Wraysbury House Limited

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Inspection report

Wraysbury House
2 Beccles Road
Worthing
West Sussex
BN11 4AJ

Tel: 01903233539
Website: www.wraysburyhouse.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 26 April and 3 May 2016 and it was unannounced.

Wraysbury House Limited is registered to provide accommodation and personal care for up to 27 people. At the time of the inspection 27 older people were living at the home. People had various needs including dementia and physical disabilities.

Wraysbury House is an older styled detached property close to the centre of Worthing with easy access to shops and the seafront. Spacious communal areas include a lounge leading to a conservatory dining area which overlooks a large garden and a further sitting room. The surrounding gardens were maintained to a high standard, hanging baskets were positioned all around the building. All rooms were single occupancy apart from one which was shared. All bedrooms had en-suite facilities.
We found the home to be clean and tidy and maintained to a high standard. Home furnishings such as pictures, flowers and ornaments decorated communal areas. Paintings were hung within vintage frames adding to the 'grand' style of the home.

A registered manager had been in post since January 2016. 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.

Care records showed how people were assessed prior to receiving support from the service and how current care was planned. Care plans failed to reflect the individual needs of people living with dementia. Care plans lacked involvement from people and their relatives. Two care plans held no information about people's personal histories, likes, dislikes and preferences. Therefore lacked the level of guidance required for staff supporting people within the home. The registered manager was able to share how improvements to care plans would be made.

Where people lacked capacity to give their consent to their care best interest meetings were held in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards legislative. However, the registered manager was unable to demonstrate that the Mental Capacity Act 2005 (MCA) had always been followed because capacity assessments had not always been completed on behalf of people.

Our observations and records confirmed there were sufficient staff on duty to keep people safe.
Staff had been trained in how to recognise signs of potential abuse and protected people from harm. Risks to people had been identified and assessed and information was provided to staff on how to care for people safely and mitigate any risks.

Staff demonstrated how they would implement the training they received in core subject areas by providing care that met the needs of the people they supported. Staff received regular supervisions and spoke

positively about the guidance they received from the registered manager.

Additional drinks and snacks were observed being offered in between meals and staff knew people's preferences and choices of where and what they liked to eat.

Staff spoke kindly to people and respected their privacy and dignity. Staff encouraged people to be as independent as possible. Staff knew people well and had a caring approach.

People and staff told us they were happy with the activities that had been organised. The home employed an activities coordinator to help engage with people.

There was a complaints policy in place. All complaints were treated seriously and were managed in line with the complaints policy.

People and their relative's views were obtained mainly through informal means however the registered manager had plans to develop their systems further. The registered manager met with people routinely to check on their wellbeing.
There were was a range of audits in place, overseen by the registered manager to measure the quality of care delivered, including checks on the environment.

Generally, people and their relatives felt the home was well-run and staff felt supported by the registered manager and other members of the management team.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider 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?

Good

The service was safe.

People and their relatives found the service safe.

Staff were trained to recognise the signs of potential abuse and knew what action they should take.

Medicines were managed safely.

There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not assessed in line with the requirements of the Mental Capacity Act 2005 (MCA) and associated legislation.

People's care needs were managed effectively by a knowledgeable staff team who were able to meet people's individual needs.

Staff attended training and received regular supervisions and appraisals.

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

Is the service caring?

Good

The service was caring.

People were supported by kind, friendly and respectful staff.

People's well-being was taken into consideration in the approach used by the staff team. They were encouraged to be involved in all aspects of their care.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place however lacked personalised current information and the sufficient guidance required for staff. They failed to demonstrate how people and families were involved with the care and treatment provided.

People knew who to go to if they had a complaint. The home worked in accordance with their complaints policy.

Is the service well-led?

Good

The service was well-led.

The culture of the home was open, positive and friendly.

People knew who the registered manager was and felt confident in approaching them and other members of the management team.

An overview of the quality of care provided was being managed by the registered manager. Actions were taken when the need was highlighted and improvements implemented.

