Littlefair Care Home Limited

Littlefair

Inspection report

Warburton Close
East Grinstead
West Sussex
RH19 3TX

Tel: 01342333900

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 August 2016 and was unannounced.

Littlefair is registered to provide accommodation with personal care and support for up to 41 older people. At the time of this inspection there were 35 older people, some of whom were living with dementia. The home is a large purpose built property spread over three floors with a well maintained garden and accessible patio area.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had recently left. The provider had an acting manager in place while recruiting a new registered manager.

The home was currently in a transitional period due to new management and staff that had recently left. People had variable experiences because of this and we found areas for improvement.

Medicines were not always managed safely and recorded correctly The provider had not ensured care and treatment had been delivered in a safe way, medicines and risks to people had not been managed safely.

The provider had not ensured peoples nutrition and hydration needs were documented correctly and guidance for staff was insufficient to support people to eat and drink safely. People were not always supported to eat and drink safely and their needs and preferences were not always recorded or respected.

People had their needs assessed and care plans devised to inform staff of their care and support needs. People told us that they were involved in their care and could make their thoughts and suggestions known. However Our findings in relation to the quality and detail of the guidance in the care plans were mixed.

Although people and staff told us they had meetings, people and staff felt that they had not been kept up to date fully on the changes that had been taking place at the home. People were concerned why some staff had left with little or no explanations. One person told us "They should have a meeting with us and tell us what's going on".

There were no formal supervision arrangements for the acting manager and limited oversight of the management of the home by the provider.

The experiences of people were positive. People told us they felt safe living at the home, staff were kind and compassionate and the care they received was good. One person told us "I'm amazed how caring they all are, even the younger ones that you might think wouldn't be that interested". Another person said "They're always happy to see me in the mornings and have a smiley happy face for me". We observed people at

lunchtime and through the day and found people to be in a positive mood with warm and supportive staff interactions.

We found staffing levels were consistent over time with the provider using permanent and bank staff. The majority of people felt there was enough staff to meet their needs. One person told us "Most of the time yes there is enough staff, sometimes I wait a little longer for them to come when I call my bell but they are busy and always come to me". The provider was also currently recruiting more staff.

People's safety was maintained as they were cared for by staff that had undertaken training in safeguarding adults at risk and who knew what to do if they had any concerns over people's safety. Risk assessments ensured that risks were managed and people were able to maintain their independence. One member of staff told us "Any concerns I had like if I noticed someone's mood had changed or any marks on their body, I would report straight away no hesitation".

People's consent was gained and staff respected people's right to make decisions and be involved in their care. Staff were aware of the legislative requirements in relation to gaining consent for people who lacked capacity and people confirmed that they were asked for their consent before being supported.

Staff felt fully supported by the acting manager to undertake their roles. Staff were given training updates, supervision and development opportunities. For example staff were offered the opportunity to undertake a diploma in health and social care. One staff member told us "We do quite a bit of training and do updates each year".

The acting manager was fully involved in the day to day running of the Home. People and staff felt they were approachable and supportive. There were systems of quality assurance in place that provided evidence of the monitoring of the service and actions for improvement.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely or recorded correctly.

There were sufficient numbers of suitably trained staff employed to meet the needs of people. Recruitment processes were robust to ensure that staff were safe to work with people.

Staff had received training and understood their responsibilities regarding keeping people safe from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported to eat and drink safely and their requirements were not always recorded or respected.

Staff were aware of the requirements under the Mental Capacity Act (MCA)
2005 and responsibilities with regard to Deprivation of Liberty Safeguards
(DoLS).

Staff had the knowledge and skills to meet people's needs. They received regular supervision and appraisal.

Is the service caring?

Good

The service was caring.

Staff treated people with courtesy and kindness and people felt cared for.

There were residents meetings and people were encouraged to be involved in day to day decisions and make their own choices.

People were treated with dignity and respect and were supported to maintain contact with family and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not all up to date so staff did not always have the most up to date information on how people needed to be supported.

Staff were knowledgeable about people's support needs, interests and preferences and supported them to participate in activities that they enjoyed.

There were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were no formal supervision arrangements for the acting manager
and limited oversight of the management of the home by the provider.

There were systems of quality assurance in place that provided evidence of the monitoring of the service and actions for improvement.

