# West Sussex County Council

# Tozer House

## Inspection report

Tozer Way
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04 February 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection took place on 28 January and 4 February 2016 and was an unannounced inspection.

Tozer House is a residential care home that provides support to a maximum of 15 people who have a range of learning disabilities and some who were living with dementia. The home comprises two houses, Rosemead and Bramley, where people live and a third building with the communal dining area and offices. The buildings are situated around a garden area. The home is located within walking distance of Chichester town centre. At the time of this inspection there were 12 people living there.

The service had a registered manager who was registered with the Commission in October 2015. 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.

In the year leading up to our inspection, there had been significant vacancies in the senior team, including at assistant manager and senior support worker level. People had continued to receive good care and support but there had been a lack of oversight in other areas. This had led to gaps in staff training and supervision and checks on the quality of the service had not always been carried out or used effectively to improve the care that people received. We found that people had not received their medicines safely as there were gaps in administration and records. This had not been identified by the registered manager or provider as there was no audit or check in place to ensure that medicines were administered safely.

The registered manager took prompt action in response to the concerns that we identified. Before our inspection, new senior support workers had been recruited and the registered manager had started to make improvements in how records of staff training and supervision, as well as documents relating to the management of the service, were made and filed. A new staff training matrix had been prepared which made clear which staff required refresher training and could be used as a tool to monitor progress. Supervisions and appraisals were underway, with each senior support worker responsible for supervising a small number of staff.

Staff felt supported in their roles. The registered manager placed high value on a good induction and staff spoke positively of their experiences and the level of support they received. There were enough staff on duty to meet people's needs and to support them to participate in social activities and to access the community. The staffing level was adapted to reflect changes in people's needs or to facilitate particular activities. The evening meal was a sociable time, with people and staff eating together. There was a choice of food available and people were supported to make choices and to eat a balanced diet.

There was a happy and open atmosphere at the home. People enjoyed positive relationships with staff and were treated respectfully. People were involved in planning their care and were supported to be as

independent as they were able. Staff monitored people's health and were kept up-to-date via handovers and regular staff meetings. Where there were changes in people's needs, prompt action was taken to ensure that they received appropriate support. This often included the involvement of healthcare professionals, such as the GP, occupational therapist or specialist clinics such as for diabetes.

People felt safe at the home and were able to speak up if they had concerns. Risks to people's safety had been assessed and were managed in order to maximise their independence. Staff knew people well and helped them to make decisions relating to their care and support. We observed that staff took time to discuss options with people and respected their wishes. Staff understood how people's capacity should be considered and had taken steps to ensure that their rights were protected in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People and their relatives were asked for feedback. People were enthusiastic about their keyworkers. They told us that they helped them with shopping and that they could talk freely to them. A new pictorial survey had been developed for people and the registered manager was planning to reintroduce meetings for people who used the service so that they had a formal opportunity to share their views and ideas on the service and their support.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

Some aspects of the service were not safe.

Some people had not received their medicines as prescribed and records of administration contained gaps.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe.

### Is the service effective?

**Good**

The service was effective.

Staff were knowledgeable about people's care needs and felt supported in their work.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People could choose their food and drink and were supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

### Is the service caring?

**Good**

The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care and encouraged to pursue their independence.

People were treated with dignity and respect.

## Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs.

They were supported in activities and pursuits of interest to them.

People were able to share their experiences and were confident they would receive a quick response to any concerns.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

The service lacked a clear quality assurance system and did not have an effective method to monitor and drive improvements.

Although staff received training to carry out their roles and received support from their managers, the frequency of refresher training and supervision had been affected by poor record keeping and a shortage of senior staff.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

The registered manager led by example and worked collaboratively with people and staff.

# Tozer House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 28 January and 4 February 2016 and was unannounced.

One inspector and an expert by experience with experience of supporting people with a learning disability undertook this inspection.

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 improvements they plan to make. We also reviewed one previous inspection report and notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care in each house and during the evening meal. We looked at care records for six people, medication administration records (MAR), monitoring records for personal care, accident and activity records. We also looked at five staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 11 people who used the service, the registered manager, two senior support workers, three support workers and two representatives of the provider. We also received feedback from the provider's moving and handling specialist, the nurse lead for learning disabilities and dementia from the GP practice and an entertainer who visited the service.