Wraysbury House Limited

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 took place on the 26 April 2016 and 3 May 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we examined the information that we held about the service and the service provider. Prior to 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 improvements they plan to make. We reviewed the Provider Information Return (PIR) and other information we held about the service. 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 also spoke with a social care professional to gain their views of the home. We used all this information to decide which areas to focus on during our inspection.

During the inspection we observed care and we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people living in the home and one relative who were visiting at the time of the inspection. We also spoke to a healthcare professional who visited the home regularly and was attending an appointment for one person. . We met with four care staff, the provider, the registered manager and spoke with other care staff during the inspection including the training manager.

We spent time looking at records including care records for five people. We also looked at three staff files including training records, medication administration record (MAR) sheets, staff rotas, activities plan, complaints, accidents and incidents record and other records relating to the management of the service.

The home was last inspected on the 4 December 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. One person said, "I think it's very good. I feel safe and have not had any falls". Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the registered manager in the first instance and failing that would refer to the whistleblowing policy for advice and guidance. One member of staff said their role was to, "Make sure they (people) feel safe, if they don't feel safe it affects a lot of things". Another staff member told us they would tell the registered manager if a person's behaviour changed and said, "We know our clients". The home had a safeguarding adults at risk policy which provided information and guidance on keeping people safe.

Risks to people were managed so that they were protected from harm. Personal emergency evacuation plans had been drawn up so that, in the event of an emergency, staff knew how to support people to be evacuated safely. People who required them had sensor mats in place in their bedrooms. These could detect whether people were moving around in their bedrooms, for example at night and alert staff to someone who may be unsettled or at risk of falling. In one instance, a sensor mat had been placed in one bedroom door way, as the person received all their care in bed. The sensor mat was in place to monitor whether other residents went into the person's bedroom as the door was left open. This provided additional safety and security to the person as staff would be alerted to anyone trying to enter the room without permission. Equipment used to support people checked in line with regulatory guidance.

Risk assessments provided information, advice and guidance to staff on how to manage and mitigate people's risks. Risks assessments covered areas such as how to support people to move safely, how to administer medicines safely and how to support people with the food and fluids they required. When potential risks had been highlighted for people the necessary guidance was provided in the person's care record. We found risk assessments were updated and reviewed monthly and captured any changes. For example one person chose not to use footplates for their wheelchair as they found it restrictive when navigating around the home. The risk assessment in place had reflected the person's choice and the potential risk of harm to the person's feet. Another person had been assessed of their risk of developing pressure ulcers. This had been completed using Waterlow, a tool specifically designed for this purpose.

Accidents and incidents were reported appropriately and documents showed the action that had been taken by the staff team and the registered manager. This also included an analysis of any people that had experienced a fall. The records showed that appropriate professionals had been contacted and subsequent support provided such as the introduction of specialist equipment. This helped to minimise the risk of future incidents or injury.

Staff confirmed that there were sufficient staff on duty to meet people's needs safely and our observations and the staffing rota corroborated this. People's personal care needs were met in a prompt manner. However we received comments from two people and a relative that suggested staff may have not always been deployed on shift effectively. One person told us, "Sometimes they're a bit overwhelmed (staff) with

the number of people". Another person said, "Sometimes people have to wait to go to the toilet". One relative said, "As far as I've seen. On the whole, I've never seen a lack of staff", but added they felt that there was a shortage of staff sometimes at mealtimes. They had also observed a couple of occasions when people had to wait to go to the toilet. At the time of the inspection there were six care staff supporting people. People and staff were also being supported by the registered manager and the training manager. The provider owner was also present throughout the inspection. One new member of staff told us, "There is more than enough staff". The registered manager explained they had recently increased the staffing levels from five staff to six staff in the morning and from two waking night staff to three to ensure there were sufficient staff to meet people's needs.

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.

Medicines were managed safely by the home using an effective medicine administration system. Medicines were stored in two medicines trolleys which were secured to the wall of the conservatory. In the main, medicines were stored through a Monitored Dosage System and people's medicines were easily identified. When medicines were administered at lunchtime, we observed the member of staff checked each person's Medication Administration record (MAR) to identify which medicines needed to be administered. Tablets were dispensed from blister packs and taken to the person and the staff member waited until the tablets had been swallowed. The member of staff said that, if people refused to take their medicine, another staff member would try again a little later. If the person still refused, then the medicine would be placed into a brown envelope, with the date, time and the name of the person, for safe disposal. The medicines guidance for staff stated that, when staff routinely administered people's medicines, that pain relief should also be offered to people. We observed this to be to be the case. Only staff trained were able to administer medicines to people. The registered manager told us they were in the process of arranging for more staff to be trained in administering medicines to increase the knowledge across the staff team. The registered manager also told us they felt confident with the medicines system they used was safe as they were 'hands on' and administered medicines to people themselves at least twice a week.

One person confirmed they received their medicines when they needed them. They also told us they received pain relief medicines when they asked staff for them. However they told us they were unhappy they had to wait for the evening staff to administer their medicines at 9pm before they could go to bed as they preferred to go to bed earlier. This was fed back to the registered manager for their review and to discuss this with the person about their preferences.

Requires Improvement

Is the service effective?

Our findings

Consent to care and treatment was not always sought in line with legislation and guidance. 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 the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us and records confirmed that a standard authorisation application had been made for all people who lived at the home as they lacked capacity. The registered manager explained they had completed these on behalf of all people due to the locked exits and, "Nobody could navigate across the road outside". The registered manager told us how they had discussed the application with people and their relatives prior to completing them; however this was not reflected within people's care records. Best interest meetings had been held on behalf of some people who lived at the home who were unable to make decisions for themselves. However further clarity on whether a DoLS application was necessary for all people was required as one person we spoke to seemed to have capacity to make some decisions but had a DoLS application made on their behalf. However, no assessment had been undertaken or recorded by the home to show this person did, in fact, lack mental capacity. The person told us their relative made decisions about their care on their behalf and said, "I would like to be involved in my care plan". We noted further inconsistencies within care records with regards to how other people's mental capacity had been assessed, recorded or reviewed by the home. As there was a lack of records which reflected how people's mental capacity had been assessed in the first instance, prior to a DoLS application being made by the home, there was a potential risk people with capacity to consent to their care and treatment may have been overlooked. We fed back what we found to the registered manager. They said, "We can't make decisions for people. We are not to assume residents lack capacity just because they have dementia". The registered manager also told us their plans to update all care records. We have written about the gaps in care records including care plans in the Responsive section of this report.

The provider had not ensured service users consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We observed staff involved people in daily decisions and choices whilst supporting them. Staff told us they had received MCA and DoLS training and they could share some insight into the topics. However training records did not confirm how many staff had completed the course. On day two of the inspection the registered manager explained how she had revisited the topic with all staff members. They showed us hand-outs they had provided to the staff team which covered the five statutory principles of the MCA. This

showed how the registered manager was keen to embed the core principles of the MCA amongst the staff team and the care practice offered to people. They told us, "I have given a lot of hand-outs to staff. They have been reminded".

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. People and relatives told us of the confidence they had in the abilities of staff and they knew how to meet their needs. One person referred to the night staff and said, "They're pretty good". We asked a healthcare professional who was attending an appointment at the home their views of the staff team they told us, "They are lovely here, on the ball".

People received support from staff who had been taken through a thorough induction process and attended training with regular updates. The induction consisted of a combination of shadowing shifts and the reading of relevant care records and home policies and procedures. Staff records showed that newer staff were supported by the registered manager and senior staff using observations to assess their competency before performing their tasks independently. The mandatory training schedule covered 11 topic areas including moving and handling, dementia and safeguarding which all staff achieved. The training records showed further topics which had been attended by some staff when they had requested additional learning opportunities. An example of this was ten staff had attended incontinence training. The training manager was also the allocated 'dementia champion' within the home. This meant they had received additional training and took the lead on this area. The training manager was aware of any knowledge gaps staff had and booked staff accordingly on training or for existing staff on refresher training.

The home had introduced the Care Certificate (Skills for Care) for staff to complete. The Care Certificate is a work based achievement aimed at staff who are new to working in the health and social care field. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment. Records showed one member of staff had completed the 15 standards in December 2015.

Eight out of the 30 care staff employed had achieved various levels of Health and Social Care Diplomas and a further four staff were working towards the qualification. . These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability to carry out their job to the required standard. The registered manager was also working towards completing a Level 7 in strategic care management.

Staff spoke positively about their induction and training. Staff told us the moving and handling training they had receiving enabled them to feel confident when using the necessary equipment and we observed staff using their skills to move people safely. A new member of staff who had worked at the home for two months told us they had already been enrolled on a Health and Social Care diploma. A member of staff who had been working at the home for over five years appreciated the training they had received and said, "You can always go to [the training manager] and request more".

Supervisions and appraisals were provided to the staff team and overseen by the registered manager. A system of supervision and appraisal is important in monitoring staff skills and knowledge. Staff told us and records confirmed they received supervision every three months and an appraisal once a year. Work related actions were agreed within supervisions and carried over to the next meeting. For example additional training requirements for staff were discussed at supervision meetings. Staff meetings were also held regularly and included items relevant to people's needs. For example a meeting in January 2016 discussed team work and how to support people with their medicines. Therefore all staff had access to effective support and guidance in order to carry out their role.

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs. People confirmed there was a choice of two or three meal options presented to them at each meal time. When asked about the food one person said, "I think it's very good. On Friday, It's usually fish and roasts on Sunday. Desserts are nice too". Another person said, "Food is okay, they give us a good variety". Most people ate their meals in the two dining areas. Staff told us people were provided with choices and encouraged to be as independent as possible when eating their meals. One staff said, "We always have a choice but they (people) may just want a sandwich".

On the day of the inspection we observed additional drinks and snacks were offered to people between meal times. Tables at lunchtime were nicely laid with table cloths, cutlery and condiments; however, there were no serviettes, so people had to ask for them. Staff provided additional support to people who needed it; they sat next to people talking to them about what food was being served. One person had chosen lamb for their lunch and we observed a member of staff intervened as they commented the person would not be able to chew the meat. The person was provided with a seemingly softer option, but staff did not discuss the change with them. Relatives were able to join their family members at meal times. One relative told us they enjoyed supporting their family member with their meal and said, "I keep [named person] company". Staff completed food and fluid charts on behalf of people to monitor what people were eating and drinking. Weights were recorded and monitored on a monthly basis. This ensured that changes to people's nutritional needs were regularly monitored for any changes and appropriate action was taken.

Staff told us they would tell the senior staff or registered manager if a person had any health issues immediately and then they would contact a nurse or a GP if needed. People and relatives confirmed that the staff team were effective in addressing health care needs. One person was cared for in bed and required regular visits from the district nurse to meet their nursing needs. Another person confirmed health care staff visited the home, "Fairly regular" and if they needed to see a GP this would be arranged. Visits from healthcare professionals, such as the GP, district nurse and chiropodist were recorded in people's care plans.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that people looked at ease in the company of staff and were comfortable when anyone in the staff team approached them. People confirmed their positive experiences of the staff team including the registered manager. One person said, "Staff are quite nice. They do what they can for you, you only have to say". Another person said, "I'm very happy here, everyone is so warm and friendly". One relative spoke highly of the staff and said, "Absolutely fantastic. I've got no qualms recommending it. The staff are wonderful". Another relative said, "Staff are very patient and willing in a nice way".

We observed numerous occasions of positive support provided by staff to people. Staff bent down to address people at their own eye level and maintained good eye contact. Staff spoke with people calmly and warmly and we overheard a member of staff say to one person, "[Named person] is there anything you want? Anything I can do to help". We observed another member of staff adjust a person's dress collar when it was sticking up and said, "Shall I just sort that for you". Staff also spoke passionately about how they cared for people who lived at the home. One member of staff said they always tried to, "Build a relationship with them (people). Try and make them laugh. I love making them smile". Another staff member said, "We do think about the people we are looking after". They gave an example of when people returned from hospital they, "Let them know they have been missed. All they want to know is somebody is here for them. It's about letting them know we care".

Whilst we observed staff supporting people in a caring way, on the first day of our inspection staff did not spend time socialising with people in the communal areas outside of their care duties. On one occasion after lunch one person sat at the lunch table with an empty pudding bowl until 3pm. When they became distressed we asked a member of staff to support them. We discussed this with the registered manager. They told us they encouraged staff to sit and talk to people and be available at all times to meet people's needs. We read staff meeting minutes on 19 June 2015 where the issue had been highlighted it stated, 'Always sit and chat with residents and not chat amongst yourselves'. On the second day of our inspection we observed staff sat next to people and engaged in conversations relevant to the individual. Staff members told us they enjoyed coming to work because of the people they supported. One member of staff said, "You have the time to sit down and talk", and added "You have to have that interaction".

During our inspection we observed that the home encouraged people to express their views on their care and treatment via informal means, however this was not reflected in their care plans. People were provided with opportunities to talk to staff including the registered manager about how they felt on a daily basis. We asked people whether they were actively involved in making decisions about their care. One person told us, "Staff come in and ask whether I'm alright today. I get up quite early, but I can have a lie-in if I want". Residents' meetings were not held at the home. We discussed this with the registered manager and provider. They told us that due to people's lack of capacity and understanding, they were not a useful forum and they felt people would not attend. Therefore they chose to engage with people on an individual basis. The registered manager felt this provided the time to gain people's views and to keep people involved in the care they received. We asked a relative whether they felt involved with care planning for their family

member. They explained that they were involved in this when their family member was admitted to the home and said, "At the beginning yes. They keep me updated", adding they were not really involved in care planning now, saying, "I leave it to them". This meant the relative was confident in the care their family member received. The registered manager told us they planned to introduce a suggestion box for relatives by the front door to provide an additional opportunity for them to share their views on people's care needs or on the environment.

We observed people were encouraged to be as independent as possible by staff. However one person said, "I think sometimes staff treat you like children". They were unhappy staff asked them what time they would like to go to bed and added, "I'm 84 and I can go to bed at the time I want". The registered manager told us their job was, "Not to de-skill people". Staff provided many examples of how they tried to promote people's independence. Staff described how they could do this when supporting people with their personal care. One member of staff said, "By offering them the flannel. Some people need to see you do the actions, show them the actions. Then people will copy and clean themselves". They also said, "Everybody has the right to be independent". A new member of staff explained how a person communicated who received all their care in bed said, "[named person] can move their arm. If they grab out at their cover it means [named person] does not want personal care at that time".

People generally felt they were treated with dignity and respect. We asked one person how staff delivered personal care and they said, "They don't do it in public in front of other people". Another person sat next to them agreed with the comment and added, "I'm quite happy". Staff told us they closed people's bedroom doors when supporting them with personal care and we observed staff knocked on doors before entering people's bedrooms. One staff member said, "We treat them (people) as adults they are not kids". A new member of staff told us, "Try and advise them (people) rather than telling them". They also added "Residents always seem to be happy".

Requires Improvement

Is the service responsive?

Our findings

Our observations indicated that staff knew people well and responded to people's needs in an individualised and caring way. Staff were also able to tell us the importance of personalised care. However, we found many inconsistencies within care plans. Each person had a box file which held various pieces of information about them. There was an index to the box file which listed the items that should have been found within. One document within each was called an 'Assessment for Good Care Planning'. Staff told us they considered this document to be the main care plan they used. The document covered all assessed areas of risk in great detail yet failed to provide a breakdown with instructions and guidance for staff on how that particular aspect of care must be provided. For example, when one person had been assessed as needing full support with their mobility, there was very little detail on how staff should move that person safely. Therefore staff may not have had a clear and detailed guidance to understand how to meet people's needs consistently.

