SHC Rapkyns Group Limited

The Granary

Inspection report

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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 7 and 11 December 2017 and was unannounced. This is the first inspection since the service was registered with the Commission in July 2015, but was dormant until it was opened to new service users in December 2016.

Since the registration of The Granary, services operated by the provider had been subject to a period of increased monitoring and support by commissioners. The Granary had been the subject of three safeguarding concerns about a person not receiving care in line with their health needs, a risk of injury posed by a person's equipment and an allegation of physical abuse. As a result of concerns raised, the provider is currently subject to a police investigation. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May and December 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

The Granary is a care home that provides nursing and residential care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The Granary is registered to provide nursing and accommodation for up to 41 people with an acquired brain injury or neurological condition. At the time of the inspection, 9 people were living at the home, including one person who was staying for a short break. The Granary provides accommodation across four ground floor units: Walnut, Pine, Yew and Alder. Each unit has a separate living room, dining room and kitchenette. At the time of this inspection, people were accommodated in Walnut, the other three units, which could accommodate 10 people each, were unoccupied. Rooms were of single occupancy and had en-suite facilities.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff did not complete specific training to enable them to understand acquired brain injury or neurological conditions that affected people living at The Granary. Staff did not receive supervisions in line with the provider's policy, which stated these should be completed three times a year.

People's consent to care and treatment was not always gained in line with the requirements of the Mental Capacity Act 2005. Where people had been assessed as lacking capacity to make specific decisions, processes were not followed to ensure decisions taken were in people's best interests.

Systems were not effective in measuring and monitoring the quality of the service provided. Where actions were identified, these had not always been completed. There were ineffective systems in place to drive continuous improvement. Monitoring records were not always completed consistently.

People were not always treated with dignity and respect, for example, how they were supported at mealtimes and how staff referred to people's personal care needs in a communal setting.

Care records did not always reflect that people received personalised care that met their needs. Some care plans relating to people's specific areas of need lacked detailed information and guidance for staff on how to support people in a responsive way, for example, in expressing sexuality. Activities were organised but did not take account of people's identified interests and preferences.

An area identified as needing improvement was the organisation and management of the lunchtime meal. People received their lunches at different times. Food that one person had chosen was not readily available. Fresh fruit or snacks were not freely available to people during the first day of inspection, but this was rectified by the time of our second visit. Menus were not in an accessible format to aid people's understanding of meals on offer.

People said they felt safe living at The Granary and staff understood what action to take if they had any concerns about people's safety. Staff had completed training in safeguarding adults at risk. Risks to people were managed safely overall, but there were some gaps in records which was an area that needed improvement. By the second day of inspection, action had been taken to complete gaps we had identified in relation to fluid recording and repositioning charts. Staff knew people well and were knowledgeable about potential risks. Staffing levels were within safe limits. Recruitment systems for new staff were fit for purpose and ensured that appropriate checks were made before staff commenced employment. Medicines were managed safely. Appropriate infection control procedures were implemented by staff. Accidents and incidents were recorded, together with outcomes for people.

People and/or their relatives were involved in making decisions relating to their care and with care planning. A variety of facilities was available to people living at The Granary including access to a salt cave, hydrotherapy and a gym and day centre at one of the provider's other locations. People commented positively about the staff and felt their individual needs were met. Staff completed mandatory training in a range of areas and an induction programme. People had access to a range of healthcare professionals and services including physiotherapy and general practitioners. Premises were accessible for wheelchair users, but were not specifically designed to meet the needs of people with an acquired brain injury or neurological condition.

People were looked after by kind and caring staff who knew them well. People's communication needs had been identified and were catered for. Where needed people had assistive technology to help them communicate effectively. Some people had access to advocates to support them in making decisions.

Some care plans were detailed and fit for purpose. People's spiritual and cultural needs were catered for. As much as they were able, and if they chose, people were involved in reviewing their care plans. People knew how to make a complaint. People's wishes and preferences for their end of life care had been recorded. Staff had completed training in areas relating to end of life care.

The registered manager described the culture of the home and the importance of recruiting the right staff. He talked about the new Key Lines of Enquiry (KLOE) which the Commission introduced from 1 November 2017. The registered manager planned to discuss these with staff at a staff meeting. Staff felt supported and

valued by the registered manager. People and their relatives were asked for their feedback about the home and residents' meetings took place. The registered manager worked in partnership with other agencies.

At this inspection we found the service was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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's risks were identified, assessed and managed appropriately.

People told us they felt safe living at The Granary and were involved in decisions relating to potential risks. Staff had completed training on how to keep people safe and knew who to report any concerns or issues to.

Staffing levels were assessed based on people's care and support needs and were sufficient to keep people safe. Safe recruitment systems ensured that new staff were vetted before they came to work at the home.

Medicines were managed safely.

People were protected from the risk of infection and staff wore personal protective equipment when required.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff completed a range of training, but no training was organised in relation to acquired brain injury or people's specific neurological conditions. Staff did not receive supervision at regular intervals as defined by the provider's policy.

People's consent to care and treatment was not always gained in line with the requirements of the Mental Capacity Act 2005. Where people were deemed to lack capacity, processes were not in place to ensure decisions were taken in their best interests.

People did not always have a choice of what they wanted to eat and menus were not readily available to people in an accessible format. From our observations, the organisation of the lunchtime meal was not well managed.

Premises were designed to be 'disability friendly', but had not been adapted to meet the specific needs of people living with an

acquired brain injury.

People had access to a range of healthcare professionals and services, supplied by the provider or externally.

People and/or their relatives were involved in planning their care.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People were not always treated with dignity and respect.

Staff knew people well and cared for them in line with their preferences. People were provided with emotional support to help them with their feelings in relation to their life-changing conditions.

People's communication needs were assessed and assistive technology employed to enable people to communicate effectively. People were encouraged to express their views and to be involved in decisions relating to their care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Activities were not organised in a way that met people's preferences or interests. Outings outside of the home were organised on a limited basis, otherwise people accessed activities within the home or at another of the provider's locations on campus.

Care plans, in some cases, lacked detailed information about people or guidance for staff on how to support people.

People knew how to make a complaint and complaints were dealt with in line with the provider's policy.

Staff had been trained to ensure staff met people's changing needs. Some people had recorded their wishes and preferences for their end of life care.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Audit systems were ineffective in identifying areas that required improvement to ensure actions were taken as needed.

Contemporaneous records in respect of people and their care were not consistently complete or accurate.

Staff felt supported and valued by the registered manager and were positive in their feedback. Staff meetings were organised to enable staff to be involved in all aspects of the home.

People and relatives' views were obtained through surveys. Overall feedback was positive. Service user meetings took place.

The registered manager had a good understanding of the requirements under Duty of Candour and put this into practice.

The registered managed attended professional development days, for example, to update their knowledge and understanding of acquired brain injury.

The Granary

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 is the first inspection since the service registered with the Commission on 20 July 2015. This inspection took place on 7 and 11 December 2017 and the first day was unannounced. The inspection team on the first day 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. Their area of expertise included learning disabilities and autism. The inspection team on the second day consisted of one inspector and a specialist nurse advisor.

Although this comprehensive inspection had been planned, the inspection plan was informed, in part, by partner agencies notifying CQC of safeguarding concerns about this location related to a person not receiving care in line with their assessed needs, an allegation of physical abuse and a risk posed to a person by their equipment. A number of safeguarding and quality concerns in relation to the provider, Sussex Health Care, are the subject of a police investigation and safeguarding enquiries and three safeguarding concerns relate to The Granary specifically. As a result this inspection did not examine the circumstances of the specific allegations made about the registered provider. However, the information of concern shared with us indicated potential concerns about safe care and treatment and delivery of person-centred care. Therefore we examined those risks in detail as part of this inspection.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection we spoke with four people who lived at the home and two relatives. We spoke with the registered manager, the nominated individual of the provider, the provider's head of quality and therapies, an area manager, the academy lead who co-ordinated staff training, the clinical lead, a physiotherapist, two registered nurses, three care staff, the activities co-ordinator and administrator. We spent time observing the care and support that people received during the two days of inspection.

We reviewed a range of records relating to people's care and how the home was managed. These included six people's care records. We also looked at medicines records and observed staff giving people their medicines.

We looked at staff training, support and employment records, audits, minutes of meetings with people and staff, policies and procedures and accident and incident reports.

At the time of the inspection, nine people were accommodated at The Granary. The service is registered to provide accommodation and nursing care for up to 41 people. It opened during the week commencing 23 December 2016 when two people were admitted to the home and is not yet fully operational.

Good

Is the service safe?

Our findings

We asked people how they were supported to understand what being safe meant and whether they had any concerns about their safety. Responses were mixed. One person said, "Yes, it's fine and staff are okay". Another person explained they were not scared most of the time, but added, "Most of the time agency staff are not good and I get very nervous if I am left with someone who doesn't know how I communicate". However, staff who were permanently employed demonstrated they had a good understanding of this person and could communicate effectively. In addition, agency staff were supported by permanent staff when supporting people. A third person said, "I feel very safe".

We discussed some safeguarding issues that had been notified to us in relation to people who lived at The Granary. The registered manager explained the actions that had been taken as a result of the concerns and said, "We endeavour to get everything right. We've had several meetings with the Commissioner". A staff member had been suspended whilst one safeguarding matter was investigated by the local authority. Following our discussion, it was evident that all appropriate action had been taken in relation to safeguarding as these matters had been fully investigated by the provider and the local authority and were subsequently closed. People were safe and protected from the risk of abuse or harm. We asked one person whether they were offered an advocate if appropriate as they were the subject of a safeguarding investigation and they told us this had not been offered to them. However another person had identified an advocate for themselves in relation to the management of their hoisting arrangements and this was working well.

Staff had completed training in safeguarding. One staff member said this topic was covered at their induction and added, "Safeguarding is ensuring our service users are safe and have a quality life free from harm and abuse; that's in all areas, not just physical". They then provided other examples of types of abuse such as mental, financial and emotional. Staff were clear on what action they would take if they had any concerns relating to people's safety. The same staff member told us, "First I would raise with the nurse in charge, but also I would tell the manager. If nothing was done, I would raise further. All policies are in the main reception including safeguarding vulnerable adults. We have to read all those and they're also on the Internet". The registered manager talked about the stress of recent investigations on the provider by the police and the local authority. They said, "Staff have been stressed. Safeguarding is a huge weight on people. We try our best".

We asked people if they were involved in decisions relating to risks and whether the management of their safety impacted on their freedom, choice and control. One person agreed they were fully aware of the risks relating to their care and described these to us. Another person said, "Staff say don't do something because you might hurt yourself". A relative told us, "We come twice a week. Staff know we take an active participation in what he does. We take him out and they tell us what to watch for".

We asked the registered manager about people who received sustenance or medicines via Percutaneous Endoscopic Gastrostomy (PEG), a tube fed directly into a person's stomach and/or who had tracheostomies and/or indwelling catheters. A tracheostomy is a tube inserted directly into a person's windpipe to help

them breathe. An indwelling catheter helps drain urine from the bladder. We then checked the risk assessments and care records in relation to these people. Overall risk assessments were effective in mitigating risks for people's assessed needs. Risk assessments were reviewed monthly and amended as people's risks changed and updated appropriately. Risk assessments provided guidance to staff on keeping people safe whilst supporting them in regaining their confidence and re-learning daily life skills.

We also looked at records relating to people's risk of developing pressure areas and moving and handling. Repositioning charts were completed where needed for people identified as at risk of skin breakdown. We saw one chart which had a gap in recording for one person and drew this to the attention of the registered manager, who agreed this was an omission. Risk assessments relating to people's levels of mobility had been completed and contained detailed actions for staff on how to move people safely. We saw evidence of the involvement of external agencies, such as GPs, being involved and advice sought. From our observations and talking with staff, advice recorded in people's care plans was implemented. Staff we spoke with acknowledged the importance of good skin care and explained that dating and recording of body maps and corresponding photographs were important. There was a culture of diligent skin care and notes documented any changes. Staff were aware of the need to be gentle with people when providing personal care. One staff member said, "We try and are very careful and monitor every time we give personal care". Staff demonstrated skilled moving and handling techniques when transferring people. Hoists were used and staff communicated with people clearly. Staff worked in pairs as required and confirmed their training was updated yearly in relation to moving and handling. People had their own equipment in relation to being moved safely.

It was clear from our observations and conversations with staff that they knew people well and were knowledgeable about people's risks. A registered nurse explained about the technique they used for people who required suctioning and that they had completed training in relation to this. We observed one person going out to the day centre and overheard a staff member saying that this person was 'nil by mouth' and that they needed a label to be put on the back of their wheelchair. The usual notice was not available so the staff member made another notice that was affixed to the back of the chair; this ensured the person would not be given fluids or food orally. The person in the wheelchair consented to this arrangement.

The registered manager explained that staff numbers were assessed based on people's care and support needs using the provider's dependency tool. He told us, "Bringing people in has to be done at the right pace and getting the right staff, which is not always easy. When I started there were two permanent staff and two service users. I've built the team as I've gone along. I think now I have a core of good staff". Where agency staff were used to cover gaps in staffing levels, they worked alongside permanent staff. The registered manager told us that they tried to use the same agency staff to ensure consistency in the standard of care delivered. We checked staffing rotas and these confirmed the numbers of staff who were on duty. At the time of this inspection, the registered manager told us they were in the process of trying to recruit more registered nurses and care staff. There were five vacancies for permanent nursing and care staff.

Feedback from people and staff was mixed in relation to staffing levels. We asked people whether they felt there were sufficient numbers of staff to support them in a timely manner. One person said, "I don't know how many people [staff] it should take". Another person told us, "I have rung my mum to say I can't reach my call bell and asked her to ring The Granary to help me". We discussed this issue with the registered manager who said this was an isolated incident when the person had dropped their call bell and could not reach it. A relative, when asked whether they thought there was sufficient staff, said, "I don't think so. When he gets left on his own all the time. Sometimes he's wet and we've changed him. There's not enough staff to go around". We asked people whether their call bells or requests for assistance were responded to promptly. One person said, "No. Last night it took me 40 minutes to get someone to get me to bed". A

second person told us, "It depends how many staff should be on, as a rule it's quite good". A third person said, "Staff come soon. When the buzzer goes I know someone is going to turn up".

