Ferringham House Limited

Ferringham House Limited Residential Care Home

Inspection report

58 Ferringham Lane
Ferring
Worthing
West Sussex
BN12 5LU

Tel: 01903242334
Website: www.ferringhamhouse.co.uk

Date of inspection visit:
02 August 2016

Date of publication:
26 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 August 2016 and was unannounced.

Ferringham House Limited Residential Care Home is registered to provide accommodation and care for up to 14 people with a range of health needs. At the time of our inspection, nine people were living at the home. Ferringham House Limited Residential Care Home is situated in a residential estate on the edge of Ferring village. All rooms are currently used as single occupancy and all have en-suite facilities. There is a large, open-plan sitting/dining room and people have access to gardens at the home.

There was no registered manager in post. The last registered manager had de-registered with the Commission in March 2015. Since that time, a number of managers had been in post and subsequently left before they could register with the Commission. The current manager was in the process of registering with the Commission, but, at the time of our inspection, a registered manager had not been in post for a period exceeding 400 days. The provider was in breach of their registration conditions as a result. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection took place on 10 December 2015. As a result of this inspection, we issued two Warning Notices in February 2016. We asked the provider to take action to address areas of concern relating to safe care and treatment and good governance. The provider was required to take appropriate action to meet the Warning Notice in relation to safe care and treatment by 4 March 2016 and in relation to good governance by 1 April 2016. In addition, we found the provider in breach of a regulation relating to staffing and asked them to submit an action plan on how they would address this breach. An action plan was submitted by the provider which identified the steps that would be taken. At this inspection, we found that the provider and manager had taken appropriate action to meet the Warning Notices and were now meeting the required standards. However, we identified that further time and action was necessary to ensure the improvements continued and were embedded consistently into staff practice.

Generally, risks to people were managed to protect them from harm. However, risk assessments for two people had not identified or assessed all areas of potential risks to keep them safe. The manager was reviewing people's risk assessments and was in the process of updating these, as well as the care plans. Medicines were managed safely overall and staff had completed the necessary training; their competency to administer medicines had been checked. The manager had implemented a new system to ensure that new staff were recruited safely and all necessary checks had been made with regard to their suitability to work in care. There were sufficient numbers of staff on duty. People felt safe living at the home. One member of staff did not understand their responsibilities in relation to safeguarding and not all staff had completed training in safeguarding adults at risk.

Since the new manager came into post, a supervision planner and schedule had been introduced to record staff had supervision meetings at least four times a year. Staff had access to e-learning and had completed training in a number of areas, although not all staff training was up to date. Staff meetings had taken place in 2016 and staff spoke positively about the changes which the new manager had implemented. Capacity assessments had been completed for people in line with the requirements of the Mental Capacity Act 2005. No-one living at the home was subject to Deprivation of Liberty Safeguards and people were free to come and go. People were supported to have sufficient to eat and drink. Comments on the standard of the catering were variable, but people had a choice from options on the menu. People's risk of malnourishment was assessed and actions taken if people lost or increased weight over time. People were supported to maintain good health and had access to a range of healthcare professionals and services.

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

The manager was in the process of reorganising the information contained in people's care plans and this was work in progress. Some care plans were not up to date and not all staff had read the care plans. A range of activities was on offer to people throughout the day and in line with their preferences and choices. An outing into the community had taken place recently with a visit to Shoreham Airport and people had enjoyed a BBQ to celebrate the Queen's Birthday. People and their relatives knew how to make a complaint although no formal complaints had been recorded in the last year. The complaints policy needed updating to provide information about when complaints would be acknowledged, investigated and completed.

Significant improvements had been implemented by the manager since our last inspection and a range of audit systems was in place. However, these were not always sufficient to measure, monitor and drive improvement for all aspects of the service. The Commission needs to be confident that the improvements made to date will be sustained over time. There was a lack of audits in relation to care plans, risk assessments and staff training. People, their relatives and staff were asked for their views about the home and generally these were positive. Staff spoke positively about the manager and of the improvements she had implemented since coming into post.

At the last comprehensive inspection, this provider was placed into special measures by CQC. This inspection found that there was enough improvement to take the provider out of special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Some people's risks had not been fully identified or assessed. Although people felt safe living at the home, some staff had not completed up to date training in safeguarding adults and risk.

Medicines were managed safely.

There were sufficient staff to meet people's needs and safe recruitment practices had been introduced.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff had not completed training in all essential areas. Staff did receive regular supervision meetings and staff meetings had been reinstated.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People had 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 looked after by kind, caring and friendly staff who knew them well. People were encouraged to be involved in all aspects of their care and they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The manager was in the process of reorganising the information in people's care plans and some information was incomplete or

not up to date. Not all staff had read people's care plans.

A range of activities had been organised by the manager which people enjoyed.

No formal complaints had been recorded within the last year. The provider's complaints policy lacked information about how quickly complaints would be responded to and investigated.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

There was no registered manager in post.

A range of audit systems that had been introduced did not cover all aspects of the quality of care delivered and service overall.

Improvements had been made to the quality and safety of the service, but the Commission needs to be confident that the improvements will be sustained over time to ensure the progress made to date is maintained.

People, their relatives and staff were asked for their views about the service and relatives' meetings took place. People spoke highly of the new manager and of the improvements that had been implemented.

Ferringham House Limited Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 2 August 2016 and was unannounced. Two inspectors undertook this inspection.

This inspection was carried out to check that improvements to meet legal requirements, identified in two previous warning notices, had been made. This inspection also checked to see whether a breach of legal requirements made as a result of the last inspection on 10 December 2015 had been met.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. The provider did complete a PIR, however, this was not available at the time of our inspection. We checked the information that we held about the service and the service provider. This included previous inspection reports and 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 examined the action plan that the provider had returned after the last inspection. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, four staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with three people living at the service and spoke with four relatives and a friend of one person. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the manager, three care assistants and the cook.

Requires Improvement

Is the service safe?

Our findings

At the inspection in December 2015, we found the provider was in breach of a Regulation associated with safe care and treatment. There were serious concerns that care and treatment was not provided in a safe way for people. As a result, we issued a Warning Notice in February 2016, which was to be met by 4 March 2016.

At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards. Generally, risks to people were managed to protect them from harm. Staff had completed or updated their training in moving and handling and certificates confirmed this. A physical restraint, in the form of a stair gate at the top of the stairs, observed at the previous inspection, had been removed. Risk assessments were in place, relating to trips or falls without the stair gate, for people who were accommodated on the first floor of the home. A system for analysing accidents and incidents had been set up by the manager. The temperature of the communal areas in the home was monitored and staff were reminded to ensure the thermostat was set to maintain a consistent and comfortable temperature throughout the home.

Concerns had been raised at our last inspection relating to skin integrity and wound management. People's risk of developing pressure areas was now assessed using Waterlow, a tool specifically designed for the purpose. One person, who was potentially at risk of injury or falling out of bed, chose not to have bed bumpers used and a best interest meeting had taken place with them and their relative. Instead, a long cushion was put in place down the length of their bed, to prevent any injury that might occur through moving around in bed. The person and their relative were happy with this arrangement and this ensured the risks to this person was managed along with respecting the person's choice.

The manager was in the process of completely revamping people's care plans, including their risk assessments. In the main, these new assessments showed that people's risks had been identified and managed to protect them from harm and provided advice and guidance to staff on mitigating risks. Risk assessments were completed for people in a number of areas including falls, moving and handling, skin integrity and infection. Whilst improvements to risk assessments had been made, additional work was required to some people's assessments to ensure they were protected from harm. For example, one person had limited mobility and walked with the aid of a walking frame or, at times, needed a wheelchair. There was no risk assessment in place in relation to their skin integrity. Lack of mobility can present a risk of pressure areas developing or skin breakdown and this person's risk needed to be assessed. Another person, who had been identified as being at high risk of falls, had their risks assessed for moving around the home. However, we observed they also enjoyed walking around the garden, so their risk should have been assessed in relation to moving safely around the garden, where pathways and uneven surfaces were a potential trip hazard. We recommend that all risk assessments are reviewed in relation to people's care, as well as environmental risks, to ensure people are safe from harm. Equipment was managed safely. A relative told is, "It's good they have a ramp and accessible wheelchairs. The equipment is always as it should be" [referring to their family member's walking frame]. "The staff are very good at making sure people have the right frames".

