Care Quality Commission

Royal Bay Care Homes Ltd

Claremont Lodge Care Home

Inspection report

Fontwell Avenue, Fontwell
Eastergate
Chichester
West Sussex
PO20 3RY

Tel: 08451256166
Website: www.royalbay.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 19 June 2017.

Claremont Lodge Care Home is registered to provide nursing and residential care for up to 35 older people. The home is purpose built, with all rooms having ensuite facilities. There are extensive landscaped gardens surrounding the home and ground floor rooms have patio doors that open on to garden area. At the time of our inspection 27 people were living at the home. People's needs varied. Some people were quite independent and only needed minimal assistance whilst others required assistance with all aspects of their care.

During our inspection the registered manager was present. 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.

At our previous inspection in May 2015 we found that as and when required (PRN) medicines were not always managed safely and this resulted in a breach of regulation. In response, the registered manager sent us an action plan that detailed the steps that would be taken to address this. At this inspection we found that medicines were managed safely and the previous breach of regulation was met. Staff followed safe medicine administration procedures and people said they were happy with the support they received to manage their medicines.

People told us that staff were kind, caring and respectful and we observed this to be the case during our inspection. People said that they were treated with respect and dignity and that their rights were promoted. We observed interactions by staff that were genuine and warm however, some people and staff commented about staffing levels. People said that this did not affect their safety but that they affected the quality of care provided. This is an area for development that the provider has started to act upon.

Staff were suitably trained and skilled and received training relevant to the needs of people who lived at the home. Staff were supported and received group and one to one supervision. Staff had received safeguarding training and reporting procedures were in place if abuse was suspected.

People said that they were happy with the medical care and attention they received. People's health needs were managed effectively. Potential risks to people were assessed and information was available for staff which helped keep people safe. Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely and staff practiced safe moving and handling techniques.

Quality monitoring systems were in place to ensure action was taken when areas for improvement were identified. Robust recruitment checks were completed to ensure staff were safe to support people. Everyone that we spoke with said that the registered manager was a good role model. Staff, people who

lived at the home and their relatives said that the registered manager actively sought their views, listened and acted upon them. Views were sought via questionnaires and during group meetings.

People received responsive care based on their individual needs. A new care planning system was being introduced at the home that would provide more detailed care plans for staff to refer to. It would also give people greater opportunities to be involved in any reviews of their care.

People said that they consented to the care they received and that their freedom of movement was not restricted. Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise.

People said that the food at the home was good and that their dietary needs were met. There were a variety of choices available to people at all mealtimes. There were no restrictions on visiting times and relatives were able to have meals with their family members if they wished. People said that they were happy with the choice of activities on offer and that they were supported to maintain links with people who were important to them.

Information of what to do in the event of needing to make a complaint was displayed in the home. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's views on staffing varied. There were enough staff on duty to provide safe care. The provider had started to take action in an effort to recruit more permanent staff in order to reduce the reliance on agency use.

People told us they felt safe. Safeguarding procedures were in place that offered protection to people.

Medicines were managed safely.

Risks were assessed and managed safely with risk assessments providing information and guidance to staff.

Staff underwent robust recruitment checks to make sure that they were safe to care for people.

Is the service effective?

Good

The service was effective.

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life.

People consented to the care they received. The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and followed the requirements of the Mental Capacity Act 2005.

People were supported to eat a choice of meals that promoted good health.

People told us that they were happy with the medical care and attention they received. People's health and care needs were managed effectively.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff. Caring relationships had been developed that promoted people's sense of wellbeing.

Opportunities were available for people to express their views and to be involved in making decisions about their care and support. Involving people in the reviewing of their care plans would expand people's opportunities further.

People were treated with dignity and respect. Staff were able to explain how they promoted people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and action was taken in response to their individual needs and preferences. People were supported to express their views but were not always involved in making decisions about their care and support. A new care planning system was being introduced that would address this.

An activity programme was in place and people expressed satisfaction with the range of activities available.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns and their views and opinions were acted upon.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a positive culture which was open and inclusive.

Systems were being used to identify and take action to reduce risks to people and to monitor the quality of service they received.

People spoke highly of the registered manager and said that the home was well-led. Staff felt well supported and were clear about their roles and responsibilities.

Claremont Lodge 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 checked 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 19 June 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

During the inspection we spoke with 12 people who lived at the home and three visiting relatives. We also spoke with the registered manager, the deputy manager, two nurses, two permanent care staff, one agency care staff and the activity coordinator. We contacted two external health professionals to obtain their views on the service provided.

We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon. We also observed medicines being administered.

We reviewed a range of records about people's care and how the home was managed. These included five

people's care records and 20 people's medicine records. We also looked at five members of staffs training, support and employment records, audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

Good

Is the service safe?

Our findings

People said that they felt safe and we observed that they appeared happy and at ease in the presence of staff. However, people commented about staffing levels and the use of agency staff. One person said, "I feel very well looked after, I'm never ignored but sometimes things don't happen as quickly as they should." A second person said, "Yes I feel safe, but I have to be moved with a hoist and that takes two people so I often have to wait a long time. You can ring the bell for ages before anyone comes." A third person said, "Most of the time the staffing is okay, but only just, they could do with more staff especially at getting up time and going to bed."

A relative said, "I do feel she's (family member) nice and safe here. I never have any worries about her being here." An external professional told us, "There always appears to be a good number of both trained and untrained staff on duty which aids in keeping the patients safe."

Staff's views on staffing varied. One staff member told us, "We are short staffed sometimes and we have a lot of agency staff working with us at the moment. Dealing with them is time consuming. It's nice to have the help but you spend a lot of time directing them, especially if they're new to the home." Another staff member said, "We could definitely do with more care staff. We usually have five carers on in the morning and four in the afternoon. We're told it's enough because the nurses can help out with the care. It's not possible most of the time as there are medicines to do, plus writing care plans, doing dressing, seeing relatives and more. I think that if some of the HCAs (health care assistants) took fewer breaks, there would be more time to spend with the residents." A third member of staff said, "Agency make up the numbers. It can be more difficult when they are new here but I have to say they are fab though. They (management) do try and get regular agency but it's not always possible. Two of the three agency today have been here before. It's nice for the residents to have familiar faces." The views regarding staffing levels were also reflected in a staff survey completed during March 2017 where 10 of the 13 staff expressed the view that at times there were not enough staff on duty.

The registered manager told us that a dependency tool was available to decide staffing but that she did not use this as she was able to decide staffing levels due to her knowledge of people at the home. However when we asked to view the dependency tool this could not be located. The registered manager confirmed that 20 people who lived at the home required the assistance of two staff with aspects of their care. The registered manager said that there were always two nurses from 8am to 8pm and one of a night. Of a morning there were between five and six care staff and during the afternoon four care staff. Of a night there were three care staff. The registered manager was supported by a deputy manager who was nurse qualified and included in the nurse numbers when on shift apart from once or twice a week when they were supernumerary.

In addition, there were separate administration, kitchen and domestic staff which helped care staff and nurses to focus on supporting people who lived at the home.

The registered manager confirmed that vacant posts were being covered by bank or agency staff and that

she was aware that some people who lived at the home were not always satisfied with these staff. Agency staff always worked with a permanent member of staff in order to attempt to minimise the impact of using agency staff who may not be as familiar as regular staff with people's needs.

We observed that on the day of our inspection, there were on the whole sufficient staff on duty to provide safe care. However, the quality of the lunch time dining experience for some people would have benefited if more staff were present. This is reported on further in the 'Effective' section of this report. We did note that call bells rang constantly throughout the day. However, when we examined the records of response times these showed all had been responded to within five minutes which assured us that people received assistance promptly. We fed back to the registered manager people's views on staffing. She said she would raise this with the provider. After the inspection the registered manager sent us documentary evidence that confirmed that the provider had taken action in order to attempt to recruit more permanent staff. This is an area for continued development at the provider has started to take action to address.

Robust recruitment checks were completed to ensure staff were safe to support people. Staff files confirmed that criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This check helps to ensure staff are safe to work with people who use care and support services. Other checks had also taken place which included obtaining references and proof of ID and confirmation that nurses were registered to practice with the National Midwifery Council.

Systems and processes were in place to safeguard people from harm and abuse. The staff members we spoke with had undertaken adult safeguarding training within the last year. They were able to identify types of abuse and they understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. They were also aware of the provider's whistleblowing policy. One staff member told us, "I would let the CQC know (if the manager didn't act) but I know the manager would." Another staff member told us, "We need to make sure people are safe and that they get good care."

Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. The registered manager demonstrated understanding of her responsibilities to report concerns and protect people from harm and abuse. Prior to our inspection, when a concern was raised she followed the instructions of the local authority and also submitted a notification to CQC.

At our last inspection a breach of regulation was made in relation to medicines. The registered manager sent us an action plan that detailed steps that would be taken to achieve compliance. At this inspection we found that the breach had been met.

The administration and management of medicines followed guidance from the Royal Pharmaceutical Society. Trollies were not left unattended when unlocked and medicines were not signed for until taken by the person. There were no gaps in staff signatures on the Medicine Administration Record (MAR) sheets we sampled. There were assessment tools available for staff to measure the level of pain people were experiencing which were used to gauge the appropriate level of pain relief needed.

Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Medicines requiring refrigeration were stored in a locked fridge which was not used for any other purpose. The temperature of the fridge was monitored regularly to ensure the safety of medicines.

Medicines given on an 'as needed' basis (PRN) were managed in a safe and effective way. PRN protocols were in place, which outlined why and how people were to receive these medicines, along with possible side effects and contra-indications. We also noted that 'time-critical' medicines were given at the appropriate time. The registered manager had also gained consent from people's GPs to administer 'homely remedies' as and when they needed. These are medicines that are normally available 'over the counter', such as paracetamol for pain relief and antacids for gastric reflux/indigestion.

We noted one person had a percutaneous endoscopic gastrostomy (PEG) in place. PEGs involve placement of a tube through the abdominal wall and into the stomach through which nutritional liquids and medicines can be infused, when taking in food and drink orally was limited or no longer possible. Staff were knowledgeable about the management of these; all nursing staff had been trained in this area.

One person living at the home managed their medicines independently. They had received a mental capacity assessment to ensure they could manage safely and had formally acknowledged their desire to do so. We noted their medicines were safely stored in a lockable cupboard.

Staff received regular training updates and the registered manager told us that this included medicine administration competency checks. However, we did not see documentation to confirm the competency checks were completed and when we asked to view this none were produced. This is an area for development to ensure there is a clear record of competency checks completed.

A range of weekly and monthly audits in all areas of medicines management, including the obtaining, storing, dispensing and disposal of medicines were completed. We noted that issues identified as a result of these audits were acted upon in a timely and satisfactory manner.

Risks to people's safety were managed appropriately. People's records contained up to date and relevant information concerning the risks associated with independent movement, including bed rails risk assessments and falls prevention strategies. These were regularly reviewed and updated as required. We spoke with staff about people's right to free movement and to take risks. One staff member told us, "We don't restrict people if we can avoid it." Another staff member said, "We have to keep people safe but that doesn't mean they can't come and go as they want."

We noted several people were at risk of having falls. The registered manager kept a record of these in order to ascertain whether falls reduction measures could be put in place. People underwent a falls risk assessment and subsequent falls intervention assessment. A frequent falls register which included information on the contributory factors to the fall and recommended future actions was also in place. The staff members we spoke with were knowledgeable in this area.

The relative of one person told us how their family member had been supplied with a sensor mat next to their bed as they were subject to falls. However as the conversation progressed the relative told us that their family member had said they did not like the black hole beside their bed. It appeared that they had been attempting to avoid the sensor mat because of poor eyesight and a medical condition which meant they perceived the mat as a hole and therefore a danger. Records were in place that confirmed the sensor mat had been put in place as the person was prone to falls. One completed in March 2017 stated the fell as they 'walked around pressure mat.' We discussed this and the family member's comments with the registered manager. She immediately made arrangements to purchase a different device and made a referral to the falls prevention team.

Suitable equipment such as hoists and wheelchairs were available for staff to use; each sling was for one

person's use only. Information about people's specific moving and handling requirements was included in their rooms so that staff had easy access to this. This included information about the number of staff needed to move the person safely, if a hoist was needed and details about the sling. The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. The registered manager completed audits of the environment to ensure it was safe. The audit dated 18 May 2017 identified that night staff needed to participate in a fire drill and that small electrical items required testing. These were arranged to be addressed during the week of our inspection.

Good

Is the service effective?

Our findings

People said that they felt the regular staff were well trained and knew their needs. One person said, "I think they're well trained and they adhere to the training. There's always two carers for lifting me. There's too many agency staff but they always have one agency and one regular staff when helping me." A second person said, "The regular girls are very well trained but the agency staff don't seem to know as much." An external professional told us, "I believe the staff are competent with managing medications and setting up syringe drivers for end of life appropriately."

Staff were skilled and experienced to care and support people to have a good quality of life. New staff completed an induction programme at the start of their employment that followed nationally recognised standards. Staff told us that they received sufficient training to undertake their roles and responsibilities. One nurse told us, "Since I have been here I have done training in end of life care and verification of expected death. There will be more training I think." Another nurse said, "That's never been a problem. My thing is end of life care and I've just been on a four day course. It was really good."

Records confirmed that staff were trained in areas that included fire safety, first aid, food hygiene, infection control, moving and handling, safeguarding and health and safety. A training programme was in place that included courses that were relevant to the needs of the people who lived at the home. Nurses and care staff had received training in areas that included continence care, end of life/palliative care, diet and nutrition and dementia care. One member of staff explained, "We have to keep up to date with our training. We complete booklets, one is about evidence and knowledge and the other questions. We have to research and complete then they are sent off and marked and if we pass we get a certificate. Its good as it makes you look into things and think."

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions and group staff meetings. Staff said that they were fully supported. One staff member said, "I get supervision every month. It's okay but it feels sometimes like we're going over the same things." A second staff member told us, "Yes, I get supervision from time to time. There is a theme each time and we discuss it so the managers know we understand it."

We attended a handover meeting in the afternoon, attended by care staff coming on duty and led by the deputy manager, which was convened daily. The purpose of this was to discuss the health and welfare needs of people living at the home and, if necessary, adjust the care to better meet people's needs. We noted discussions were person centred rather than task oriented. It was clear staff possessed a high degree of knowledge about the people they were caring for.

People said that they consented to the care they received. 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 asked staff about issues of consent and about their understanding of the MCA. They could tell us the implications of Act and of DoLS for the people they were supporting. Staff understood the rights of people to take risks. One staff member told us, "If someone has mental capacity, then they can weigh up the risks and it's up to them." A second member of staff said, "If someone has capacity always ask how they want things done. If less capacity we have to do things in their best interest and rely on contents of care plans."

The registered manager demonstrated understanding of her responsibilities in relation to the MCA and DoLS. She explained, "We do the acid test when people move in and if needed submit a DoLS application. We encourage choice regardless and respect people's wishes. People's preferences are sought and acted upon. We teach staff that regardless of people's abilities they must be able to take risks." Mental capacity assessments were in place for people who required them, which included information about the person's level of ability to make decisions for themselves. We noted that several people were subject to DoLS authorisation. The documentation relating to these was relevant and up to date. The requests made by the registered manager for authorisation were 'decision specific.' This meant there was a stated reason or reasons why the person should be deprived of aspects of their liberty.

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. The registered manager involved a range of external health and social care professionals in the care of people, such as dieticians, speech and language therapists and Consultant Ophthalmologists. We noted advice and guidance given by these professionals was followed.

People said that the food at the home was good and that their dietary needs were met. One person said, "The food is excellent and they are always willing to do something else if you don't want what's on the menu." A second person said, "The meals are marvellous, occasionally if the kitchen is short staffed there may be a little lapse of standard but on the whole it's absolutely wonderful." A third person said, "The meals are very good, they make my husband very welcome when he comes on a Sunday and Wednesday and he has a meal with me because it's a roast then and he wouldn't cook a roast for himself."

We observed the lunch time dining experience and saw that there were jugs of juice available for people and these were offered at the start of the meal. There were eight people who chose to have their meal in the dining room; some were offered sherry at the start of the meal. We observed meals were well presented and looked appetizing. We noted that a member of staff supported one person to eat. When doing this the staff member was patient and offered encouragement and support. We observed two people who were able to eat independently but would have benefited from staff support as they dropped items of food they were attempting to put into their mouths. There was no staff available apart from the one who was already helping another person. We saw that there was good signage regarding food/menu options both written and in picture form for people who were unable to read.

It was an extremely hot day and we noted that there were jugs of juice available in the dining room and that staff asked people if they wanted drinks and encouraged people to drink to avoid dehydration. Every person's room we visited had a fan to help keep them cool.

Good

Is the service caring?

Our findings

People said that they were treated with kindness and respect. One person said, "The girls are very kind, they always, always treat me with respect. They always keep your door closed when they are helping you with washing and dressing, they're very good." A second person said, "They know what to do for me now and how I like things done so they don't need to ask, they just do it. But then they do say shall I do this for you, or shall I do that. They're very friendly, you need that."

We observed positive interactions between people and staff who consistently took care to ask permission before intervening or assisting. We observed interactions by staff to people that were warm, positive, respectful and friendly whilst remaining professional. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose and meant that the care given was of a consistent standard.

Staff understood the importance of respecting people's privacy and dignity and of promoting independence. One member of staff said, "Some people like to wash bits of their body themselves so we let them. Also talking is important." A second member of staff said, "It's important to be mindful that people have preferences such as how they want to be washed. Be respectful and explain what you are doing and why."

A notice on display near the entrance of the home reminded staff 'Remember that when you are going into an individual's room you are probably going into the only space they can still call their own. Act as you would in anyone's home, giving the person your full attention.' We observed staff respected people's right to privacy; all staff we observed knocked before entering people's rooms. Staff also placed a sign on people's doors when they were in receipt of personal care, notifying people not to enter. The registered manager told us that she walked around the building to observe staff practice promoted dignity and respect.

People were supported with kindness and consideration when reaching the end of their life. End of life care plans detailed what care and support people wanted and arrangements were in place for medicine that would ensure a pain free death. The registered manager worked closely with a local hospice who also gave support to people who were reaching the end of their life. Staff had received training in death, dying and bereavement.

Relatives were welcomed at the home. There were no restrictions on visiting times and relatives were able to have meals with their family members if they wished. Written compliments had been received from relatives thanking the registered manager and staff for events they had arranged and the care and compassion that was shown to their family members.

People were supported to express their views and to be involved in making decisions about their care and support informally on a day to day basis. We noted that care plans and risk assessments were reviewed regularly by staff but found little evidence that people or their representatives had regular and formal

involvement in on-going care planning or risk assessment. One person had signed a form to state they agreed with the content of the care plan but they had no further formal involvement. Some people we spoke with were not sure what a care plan was and whether they had one. One person asked us, "What's a care plan?" and when we explained they said, "Oh no I don't have anything like that." Another person told us, "They probably talked my care through with my husband more than me. I expect he'd know." We fed this back to the registered manager who agreed this was an area for development. Despite this, opportunities for people to express their views were in place as resident/relative meetings took place. These usually were linked to a planned activity. One member of staff explained, "We tie the meetings with an activity such as a cheese and wine event as we get a better attendance." The minutes of a residents/relatives meeting that took place during March 2017 were on display. These confirmed people's views had been obtained on areas that included activities and the increased use of agency staff.

Good

Is the service responsive?

Our findings

People received responsive care based on their individual needs. An external professional told us, "The systems within the nursing home appear safe and if anyone is in any doubt about a patients care plan or symptoms they contact me to arrange a review."

One person had developed a pressure sore before admission to the home. We noted risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration. The person had been placed on an air mattress, the pressure of which were calibrated and regularly checked. The wound had been treated by the nurses at the home. We noted photographs of the wound were taken regularly and body maps updated. The wound was dressed according to a prescribed protocol and was completely healed by the time of our visit.

We did note that the contents of some people's care records were not detailed and had the potential to impact on the service they received. For example, one person had recently started to present with challenging behaviours and did not have a care plan in place for this. A challenging behaviour record was used to describe incidents after they occurred and evidenced staff responded to incidents as they occurred. However, a holistic management plan would give guidance to staff in order to prevent incidents before they occurred. The registered manager said that she would ensure this person had a care plan put in place immediately.

Peoples care plans were legible and securely stored. However, they were not person centred; people's choices and preferences were not consistently documented. The care plans we looked at did not contain any meaningful information about people's social and personal histories. It was not possible to 'see the person' in these documents.

The registered manager was aware for the need to improve care documentation. We were shown evidence of a new care planning system that was due to be introduced at the home once staff had completed training in its use.

Most people were enthusiastic about the activities and in particular had enjoyed the vintage tea party that had taken place the week before which families attended. It was clear from what people told us and our observations that the activities co-ordinator worked hard to try and ensure that people had something on offer each day. People who stayed in their rooms told us that the activities co-ordinator visited them sometimes and this was borne out by our observations on the day. The activity coordinator demonstrated a clear knowledge of peoples likes and dislikes in terms of the type of activity they would like to take part in. She explained that most in house activities took place in the communal areas as, "We bring people to the communal area as it encourages those who say they don't want to join in to do so. They see others joining in and then decide to participate."

On the day of inspection during the morning some people were seen enjoying a game of dominoes and an external musical entertainer visited during the afternoon. The activity person on duty explained that she

had completed dementia training and that this helped her to organise activities with consideration of the needs of people living with dementia. They explained, "We do reminiscence and lots of quizzes. There is a diverse range of people and no one is left out. I build the activities around the residents. They are very much based on what they want. I do one to one with people, chat in their rooms and walk with them around the gardens.

We saw that some people sat out in the garden to enjoy the fine weather and we observed that the activities co-ordinator checked on them at intervals to see whether they wanted to move into the shade or back into the building. Raised flowerbeds in the garden had flowers planted by people who lived at the home.

A folder was maintained near the entrance of the home that contained photographs of activities and events that people had participated in. these included visits to Chichester cathedral flower festival, attendance at a remembrance service and to a farm. The home had its own transport that was used to support people to access activities in the wider community with an outing arranged each week.

People were supported to raise concerns and complaints without fear of reprisal. People told us that they would complain if something upset them and that they would complain to the manager although they were then quick to say that they had never had cause to make a complaint. One family member told us how they had made a complaint which they had raised with the registered manager who had acted upon it immediately. The relative told us that they felt confident that if they needed to complain about anything else that they would be listened to.

Staff we spoke with were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures, which were on display in communal areas. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. A record was in place of complaints received that included a record of actions taken to investigate the complaint and outcome.

Good

Is the service well-led?

Our findings

Staff said they thought the home was well-led. One staff member told us, "I think so. I do feel part of a team and I can go to the manager or deputy if I have a problem." Another staff member said, "Yes, without doubt. I think it's a good place to work." A third member of staff said, "I love my job, and like working for the home." One member of staff told us that if she saw anything untoward from one of her colleagues she would have no hesitation in speaking to the registered manager about it and felt sure that it would be acted upon and dealt with quickly. However she then went on to say that she'd never seen anything that had given her cause for concern. She said she felt "The manager is good and fair."

A range of staff meetings took place to share information with staff and to obtain their views. One member of staff told us, "Normally they try and do a staff meeting monthly but they can't always. Basically we have carers meetings, trained staff meetings and also full staff meetings. If you can't attend they put the minutes of the meetings in the staff room and in the nurse room so you still informed."

The registered manager was aware of the need to create a positive culture at the home to ensure this was inclusive and empowering. The provider had implemented a Duty of Candour policy. Duty of candour forms part of a regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. The registered manager demonstrated understanding of the policy and reflected an open and transparent demeanour throughout our inspection. For example, she told us, "When we have residents/relatives meetings I advise everyone that I am always available, that I have an open door policy. When issues are raised I try and act as soon as possible. I try and be open and transparent."

A range of quality assurance audits were completed by the registered manager to help ensure quality standards were maintained and legislation complied with. These included audits of medicines, complaints, infection control, dignity, activities, accidents and incidents, meals, care and health and safety. The registered manager confirmed that call bell response times did not form part of any audit but said, "If there was a concern I would pull up the information from the system to check." The findings from audits were included in weekly reports that were shared with the provider and a representative of the provided visited the home on a monthly basis. The registered manager was aware that staffing and care planning needed to improve to ensure people received a consistent quality service. For example, arrangements had been made for a new electronic care planning system to be introduced that would ensure comprehensive, personalised care plans and documentation were in place for all people.

People's views were obtained in order that these could be used to drive improvements at the home. For example, their opinions on activities were obtained during February 2017 and catering questionnaires were completed March 2017. Ten people completed a catering questionnaire with the majority confirming that

they were happy with the meals provided. One person commented that they thought meat could be more tender and this was passed onto the chef and addressed. Many people commented positively about the new chef and change of menu. Two people commented that they felt more staff were needed and these comments were reflected by what people told us on this inspection.

During March 2017 four professionals completed questionnaires. All praised the home and the staff that worked there. One person wrote, 'Best care home in area.' Another wrote about the registered manager stating, 'Very friendly and efficient.' A third wrote, 'The care provided was excellent and the staff kind and caring.'