On the first day of our inspection, two registered nurses were on duty; one nurse was new to the service and was supernumerary. Six care staff were on duty, including the two registered nurses. Usually, one registered nurse was scheduled to be on duty with five staff, including an activities co-ordinator. At night, five care staff were on duty with a registered nurse. One person had 24 hour 1:1 support and this was delivered as planned. We asked staff whether they were happy with the staffing levels. One staff member said, "There's not always enough staff and I think it could be improved. Sometimes due to sickness or agency not turning up or right numbers, because people's needs can be demanding. For example, people all call at the same time. The manager is great and will come and support, also the nurses". The staff member added, "I would like more staff so we could do more. Other than that I can honestly say I really like working here. We spoke to the manager about this and he said he would have to raise it with senior management. It's documented in the team meeting notes". Referring to staffing levels, another staff member said, "We provide quality care regardless. If we're short staffed for whatever reason, it affects us, not them. People need so much support and they have rights – they keep us on our toes". This staff member also told us, "If we have to do three hydro in one day, we are wiped out. I am extremely proud of everyone I work with. The thoroughness of personal care is second to none and attention to detail. It helps people feel good about themselves". They gave an example of the length of time two staff might have to spend providing personal care for one person which could take between 1 ½ hours and 3 hours if agency staff were used. The staff member explained that time and patience were needed to spend time with people and provide appropriate support, not just physical support. Where needed, the registered manager also provided additional support, for example, when people used the hydrotherapy pool. We observed staffing levels on both days of inspection and saw there was enough staff to meet people's needs in a timely manner. Staffing levels had been assessed based on people's care and support needs

We looked at three staff files and checked the systems for the recruitment of new staff. Where needed, proof of identity and permission to work in the UK had been sought. Checks were in place to ensure that nurses had up-to-date PIN numbers and were registered with the Nursing and Midwifery Council (NMC). Agency nurses were vetted before working at the home and recruitment checks were completed, including with the Disclosure and Barring Service (DBS), to ensure that new staff were safe to work in a care setting. References were obtained and employment histories recorded. The academy lead told us, "The support staff are very good. I meet with new staff", adding that part of the induction was focused on safeguarding of vulnerable adults and duty of care.

We asked people and relatives about their experiences of medicines administration. One person said, "Staff give it to me every day" and a second person told us, "They give me my medicines. I get it at night". We asked people about their understanding and access to information about their medicines. One person talked about the laxatives they might need and a relative said, "If he's had a rough night, staff will give him something".

We observed medicines being administered to people on both days of the inspection. On the first day, a new registered nurse was working alongside another nurse who observed their practice in giving people their medicines and the recording of these. Medicines were administered from a trolley, with some medicines administered from blister packs via a Monitored Dosage System. We observed the medicines trolley was locked between each administration of medicines and when left unattended. The nurse on duty explained to each person what their medicines were for and gave them a drink to help them swallow their medicines. One person refused to take their medicine at the time it was offered. The nurse administering this explained, "She didn't want it and I need to get consent, so I'll try again later. We'll have to space the

next one [medicine]", referring to a safe time interval between the administration of certain medicines. The registered manager told us about one person who consistently refused their medicines. This person had been assessed as having capacity to make this decision, so their wishes were acknowledged. Occasionally the person would agree to take their medicines and had accessed specialist support to enable them to understand any impact on their physical and mental health by not taking their prescribed medicines. We asked a registered nurse about people's risks to their health if they refused to take their medicines. They said, "If people have mental capacity, you can't force them. They have rights". Where medicines were given to people on an 'as required' (PRN) basis, for example, pain killers, staff followed the provider's policy and procedures on PRN guidance. Guidance referred to people's level of pain, when to take people's temperature and details of maximum dosages for specific types of pain killer. Medication Administration Records (MAR) that we checked were completed accurately by staff to show people had received their medicines as prescribed. Medicines were ordered, stored, administered and disposed of safely.

People were protected from the risk of infection and staff had been trained in infection control procedures, although we did note one example which indicated an area for improvement. We observed a member of care staff putting on disposable gloves and an apron before entering one person's bedroom. We asked people about the cleanliness of premises and equipment. One person said, "Yes, they keep it clean". Another person talked about a urine infection they had suffered and of the action taken by staff to treat this. Staff told us there was adequate equipment to meet the needs of people. One staff member said, "We have enough equipment to use here". We observed staff using protective equipment such as gloves and aprons. Staff were also aware of which bags to use for the laundry in relation to infection control. However, we observed that staff were suctioning people without wearing protective equipment and moving between people. We looked at the care plans and the provider's infection policy, both of which said that staff should use aseptic techniques. We discussed this issue with the registered manager at the end of our inspection. He explained that when people needed suctioning, on occasion this needed to be completed quickly to prevent any potential harm to people, so that staff did not have time to put on aprons or gloves. The registered manager said that the provider's infection control policy needed to be amended to reflect this practice.

We looked at records in relation to incidents and accidents. Details were recorded appropriately including actions and outcomes for people. Each person had a Personal Emergency Evacuation Plan (PEEP) which showed the support they required from staff should the building need to be evacuated in the event of an emergency. The provider also kept a 'lessons learned' folder which had been read and signed by eight staff. The registered manager told us that any events that might be significant and impact on people's safety, were recorded and shared across all the provider's locations.

We asked people whether they were involved in investigations or reviews in relation to their safety or when things went wrong. We asked people if they had experience of the Duty of Candour regarding their care and treatment and whether communication was effective. One person told us that nothing had ever gone wrong, so they had no concerns.

Requires Improvement

Is the service effective?

Our findings

We asked people about their experiences of assessments in relation to their care planning and outcomes. One person told us that their wife was involved in this. Another person confirmed they were consulted and included in planning their care and a third person told us, "They discuss things with me as well, but more Mum and Dad". This person's relative confirmed their involvement and added, "Yes, they have had to ask us to pass lots of things on and discuss things with us". Both relatives said they were involved in review meetings and that their family member attended too.

We asked the registered manager how they ensured people's needs were assessed in a holistic way. We talked about people with an acquired brain injury or who had been affected neurologically, who might need additional emotional support to come to terms with the changes in their lifestyle. The registered manager told us there were plans to employ a person who was completing a qualification in counselling, who could meet with people independently. The registered manager added that people also received ongoing emotional and physical support from staff who worked at the home.

Facilities at The Granary included a salt cave and hydrotherapy pools. A salt cave helps people with respiratory conditions and the registered manager explained, "It's like a giant nebuliser". People accessed the salt cave and were supported by staff with this. People, where funded as part of their care package, could also access the hydrotherapy pools which helped with relaxation, promoted wellbeing and reduced discomfort. The home included a sensory room with various sensory items of equipment, but this was not in use at the time of the inspection. People could access a gym which was located at one of the provider's other services and was used as a shared facility. We asked the registered manager about how facilities at The Granary would be shared and accessed by people who lived at different locations. For example, access to the salt cave meant that people who did not live at the home would need to walk past people's bedrooms down a communal corridor, which could affect people's privacy and rights in their own home. We discussed this with the registered manager who said he would look into this, but it was not a concern at the moment because the unit in which the salt cave was situated was not occupied. The registered manager told us, "That's something we need to consider. My vision is to engage with families and we want them to shape how the service will work". He also told us that he was working collaboratively with another organisation that was experienced in the field of acquired brain injuries, in order to enhance and support the delivery of care to promote people's independence.

People were asked for their views about the approach of staff to meet their individual needs. One person said, "They are quite good". Another person told us, "Some are pretty borderline" and a third person said, "Very good, all good". A relative expressed concern that a physiotherapist could not manage people of a large stature. People felt that staff had the skills and capability to look after them successfully. The registered managed talked about their training in relation to tracheostomy care, but agreed that training specific to acquired brain injury was lacking across the service. He told us, "That's an area we need to work on more. It's about how I engage with my staff. At staff meetings we do engage and talk about residents individually. As we grow, we'll look at more targeted training". A member of care staff said they had received training on acquired brain injury in their home country, but not with this provider. The academy

lead who co-ordinated staff training said, "We're looking at the whole year and have a rolling three month programme. We need to look at mandatory training. For example, here it would be PEG, tracheostomy and maybe learning disability or acquired brain injury training". They went on to say, "I think it's good to use external training opportunities too. It's meeting the needs of the service users within each individual home". Training was organised via e-learning, learning books, internal and external face to face training.

We looked at the staff training plan for 2017. Mandatory training included management of hazardous substances, safeguarding, infection control, mental capacity, food hygiene, moving and handling and fire safety. Some staff had completed additional training in areas such as health and safety, medicines, catheterisation, tracheostomy care and gastrostomy care, epilepsy, Midazolam administration and wound care. On the provider's website it states, 'The Granary is a purpose built unit providing a safe, comfortable, homely environment for people with long-term neurological conditions such as Multiple Sclerosis, Motor Neurone Disease, Huntington's Disease, Acquired Brain Injury and Cerebral Palsy'. We asked the academy lead and registered manager whether training was organised specifically in relation to acquired brain injury or in relation to people's assessed needs prior to them moving into The Granary. They confirmed this did not happen and, although staff were supporting people with a range of neurological conditions, bespoke training was not organised by the provider to ensure that staff had a good understanding of specific conditions. The academy lead talked about the mandatory training and said, "Next year, I'm adding dementia and learning disability. Reflective practice is used to help staff understand how people's needs are managed. I would be expecting the manager to use supervision to find out where the challenges are".

The provider's staff supervision policy states that staff should receive supervision three times a year and an annual appraisal. The policy recorded, 'Supervision is not carried out in groups, it is individual to each staff member and recorded in compliance with Sussex Health Care policy in each home'. According to the supervision and appraisal planner, not all staff had received supervisions at this level of regularity. The registered manager agreed there were some gaps and did produce some supervision notes for staff which had not been filed. Nevertheless, not all staff who had been employed in 2017 had received three supervisions in the year to date.

The above evidence demonstrates that the provider had failed to ensure staff received training to enable them to fully understand or meet the needs of people they cared for and supported. When people moved into the home, specific training needs relating to people's health conditions were not identified and organised for staff. Staff did not always receive supervisions in line with the provider's policy. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff completed an induction programme that including training in first aid, moving and handling, care planning, food hygiene, foods and fluids, safe nutrition, personal care, safeguarding and mental capacity. Where staff had no previous experience of working in care they were required to complete the Care Certificate, a nationally recognised, vocational qualification. New staff were also required to complete literacy and numeracy tests devised by the provider to demonstrate their competencies in these areas. Staff were encouraged to study for additional qualifications. Nursing staff confirmed they had received clinical training in a range of areas including nutrition, pressure ulcer care and wound management and supported each other to ensure people received suitable support. Where agency staff were deployed to ensure safe staffing levels, these staff worked alongside permanent staff to ensure their knowledge and skills were monitored closely. During the inspection we observed a member of agency staff working alongside a member of permanent staff.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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).

Some people living at The Granary did have capacity to make their own decisions. However, in one instance, whilst the person did have capacity to make decisions relating to their care and support, their wife had signed a consent form in relation to this person receiving personal care. In another case, where a person had been assessed as lacking capacity to consent to a 'flu jab, their 'next of kin' had signed their agreement. However, there was no evidence to show that the next of kin had appropriate legal status to make this decision and no information to show that this was a decision made in the person's best interests. We discussed this issue and another instance where the person's next of kin had given their consent, with the registered manager. He had thought the next of kin in both cases also had lasting power of attorney to make decisions on behalf of people, when this was not so. We discussed the need for obtaining copies of legal documents to show where relatives or other representatives did have legal power of attorney, rather than this being assumed when consent was obtained from people's next of kin.

It was not always clear how people's consent had been gained in particular situations and evidence was lacking to show how decisions had been made in people's best interests. For example, one person had their medicines administered covertly and this had been authorised by the GP. Nursing staff would offer the person their medicines and lie to them about what the medicine was, knowing that the person would take them if they thought the medicines were vitamin supplements. The National Institute for Clinical Excellence (NICE) Guidelines state, 'The covert administration of medicines should only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005. However, once a decision has been made to covertly administer a particular medicine (following an assessment of the capacity of the resident to make a decision regarding their medicines and a best interests meeting), it is also important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed (as capacity can fluctuate over time). Medicines should not be administered covertly until after a best interests meeting has been held'. In this instance, the Guidance was not followed since the person's medicines were administered solely on the advice of the GP and the best interests' decision-making process had not been followed.

Staff had not always completed records to show how restraint might be necessary, for example, in the use of bed rails or lap belts on wheelchairs, and gained consent from people or made a best interests decision. In one care record, a risk assessment was in place for the use of bed rails, but no best interests' decision was documented, even though this person had been assessed as lacking capacity. Another assessment form had been completed in relation to the use of various types of restraint, such as lap belt, foot straps and neck support, but did not include that bed rails were in place and bed rails are also a potential form of restraint. In this person's care plan relating to being moved from their bed to a chair or shower trolley, we read that a lap belt should be secured by staff when the person was in their chair and that side rails were to be used in the shower trolley, both of which are forms of restraint, but which had not been separately assessed in terms of the decision-making process under the requirements of the MCA legislation.

The above evidence demonstrates that the provider had failed to provide care and treatment to people with the consent of the relevant person. This is a breach of Regulation 11 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Staff demonstrated they had a good understanding of the MCA and DoLS and confirmed they had completed training on this. One staff member said, "The MCA is being able to make decisions for self, which is a right. Some here can, others can't. Some people have capacity to make decisions about all aspects of their care, but not others, for example, with their health, but not on finances. On DoLS, I'm taking away someone's freedom. A form of restraint might be not allowing someone out. One person will say they want to go out or home, but it's not safe. We walk around with her, giving her freedom, but keeping her safe. She doesn't have capacity to make a decision". Another staff member talked about MCA being a continuous assessment and key to quality care. They said, "Our service users are free to go outside when they want. The lock on the door is more for security, not to keep people in". People we spoke with confirmed they were asked for their consent to care and treatment. One person said, "I didn't sign a consent form, but staff do ask me before they wash me".

We asked people and their relatives about the food provided at The Granary and whether they were given choices of what they would like to eat and involved in the planning of menus. Some people were unable to eat orally and received sustenance via PEG. People had mixed comments about the catering arrangements and choices. One person told us they did not have a choice of what they wanted to eat and said, "No they just give it to me". Another person said they had a choice of two options from the menu. We asked people whether they had access to food and drink outside mealtimes and whether drinks were offered regularly. One person said, "Yes, I think so". Another person told us, "I can press the buzzer and can get a cup of tea or coffee". We observed that people were not routinely offered snacks outside of the organised meal times. We looked in the cupboards and refrigerator of the kitchen area in Walnut Lodge. There were some open sandwiches in the refrigerator and other foods left over from meals. In the cupboards we found some packets of cereals and a container labelled 'Service users only' which held approximately six broken biscuits. A shelf labelled 'wet snacks' was empty and another shelf labelled 'dry snacks' had one packet of crisps upon it. Fresh fruit or snacks were not readily available to people, although the registered manager told us that people could ask staff if they wanted something to eat. Fresh fruit was not routinely provided and a relative said, "No, I bring fruit in". On the second day of our inspection, we saw that fresh fruit was made available for people, but this was not the case on our first day of inspection. Menus were planned over four weekly cycles and records confirmed this. Menus were not available to people in an accessible format and the menu choices of the day were written by staff on to a whiteboard in the dining room. On the second day of our inspection, the menu choice was written up as 'crusted salmon', but turned out to be sausages when people were given their meals.

We observed people having their meals on the first day of our inspection. People were wheeled into the dining room by staff and sat around a central table. The lunchtime meal was delivered in a thermal bag from one of the provider's other locations, there being no operational kitchen on site at The Granary. Staff washed their hands and put on plastic aprons before serving the food. Meals within the thermal bag had already been plated-up.

Tables were not laid up in an inviting way. There were no serviettes or table cloths and drinks were not readily available, although staff did ask people what they would like to drink. A member of the nursing staff came around with people's lunchtime medicines and one person who was waiting for their lunch asked the nurse where their medicine was. The nurse said it was in the trolley. Another nurse asked the person if they had enjoyed their lunch. The person did not respond as they were still waiting for their meal to be served. Dessert consisted of what looked like pie and custard. It was not in the thermal bag but wheeled into the dining area on an unheated trolley. The food did not look particularly appetising.

Although this did not impact upon people's nutrition and hydration needs being met, people's experiences during meal times were not always positive. This is an area that needs improvement.

We looked at records to see how people were protected from poor nutrition and supported with their eating and drinking. There was clear guidance within people's support plans about how staff should support them at mealtimes, along with any associated risks. Several people had been identified as being at risk of choking and there was clear guidance for staff to follow about how to keep them safe. Staff also told us how they kept people safe when supporting them to eat and drink.

In addition to receiving care and support from staff who were based at The Granary, people received physiotherapy from a physiotherapist employed by the provider. The registered manager told us of the physiotherapy people received which had been funded for. The physiotherapist we spoke with was skilled and educated in current research about acquired brain injury. There were detailed therapy notes within people's care plans. People also had access to a gym facility based at one of the provider's other locations and we saw people being supported by staff and taken over to the gym or a day centre facility at another location. The registered manager told us that the physiotherapist recorded all interventions, for example, hydrotherapy that people received and records confirmed this. The registered manager added, "We're going to start handing this over, so other staff can do physio". People also received input from a speech and language therapist on site and received healthcare support from their GP, dentist, chiropodist and optician. Other specialists were involved as needed, for example, psychiatrists and neurological consultants. There was evidence that the home worked with external health and social care agencies to ensure people received the care, treatment and support they needed. People confirmed they received, and had access to, healthcare services and advice. One person said, "They would refer to the GP if I was feeling unwell".

On the provider's website it states, 'The Granary has its own kitchen and dining area plus an IT/games room where service users can access the facilities'. At the time of our inspection, the IT room was not used by people and appeared to be utilised as an office area for staff to access a photocopier. We asked people about technology available to them that was not related to their specific neurological condition. One person told us they used to have a computer at home, but did not have access to a computer at The Granary. Other people did have their own laptops in their bedrooms, but there was no communal facility available to them as indicated on the provider's website. All rooms at the home were spacious and of single-occupancy with en-suite wet room facilities. Each unit comprising a suite of rooms had its own lounge, dining room and nurses' station. In addition there were two 'flatlets' comprising a bathroom, kitchen and sitting room. These were unoccupied at the time of our inspection, but were intended for people to rehabilitate and develop their independence. Whilst the premises were 'disability friendly' having overhead tracking and hoisting and ample space for wheelchair users and equipment, they have not been specifically adapted to meet people's assessed needs. For example, everyone living at The Granary was a wheelchair user and many people could navigate their way around the home independently. However, doors to people's bedrooms and access to outdoor areas were equipped with door handles, which were quite stiff to operate. Metal pads which could be depressed easily to open doors would make it easier for people to come and go more easily. People had access to grounds surrounding the home, but could only access these if staff accompanied them. We asked people if they went outside for recreational activities. One person said, "I go to the pond. Staff took me to see the fish, but you can't see any fish". Relatives were welcomed by staff when they visited their family members and there were no restrictions.

Requires Improvement

Is the service caring?

Our findings

Although we observed examples where people were treated with dignity and respect, we did, however, observe occasions when this was not the case. For example, when a staff member called across the room to another member of staff, in front of people and relatives, "Before you put the kettle on, [named person] needs the toilet". This was communicated in such an insensitive and open way and the staff member could have been more discreet in protecting the person's privacy and dignity.

Our observations of people's experiences when eating and drinking did not demonstrate dignity and respect. As a result some people did not have a positive dining experience that took their needs into consideration. We observed one person had their lunch served to them with no cutlery provided, so they started eating the food with their hands. They were then offered cutlery and asked if they would like the food cut up, to which the person replied they would. The food did not appear to be too hot and was safe for the person to handle. We observed this person had not been positioned close enough to the table, so they were slouched over and the food kept falling off their fork and onto their clothes protector and table. This person might have benefited from a plate guard as some of their lunch ended up on the table. A member of care staff did get them a spoon and knife and asked the person if they would like the food back on their plate (from the table) or asked if it should it be disposed of. The person agreed the food could be thrown away. Another person had a sandwich and a member of staff said, "I have to take it back because it's white bread". They then said that there was no brown bread available until the next day, so they would try and get some from another of the provider's homes on site. The person responded, "They don't have a freezer". The person who was waiting for their sandwich was offered tea or a cold drink and staff said they would, "Try the kitchen again" to find out what was happening. Eventually, the brown bread arrived, over half an hour after everyone else had received their meals. We saw one person used their dirty knife to stir their hot drink which resulted in bits of food floating in their drink. Staff did not notice this happening.

The above evidence demonstrates that the provider had failed to ensure people were always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these observations, people living at The Granary described how they felt respected by staff. Referring to staff, one person said, "Quite good and they treat you kindly". Another person told us, "They are kind and caring and their general attitude is nice. They made me a birthday cake out of cardboard. Staff hid behind it and jumped out!" Remembrance Sunday was of particular significance to one person and their relative said, "Staff bought him poppies and took him to the Remembrance Day service in Horsham and a parade". However one person told us that, "Some staff are more caring than others".

We talked with the registered manager about people's diverse needs and he gave us examples that demonstrated the difficulties some people faced in coming to terms with life-changing conditions. The registered manager explained the importance of being patient with people and how staff managed when people were discourteous or rude. One person was not keen to access the hydrotherapy pool, but with the support and encouragement of staff, had now agreed to use the pool. Care plans included information

about people's emotional state and guidance for staff on how to support people when they became upset or experienced a low mood. However, in relation to one person who experienced bouts of depression, staff were instructed to support them to 'think positively'; it was not clear what this meant and how this would aid the person to cope with their depression. Nevertheless, when staff interacted with people, they showed consideration for them, addressed them by their preferred names and were patient and kind. The registered manager told us about supporting one person and said, "We've offered him counselling and he has engaged with that, which is good".

We looked at whether people's communication needs were taken account of and how staff sought accessible ways to communicate with people in relation to decision-making. One person had a specialist item of equipment that enabled them to communicate with staff through eye gaze. This equipment also enabled the person to send and receive emails and to write. Although this person had a severe disability, communication from staff was kind, patient, caring and personal and, from what we saw, the person appreciated this. We chatted with this person via their communication aid and they said in jest, "Are you the reason people are being nice to me today?" Throughout the inspection, we observed positive and caring interactions between people and staff. Staff knew people well, including their likes and dislikes. For example, one person enjoyed wearing jewellery and cared about her appearance. We saw their nails had been painted, they had their handbag with them and were wearing their chosen jewellery. This was documented in their care plan and staff had followed this guidance. However, in relation to people's lives before they entered the home, information was, in some cases, scant or non-existent. We discussed this with the registered manager who told us this was work in progress and they had contacted people's relatives to find out about people's past histories.

As much as they were able, people were supported to express their views and to be involved in making decisions about their care. One person said, "They speak to my wife more". When we asked if staff spoke to them personally, they said, "Yes-ish". The registered manager told us that some people had access to an advocate to support them in making decisions and said, "I want to do the best I can for all the people here". However, people we spoke with did not uniformly have access to an advocate. Many people opted to involve their relatives in any decision-making and some relatives had Lasting Power of Attorney to make decisions in relation to finances, health and welfare. We asked two relatives how they were coping and they told us, "We just have each other. We don't have any other support".

In relation to respect, one person said, "Staff knock on the door before they come in". We observed that some doors were left open when people were cared for in bed. We asked the registered manager whether this was people's choice or whether it was because staff found it more convenient to check on people's wellbeing as they walked past. The registered manager told us that people were asked if they minded having their doors left open or not. We asked people if they were supported by staff with their independence. One person said, "I'm not really. I want to walk, although I can move myself around with my wheelchair". People told us that relatives and friends were able to visit at any time they liked and were made to feel welcome by staff at The Granary.

Care plans included information for staff about people's personal and intimate care needs and the need for privacy.

Requires Improvement

Is the service responsive?

Our findings

Staff did not have a good understanding of how to support people in a person-centred way in relation to ensuring they were protected from discrimination. We asked the registered manager how people's diverse needs, including different backgrounds and cultures, were addressed. He told us that people's specific cultural needs would be catered for, but could not think of anyone who met this criterion currently. He said, "I've been with the company about a year. People's needs are assessed before they are admitted. For example, a person might follow the Islamic faith, so food would need to be prepared accordingly". We asked a member of staff about their understanding of equality and diversity and whether anyone living at The Granary had specific needs. They said, "None as far as I'm aware. Everyone is individual. There are no cultural or sexual needs. We need to be open-minded as individuals, for example, one person swears in a humorous way. [Named person] enjoys socialising, but not with other service users, with staff, and he has a unique sense of humour". They went on to tell us about differences between people with regard to their age and language. Another staff member told us, "We have to take care of people physically, emotionally and socially. I relate to some people more than others, which is normal life, but I don't discriminate against any. We laugh, joke, make decisions together. We share in the boundaries of good taste and being professional in our relationships". We asked how people's spiritual needs were met and looked at the information held within people's care records. In one care record we read that staff should respect the person's spiritual needs, but it was not clear what these were or how staff should support them. Staff understanding in relation to the recognition of people's diverse needs or protected characteristics, and how to support these, was lacking.

We asked the registered manager how people's needs were met in relation to expressing their sexuality and he gave us an example of how one person chose to wear a particular colour and that their standing frame was also this colour. We discussed people's sexual preferences and their right to be involved in relationships of importance to them. The training lead at the provider's academy said, "It's about people's human rights from the beginning. It's about the service user, not about brain injury. It's important that staff talk about any issues". Within people's care records, there was a separate plan relating to 'expressing sexuality'. However, the plans we looked at did not relate to this topic specifically. For example, we read that one person was unable to express their sexuality due to their impairments. In another care record, the section entitled 'expressing sexuality' related to the person being clean and respectable at all times and of the need for staff to knock on their door and to close the curtains. There was information about how the person might be sexually inappropriate, but no guidance for staff on how to manage should such a situation occur. In a further care record we read that if the person was in a communal area, staff should distract them or assist them to their room, but it was not clear why staff should follow this course of action. This demonstrated a lack of understanding by staff and the registered manager about people's needs and views in relation to sexuality.

Activities were not organised in a person-centred way. Weekly schedules had been completed for each person living at The Granary and these included interventions by care staff. The weekly schedules also recorded people's access to activities, but according to the schedules we looked at, these were limited. For example, we read for one person that they had access to 1:1 and an activity for one hour per week. Other

people's weekly schedules were similar. We were told that there were no planned activities at weekends since many people had relatives or friends who visited. An activities co-ordinator planned activities for people during the week, but these did not necessarily take account of people's interests or hobbies. One person told us, "I used to like playing golf and I played pool, I was quite good at that. I'd go to the £1 shops and bowling before I came here, but I don't do any of that now".

On the first day of our inspection, the activities co-ordinator had organised mince pie taste testing and pies were judged on their look, smell, texture, pastry, filling and taste. Three people and two relatives took part in the tasting, however, it was not an inclusive activity, since people who were 'nil by mouth' were unable to participate. We were also told that a residents' meeting was due to take place that afternoon, but this did not happen. People who were not involved in the mince pie tasting were left to watch television in the lounge area. We observed one person required suctioning and the noise of the machine interrupted the viewing for people who chose to watch television.

The registered manager told us that activities usually started at around 10am each morning. However, on the first day of our inspection, we observed that the activities co-ordinator was asked to sit with one person whilst other care staff worked elsewhere. On the second day of our inspection, the registered manager told us that this practice had stopped and that the activities co-ordinator would be solely concerned with organising activities and not with care duties. A variety of activities were available to people, however, there was no evidence to show how these activities reflected people's preferences. We discussed this with the registered manager and how people living at the home, the majority of whom were male, might be interested in watching sports, playing snooker, pool or darts and have access to a bar area. Following this, the registered manager had bought a magnetic darts board and a karaoke machine, however, it was not clear how people's preferences had been identified or interpreted in relation to organising meaningful activities that people wanted.

We asked whether external entertainers visited the home and the activities co-ordinator said, "Not at the moment. People can go to other homes on site and they let us gate-crash. When we get busy we will do more".

Activities were sometimes limited within the confines of the home or to the immediate vicinity, at facilities based at the provider's other homes on the same campus. We were told that people could go out in a minibus, but access to this facility did not appear to happen on a regular basis. A staff member told us, "We don't have a specific driver, so we have to fit in with other homes". People had access to grounds surrounding the home, supported by staff. However, there was little to engage them with other than access to nearby grassed areas and a patio furnished with wooden picnic tables and chairs. Opportunities were limited in relation to people participating in activities in the wider community and away from campus.

The above evidence demonstrates that the provider had failed to ensure that people received care or treatment that was personalised specifically for them. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us of a particular event that had been organised recently, a horseshoe making competition, because one person loved horses. A farrier had come in to the home to help organise the activity. Referring to the organisation of activities, the registered manager said, "I think moving forward we will touch on activities. We do look at the individual needs of service users. The social side is probably key, engaging with people outside like therapy dogs. It's breaking down barriers. There are opportunities on site and outside". The activities co-ordinator told us, "We have a very diverse group, so it can be difficult to organise activities".

Care records did not always reflect how people received personalised care. We observed that people living at the home were supported with all aspects of daily living, but it was not clear from the care plans whether people were being supported to develop their daily living skills and to become as independent as possible. For example, care plans did not include any specific recovery or rehabilitation plans, such as people being involved with food preparation, laundry and tidying and cleaning their bedrooms. However, people who had difficulty with communication and/or co-ordination were supported and encouraged to be as independent as possible. Where people required full assistance, they were given 1:1 support from staff. Staff were very caring and took account of people's various disabilities, however, staff did not have an in-depth knowledge of acquired brain injury, as this was not considered to be mandatory training by the provider. We asked the academy training lead about this and they told us, "I'm looking at training at provider level. The registered manager comes back to me with verbal feedback about training and what staff think". They added that handover meetings for staff between shifts could be used as 'mini training sessions'.

We asked people whether they were involved in reviewing their care plans. People we spoke with and relatives confirmed they were involved with care plans. A staff member told us that an advocate had visited one person recently and went through their care plan with them. People's likes and dislikes had been recorded and staff signed people's care plans to confirm these had been read. Before people were admitted to The Granary, a pre-assessment was completed which included people's personal and medical histories, health conditions, capacity assessment, medicines and details of next of kin. We looked at care plans and these were detailed in relation to people's care needs such as sleeping, management of seizures, communication and moving and handling. Whilst people who lived at the home understood and conversed in English, some people's cognitive impairments were such that their speech might not always be relevant to the situation, so that sentences they spoke could be confused. Staff demonstrated a good understanding of people's needs and could interpret people's comments in a way that ensured the care and support provided was responsive to their wants and needs. In one person's communication care plan we read that staff should communicate with the person in, 'the best possible way' and that the person's long-term aim was for interventions that were in their best interests with regard to communication. This care plan lacked detail and guidance for staff on how best to communicate with the person or guidance on future communication needs. Care plans did not always provide sufficient, detailed information about people or guidance to staff in relation to exactly how they should support people's needs. This is an area that needs improvement. From August 2016, all organisations that provide NHS or adult social care are legally required to follow the Accessible Information Standard. The Standard aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Care plans we looked at were not completed in a way that was accessible or focused on people's individual characteristics, sensory or health needs.

Staff completed daily records to show how people's care and support needs had been met from day to day. Interactions were 'coded' by staff, for example, '4' related to mobility, so staff would record the number which related to an area of care, then write about any interventions that had been completed or observations for the day in question. Where people's needs changes, staff were quick to make appropriate referrals to external health resources such as the GP to ensure people's health needs were addressed.

We asked people if they knew how to raise a concern or make a complaint. One person said, "I would tell my wife or keyworker". Another person told us, "I would talk to the manager". We looked at the provider's complaints policy which stated that people's verbal complaints would be responded to immediately and written complaints would be acknowledged within two days and responded to within 28 days. We looked at the complaints log which showed that the complaints had been dealt with satisfactorily overall.

Some people had recorded their wishes and preferences for their end of life care. Where the decision had been taken not to resuscitate a person if they suffered a cardiac arrest, the appropriate Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms had been completed. The original of this form was kept at the front of each person's care record for easy access by staff if needed. The training lead at the academy told us about specialised training that was organised for nursing staff in relation to caring for people as they reached the end of their lives. For example, some staff had accessed a local hospital and completed training, 'Responding to the deteriorating patient'. Other specialised training had been sourced from London teaching hospitals to enable nursing staff to meet the diverse needs of people living at The Granary. The training lead at the academy also explained that staff wellbeing and welfare was important and said, "We have a trainer who does stress management and mindfulness for staff which equips staff to think about the anxieties people may be feeling. Reflective practice is used to help staff understand how people's needs are managed".

Requires Improvement

Is the service well-led?

Our findings

An internal audit had recently been completed by the provider's clinical auditor and the registered manager discussed the initial findings of this. According to the audit, care records were considered to be generally good and staff were reminded about recording isolated incidents and the coding to use. This did not reflect what we found at inspection. The audit also stated that more detail was needed when recording people's falls. Our findings confirmed that there was no analysis of falls. For example, we looked at a falls record for one person who had sustained falls in May, July and November 2017 in the presence of staff, but these had not been evaluated for any themes or trends to reduce the future risk of falls. The hydrotherapy pools were checked when in use, but regular checks were not completed, which was a recommendation from the clinical auditor. Medicines were managed safely according to the clinical auditor's findings. Staff we spoke with reported that mattresses and bed rails were checked and cleaned every day, but were unable to show us records to confirm this. Overall risks were managed safely but there were gaps in some records, Care records did not always reflect people's care and support needs. For example, how people's independence could be promoted.

We looked at internal audits that were completed on a monthly basis by one of the provider's area managers. Colour codes were used – green indicated full compliance, yellow meant minor aspects needed to be solved, amber indicated some aspects relating to documentation/services provided needed to be improved and red denoted there were major issues in the provision of care services that needed to be addressed. Audits were basic in terms of the number of records checked and how colour codes were allocated. For example, the area manager checked a Medication Administration Record (MAR) and personal emergency evacuation plan for one person, spoke with this person and reviewed their care plan. On this basis, 'yellow' was judged to be the appropriate rating. However, since only one person's records had been scrutinised and evaluated, the award of a yellow rating was erroneous and did not assess the full picture of risk at this service. Observations were made around the home which was observed to be, 'clean and tidy'. Activities were also observed by the area manager, including future plans for outings. An area identified for improvement in the audit completed in September 2017 was the lack of a pictorial menu to aid understanding for people when they chose their meals. At the time of inspection, this action had not been addressed even though the action plan stated this should be completed within four weeks. The area manager also identified that accidents and incidents needed to be analysed and updated for August and September 2017; these had been updated in October 2017, but not since that time. A 'management of medicines checklist' had been completed for January, March, May and July 2017, but none since. Audits were not structured to ensure that any areas for improvement or actions needed were addressed in a timely fashion. For example, a review of the previous month(s) audit would ensure that any outstanding actions were revisited and progress recorded in terms of whether appropriate steps had been taken to rectify any shortfalls. The auditing systems in place had not identified the issues we found at inspection in relation to staff training and supervisions and that people's consent was gained lawfully. We drew this to the registered manager's attention as, in our view, audits were not sufficiently rigorous to ensure areas for improvement were identified and follow-up actions were taken when needed.

We talked with the registered manager about a system for identifying whether people should be

resuscitated or not in the event of a cardiac arrest and how they could be identified in a discreet way through a colour code. The colour code was on people's care records, but not on people's bedroom doors as recommended by the provider's head of quality and therapies in a communication dated 21 November 2017. The registered manager appeared unaware of the contents of this communication so had not been able to implement the recommendations cited.

Monitoring records were not always completed fully and there were gaps in the information recorded for some people. For example, the completion of food and fluid charts to show people's input and output was not always consistent. For one person on a particular day, the record showed they had received 300ml of fluid and a recorded output of 450ml, nothing else. The total amount of fluid people should receive to maintain good health was not always recorded. Where fluids had been consumed by people throughout the day, the amounts were not always totalled, making it difficult to see at a glance people's total input and output of fluids. Another assessment was incorrectly completed. This recorded the person was fully mobile and had no neurological defects. We observed the person did require a wheelchair to enable them to be fully mobile and had a health condition that affected them neurologically.

The above evidence demonstrates that the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not maintained complete and contemporaneous records in respect of each service user, including a record of their care and treatment. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the issues in relation to monitoring records and assessments with the registered manager and on the second day of inspection, where needed, improvements in the recording of food and fluid charts had been made.

A risk assessment for Legionella control had been completed by an external contractor in June 2017 and the risks identified had all been completed as needed.

According to the provider's website, 'Our aim is to provide a care home that offers nursing support and stimulation to help service users maximise their potential physical, intellectual, emotional and social capacity within an individualised person-centred plan of care. All service users have the right to live as normal a life as possible and to have the respect of those who support them. Sussex Health Care's philosophy is focused very much on a person-centred holistic approach to care, recognising the unique strengths and skills of each individual'. We asked the registered manager about the culture of the service and he said, "I work for Sussex Health Care and I also feel I work for the Commission. I went through each of the Key Lines of Enquiry (KLOEs) and I feel we're doing really well". We talked about the new KLOEs which came into effect on 1 November 2017 and how these were being met. The registered manager told us he had plans to discuss the KLOEs at the next staff meeting, so staff would have an understanding of these.

We also asked the registered manager how staff worked collaboratively and how they were supported and valued. The registered manager told us about staff who worked at the home and who did not have English as their first language. He explained that staff from other countries might have different characteristics, for example, in the way they talked with people. We looked at the provider's Duty of Candour policy and the registered manager demonstrated their understanding of this and the need for open and honest communication and meeting with people and/or their relatives if an incident occurred. In the Provider Information Return (PIR) which the registered manager had submitted in November 2017, it stated, 'I always address with staff the importance of duty of candour and I will routinely give examples of what I expect in this area. I believe the culture that I and my team are creating is that of a very caring environment where

many staff have gone above and beyond what would routinely be expected of them'. We discussed an issue that had been raised in relation to one person who lived at the home. The registered manager explained the action they had taken to address the concerns. He had met with the person and their relatives to discuss the actions that had been taken and arranged regular meetings with the person to respond to any anxieties they might have. We looked at the provider's whistleblowing policy which stated that staff could report any concerns to the registered manager, the nominated individual of the provider or the Commission.

People were asked for their views about the home through service user meetings and we looked at the record for 7 November where activities, trips out and people's wellbeing were discussed. A meeting scheduled for 4 December did not take place and we were not told when this would be rescheduled. We asked people for their views about the management of the home. Referring to the registered manager, one person said, "He's got his hands tied. I don't think things are up to him because he promised the world and can't deliver". Another person told us, "He's a nice bloke and I think he's very good. I know him by name". People spoke positively about the staff who cared for them. People and relatives were asked for their feedback about the service. The majority of responses were positive, apart from one. This related to the lack of outings into the community. The registered manager told us that people were given the opportunity to go out and provided some examples. We looked at compliments that had been received. One of these stated, 'Just wanted to say thank you for looking after [named person] so well during his stay with you. He thoroughly enjoyed himself and I have to say he looks well and really relaxed'.

Notifications, that the provider was required to send to us by law, had been completed and sent to the Commission as needed. Managers from the providers other locations met on a regular basis, to exchange ideas and to identify areas that were in need of improvement. Information was shared across the organisation between members of the senior management team, area managers and registered managers. Minutes of managers' meetings were kept and we looked at minutes relating to March, July, August and September 2017. Information relating to people's care was kept in a confidential way and locked in a room behind the nurses' station.

Staff we spoke with felt supported by the registered manager, were clear about their roles and duties and were positive in their comments about him and the management of the home. One staff member said, "[Named manager] is a very supportive boss. The nurses are too when you ask for help. I have 1:1 with the manager. Because we're a new unit things are still being established, it's an evolving system. Most staff here are good and help each other". Another staff member told us, "The service users are so different. [Named manager] is a fantastic manager and I've worked with lots. He comes and says 'hi' every morning and comes by again at the end of every shift. He is great with the service users and has time for everybody". Staff meetings were held every four to five weeks and records confirmed this. At the last staff meeting held in December 2017, items discussed included: CQC inspection, staffing, key lines of enquiry, mandatory training, annual leave, audit, service users and families and the Christmas party. The academy lead told us that staff meetings could also be used as group supervisions if needed, although this was contrary to the provider's supervision policy. In the PIR, the registered manager wrote, 'I have ensured that we have had regular staff meetings where we talk about the values of the Care Quality Commission. Within the staff meetings staff have an opportunity to share experiences, raise any concerns and development needs of the service'. We asked the registered manager about his role in managing the home. He said, "It's the opportunity to grow a team, to get involved in the care. It's important I look at what is happening on the shop floor and I teach others. Working with family is equally very important. Ideally to get out there and showcase what we're doing. If you get the support and 'buy-in' from the parents and engagement from service users, you will hopefully get it right. It's about being positive and my professional development too. It starts with recruitment of the right staff, that's key, growing others".

We asked the registered manager how they worked in partnership with other agencies. They told us they had attended professional days throughout the year to update their knowledge on acquired brain injury. These days had been arranged by an organisation that had expert knowledge and experience of neurological conditions. In the PIR the registered manager stated, 'I have had the opportunity to attend three conferences this year associated with acquired brain injury to hear the latest in advances with assistive technology, communication and outcomes'. The registered manager told us that he shared his learning with the care staff at the home. The registered manager also worked closely with healthcare professionals, including specialists, to enable people to receive appropriate treatment in relation to their specific health needs and support their continuity of care.