Since the previous inspection, improvements had been made in relation to medicines management. Medicines were managed safely, staff completed appropriate training and their competency to administer medicines was checked by the manager. People had been assessed on their capacity to administer their own medicines. A medicines assessment for one person stated, 'I would like the carers to administer the medication for me and please wait with me to ensure I take them, just in case I drop one'. A relative told us, "I've never had any issues about her medication". Since they came into post in February, the manager had worked hard to ensure people's medicines were managed safely and taken the necessary action. They had implemented a 'Medicines Communication Book' in which staff recorded when a person's medicine or particular dressing had been received or when stocks were running low. The book was a useful tool for communicating messages about medicines; however, there was no evidence to show that staff had read the various messages, as they had not signed the book to indicate this. Guidance for staff was now in place in relation to the administration of medicines 'as required' or PRN. The manager had completed a medicines audit and new photographs of people had been affixed to their Medication Administration Records (MAR), to ensure medicines were administered to the right person.

We observed a member of care staff administering people's medicines during the lunchtime period. The majority of medicines for people were kept in a monitored dosage system in blister packs. We saw four people had medicines at lunchtime. Where medicines were administered to people on the first floor, the staff member went to each person's room, ensured they took their medicine and then recorded this on their MAR. However, in the dining room, we observed the member of staff signed the MAR as they removed the medicine from the blister pack and before the person had actually taken the medicine. We observed that people took their medicine as prescribed, but it is not good practice to sign a MAR in advance, in case people do not actually take their medicine. The member of staff realised their error at the time and assured us this practice would not occur again in the future. We observed the staff member was reassuring and kind to people as they administered their prescribed medicines and waited patiently with them. All bottled medicines had the opening date recorded, so staff could easily see how long a medicine had been in use for. At our last inspection, some medicines, such as eye drops, were stored in a domestic refrigerator in the kitchen. At this inspection, a separate, lockable refrigerator had been purchased and medicines that required to be stored at a certain temperature, were kept appropriately. This ensured the effectiveness of the medicine as well as reducing the risk of cross-contamination with items stored in the domestic fridge.

At our last inspection, we found that safe recruitment practices were not in place and that there was no evidence that references had been obtained for one member of staff who had worked at the home for nearly a year at that time. Following the inspection, the provider obtained the references that were required. The manager had implemented a new system and checklist that ensured new staff had all the necessary checks undertaken to ensure they were safe to work in care. We looked at staff files which included two references and a Disclosure and Barring Service check, which recorded any criminal convictions or concerns. The manager told us they were in the process of recruiting new staff as some existing staff were working in excess of 48 hours per week.

People and their relatives felt that there were sufficient numbers of staff on duty to keep people safe and our observations confirmed this. A relative said, "I'm not concerned, they always have staff to help move aunt. It's very safe. Usually two staff are around to help". Two people told us there were always staff available to assist them when they needed help. On weekdays, there were two care staff on duty and the manager was also available to assist; sometimes the provider also visited the home. At weekends, there were two care staff on duty, plus the cook, and staff told us that either the manager or provider were 'on call' if needed. At night-time, two care staff were on duty. Ideally, the night staff were awake throughout the night. However, the manager said that if they needed to be on duty the next day, then they would sleep during the shift and only provide assistance if required. We checked the staffing rotas which showed that for night shifts in the

week commencing 25 July, there were one waking and one sleeping staff for four nights and both staff were awake for the other three nights. In the week commencing 1 August, both staff were on five 'waking nights' and the other two nights had one member of staff awake and the other asleep, as they had a shift early the next day. Any gaps to staffing levels were either filled by existing staff working additional hours or by agency staff. In addition to their caring responsibilities, staff were expected to undertake cleaning and housekeeping duties.

People told us they felt safe living at the home. We asked two relatives whether they felt the home was safe. One relative said, "Absolutely. I haven't had cause for concern of any of her care". Another relative told us, "I think he's safe. He used to fall before he moved here. Our minds are at rest. He's happy and he wasn't happy before. The staff are always aware of where he is". Not all staff were up to date in training in safeguarding adults at risk and records confirmed this. However, one member of staff had a good understanding of the different kinds of potential abuse and explained what action they would take if they suspected abuse was taking place. We asked another member of staff about safeguarding and what this meant for people's safety. They thought safeguarding was about, "When you try to assist clients in the proper way". When we asked about recognising abuse, they said, "Any risk of abuse, they [referring to people living at the home] tell me. I would report to my manager". We asked the staff member to think about an example of abuse and they told us, "Money and trying not to talk to them in a rude way". It was clear this member of staff did not have a good understanding about safeguarding and their training had not been updated since August 2014 which was with another provider. This was an area for further improvement.

We observed that the home was clean and tidy. We asked staff whether they felt they had sufficient time to undertake cleaning and caring tasks. One staff member said, "We are trying our best. Our residents can be demanding". Another member of staff felt that the recent installation of laminated flooring in some areas made cleaning, "Much easier". A third member of staff said, "You make time to do cleaning, you fit it in", adding, "It would be nice if we got a cleaner".

Requires Improvement

Is the service effective?

Our findings

At the inspection in December 2015, we found the provider was in breach of a Regulation associated with staffing. We asked the provider to take action because staff did not receive appropriate support, training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. Following the inspection, the manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

Since the manager came into post, staff had received regular supervision meetings and records confirmed this. One member of staff confirmed they had met with the manager three weeks ago and said, "She's happy with the way I work. We work as a team". Records showed that supervision meetings were planned to take place at least four times a year and the manager had put in place a staff supervision schedule and planner for 2016. Various items were discussed at supervision including shift working, staff training and additional qualifications. A member of staff said, "[Named manager] pushes training. She thinks it's important". Staff were encouraged to pursue additional qualifications, for example, a National Vocational Qualification, a work based and externally assessed award, in health and social care. The manager had set up a 'Carers' Corner' which was an area in the office where staff could sit and read information that was pertinent to their role. A member of staff said, "At night or on half-hour break you can sit down and read information and leaflets". Guidance was provided on what staff should do if people sustained a fall and what to do if a person needed emergency healthcare assistance.

In addition to studying for qualifications through a local college, staff completed e-learning in a range of areas including moving and handling, mental capacity, basic first aid, medication, food hygiene, nutrition, fire safety and infection control. Staff were required to complete a series of on-line questions, their answers were assessed and marks awarded were provided as a percentage which indicated how well staff had understood the particular training topic. One member of staff had not scored highly in the topics of mental capacity and Deprivation of Liberty Safeguards, achieving between 50-52% in each area. This meant that they may not have a thorough understanding of the subject matters and that their training was not effective. According to the staff training plan, some staff had not completed training in all the subject areas identified, for example, in safeguarding vulnerable adults and in equality and diversity. We recommend that the provider puts arrangements in place to ensure staff complete required training to a sufficiently high standard and sets clear benchmarks for staff assessment scores to ensure staff understanding. If staff fail to reach this standard, the provider would need to make arrangements to ensure staff understand the content of the training.

The manager had convened staff meetings since they came into post and the last meeting was held in July 2016. Items discussed included care plans, activities for people, rotas, recruiting, medicines and keyworking. One member of staff talked positively about the changes implemented by the new manager and said, "A lot has been changed, it's doing well. The management is good now". They added, "Everyone is asked to contribute ideas for improvements".

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). No-one living at the home was subject to DoLS and people were free to come and go as they pleased.

We checked whether the service was working within the principles of the MCA. The manager told us that a GP had completed 'mini-memory assessments' for people living at the home. In addition, the manager had completed capacity assessments in line with the requirements of the MCA. These showed that some people had capacity to make decisions, whilst others required support to help them make specific decisions. For example, records showed that a meeting had taken place between one person, their relative and the manager about the stairgate which had been in place at the last inspection. The meeting, which had taken place in March 2016, showed that the decision to remove the stairgate had been discussed and the implications of not having a physical barrier at the top of the stairs were explored and understood. Staff we spoke with had a good understanding of the MCA. One staff member explained, "Everyone has mental capacity and there are different kinds. We help people make decisions, they make choices with day-to-day decisions". They described a decision they helped one person to make with regard to eye surgery and how they had explained that the operation would result in improved eyesight. When the person was supported to understand what the operation involved, they had agreed, resulting in a successful outcome.

People were supported to have sufficient to eat, drink and maintain a balanced diet. People's comments about the food on offer were variable. One person said, "The food is a big drawback, there's not enough quality in the food, although sometimes it can be very good. We only have one cooked meal a day and the last meal is at 5.30pm, it's too long to go. We need more of an evening meal. They will give you a snack, but it's too long to go". Another person was not happy with one of the lunchtime options available on the day of our inspection and expressed their dissatisfaction quite volubly. However, later on in the day, they told us they were happy with the food, describing it as, "Good. I like all the food. I don't mind what it is". A relative told us, "The lady that does the food interacts well with people and asks them what they like. The food is good". We recommend that people's satisfaction with the quality of food and meals on offer should be kept under review to ensure it is meeting people's needs and preferences.

We observed people gathering in the sitting and dining areas of the home just before lunch was served. Some people were enjoying a glass of sherry which their relatives had brought in for them. Other people were offered soft drinks or water. Menu choices were written up on a chalkboard in the dining area. On the day of our inspection, people could choose from liver or sausages, with a selection of vegetables. Other vegetarian options could be cooked to order, for example, jacket potato. Dessert consisted of fruit salad and ice-cream, although one person had chosen to have apricots. Six people sat down to have their lunch in the dining area and two people chose to have their lunch in the sitting room. Where necessary, staff supported people to eat their lunch, although most people could eat independently. The atmosphere in the dining area was relaxed and friendly and two people started to sing; everyone appeared to enjoy each other's company. Tables were nicely laid with cloths, condiments and fresh flowers. Drinks were freely available. The food looked and smelled appetising.

We talked with the cook about menus and food choices available to people. They told us that people had

two food choices at each meal. On the day of our inspection, five people chose to have liver and bacon and the rest chose sausages. People could choose whether to have their potatoes mashed or boiled. The cook knew people well, how they preferred their food and their likes and dislikes. Summer and winter menus were on offer at different times of the year. The cook was also trained to assist people with their personal care and could assist if they were needed to work on the floor. Some care staff also helped to prepare meals. One member of care staff confirmed they had completed a Certificate in Food and Hygiene and that they helped out with serving supper sometimes. They told us, "I cook pasta for one of the residents, with garlic and tomatoes, she likes that".

People's risk of malnourishment was assessed and monitored through the Malnutrition Universal Screening Tool (MUST), a tool specifically designed for this purpose. People were weighed monthly and any sustained weight losses or gains were noted and communicated to the manager, who was then able to make a referral for specialist advice, for example, from a GP or dietician. One person had increased their weight slightly and information for staff recommended, 'Encourage [named person] to be more mobile as he has been gaining weight over the last two months'. Staff had acted upon the advice and a further entry stated, '[Named person] has taken regular walks around the home to encourage mobility'.

People were supported to maintain good health and had access to a range of healthcare professionals and services. We asked staff what action they would take if they suspected someone was unwell. They said, "We try and see what is going on", explaining that they might test people's urine to monitor for any infection if people appeared confused or their behaviour changed. Another member of staff described how they supported one person with a particular eye condition and that the optician had conducted an eye test. Care records included notes of people's involvement with healthcare professionals, documenting district nurses and hospital appointments. We saw a chiropodist had visited one person at the home in April 2016. The note stated, '[Named person] will be seen again in five weeks' time', however, no further chiropody visits had been recorded, so it was not clear whether this person received regular check-ups or not. One person explained the staff would arrange any appointments with the GP, that their daughter would go with them and also added, "The doctors also come here".

People's individual needs were met by the design and decoration of the home. People were encouraged to have their own furniture and items of importance to them, such as photos and pictures. Some people had photos on their bedroom doors. One person told us they were really happy with their room and told us, "It's lovely. The bed is very comfortable".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People were complimentary about the manager and the staff working at the home. One person said, "I'm very happy here. I need a lot of care and care on the whole is very good", adding that, "Staff are happy girls". Another person told us, "I'm as comfortable as I would be anywhere" and said they were treated fairly and were able to do what they wanted. They said, "I get lonely sometimes as my family are all so far away. I don't get a lot of visitors", but added, "I've got a friend who picks me up for church". The care plan for this person stated, 'The Reverend [name] comes to the home once a month and I like to attend the service. I may need reminding of this'. We observed staff were kind, warm and friendly with people and shared a sense of humour. A relative commented that staff were caring and said, "Staff took photographs of where he [family member] used to live and showed them to him, which was so lovely". They went on to say, "It feels like a home from home. The staff get to know the residents very well. [Named family member] feels at home and they include him in things. They try to get him involved. We find all the staff want to help". We observed the manager knew people very well and demonstrated a caring and knowledgeable approach with them; people really seemed to like her. Another member of staff bent down and made eye contact with people when talking with them. We observed them place a gentle touch on people's shoulders, offering reassurance when needed. The same member of staff talked about their friendly relationship with one resident and said, "We crack jokes together. She calls me 'Izzie', which isn't my name, but it doesn't matter!" They went on to say, "I love the residents. They're like my family and the staff all get on with each other".

Some care plans contained information about people's previous lives before they were admitted to the home. The manager had spent time updating and reviewing all the care plans and this was work in progress. 'Life maps' had been completed for some people which recorded where they were born, their family life, pets, beliefs, hobbies, interests, likes and dislikes. Under one person's 'likes', was written, 'I also like a cheeky whiskey for medicinal purposes □'

People were supported to express their views and to be actively involved in making decisions about their care and treatment. Where they were able, people had signed agreements relating to their consent to care, copies of which were contained within people's care records. Staff confirmed they tried to involve people in their care planning, although, when asked, one person did not appear to know what was meant by 'care plan'. Another person did not appear to know what their care plan was, but said, "The staff are patient with us, I like the fact they bring in good food. They help me dress and help me when I need a wash. I manage to do lots of little things". A relative told us, "My sister is involved in the care plan. She knows more about that as she is a psychiatric nurse". Another relative referred to the staff and said, "They know what they are doing. When mum had the odd infection, they have always dealt with it, even when the manager's not here. I get regularly asked about my mum's care. I completed a questionnaire. It's a 'working together' relationship". A third relative said, "We have seen the care plan and are able to ask questions about it. The present manager has it in hand".

People were treated with dignity and respect. Advice to staff posted in the 'Carers' Corner' suggested staff could promote this with, 'Words we like to hear, 'Yes, can I help you? Is there anything you need?' ' and

words that staff should try to avoid using such as 'No, I'm busy, in a minute'. We observed one person became distressed at lunchtime and was complaining of being in pain. A member of staff quickly came to their aid and assisted them to the bathroom in a sensitive and discreet manner. We asked staff how they would treat people with dignity and respect. One staff member said, "You knock on the door and explain what you've come for. It it's not convenient, we can come back later, say if they have a wash". They told us, "A few people don't like to have a wash, but we try and persuade them".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we made a recommendation to the provider to consider how the programme of activities on offer for people might be planned and delivered in a person-centred way. We asked the manager whether any changes had been made relating to the activities on offer since our last inspection. They told us, "We ask them [referring to people] daily what they want to do, because they all have different needs". A relative said, "[Named manager] organises activities. She has done a fantastic job in getting things under control again. She's organised Bingo, dog visits, crafts and keep fit. The BBQ and cream tea, they really enjoyed". The manager had introduced activity folders for each month since March 2016 and these showed the activity on offer, with feedback from staff and people. For example, with regard to a card game that had been organised in early May, it was noted that one resident enjoyed it, but that another resident found it difficult to understand the game. Therefore this feedback could be used to make changes to the choices of activities offered.

On the day of our inspection, a member of staff had organised a game of Bingo and was calling out the numbers in a very entertaining manner, which people seemed to enjoy. We asked one person about the activities on offer and they said, "There are not enough of us to create a routine" and added that they enjoyed the entertainers who visited the home to play instruments, saying, "Some are better than others!" A relative referred to staff with their family member and said, "The staff are very good at jollying her along. They have various activities. I am very positive about the home, they try their best". People had recently enjoyed an outing to Shoreham Airport and cream tea. The Queen's official birthday had been marked with a BBQ at the home and all feedback was positive. Improvements had been made to the gardens surrounding the home and the manager said that some people had been involved in growing tomato plants. A gazebo had been erected to provide a shady area for people to sit in the garden.

People's care plans were in the process of being reorganised by the manager. A one page summary at the front of the care plan provided a quick reference for staff and summary of people's needs, for example, with washing, memory, beliefs, social activities and social skills. Under the heading of 'social skills', one person's care plan stated, "I like chatting to the other residents. I like to go out with my friend'. Before people were admitted to the home, a pre-admission assessment was carried out and this information provided the basis for people's care plans. Care plans had information about people's needs, choices, any equipment needed and assistance required from staff. For example, one person's care plan provided information on their sight and stated, 'Needs glasses, eyes tested annually' and on their hearing, 'Hard of hearing'. Assistance from staff was recorded as, 'I would like the carers to come down to eye level. I am hard of hearing. I need carers to speak clearly so I am able to understand them and answer questions'. Information was provided to staff on people's personal care needs, such as whether they required assistance with washing or showering and on their continence needs. People's daily care needs and night-time routines guided staff on the assistance that people needed, whilst still promoting people's independence.

We asked staff about their understanding of people's care and their care plans. One member of staff appeared to be confused by what was meant by 'care plans' and referred to the daily records which they completed and recorded information on how people had spent their day. They told us, "We write what we

do. There's a cabinet in the lounge and daily records are kept there". A sheet at the front of people's care plans invited staff to sign the sheet to confirm they had read the care plan, however, only one member of staff had signed this. We discussed this with the manager, who explained that they were still re-writing and reviewing care plans. People's care plans were reviewed monthly and records confirmed this. Although improvements had been made to care plans to ensure they were person-centred and reflected people's needs, further work was planned to ensure they were fit for purpose and provided necessary guidance to staff.

We asked the manager how complaints were managed and they told us no formal complaints had been made within the past year. The complaints policy, which had been on display in the hall area, did not provide any detailed information and timelines for when a complaint might be acknowledged or responded to. The policy stated, 'Initially, complaints or comments should be reported to a member of staff, who will listen and possibly resolve such complaint immediately. If this is not possible, you will be asked to record your complaint on the complaints form and present it to the Proprietor/Manager at the earliest convenience'. Whilst the contact details were provided for the Care Quality Commission, information on how to contact the Local Government Ombudsman was not provided. We discussed the complaints policy with the manager, who stated they would bring our concerns to the provider's attention.

We asked people and their relatives whether they knew how to raise a complaint if they had any concerns. One person said, "If I wasn't satisfied with something, I would certainly speak out". Another person referred to the manager and said, "She's nice, because she's friendly and she listens to what we say. If I had a problem, I would speak to [named manager]". A relative told us, "If I did have any issues, I would go to [named manager" and added, "She seems very good and easy to approach".

Requires Improvement

Is the service well-led?

Our findings

At the inspection in December 2015, we found the provider was in breach of a Regulation associated with good governance. There were serious concerns that there were no effective systems or processes in place to meet this regulation. As a result, we issued a Warning Notice in February 2016, which was to be met by 1 April 2016.

At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards. It was evident that significant improvements had been made across all areas of the home since our last inspection. However, as indicated in this report, further time and improvements will be required to ensure good practice and consistency of care is embedded and sustained across the organisation. Except for the rating of 'Good' under 'Caring', we have rated each domain as 'Requires Improvement'. It was clear from our discussions with the manager, the actions they had taken and the documentation we examined, that progress had been made in relation to the areas of concern previously identified in two warning notices and a breach of regulation. However, the Commission needs to be confident that the improvements will be sustained over time to ensure the progress made to date is not transitory. We also need to be assured that the management arrangements in place will be conducive to drive continuous improvement.