The acting manager was fully involved in the day to day running of the
home. People and staff felt they were approachable and supportive.

Littlefair

Detailed findings

Background to this inspection

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

The inspection took place on the 10 August 2016 and was unannounced.

The inspection team consisted of an inspector, inspection manager 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. In this case the expert had experience in older people's services.

On this occasion we did not ask 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.

Before the inspection we checked the information that we held about the service and the provider. This included statutory notifications sent to us by the manager about incidents and events that had occurred. 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.

During our inspection we spoke with 14 people, three relatives, five care staff, kitchen and domestic staff, an activity co-ordinator, a team leader, an acting manager and the registered provider.

We reviewed a range of records about people's care and how the service was managed. These included the care records for six people, medicine administration record (MAR) sheets, five staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We observed care and support in the communal lounges and dining room during the day. We spoke with people in their rooms. We also spent time observing the lunchtime experience people had and a member of staff administering medicines.

The home was last inspected on the 17 and 19 November 2014 and no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the service. Comments from people included "Oh yes, I feel very safe here my family visit me and know I am safe", "I'm not frightened or upset about anything and I know if I was they would do their best to make it better for me" and "If I didn't feel safe I'd probably speak to the carers first and then the manager if I needed to, she's nice enough to talk to". A relative told us "My relative likes it here and feels homely and safe here, the staff make sure of that". However, despite these positive comments, we found an area of practice that requires improvement.

Medicines were not always managed safely. We observed the acting manager administering the morning medicines for people. With one person we saw the acting manager explain the medicines and how the person needed to take them. The acting manager stayed with the person until all the medicines had been administered and completed the persons MAR. The person told us "Oh she always takes her time there is never any rush". However the acting manager was the only member of staff trained to administer medicines on duty. Morning medicines were still being administered at 10:36am and eventually completed by 10:45am with the acting manager consistently being interrupted due to being the only senior person on duty at that time which could have led to errors being made. This delay did not appear to be a one off and meant that people's medicines were not evenly administered throughout the day. For example one person's MAR stated they needed to take their medicines 30 to 60 minutes before having any food, which both the person and acting manager agreed was not happening.

Each time as and when needed (PRN) medicines had been administered an entry had been made on individuals MAR but the reason for administration had not always been entered. Therefore it was not possible to establish why these medicines had been administered and the effectiveness of them. There were no specific guidelines in place in relation to when 'as and when' needed medicines should be administered for example; in what circumstances a pain relieving medicine could be administered or topical cream should be applied, for how long or at what point medical advice should be sought in order to ensure that they would be consistently administered. A lot of people had been prescribed topical creams for which their MAR specified 'apply as directed' but there was no detailed guidance for where on the body they should be applied or how often. Therefore the provider had no way of assessing whether these medicines were being administered as the prescriber intended, assessing whether the medicines were effective or of monitoring the person's condition.

Medicines which had a short shelf life such as eye drops had been opened but had not been recorded. The majority of creams and eye drops in use had not been dated when opened despite the prescription label saying discard after 28 days. Therefore there was a risk that people could be administered out of date medicines which may cause them harm or be less effective.

Medicines were stored in a recess by the kitchen which was very noisy and could be distracting for staff. We discussed the unsuitability of this with the acting manager who agreed and told us of their intention to convert some of the dining room into a quiet medicines room. However no timescales were given and they said they would be discussing this again with the provider. Medicines that were required to be stored below

a certain temperature were stored in the fridge, fridge temperatures had been monitored and recorded to ensure that the medicines were stored at the correct temperature. However, observations showed that medicines that needed to be returned to the pharmacy and those that were required to be stored in the fridge, were not stored securely.

Medication administration records (MAR) contained gaps which should have included the signature of the member of staff that had administered the medicine or a code to indicate why it had not been administered. One person's medicine was in stock however it had not been recorded on the persons MAR. Therefore it was not apparent that it was being administered to relieve the person's symptoms. A MAR for another person who required a cream to be applied twice a day had not been consistently completed, indicating that it may not have been administered. There was no evidence to show that these gaps had been identified prior to our visit or that any investigation had been undertaken to establish the reason for them.