Tozer House was last inspected in May 2013 and there were no concerns.

Requires Improvement

# Is the service safe?

## Our findings

Medicines were not always managed safely. There were missing staff signatures in Medication Administration Records (MAR). In one house, MAR for four of the six people contained gaps. The missing signatures were not explained in the notes and the tablets had been taken from the blister packs. In the other house, the MAR for one person had been signed to say that medicine had been administered but we found two different tablets still in the blister pack. The records did not demonstrate that people had received their medicines in accordance with instructions from the prescribing GP.

Where medicine was given on an 'as required' (PRN) basis, staff had not always recorded the time that the medicine was given. This is important where there is a recommended gap between doses and a maximum dose within a 24 hour period to ensure the person does not receive more than the recommended amount. Creams and liquid medicines were not dated on opening. This could mean that they were used for longer than recommended by the manufacturer which might reduce the effectiveness of the medicine.

We noted that one person had not received a medicine used to delay the progression of Alzheimer's disease for a period of five days. The reason given for this was that the medicine was out of stock. There was no evidence that the GP or pharmacy had been contacted to seek advice and to obtain a new prescription until two days after the first dose was missed. By the time of our inspection new stock had been received and the person was receiving this medicine as prescribed but in the intervening days we could not find evidence that staff had chased the prescription to ensure that there were adequate supplies to meet this person's needs.

The above demonstrates that the provider had not ensured safe management of medicines or that there were sufficient quantities of prescribed medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the registered manager and a representative of the provider. Following our visit we received copies of two safeguarding alerts that had been raised concerning missed medication and discrepancies in the records. The registered manager had also requested and booked a full audit of their medication practice with the pharmacy. A senior support worker who had attended further medication training was due to begin competency checks for each staff member with responsibility for administering medicines.

People told us that they felt safe and that the staff were good at their jobs. In each house, there was a photo board with pictures of the people who lived there and of the staff. The registered manager explained to us how one person, who was unable to communicate verbally, used the photographs to point to and show if someone had upset them. Staff supported most people with their finances. They kept records to ensure that people's money was managed appropriately. One staff member told us, "You get the receipts, it's written in the book. It's all by the book. I feel it is all above board".

Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed

or were at risk of harm. Staff told us that they felt able to approach the registered manager if they had concerns. One told us, "If you had any worries you would be able to go in (to the office) and say". They also knew where to access up-to-date contact information for the local authority safeguarding team. The registered manager had raised alerts with the local authority safeguarding team and had taken action to respond to and investigate any allegations of abuse.

Although the registered manager had notified the safeguarding team, we found that they had failed to notify the Commission of four allegations of abuse. The law requires that services notify the Commission of any abuse or allegation of abuse in relation to a person who uses the service. Although we had received other notifications from the registered manager, she had not been aware of this part of the regulation.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Before a person moved to the service, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling or from seizures, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support that people required from staff. For example, moving and handling care plans detailed the number of staff needed to support the person, the person's ability to communicate, the equipment to use and guidance on how to carry out the transfer or support the person to walk safely. As people's abilities changed, their support was reviewed. Staff had made referrals to the provider's moving and handing specialist and to the occupational therapist (OT) for one person whose mobility had recently declined. Staff were concerned that the person was no longer able to safely control the rollator that they used to walk with and were seeking advice and guidance on alternative equipment to maintain the person's independence.

Staff involved people in assessing risks in the activities they wished to pursue. One person used their bike to cycle on public roads. A staff member told us, "I sat down with (name of person) and discussed it with him, asked what he thinks the hazards and risks are". Before going out alone, the person had undertaken training in road safety and cycle maintenance. When cycling they wore protective equipment such as a helmet and high visibility clothing and ensured that they had their mobile telephone to hand. A second person expressed a wish to eat alone in their house whilst everyone else dined together in the main building. Staff had assessed this person's risk of choking and had nominated a staff member on duty to make regular checks to ensure that the person was safe and well. This enabled the person to eat in their preferred place whilst minimising the risk to them. A third person, who was a smoker, had agreed to give their lighter to staff at night time. In their care plan we read, 'I have always smoked and there is a seating area outside for this, the duty officers help me not to smoke too much. Please help me to wrap up warm before I go outside'.

The service had a staff member responsible for maintenance. This staff member checked the environment and carried out regular checks, such as on fire safety equipment. The West Sussex Fire and Rescue Service had checked the fire safety procedures in the home in June 2015. They did not identify any significant issues. The registered manager told us that they were due to carry out a fire evacuation drill. She explained that when the alarm sounded both houses were evacuated. She told us, "People in both houses react to the bell, as it is too confusing otherwise".

People told us that there were enough staff to help them and to support them to go out in the community. As most people went to day centres the staffing level varied across the day. From 7am to 9.30am there were three staff on duty. In the day there was usually just one staff member, increasing to four staff from 3.30pm when everyone returned. At night there was one staff member on shift. In addition to this staffing there was a duty officer working for a 24 hour period, which included a sleeping night duty, the registered manager,

housekeeping, kitchen and maintenance staff.

The staffing rotas were arranged on a four week cycle. On some days additional staff were on duty to support planned activities. The rota made clear when a staff member was on leave or training. This enabled the duty officer to cover the shifts, either by regular staff working additional hours or by asking relief or agency staff to work. On the first day of our visit the rota for the following week contained gaps but these had all been filled by the time we returned. Staff told us that there was flexibility and they were able to increase or decrease the staffing level to meet people's needs. One said, "You need to be able to respond to changes, for example a new client. (The registered manager) has given the go ahead to increase evening staffing". Speaking of the increase from three to four staff in the evening, another staff member told us, "Now we've got a fourth person on it is working better. You need someone there to sit and talk".

At the time of our visit the service was recruiting new staff. The registered manager told us that they had vacancies for a senior support worker, a support worker, a cook and a part-time cook. Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

Good

# Is the service effective?

## Our findings

People had confidence in the staff who supported them. One person told us, "Oh yes, the staff look after us well". Staff had received training and were encouraged to pursue diplomas in health and social care. Some staff were being trained as leads in specific areas, such as infection control and medicines. This meant that they received additional training and would take on additional responsibilities such as for checks and audits in their designated area. In addition to training that was made mandatory by the provider, staff received specific updates in staff meetings. For example, to meet the needs of a person who had recently moved to the service, there had been a session on autism. Staff told us that this was useful, and that it had been focused on helping them to meet the needs of the person they were supporting.

Staff spoke positively about the induction they received. One told us, "The transition in was good". A senior support worker told us, "It was a really good induction. (The registered manager) did a thorough induction so we spent a whole 24 hours together". This is the duration of the duty shift which includes a night sleep duty. The registered manager explained that all new staff completed a period of induction, which included shadowing in each of the houses for a period of two or three weeks. She told us, "Induction is the foundation to giving good care". The service had introduced the Care Certificate, a nationally recognised qualification, and two staff had been trained as assessors for new staff.

Staff felt supported. They told us that they could approach the registered manager or senior staff at any time. One staff member said, "It's a nice place to work, we have a good team". Staff told us that they received supervision and that they were able to discuss their work and aspirations. Several staff shared with us that they had started in different roles and had received training and support to develop in their careers. One staff member told us, "The support I got was overwhelming. Every day I come in I'm learning and it is great".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our visit, six applications to deprive people of their liberty had been made to the 'Supervisory Body' for authority to do so. A further four applications were in progress.

Staff understood the requirements of the MCA and put this into practice. For example, staff followed the presumption that people had capacity to consent by asking if they wanted assistance and waiting for their response. During our visit we observed that staff involved people in decisions and respected their choices.

People were able to decide how they wished to spend their time, for example one person had opted to go to the day centre for half days only as they were finding it too tiring. Staff had worked with another person to help them to understand why they needed surgery and what would happen. During our visit this person told us that they were having an operation, when they were going to the hospital and the treatment they expected. The registered manager told us, "If you give him a time and explain it to him, he will take it in. We've been working for several months with him on this. He understands".

Two people who used the service had advocates who supported them to be involved in important decisions. A best interest meeting had recently been held for one person to determine where they would live in the future. The person attended this meeting, supported by their advocate. A staff member shared that they had attended a meeting to review another person's placement at the service since they were the person's keyworker. They told us, "I've known (name of person) before they were diagnosed with dementia and I've got a great relationship and communication with them and their family". As a result of the meeting, the person, their family and psychiatrist had determined to delay a move as this was in the person's best interest.

People's care records included information on their ability to make or be involved in decisions that affected them. For example they noted that one person did not have capacity to manage their finances but that they were able to make day to day decisions on how and where they wished to spend their time. One staff member told us, "They've got to be able to understand what you are asking of them. It must be assessed to see if they have capability to decide. You can't restrict them. They've got freedom unless deemed otherwise". There was evidence that decisions to refuse care or treatment had been respected. Where a decision to refuse treatment, such as taking an important medicine, was refused, there was guidance for staff on when they should contact the GP or out of hours helpline for advice.

People told us they had plenty of choice over food and, "Ate big lunches and dinners". One person said that the cook made, "Really lovely food". People tended to eat breakfast in their houses, take a packed lunch to the day centre and then eat all together in the main building in the evening. The evening menu contained two main options, in addition to daily alternatives such as a jacket potato or omelette. People were asked to choose their menu for the week but were able to change their mind on the day if they preferred the other option. People were free to make choices as to what, when and where they wished to eat. For example, one person who was not keen on sandwiches preferred to have soup or scrambled eggs when they returned in the afternoon. Another person sometimes preferred to eat later in the evening and this was accommodated.

The evening meal was a sociable occasion with people chatting amongst themselves and with staff. One person told us it was, "A really good laugh". Staff ate with people and were available to provide support. People collected their meals from the hatch and were encouraged to return their plates when they had finished. A choice of desserts was available. Staff used different methods to present the options, some people responded to verbal information, whilst others were shown the selection in order to make their choice.

Staff supported people to eat and drink where they required assistance. Two people had been assessed by a speech and language therapist (SALT) and had guidance in place to support them to eat and drink safely. This included how they should be positioned, any specialised equipment that would help them and the level of staff support required. These guidelines were available to the kitchen staff, as well as in the individual houses. We observed that one person was supported to eat, that another had their food cut up for them and that a third required soft foods that could be mashed with a fork. Staff monitored people to ensure that they had enough to eat. Weight records were maintained and the frequency they were weighed depended on the person's needs and if they were at risk of weight loss or malnutrition.

During our visit we observed that drinks were available and that staff regularly offered people drinks. It was clear that staff knew what people liked as they offered specific drinks such as banana milk to some and encouraged others to make their own cups of tea. One person who had just completed 'dry January' was celebrating with a can of cider to accompany their evening meal. A fluid chart was in place for one person who was known to be at risk of dehydration. This chart had been completed by staff and demonstrated that the person was receiving support to drink little and often. In the handover notes we saw that staff highlighted any concerns such as, '(name of person) has drunk only 100ml'. This meant that the staff taking over on the next shift could monitor the person, offer additional support or seek further advice if concerned.

People had access to healthcare professionals to ensure that their health needs were met. One person told us that they only went to the doctor when she needed to but still had to go to the dentist every six months. Each person had a Health Action Plan (HAP) in place. A HAP details information about the person's health needs and the professionals involved. People had been supported to attend regular dentist and chiropody appointments, as well as medication reviews with their GP. One person who had diabetes attended regular check-ups and podiatry appointments. The nurse lead told us that staff were well aware of health, emotional and psychological changes in people. She told us, 'Health concerns of individual residents are focussed and dealt with by requesting a visit by a GP when necessitated or raised to myself during Health Action Plan or Dementia Reviews and addressed as required'.

The service consisted of three buildings, two houses where people lived and a main building which included the main dining area and offices. There was a fourth building on the premises which was used for supervision, staff meetings and storage but this did not form part of the registered service. The different buildings were connected by a garden which people really enjoyed. One person said, "The garden is really lovely, isn't it?" There was a covered smoking area in the garden which was accessible to all. Each house had its own lounge and kitchen.

Good

# Is the service caring?

## Our findings

There was a relaxed and happy atmosphere during our visit. People and staff appeared to enjoy each other's company and were busily engaged in a variety of activities and tasks. People told us that they were happy living at Tozer House and that they liked the staff. They told us the names of the staff who usually worked in their house and talked enthusiastically about their keyworkers. Each person had a named key worker. In one person's care plan we read, 'My keyworker supports me with my bed change and room clean. She also supports me to go shopping to buy clothes and things I need. She supports me with my medical appointments. We go for bus rides and then to a café for shopping and lunch. She is there for me to talk to when I need somebody'. Staff spoke positively about this role and the ways that they had supported individuals to maintain or improve their independence. The nurse lead said, 'The carers are committed to providing support, both physical and emotional on a holistic basis as required. It is apparent that all the key workers have a great understanding of their clients even without the ability of the resident to verbalise their needs, their ability and patience is unquestionable'.

During the evening meal it was clear that people and staff knew each other well, with people asking after staff members' partners or children. We also saw how staff provided discreet reassurance to those who needed it. As one person was feeling anxious we saw that a staff member gently touched them on the hand and said, "You're alright, you don't need to worry". One staff member told us, "As a new person it struck me how caring the staff are towards the residents. It was an easy team to come in to". Another said, "The strength is the long continuity of support". This staff member went on to explain that many staff had worked at the home for more than 10 years, some up to 30 years.

We looked at a selection of compliment cards and letters of thanks that had been sent to the staff. One letter from a relative thanked staff for their, 'Compassion and friendship', another spoke of, 'All the love and kindness you gave her'. One staff member told us they had spent three days in London with one person when they went to hospital for an operation. They were there to support the person and to liaise between the professionals and person's relatives. The provider's moving and handling specialist told us, 'I have observed on several occasions the care and compassion shown to individuals. Staff are very person centred in their approach and always focus on the best outcomes for that person'.

People were involved in decisions relating to their home and the running of the service. Each person's means of communication was detailed in their support plan. For example we read, 'Good verbal communication skills but I sometimes need a bit of extra time to process information'. This helped staff to understand people's wishes and involve them in decisions. People were enthusiastic about their bedrooms; one person was keen to show us their room which had been decorated in their favourite colour, with matching bedding and curtains. A second person told us that they were, "Very happy and excited" about their newly decorated room. A third person had recently moved to another bedroom as they had requested a room with two windows. Empty bedrooms remained undecorated until a new person arrived and was able to select their colour scheme and furnishings. Visiting one room, the registered manager told us, "The person who was in here wanted blinds but the one coming wants curtains".

When a new staff member was being recruited to the service they met with people in the houses and had time to sit and chat with them. The registered manager and staff involved in the interview process observed the potential staff member's interaction with people and asked people for their views.

People were supported to be as independent as they were able. Support plans included guidance for staff on which tasks people could manage independently and where they required support. For example we read, 'I need a lot of support and prompting to dress myself. Please encourage me to keep my skills going' and, 'I can use my electric shaver myself, but please remind me to do so'. One person was proud to tell us that staff left her laundry on her bed because she knows how to operate the washing machine. We saw that people were encouraged to complete tasks, such as laying the table, making their sandwiches or taking their plates back to the kitchen once they had finished their meal. When people completed these tasks, staff shared in their achievement. After taking their plate back, a staff member said to one person, "That's it, well done. Excellent". Once seated they tapped them on the arm and said, "Well done (name of person), brilliant". The registered manager told us, "You do with them, you don't do for them". She spoke of how it was rewarding to see people develop their skills and be able to move to supported living.

Staff treated people respectfully. Before entering either of the houses staff rang the doorbell and checked it was alright to enter. The registered manager told us that some people had requested that agency staff did not support them with personal care. She told us that these requests had been accommodated and said, "I always think, how would I feel?" A staff member said, "It's a huge thing for them to trust us, not only for finances but for personal care".