Two care plans had yet to be completed. One related to a person who moved into the home in October 2015. One section of the care plan was entitled, 'Daily care plan needs and preferences' with headings for personal care, mobility, social care including religious and cultural needs, food, drink, dietary and medication. None of the sections had been completed. The same person had a 'Knowing Me' document. 'Knowing me' care plans are a useful document some care services use when people are admitted to hospital, as well as providing personalised information about people for staff to read. They provide an overview of a person, their likes and dislikes and are often completed with a person and/or their families at the point of admission to a home in the event that they may not be able to express their wishes and needs. The same person's 'Knowing me' care plan was also blank. A further two 'Knowing me' care plans we read had been completed with extensive personalised information and were completed in 2013 when the people moved into the home. However they failed to show if a review of the information had taken place, even though the provider and manager told us they were a relevant and current guide for staff to use.

There was very little evidence in the care plans we read that reflected people and their relatives were routinely involved in their care planning process. There was also limited information on how consent to people's care had been established and the extent to which people were involved in decisions about their care. One person told us, "I don't think staff know much about me, some do, some don't". We discussed the care plans with the registered manager who was aware of the issues and agreed with our findings. They had already purchased new folders prior to our visit and told us they knew what had to be achieved. However a care plan audit which had been carried out in October 2015 provided no details of what was found and identified no time frames within which the care plans had to be updated by. People were at risk of their care needs not being understood or met because the records related to their care planned were not fully completed, personalised or fit for purpose.

The above evidence showed the provider had not ensured that the care and treatment of service users was appropriate, met their needs and reflected their preferences. This is a breach of Regulation 9 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection the registered manager had started making changes and they showed us a signed care plan from one person. They said, "Since last week I have been focusing on care plans". They also told us they had removed information and recording charts which were no longer relevant to people's current needs and to avoid confusion especially for new staff who did not know people well.

Daily records were completed about people by staff during and at the end of their shift. They included information on how a person had spent their day, what kind of mood they were in and any other health monitoring information. We observed staff handing over information from one shift to another. These meetings and the daily records ensured staff handed over information to other shifts to ensure any changes to people's care needs were communicated to staff.

People told us they enjoyed the activities provided by the home. We asked people about the activities on offer. One person said, "There's always something going on. If you want to join in you can. No-one says you have to". The same person went onto tell us about their love of reading and knitting. The person added, "You can go for a walk around the block as I call", referring to a circular walk around the ground floor of the home. Another person enjoyed the activities on offer and said they particularly liked the quizzes. People and staff told us about the activities co-ordinator who worked at the home and organised activities for people from Wednesday to Sunday. People spoke fondly about the activities co-ordinator and how they engaged with them. One person told us it was because they had time to chat. Another person told us, "It would be nice to go out more in the grounds", adding that, unless accompanied by staff, people could not go out in the garden alone. A reminiscence magazine, 'Daily Sparkle' was made available to people and their relatives. The magazine offers articles of interest appropriate for older people.

On Mondays and Tuesdays external entertainers visited the home. Larger events were also organised by the home. They had recently held a fete in celebration of the Queen's birthday. Decorations from the fete remained up in the lounge which added character to the room and a talking point for people. On the day of our inspection, an entertainer had come in and organised a ball and balloon throwing session and a reminiscence quiz. We observed the ball and balloon throwing session. Whilst one person particularly enjoyed the session provided, others appeared not to be interested. However the musical quiz, designed to encourage people to recall musical themes relating to radio and television shows engaged the interest of more people. Activities were provided in short bursts to accommodate people who had limited attention spans or concentration skills. The registered manager provided an extensive list of all the activities offered to people. This included singers and a massage therapist who visited the home. In addition a separate hairdressing room was made available for people to use and a hairdresser visited the home to attend to people's hair on a regular basis. This meant opportunities were provided by the home which offered social stimulation to people and minimised the risk of social isolation.

Complaints were looked into and responded to in a good time. There was a clear log of all complaints and the actions taken by the registered manager and the staff team. We asked people whether they would feel confident to raise any concerns or issues with staff. One person said, "I would tell more senior staff I suppose, although I have never made a complaint". We read the comments book which was placed in the entrance to the home. A relative had suggested staff wear name badges in January 2016. The registered manager had responded and taken action and all staff were seen wearing name badges. They had also suggested photographs and names of the staff to be hung in the foyer of the home. The registered manager told me they planned to do this in the next month to assist people and their relatives in building links with the staff within the home. There was a complaints policy in place. There were no current open complaints.

Good

Is the service well-led?

Our findings

Although we had highlighted shortfalls and issues with our findings during the inspection, mainly with care records and capturing the consent of people, the registered manager and provider were open to discussions held and were keen to make the necessary improvements. By the second day of our inspection improvements had already started. The registered manager was focused on delivering a high standard of care to the people living at the home.

We observed the management team supporting people throughout the inspection. People approached the registered manager and training manager with requests and the necessary support was provided. One person told us, "I think they do their very best for you. If you've got a problem, they help you with it." The registered manager was registered in January 2016 and had already made a positive impression with people and the staff team. A deputy manager was new in post however they were on annual leave during our inspection. We observed the registered manager made herself available for people and staff and offered a 'hands on' approach. She explained it was important to not always be in the office and wanted to know what was happening in the home. The registered manager had worked night shifts so had a real sense of what was happening outside of office hours. They shared how they had focused on building a happy staff team to support people and both the registered manager and provider felt they had now achieved this.

We asked the registered manager how they promoted a positive and open culture. They said, "By working with the clients, working with their preferences". They also told us staff could come to them at any time and they would never be too busy to help. The registered manager told us their vison for the home was to, "Have the best outcomes for the clients that live here". The registered manager had yet to send out satisfaction surveys to people and their relatives however they told us they planned to do so very soon so they could have a current overview of people and their relative's views. This meant people and their relatives would be more involved in how the service was developed to meet their needs. Satisfaction surveys carried out in 2014/2015 (prior to the current registered manager being in post) recorded feedback of the care people received was mainly positive. One relative told us they were asked annually for their views on the care provided. Another relative had sent in a thank you note to the home in April 2016 it read, 'Thank you for the loving and caring way you have looked after our mum'.

We asked staff what they perceived to be the visions and values of the home. One member of staff said it was all about, "Really good team work". Another member of staff told us it was about, "Keeping the residents well. Make sure they have all their needs met and give them the love they need". A third member of staff said, "Make sure it's a welcoming home".

We asked staff how they felt about the way the home was managed and whether it was well-led. Staff spoke enthusiastically about the registered manager and other members of the management team. They appreciated the flexibility in their approach. One member of staff had experienced potentially serious health issues and shared how they had been supported by the management team. They told us, "This place is brilliant from the owner right the way down". They added the registered manager had an open door policy. Another member of staff told us, "There's always someone you can go to" and added, "They are a

really good bunch". A third member of staff told us, "She's (registered manager) very good. She's very concerned about the staff and the residents care". The registered manager told us they, "Always thank the staff, always try and support them". A fourth staff member said, "It is well-led. [The registered manager] is still relatively new but she is very supportive".

We assessed how the registered manger reviewed the quality of the care the home provided. There was a range of audits carried out throughout the year overseen by the registered manager in all areas of the care delivered and the environment. These included training, medication and infection control and food safety. Most audits were effective in recognising areas and supported driving improvements. The accident audit form was clear and effective in providing an overview and identifying patterns and trends to when and where accidents, for example falls, were more likely to occur. We discussed how care plans could be improved in the Responsive section of this report.

The registered manager told us she had a strong support network within the organisation and received plenty of support from the provider and aimed to work alongside other agencies including the West Sussex health and social services teams. When we asked the registered manager what her greatest achievement so far was, she said, "Getting positivity in the workplace".

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c) (3) (a) (b) (d) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured service users' consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. Regulation 11 (1)