One person's life effecting medicine could not be found. The acting manager told us that this was still being prescribed but did not know where it was. They thought it may be in the person's room but could not be sure. This medicine should have been easily accessible at all times and clearly recorded as to when it was needed, which placed the person as risk of not being able to receive their medicines. The acting manager was asked to look into this immediately. Subsequently to the report being produced the acting manager stated the medicine was always kept in the person's room and they also kept a spare in the medicine cupboard in the office, in case the person is in a different part of the building.

The provider had not ensured care and treatment had been delivered in a safe way, medicines and risks to people had not been managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of abuse because staff understood how to identify and report it. Staff had access to guidance to help them identify abuse and respond in line with the policy and procedures if it occurred. They told us they had received training in keeping people safe from abuse and this was confirmed in the staff training records. Staff described the sequence of actions they would follow if they suspected abuse was taking place. They said they would have no hesitation in reporting abuse and were confident that management would act on any concerns. One member of staff told us "Any concerns I had like if I noticed someone's mood had changed or any marks on their body, I would report straight away no hesitation". Staff were also aware of the whistle blowing policy and when to take concerns to appropriate agencies outside the service if they felt they were not being dealt with effectively. We observed people smiling at staff and looking relaxed and happy in their company throughout the inspection.

Risk assessments identified hazards and how to reduce or eliminate the risk. For example one person's falls assessment included analysis of their room and flooring considered whether they presented a risk of trip, slip or fall for a person and how staff were to be observant of any hazards for the person. Other potential risks included the equipment people used and how staff could ensure they were used correctly and what to be aware of. For example in one care plan it described how one person used a walking frame to manoeuvre around the home. The plan detailed the support the person required. The assessment detailed how staff were to make sure the person was supported and reassured when needed. This meant that risks to individuals were identified and recorded so staff could provide care in a safe environment. Staff told us that they talked through the risks with people to ensure that they were happy with any suggested changes that would reduce the risk. One member of staff told us "[Person's name] likes to go out in to the garden some days and began to feel a little nervous that they may trip over. They now like a member of staff to accompany them as they feeler safer and we are there to reassure them".

The majority of people felt there was enough staff to meet their needs. One person told us "Most of the time yes there is enough staff, sometimes I wait a little longer for them to come when I call my bell but they are busy and always come to me". Another person told us "Some staff have left recently but they always attend to my needs. If you need someone you only need to shout someone is always around". A member of staff told us "We are a bit stretched sometimes if someone is sick or on holiday but we use agency staff, but things always get done". Staff rotas showed staffing levels were consistent over time and that consistency was being maintained by permanent staff and agency staff. When people required help they could press a call bell and staff wore pagers to inform them of who required assistance. The pagers were going off throughout the morning which gave an impression that staff were very busy. One person told us they had pressed the call bell to go to the toilet and was told they would have to wait. A member of staff told us they felt there was not always enough staff in the morning and some people required two members of staff to assist them. The acting manager told us they had used agency staff and ensured they came to work at the home regularly so they knew how the home worked and people saw familiar faces. People's care needs had been assessed so the acting manager could adjust the number of staff on duty based on the needs of people using the service. However we found there was not enough trained staff that were able to administer medicines to people and the acting manager had to carry out this duty. The deployment of staff needed to improve to ensure that there was sufficient staff that were able to effectively support people and their needs. The acting manager told us "We have a new member of staff starting next week and have interviews planned later on this week". The provider was currently recruiting more permanent staff around key times of the day and told us "We are looking at staffing and recruiting more as soon as we can and plan to also have our own bank staff to call on when needed".

Recruitment procedures were in place to ensure that only suitable staff were employed. Records showed staff had completed an application form and interview and the provider had obtained written references from previous employers. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded in the accident and incident book. We saw specific details and any follow up action to prevent a reoccurrence. Any subsequent action was updated on the person's care plan and shared with staff at handover meetings.

Requires Improvement

Is the service effective?

Our findings

People and relatives felt confident in the skills of the staff. One person told us "They know what they are doing, I think they are patient and skilled". Another person said "They all seem to know what to do and I'm not worried about how they do things for me". A relative told us "My relative is looked after and had an incident recently and they were so good on how they dealt with it". However, despite these positive comments, we found an area of practice that requires improvement.

Risks associated with eating and drinking were not managed and recorded consistently and guidance for staff lacked detail or was unclear. For example one person had a fluid chart in their room which recorded what fluids and food the person had throughout the day. It recorded the person had sips of juice, yet had not recorded the amount the person had or what the recommended amount was. There was no detail on what action had been taken on the days the person had drunk or eaten very little. In another person's care plan it was difficult to identify what actions had been taken regarding the persons significant weight loss since recordings started from February 2016. Only on a recent entry dated the 27 July 2016 was there reference made to staff chasing-up a dietician and the person's fluid and food intake being monitored through the use of a food diary. The food diary would enable staff to see what food the person was eating. This had not been completed fully nor did it provide sufficient information to be able to assess that the person was receiving appropriate food and nutrition. Therefore there was no robust way of monitoring or ensuring that people had the correct nutrition and hydration. Subsequently to the report being produced the acting manager provided evidence that the person's food and fluid chart had been completed, which was kept in the person's room. However had only recorded sips and still not the amount the person had taken.

The provider had not ensured peoples nutrition and hydration needs were documented correctly and guidance for staff was insufficient to support people to eat and drink safely. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime experience with the provider. The majority of people went to the dining area for their lunch and sat at tables which had cutlery, flowers, glasses, condiments and a centre piece containing information about the weather and the daily activities. People had two main choices to select from and could choose about an hour before lunch what they would like. One person who couldn't eat what was on the menu chose to have a jacket potato with cheese. Some people required to have their food pureed and some had thickener added to their drinks. People were also offered water or juice with their meals. One person who was at risk of choking started to cough and staff were very attentive in asking if the person wanted to get up and walk into the lounge to clear their chest which the person was keen to do. People chatted with each other at the tables and told us that they enjoyed their meals and in the main the food was described as good. One person told us "Yes, I fancied a cooked breakfast this morning which I enjoyed". Another person said "The roast beef was lovely and tender today". People told us that they had plenty of fluids and when in their rooms, always had easy access to their drinks. One person told us "I prefer this type of beaker as I have problems with my grip these days and they [staff] keep it close and topped up for me". We saw little interaction between people and staff. Staff were seen roaming, waiting to collect people's

plates. Some plates showed that very little had been eaten, a staff member asked people if they had had enough and then removed the plate with no attempt to further encourage the person to eat more. People who were sitting at the same table were served at different times. One example showed a table of four people being served at different times, so while one person's plate was cleared another person was still waiting for her meal. The issue was that meals were individually plated up by the chef so were held up within the kitchen as staff had to say what meal they wanted. A trolley which had a bucket on it was being used by staff to scrape waste food that people had left. This was positioned behind a table of people who were still eating. The chef and acting manager said that they had lots of ideas about how the dinning experience could be improved and the provider agreed that what had been observed needed to be improved and that this did not create a pleasant dining experience for people. The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that healthcare professionals should ensure that care provides food and fluid of adequate quantity and quality and in an environment that is conducive to eating'. We recommend that the provider access guidance regarding improving the dining experience and the support for older people at mealtimes.

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. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions. People and a relative confirmed that staff always asked for people's permission and consent before supporting them. One person told us "The staff ask me if I am happy before they do anything for me. Sometimes I like to have a rest in my room and they understand that".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty that these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority where required. We found that the acting manager understood when an application should be made and how to submit one.

People were cared for by staff that had the appropriate training, skills and experience. People told us that they felt that staff had appropriate and relevant skills to meet their needs. One person told us "They are good and know what they are doing". New staff were supported to learn about the provider's policies and procedures, undertake essential training and work towards the Care Certificate. The Care Certificate is a set of standards that social care and health workers work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers. In addition to this, staff that were new to working in the health and social care sector, were able to shadow existing staff to enable them to become familiar with the home and people's needs, as well as to have an awareness of the expectations of their role. One member of staff told us "I am shadowing a team leader before I start on my own and doing lots of training". Another member of staff said "We do quite a bit of training and do updates each year". Records showed that staff had undertaken essential training. The training plan documented when training had been completed and when it would expire to show when staff needed to attend a refresher training course. The acting manager had links with external organisations to provide additional learning and development for staff, such as a diploma in health and social care.

Staff received supervision and an annual appraisal. Supervision is a formal meeting where training needs,

objectives and progress are discussed as well as considering any areas of practice or performance issues. These meetings could also be used as competency spot checks to assess staff member's practice. Staff told us that they found these meetings useful. One member of staff told us "We have supervision and I have my annual appraisal due soon. It is good to sit down and talk about how everything is, we have had a lot of changes recently and it will be nice to catch up".

People received support from specialised healthcare professionals when required and visits from professionals were recorded in people's care plans. In one care plan it detailed one person was prone to a UTI (Urinary Tract Infection). A member of staff had noticed this person was becoming confused and first called a district nurse and then a GP who visited the person 24hrs later. The GP tested the person's urine and prescribed antibiotics, which were then collected and administered. This showed that staff responded to the person's healthcare needs in a timely manner. One person told us "I've no doubt that they would get a doctor for me if I was ill and I'm going off for a hospital appointment later today. The district nurse comes in to dress my legs each week". Another person told us "Yes the chiropodist comes to do my feet regularly and I see a dentist and my glasses get checked too". The acting manager confirmed that staff liaised with health professionals such as GP's, dieticians and district nurses in supporting people to maintain good health.

Good

Is the service caring?

Our findings

People and their relatives described the staff as caring and kind. Their comments included "The girls [staff] are good and look after me, they are very kind", "I'm amazed how caring they all are, even the younger ones that you might think wouldn't be that interested" and "They're always happy to see me in the mornings and have a smiley happy face for me".

There was warmth and affection in the approach of the staff when checking on people's comfort and well-being. We observed staff to have a cheerful and approachable disposition. Staff reassured and spoke to people in a kind, calm manner using eye contact and ensuring that they were at the same height as people when communicating with them. There was often an arm placed around someone's shoulders as they spoke to someone and we could see people were happy and comfortable with this. One member of staff asked if a person had their hearing aids in and offered to get them from their room. We observed another member of staff asking if a person wanted to go out into the garden to pick a flower. The person appeared very happy about this and held on to the flower smiling. Staff gently supported and guided people to move around, again a gentle arm was placed on someone's back or shoulders to reassure them.

Staff spoke about their roles with commitment and enthusiasm. Some staff members had been in post for a long period of time and attributed this to the enjoyment of their jobs. One member of staff told us "I have worked here for many years and enjoy my job. I ensure people are happy and help them in whatever they need". Another member of staff said "Despite all the gossiping that goes on in this place. I love the residents and keep on doing it in order to make a difference". We observed one person stretching their hands out when they saw a member of staff and they immediately stopped what they were doing and went to hold the persons hands. The person's body language showed that they welcomed this interaction and were at ease in the staff members company.

Care staff were aware of the need to preserve people's dignity when providing care to people. Care staff we spoke with told us they took care to cover people when providing personal care. They also said they closed doors, and drew curtains to ensure people's privacy was respected. One member of staff told us "When assisting people to the toilet we give them privacy and are close by if they need us. Some people require help so we are there to ensure they get it". People we spoke with confirmed their dignity and privacy was always upheld and respected. One person told us "I think they treat us well and we're not made to feel uncomfortable".

Staff recognised the importance of promoting people's independence. People confirmed they felt staff enabled them to have choice and control whilst promoting their independence. Care plans provided details on how staff could promote independence for people. One care plan recorded how a person needed encouragement on wearing clean clothes and to let the person choose and do what they could for themselves and staff to assist if required. Staff told us how they promoted peoples independence and let the person do as much as they could for themselves. One person told us "The staff help in the morning to get up, I could do it myself but sometimes need the help and they encourage me. They are very sweet".

Although people and staff were busy, the atmosphere at the service was calm and relaxed and people were spending their day in a manner that suited them. Some people chose to stay in their rooms, others in the lounge or dining room. Each person had their own room which had been personalised with their belongings such as furniture, photos and memorabilia. People we spoke with said they were happy with their rooms, that their beds were comfortable and they got the rest they needed and that they had everything they required. Visitors were welcome at any time and friends and family were coming and going throughout the day. Friendships had also established between people living at the service. We observed one person having a discussion with another person on their previous jobs they had throughout their life while smiling and chatting to each other.

Resident meetings provided an opportunity for people to make their thoughts known. For example, minutes of one residents meeting showed people had been involved in decisions regarding the menu and planning of the summer garden party that had been held. The provider recognised that people may need additional support to be involved in their care and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's confidentiality was respected. Staff understood not to talk about people outside of the home or to discuss other people whilst providing care to another person. Information on confidentiality was covered during staff induction, and the service had a confidentiality policy which was made available to staff.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff were responsive to their needs and staff were skilled in their role. One person told us "Oh the girls [staff] know what I like and do a great job". Another person told us "The staff know what they are doing, I don't know how they do it all. They are lovely". However, despite these positive comments we found an area of practice that needs improvement.

Care plans were person centred and reflected the individualised care and support staff provided to people. People's needs had been assessed before they moved into the service. These assessments had been used as a basis on which to formulate a care plan. Our findings in relation to the quality and detail of the guidance in the care plans were mixed. Some care plans were very detailed and provided specific guidance for staff to follow when supporting people with their individual needs, for example they included step by step guidance on how to support a person to transfer from their bed to their wheelchair using a hoist. In another care plan there was limited information for staff to follow. We discussed this with the acting manager who told us the care plan was still being written and created as the person had recently moved into the home. It was evident from the information in care plans that individuals and or their relevant family members had been consulted. For example people's life history and likes and dislikes were detailed. Care plans were reviewed every six months or as and when required to ensure they met people's needs and observations of daily care were completed for day and night shifts, and provided an account of how people's needs had been met.

The care plans were supported by risk assessments, these showed the extent of the risk, when the risk might occur, and how to minimise the risk. For example a Waterlow risk assessment was carried out for people. This is a tool to assist and assess the risk of a person developing a pressure ulcer. This assessment takes into account the risk factors such as nutrition, age, mobility, illness, loss of sensation and cognitive impairment. These allowed staff to assess the risks and then plan how to alleviate the risk for example ensuring that a correct mattress is made available to support pressure area care. In one care plan the water low score was 23. The form noted that this score placed the person at a high risk. There was no reference as to the actions that were being undertaken to manage or reduce the risk for the person.

One person had recently been admitted to the home as an emergency admission. The acting manager and staff told us that the person had complex needs and required two members of staff to assist them. Records showed that despite the person living at the home for a month, their care plan was still being developed. Basic assessments had been completed, as well as information about the person's life history. However, there was a lack of risk assessments, detailed information or guidance available for staff to enable them to meet the person's needs and support them safely and effectively.

The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

We spoke with the activities co-ordinator about their role and responsibilities. We were told a variety of

social and educational activities were on offer, including trips out and activities including knitting, arts and crafts and discussion groups. People were also able to see staff on a one-to-one basis if they preferred or remained in their rooms. People's interests and hobbies were discussed when they moved into the home and detailed in their care plans. On the day of the inspection there was a visiting PAT (pets as therapy) dog which people spoke about with great excitement and manicures took place in the lounge in the afternoon. There was list of activities on a wall for people to see and also displayed on the tables in the dining room. There were activities available throughout the week and people who had family also took them out. Comments from people around activities included "We have a coach that takes us to Eastbourne or other seaside places it's always a good day out", "The activity coordinator provides us with drama groups, crafts and things. The knit and natter is good and I like the bingo and scrabble" and "It's not a boring place, we're quite an adventurous bunch". We were also told of the recent summer garden party that had taken place. We were shown photos of the day and people told us how much they had enjoyed the day.

One person told us how they enjoyed going into the garden and looking at the flowers and trees. Another person told us how they enjoyed watching their favourite television shows and that they could watch them in the communal lounge or their own room. They told us "It is the Olympics today which I like. I also have helped others with the remote control if they want to watch something different". A further person told us how they enjoyed spending the afternoon in the smaller lounge area as it had books and games and was a little quieter for them. Staff told us how people were encouraged to participate in activities if they wished. One member of staff told us "Everyone is different and sometimes they just like to talk about things or play a game. We always have group activities and things for people to get involved in". The home also had two resident pet cats which people interacted with and talked about throughout the inspection. One person told us how they liked to go for a walk around the home in the afternoon to look for them. This ensured people's social needs and interests were being met through a range of suitable activities.