People were also supported by staff to respect other people's privacy and space. They prompted people to ring the bell if they were entering the other house. Staff also supported people in how they greeted us by firmly and effectively asking them what they should do rather than hugging and kissing people they had not met before. People were able to respond appropriately with, "High-fives and handshakes".

Staff had supported one person at the end of their life to remain at Tozer House. Many of the staff spoke of this experience and of their pride in knowing that they had fulfilled the person's wishes to stay at home. One staff member said, "(Name of person) wanted to stay here. We all worked so hard, it was the best thing for him". The registered manager explained how they had arranged training in palliative care for staff in anticipation and, with support from nurses and other healthcare professionals, they were able to meet the person's needs and support them to have a comfortable death. Following this person's death, staff had arranged for a bench to be made and placed in the garden in the person's memory. The bench was made from wood sourced in the area the person was from. The registered manager told us, "He was a real country person". Staff had put on a buffet for people and for the family of the person as a celebration of the person's life and official opening of the bench in their memory.

Good

# Is the service responsive?

## Our findings

Staff knew people well and understood how they liked to be supported. When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. Support plans included information on what people enjoyed doing, what was important to them, things they liked and did not like. This information was detailed and was presented in a colourful format that included pictures and symbols. This helped people to understand the information in their support plans and to engage with the process of planning their support in a way that suited them.

The support plans included information on people's typical daily routines, how they communicated and on the support that they required. In one we read, 'I always go to bed early, and on a weekend I will have a nap in the afternoon, but I like to be up early'. In another, 'I will often get out of bed during the night, come downstairs to the main lounge and sleep on the sofa. Whilst the night staff have encouraged me to return to bed I will often choose to remain downstairs'. Where people did not communicate verbally there was detail as to the gestures or behaviour they would use to communicate, for example one person rubbed their tummy to indicate that they wished to use the toilet. There was guidance for staff on how to communicate and promote positive behaviour, such as by sticking to routines and using simple sentences that the person could understand. Where people had particular health conditions, there was information for staff to help them to understand the person's symptoms or additional needs.

Staff had a good understanding of people's needs and preferences. The support that people received was monitored through a personal care log and daily support notes. Where necessary additional monitoring was in place such as for seizures, fluid intake or bowel movements. These records had been completed and used effectively to ensure that changes in people's health were identified and addressed. At the time of our visit staff were not formally monitoring the behaviour of anyone who used the service. The nurse lead told us, 'The behaviour of some of the residents can be challenging, but the key workers fulfil this demanding role to a very high standard with a great degree of empathy and commitment'.

At the beginning of each shift, staff received a verbal and written handover. We saw that this was used to update staff and to plan ahead, for example to arrange additional staff support for one person when they returned home after surgery. The handover documentation also detailed forthcoming appointments or professional visits so that staff could support people to be ready and prepared. One staff member told us, "The handover is good. There's not much that gets past you". The nurse lead said, 'The level of communication between staff appears to be excellent'.

People's support plans had been reviewed to ensure that they met their current needs. One person now needed to use a hoist first thing in the morning and required two staff to support them with personal care. This person had also been supported to move to a downstairs bedroom to make it easier for them to access and as there was more space for staff to manoeuvre equipment. Another person now used a wheelchair over longer distances, including to access the minibus. Staff had noticed that a third person was struggling to walk over a section of the outside path. They thought that this was due to the person's advancing dementia

and a decline in their visual perception. As a result the registered manager was arranging for the patterned surface to be replaced and for the outside lighting to be improved. Staff were also planning to purchase red cutlery and crockery for this person in the hope that it would help them to differentiate between the different items on their plate more easily. We found that the service was quick to pick up on changes in people's support needs or abilities. One staff member told us, "They reacted really quickly when her care needs changed and changed her paperwork".

We observed that staff were attentive to people's needs and moods. When one person dropped their drink on the floor they became anxious and kept apologising even after it had been cleared up. Staff were very good at calming this person down and reassuring them that it was no big deal. Another person became upset when a staff member ended their shift and was going home. The other staff were patient and calmed the person down by assuring them that the staff member would be back in the morning.

People were involved in activities that interested them. Each person had a schedule for the week but this was flexible. Most people attended day centres during the week but there were also entertainers who visited. Several people attended a disco on a Friday night and some went to an art club on a Saturday morning. Others pursued their own hobbies, such as horse-riding or swimming. The service had access to the minibus at weekends which meant that they were able to organise trips out such as to the seaside. Staff told us that at the weekend they would often go out for coffee in town or shopping with people. Specific trips had been arranged for some people, for example one person had been to the Doctor Who Experience in London. People were also supported to visit their families and to maintain social contacts. One person who was no longer able to attend the day centre was supported by staff to pop in for coffee or lunch so that they did not lose contact with people they knew. A staff member said, "The social aspect of their lives is really important".

During our visit people appeared confident in expressing their concerns to staff. We observed that when one person became frustrated by another they went straight to the staff to voice this. Staff then spoke with both people to try and resolve the issue. In each house there were 'Speaking up' forms which people could use to voice a concern or make a complaint. Six of these forms had been received by the registered manager, completed by three people. The registered manager had spoken with each of the people and explained what was being done as a result of their concerns. She told us, "It's their home and it is important".

The provider had a complaints policy and information on how to complain was available in written and an easy to read format. This informed people that they could request the support of an advocate, 'Someone who can speak on your behalf, or support you to speak to us'. There was also information on who to contact if the complaint had not been resolved to the person's satisfaction. The registered manager had not received any formal complaints.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager did not have a system of checks and audits to monitor the quality of the service. This had led to shortfalls such as in the safe administration of medicines because gaps and errors had not been addressed. The current system relied upon staff spotting errors and taking prompt action. When we asked staff what action they would take if they noticed a gap in the MAR one told us, "I'd tell them (the staff member who had been on duty) the next time I see them but you've got to remember!" Similarly, accidents and incidents were recorded but there was no oversight to ensure that any patterns were noted to reduce the risk of reoccurrence. The provider had a system to oversee incidents but this had broken down due to a glitch in the computer system. We found that incidents between June and December 2015 had not been entered on the computer system. In the absence of checks on the paper records, this could mean that patterns in incidents or injuries may not be identified and steps to mitigate risks to people could be missed.

There was no system to record actions identified as necessary to improve the quality and safety of the service, or to monitor progress. The registered manager told us that a health and safety audit had been conducted by an external company during 2015. She was unable to locate the report or to tell us what the findings had been. This meant that opportunities to improve the safety of the service may have been missed. An infection control audit had been carried out by an external company in September 2015. Many of the actions had been marked as completed, for example the introduction of documented cleaning schedules, but others including setting up six monthly infection control audits in the home were outstanding. There was no plan in place to ensure that these actions were addressed.

Although staff felt supported and had confidence in their skills and abilities, we found that the service had failed to maintain accurate records in relation to staff training, supervision and appraisal. This meant that the registered manager did not have an accurate picture of which staff required training updates, supervision or appraisal.

We asked the registered manager to provide an overview of staff training and supervision by the second day of our visit. The training information had been collated into a matrix. This showed that staff were overdue refresher training, according to the provider's timescales. For example, moving and handling training for 13 staff had expired in November 2015 and safeguarding training was due for 10 of the 23 staff listed. The registered manager explained that in 2015, they had moved from in-house training to a provider-wide system of training whereby staff had to register and book themselves directly on to courses. She told us that some staff had struggled to register on the system and that she found it more difficult to monitor the status of staff training. Staff also expressed their views. One said, "I've tried to get on courses and they've been full". Another told us, "I don't drive so I can't be going to Horsham". he registered manager was unable to collate information on staff supervisions during 2015. She explained that due to vacancies in the senior team, staff had not been supervised at the frequency of every 4-6 weeks as set out in the provider's policy.  system of regular refresher training, supervision and appraisal is important in monitoring staff skills and knowledge to enable them to deliver safe care.

The lack of accurate records in relation to staff training, supervision and appraisal was a breach of

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been significant vacancies in the senior team. The assistant manager post had not been filled and there had been several vacancies at senior support worker level. The registered manager told us, "We have been 90 hours' down on senior staff at stages. It hasn't been easy with the shortage of seniors but the staff are very supportive and will go the extra mile". We found that there had been little impact on the care and support that people received, but that management tasks including quality assurance checks and ensuring that staff received regular supervision had fallen behind.

By the time we visited, two new senior support workers had been recruited. The registered manager was also receiving support from a new representative of the provider who had drafted in support from other services to assist with specific tasks, such as in taking action to assess the status of staff training and provide the registered manager with the tools to monitor this going forward. The registered manager told us, "There are lots of things I'm trying to implement for this year now we have some senior staff in. We are moving forward now".

By the second day of our inspection, future dates for moving and handling training had been posted on the office door and supervisors had been asked to follow up with individual staff members on their training needs. A supervision matrix was in place for 2016 and supervision and appraisal meetings had taken place in January. These supervisions included a check on the status of staff training and some staff had been assisted by their supervisors to access the online training booking system.

The registered manager was quick to address the concerns raised during our inspection. In response to gaps in the administration and recording of medicines, safeguarding referrals were made and a full audit by the pharmacy had been booked to take place in February 2016. With the additional senior staff on board, senior support workers were in the process of being trained to take responsibility for specific areas, including medicines and infection control. The registered manager explained that as the lead or champion these staff would be responsible for ensuring the competency of other staff members in these areas and for conducting regular audits.

While people told us that they were able to speak with their keyworkers, at the time of this inspection there were no formal opportunities for people who used the service to provide feedback. The registered manager told us that they intended to reintroduce full and individual house meetings to provide people with an opportunity to share their thoughts on how the service was run. These had not taken place in the last year. The registered manager had also devised a template for feedback surveys which were to be given to people in the next three months as a means of seeking feedback on ways that they could improve the service.

There was also evidence of positive changes that had been made in response to feedback. For example, following induction some staff had suggested that an extended period of shadowing would be helpful. The registered manager had now extended the time that new staff spent shadowing so that they had at least a full week in each house. There had also been progress in recruitment and the continuity of staffing. One relative had provided feedback in May 2015 to say that the lack of continuity in staffing was a negative point. In a letter from this same relative dated January 2016 we read, '(name of person) has very poor communication skills and can feel threatened/insecure which has led to our concerns when both managerial and care staff have been agency, however good leadership over the past 18 months has led to a noticeable improvement in permanent staffing levels'.

The registered manager was well respected by people and staff. When we were being shown around the service, one person was clearly happy to see the registered manager and said, "I like you". One staff member

told us, "I'm proud of (the registered manager) for taking on the role she has and for doing two jobs, and especially the support she gives to other people. She's an amazing lady". Another said, "I love (the registered manager), she has been the kindest and most wonderful manager". A third told us, "(the registered manager) is really approachable, she never minds being hassled!" The registered manager told us that she had an open door policy and spoke of her commitment to the wellbeing of people who lived at the service. There were regular staff and senior staff meetings which were used to plan forthcoming reviews of people's care and to discuss any changes. Staff were able to add items for discussion to the agenda of these meetings.

There was an open and positive culture at the service. The registered manager and senior team were approachable and were highly motivated to see that people were supported to live their lives to the full. On relative had written in a letter to the staff, '(Name of person) is always happy to return to Tozer, often forgetting to say goodbye and he makes his way to his house'. A staff member said, "When I came here I got a positive vibe, it's a homely environment, not institutionalised. It's got a nice feel and the whole team were very welcoming". Another told us, "It's not like a job, we know everyone. They know me like I'm a family member. When my dog was ill they all asked me how the dog was". Staff felt valued and were engaged in contributing ideas to improve the care that people received. One staff member told us, "I feel I've been able to make a contribution to the team and it has been appreciated. (The registered manager) will always come and say 'Thank you'". Another said, "I come home exhausted and tired but always smiling".

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify the Commission of allegations of abuse in relation to service users. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Medicines were not managed safely.<br><br>Regulation 12 (2)(f)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes to assess, monitor and improve the quality and safety of the services provided were not established or operated effectively.<br><br>Records in respect of staff and the management of the service were not always up-to-date and could not always be easily located.<br><br>Regulation 17 (1)(2)(a)(d)(i)(ii) |