made had been dealt with appropriately and in accordance with the providers' policy. The manager encouraged and welcomed feedback from people and their relatives. Annual surveys were sent to gain feedback and people told us that they knew how to make a complaint. One person told us, "It's very friendly and they don't mind if you suggest trying something new. They listen to you and are happy to try it a new way". Another person told us, "We do have residents' meetings and if we ask for something to be changed it's no problem. If I can't go they always tell me what happened".

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff were complimentary about the leadership and management of the home. They told us that the manager was supportive and approachable and had implemented some positive changes since being in post. "Oh yes we can speak up and we do here. You could talk to anyone really and the manager is very helpful". A healthcare professional told us, 'The new manager has established good communication and appears keen to improve the service and establish good communication with us, the residents and relatives". However, despite these positive comments, we found areas of practice in need of improvement.

There were some good systems in place to ensure that the home was able to operate effectively and to ensure that the practices of staff were meeting peoples' needs. There were quality assurance processes such as surveys that were sent to gain feedback as well as regular audits conducted, including medication and infection control, which provided the manager with an oversight and awareness of the home to ensure that people were receiving the quality of service they had a right to expect. However, there were further plans to increase the amount of audits conducted to ensure that all aspects of the service were analysed to identify areas that needed to be improved. For example, the manager told us that they wanted to implement an audit to monitor the amount of accidents and falls that were occurring. An audit for the care plans and day-to-day records that were completed did not take place and therefore it had not been recognised that these had not always been completed effectively and had not identified the possible need for further DoLS applications to be made. The auditing of systems and processes within the home, to ensure people are receiving good quality care is an area of practice in need of improvement.

Records, in relation to peoples' care and treatment, were not always consistently maintained. For example, daily records documenting peoples' moving and positioning or food and fluid intake had not always been consistently maintained. Records did not always contain sufficient information to ensure that staff were provided with comprehensive and up-to-date information on peoples' care needs. For example, changes in a person's mental health which had led to an incident had not been sufficiently recorded to ensure that staff were aware of the incident and the measures that needed to be taken to mitigate future risks and ensure the person's safety. Although relatives told us that people received good end of life care, end of life care plans did not contain sufficient information to inform staff of peoples' care needs and future wishes with regard to how they wanted to be cared for. Records for one person, who was living with diabetes did not contain sufficient information on how their condition should be managed, what signs to look for that might indicate low or high blood sugar levels and actions to take if there were concerns over the person's health and well-being. When the issue of records not being sufficient was raised with the management team, immediate action was taken and care plans and risk assessments were updated to ensure they contained sufficient and comprehensive information. However, the management of records to ensure they are sufficient and completed in their entirety is an area of practice that needs further improvement to ensure it is fully embedded in practice.

Part of the registered person's responsibilities, to ensure they are complying with the CQC registration requirements is to notify us of certain events that occur within the home. However, prior to the manager

being in post there had been several occasions when notifications had not been submitted to CQC. Staff had demonstrated good practice by identifying and acting on concerns in relation to a pressure wound for one person, however had not notified us of the deterioration of this. Neither had they notified us of safeguarding investigations that were being carried out by the local authority. Registered persons are required to notify us of events such as these to ensure that we have an awareness and oversight to ensure that appropriate actions are being taken. Although this is an area of practice that had improved since the new manager had been in post, this needs to be fully embedded in practice.

The home had been without a registered manager for over a year, however, there had been a number of managers that had managed the home during that time who had started the process of applying for registration with the Commission before leaving. The management team consisted of two providers and a manager, who had been in post for several months and who was applying to be the registered manager. There was a warm, homely and relaxed atmosphere and people told us that they were comfortable and felt at home. The providers had a philosophy of care which stated, 'At Glen Arun we aim to create a welcoming and warm home for the elderly. We aim to provide a very caring and comfortable environment, where individuality, independence and respect for the dignity of our residents are always the priority'. This was evident in the atmosphere of the home and was implemented in practice as it was apparent that the staff shared a similar vision too. When asked about the values and vision of the home, a member of staff told us, "It's about providing a home from home". Another member of staff told us, "It's to protect the residents and give them a good life". People were complimentary about the home and told us they would happily recommend it to others. A relative told us, "As soon as we walked in I knew my relative would be happy here".

The manager ensured that there were links with external organisations and professionals to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. There were plans to improve this even further and the manager had plans to attend regular meetings with other registered managers and providers within the area to share best practice. The registered manager worked closely with external health care professionals to ensure that peoples' needs were met and that the staff team were following best practice guidance.

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 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 Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed.