SHC Rapkyns Group Limited

The Granary

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
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 21 September 2018 and was unannounced.

The Granary is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and care for up to 41 people with an acquired brain injury or neurological condition, learning and physical disabilities. At the time of our visit 11 people were living at the home, including one person who was staying for a short break.

The Granary provides accommodation across four ground floor units: Walnut, Pine, Yew and Alder. Each unit has a separate living room, dining room and kitchenette. At the time of this inspection, people were accommodated in Walnut and Alder, the other two units, which could accommodate 10 people each, were unoccupied. Rooms were of single occupancy and had en-suite facilities.

At the time of our inspection the service did not have a registered manager in post. The last registered manager left in July 2018. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations. The acting manager assisted us with the inspection. The provider had put measures in place to ensure the service had adequate management support whilst they were recruiting a new manager.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been made. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and July 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

This inspection was brought forward due to information shared with CQC about the potential concerns around the management of people's care needs. This inspection examined those risks.

At the last inspection on 7 and 11 December 2017 the service was rated requires improvement. The report was published in March 2018. At that inspection we identified five regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to the provider failing to ensure that staff received the training they needed to meet the needs of people. Some staff did not have regular supervisions as defined by the provider's policy. The provider had failed to ensure that care and treatment was provided to people with the consent of the relevant person. People were not treated with dignity and respect at all times. The provider had failed to ensure that people using the service had care or treatment

that was personalised specifically for them. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve each of the key question's to at least good.

At this inspection, we found although improvements had been made the registered provider remained in breach of one of the five previous breaches of Regulation. People were supported to access a wide range of activities, which included involvement and use of the local and wider community. However, people's interests were not fully reflected in their weekly activity timetables. People were supported to express their views and be actively involved in making decisions about their care as far as possible, this was not always fully documented and reflected in their care plans. The documentation to support the monitoring of people's health needs was not always fully completed. You can see what action we told the provider to take at the back of the full version of this report.

The Granary was designed, built and registered before the guidance was published regarding Registering the Right Support and other best practice guidance. Which states, people with learning disabilities and autism using a service should be able to live as ordinary a life as any citizen. We found the provider was in the process of making improvements to demonstrate they were working in line with values such as choice, promotion of independence and inclusion when considering, planning and supporting people's needs. The model and scale of care provided was not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs. Had the provider applied to register The Granary today, the application would be unlikely to be granted. The model and scale of care provided was not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs. The provider acknowledged further time was needed to demonstrate the full impact of the recent changes.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected.

Arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and to meet their needs. Background checks had been completed before care staff had been appointed which showed that staff were of good character.

Medicines were managed safely and staff had a good knowledge of the medicine systems and procedures.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Training was provided to staff to meet the needs of people. Staff received regular supervision and appraisal and told us they felt supported in their roles.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

People were supported with their nutrition and hydration needs. Clear guidance was available for staff to

follow when people had specific dietary needs.

People received coordinated and person-centred care when they used or moved between different services. People had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. Furthermore, people had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

People were treated with dignity and respect. Dignity was embedded in the services' values and culture. Confidential information was kept private.

There was a complaints policy and procedure made available to people who received a service and their relatives. All complaints were acknowledged and responded to quickly and efficiently. At the time of our inspection no one was receiving end-of- life care.

There was a positive culture in the service that was open, inclusive and focused upon achieving good outcomes for people. People benefited from there being a management framework which ensured that staff understood their responsibilities so that risks and regulatory requirements were met.

Quality audits were completed by the management team. These were up-to-date and completed on a regular basis. People and staff, we spoke with told us they felt the service was well-led; they felt listened to and that they could approach the management team with any concerns. Staff told us they enjoyed working at the service and enjoyed their jobs.

The views of people who lived in the service had been gathered and acted on to shape any improvements that were made. Good team work was promoted and staff were supported to speak out if they had any concerns in their work. In addition, the management team worked in partnership with other agencies to support the development of joined-up care.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

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 were protected from the risks of abuse by staff who understood their responsibility to safeguard people.

Risks associated with people's needs were assessed and action was taken to reduce these risks.

The provider's recruitment process ensured appropriate checks were undertaken. Staffing levels were appropriate and were based on individual needs.

Medicines were managed safely.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Good

The service was effective.

Staff received supervisions, appraisals and training to ensure they had the right knowledge and skills to meet people's needs.

People's rights were protected by staff who had received training and had knowledge of the Mental Capacity Act 2005.

People were supported to ensure they received adequate nutrition and hydration.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring and supported their independence.

People were involved in decisions about their care and the home.

People's privacy and dignity was respected and maintained.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always individual and person centred.

People were supported to access activities of their choice; however, their activity timetables were not always personalised.

Staff understood people's needs and responded appropriately when these changed.

The registered provider had a complaints policy and procedure that was available in easy read and pictorial formats.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a lack of managerial oversight regarding the monitoring of daily written records.

There was an open culture and people benefited from staff who understood their responsibilities so that risks and regulatory requirements were met.

People who used the service, their relatives and staff were engaged and involved in making improvements.

There were suitable arrangements to enable the service to learn, innovate and maintain its sustainability.

Quality checks had been completed and the service worked in partnership with other agencies.

The Granary

Detailed findings

Background to this inspection

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

This inspection took place on 21 September 2018 and was unannounced. The inspection team consisted of two inspectors', two specialist nurse advisors and a specialist advisor who was a dietician. There was also one expert by experience. An expert by experience is a person who has personal experience of using this type of service.