Several managers had been employed at the home since the provider took over ownership of the home and registered with the Commission in 2011; the current manager is the ninth in succession and is in the process of registering with the Commission. They commenced employment at the home in February 2016 as 'trainee manager'. The last manager had left the home in January 2016 and a registered manager had not been in post since March 2015, a period in excess of 400 days at the time of this inspection. The provider is in breach of their registration conditions which say that they must ensure that the service is managed by a person registered as a manager.

Following the last inspection, the provider drew up an action plan in which they stated, 'Create a new role of Manager's Assistant, to help ease the pressure of the highly demanding job, relieving the manager of duty such as care plan reviews, staff management, auditing and other tasks as the manager feels appropriate'. We asked the manager whether this new role had been recruited to and were told that the provider had not implemented this part of the action plan. Following the inspection, the provider stated that a decision was made with the manager that an assistant was not required at this time. At a multi-disciplinary meeting held with the local authority in February, the provider had stated they would be recruiting a cleaner, which would free up care staff to look after people. However, a cleaner had not been recruited and staff told us that the provider would recruit to the post when the home had a higher level of occupancy. Following the inspection the provider had revisited the action plan and determined a dedicated cleaner was not required at this time due to the current occupancy level. However, we remain concerned that a long period of instability and lack of actions previously identified as needed, but not addressed or subsequently changed, may affect the consistency and quality of the service provided in the future.

People were asked for their feedback about the service through questionnaires, the latest of which was circulated in April/May 2016. Responses from people were generally positive and the level of satisfaction

had increased from 'satisfied' to 'very satisfied' in many cases, since the previous questionnaire was sent out in February/March 2016. A relative had responded, '[Named person] always tells me the carers are doing their very best which is what is the most important – his confidence in the carers. I always find all the staff very approachable and supportive'. People were asked to rate their satisfaction such as the support they received, the activities on offer, the menu choices and whether they were involved in planning their care. Relatives' meetings had been reinstated and the last meeting was held in July 2016.

Staff spoke positively about the manager and felt that the majority of improvements were as a result of her leadership and management of the service. One staff member said, "We're better off than compared to before". Another staff member said, "I really like [named manager]. She wants to bring positivity, especially in the way she treats the residents. She cracks jokes with them and she's organised the activities and outings". They added, "If [named manager] goes, I wouldn't want to stay. I like it here and I love the residents. She is like the captain of the ship and she is my professional support". Staff had been asked for their views about the home in a questionnaire in July 2016. One member of staff stated, 'Our manager helps us in every way … we are able to go to her anytime if needed'. Three staff members felt that the focus of the job description concentrated more on the cleaning elements of the role, rather than caring. It was evident that the manager had worked extremely hard to change and improve the standard of care and overall service at the home. A resident commented, "I find her approachable. She keeps things running all right I think".

A relative had noticed significant improvements under the new manager and told us, "Managers start something with mum, then they leave. [Named manager] has done an awful lot. She has made sure stuff happens for mum". They added, "[Named manager] has done a good organisational job here. There is not such a high turnover of staff". Relatives spoke positively about the care at the home. Another relative told us, "[Named manager] knows a lot about my aunt. She has a good rapport with her. When my aunt went into hospital, [named manager] went to visit her there, which was very nice". A third relative referred to their family member and said, "He's safe, he's warm, he's happy and he seems to be content".

Audits were in place relating to medicines management, a monthly accidents and incidents analysis and checks relating to premises such as Periodic Electrical Testing and weekly fire checks. A system had been introduced to ensure all necessary checks had been undertaken before new staff commenced employment. People, their relatives and staff were asked for their feedback about the service. However, there was no audit in place to ensure that people's care plans had all the necessary information included and no audit of risk assessments. There was no effective system in place to ensure that staff training was up to date, although we were given a spreadsheet containing some information on training that some staff had completed. Effective audit systems are necessary to monitor the quality of care and service overall; over time, areas for improvement can be identified and addressed. The newly implemented audit systems need to be embedded, then monitored so that the results can be analysed to drive continuous improvement. This was an area for further improvement.