People and relatives we spoke with were aware of how to make a complaint and all felt they would have no problem raising any issues. The complaints procedure and policy were accessible for people in the home and complaints made were recorded and addressed in line with the policy. Most people we spoke with told us they had not needed to complain and that any minor issues were dealt with informally and with a good response. One person told us "Any concerns I have I would voice. Staff would listen and sort it out for you".

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager had recently left the service. The provider was in the process of recruiting for a new registered manager. A senior member of staff who had worked at the home for many years had been asked by the provider to be the acting manager until a new registered manager was recruited. People spoke positively of the acting manager and found them to be approachable and friendly. Comments included "Oh yes she [acting manager] is busy but always helping us all", "I think the manager does a good job, I see her most days and is nice". However, despite these positive comments, we found an area of practice that required improvement.

The home was currently in a transitional period due to new management and staff who had recently left. We found areas for improvement and variable experiences were had by people. People and staff felt that they had not been kept up to date fully on the changes that had been taking place at the home. People were concerned by why some staff had left with little or no explanations. Staff felt that they were not communicated to enough by the provider on the changes that had been taking place. People spoke positively around the management of the home and told us they had regular resident meetings. One person told us "I don't always go to the meetings but I get the minutes so I'm not left out and they always remember to invite me". However people told us how they felt about all the recent changes and explained that, they were not being communicated to enough. One person told us "They should have a meeting with us and tell us what's going on". Another person told us "I shall really miss [member of staff who had recently left], they don't tell us anything". We discussed this with the provider and acting manager who told us they had communicated to people on who had left but agreed they should reassure people and hold a meeting to answer any concerns or questions people may have.

The acting manager told us they were supported by the provider and they could contact the provider by telephone when needed. The acting manager told us that the provider visited the home and carried out checks. However we did not see any recording of checks carried out by the provider to confirm their oversight of the service. The acting manager had not received formal supervision. The absence of any formal support, oversight for the acting manager and the home meant that the provider could not always be assured of the quality of the service being provided at Littlefair. During this transistional phase strong day to day leadership and direction was needed in order to drive through the improvements the provider wanted. Due to the lack of effective quality monitoring for the range of systems and processes used within the home, the lack of oversight by the acting manager and provider, there was a risk that people could receive inconsistent care and a poor quality service. Subsequently to the report being produced the acting manager provided evidence that supervisions had taken place between themselves and the provider in June and July 2016.

The provider had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of experience of service users in receiving those services). This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

We have asked the provider for an action plan on how they were going to ensure the home had consistent

leadership and how the quality of care would be improved.

The acting manager was approachable and supportive and took a proactive role in the day to day running of the service. People and staff appeared very comfortable and relaxed while talking with her. We observed people and staff approaching the acting manager throughout the day asking questions or talking with them. The acting manager although very busy in their role took time to listen to people and provided support where needed. Comments from staff included "I don't get involved in all the gossip, I just like working here. The acting manager is nice you can approach her about anything. We don't see the provider from one week to the next". Another member of staff said "The acting manager is doing a good job. Any concerns or questions I have she will always help me". Staff spoke of a positive and open culture where they were supported although felt that with the recent changes and with some staff who had left, they had not been communicated to enough.

Regular audits of the quality and safety of the home had been carried out by the previous registered manager and the acting manager. These included the environment, care plans, infection control and health and safety. Action plans were developed where needed and followed to address any issues identified during the audits. From a recent infection control audit it had detailed that a deep clean on some chairs needed to be completed and lime scale had built up on a couple of hand wash basins. An action plan had addressed these issues which also detailed the staff responsible to undertake the tasks. Feedback was sought by the provider annually via surveys which were sent to people at the home. Survey results from the 2015 survey were found to be positive. The 2016 survey was due to take place in September. The acting manager had recently undertaken a satisfaction survey and people were found to be happy with the care they received at the home. They told us "I will continue to undertake surveys to ensure we continue to meet our resident's needs and wishes".

The provider and acting manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They were aware of the requirements following the implementation of the Care Act 2014, for example they were aware of the requirements under the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that care and treatment was provided in a safe way for service users in relation to the proper and safe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person had not ensured that the nutritional and hydration needs of service users were met through the receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health. Regulation 14 (1) (2) (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. Regulation 17 (1) (2) (c) The registered person had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of experience of service users in receiving those

services) Regulation 17 (1) (2) (a)