Before our inspection we reviewed the information, we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We used a range of different methods to help us understand people's experiences. Some people who lived at the home had limited verbal communication. Therefore, as well as speaking with five people, we observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit.

During our visit we spoke with the chief operating officer, operational director, acting manager, two registered nurses' (one of which was an agency nurse), two senior health care assistants, two care staff (one of which was agency) and the chef. We spoke with six people and four relatives for their views about the safety and quality of the services provided for people.

To help us assess how people's care needs were being met, we case tracked nine people on special diets and who had other complex needs. Case tracking involves talking to the person (if they are able), observation of their care, talking to staff who supported the person and examination of care records. We looked at other records, these included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and

procedures. We displayed a poster in the communal area of the service inviting feedback from people and relatives while we conducted the inspection.

Following our visit, we sought feedback from Healthwatch and staff from the local authority on their experience of the service. Healthwatch are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change. The feedback we received is included in this report.

Good

Is the service safe?

Our findings

At our last inspection in December 2017, the key question of safe was rated as good. At this inspection we found safe remained good.

People who were able said they felt safe. Our observations confirmed people who were unable to initiate communication were regularly asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were checked to see if they were in pain or needed assistance, which we observed.

Feedback from one health care professional from a funding authority told us, their view of how safe the service has been. A continuing healthcare manager told us, 'The Granary has provided very good quality care to people we have placed there. They have a well-staffed MDT (multi-disciplinary team) and patients have benefitted from the high staff/person ratio.'

People continued to be kept safe from abuse and harm. Staff understood their local safeguarding policies and procedures could identify signs of abuse and explain their responsibility to report any concerns. There was an equality and diversity policy in place and staff received training in this area. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected. Staff told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm.

We found that risks to people's safety had been assessed, monitored and managed. People were supported to stay safe while their freedom was respected. This included measures that had been taken to help people to avoid preventable accidents. For example, hot water was temperature controlled and radiators were covered to reduce the risk of scalds and burns. In addition, people were provided with equipment. Equipment such as hoists, profiling beds were in good working condition.

People's care records included risk assessments for relevant areas of risk such as nutrition, diabetes, choking, and, catheter care. These were reviewed and updated on a monthly basis. Care plans showed how the risks were mitigated with instructions for staff.

Moving and handling assessments contained clear guidance on how to support people when moving them. Suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only. This ensured that appropriate infection control measures where followed for the use of slings.

People were protected from the risks of developing pressure sores. The nursing care plans for skin integrity were based on The National Institute for Health and Care Excellence (NICE), which provides national guidance and advice to improve health and social care. The providers care plans for clinical complex health needs also followed guidance around procedures from The Royal Marsden Nursing. Appropriate referrals had been made to health care services. These included referrals for assessment by the tissue viability service

for pressure area care. People were supported with specialist equipment such as pressure relieving mattresses to reduce the risk of pressure areas. Three people were repositioned regularly to relieve the pressure on their skin due to being unable to move themselves without staff support. Care plan's included instructions of how often repositioning should take place. We viewed records of when people were repositioned, which showed that these were happening. These records were audited daily to ensure people were being safely supported.

People were protected from the risks of falling and received physiotherapy support when this was required. Each person had a falls diary that was analysed monthly. Appropriate specialist falls prevention sensor mats were used to safely monitor and reduce the incidence of falls.

People were protected by the completion of appropriate health and safety checks as required in law. The premises were purpose built and the layout supported people to be safely evacuated in the event of an emergency. People had individual Personal Emergency Evacuation Plan (PEEP). This detailed how they should be supported to evacuate the building in the event of a fire. An environmental risk assessment was in place which identified risks to people, staff and visitors. Weekly, monthly and quarterly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose.

People received a service from staff that were of good character. Staff recruitment checks were robust and thorough and suitable staff were employed. We looked at six staff files and checked the systems for the recruitment of new staff. Where needed, proof of identity and permission to work in the UK had been sought. Checks were in place to ensure that nurses had up-to-date PIN numbers and were registered with the Nursing and Midwifery Council (NMC). Agency nurses were vetted before working at the home and recruitment checks were completed, including with the Disclosure and Barring Service (DBS). This ensure that new staff were safe to work in a care setting. References were obtained and employment histories recorded.

There were enough staff working across each of the two units. The provider used a dependency tool which ensured there were enough staff on duty. Rotas for the month before the inspection showed staffing levels had been consistently maintained. In addition to nursing and care staff the provider employed the support of a physiotherapist and activity co-ordinators. The provider employed an administrator, chef, a chef assistant and other domestic and maintenance staff including drivers to support the home. This gave the care staff enough time to care for people and their individual needs. When agency staff were used from outside the home, appropriate measures were taken by the management team which ensured that they had enough information to provide safe care for people. Records confirmed this.

Medicines were safely managed and people received medicines as they were prescribed. Medicines were stored securely in a locked cabinet. There were arrangements in place for any medicines that needed to be stored at lower temperatures. All nursing staff had received training to enable them to give medicines to people safely. Some people had prescribed medicines to use 'as required' to help them when they were anxious or distressed. There were protocols in place for staff to follow when they gave these medicines. However, these could be more detailed. We found this had not impacted people's safety and we fed this back to the acting manager who provided assurances she would review these protocols. Medicine Administration Records (MAR) were well organised and clear.

People were protected from the risks of infection. Records showed that the management team had assessed, reviewed and monitored the home to ensure that good standards of hygiene were maintained. The home was clean and had a free from unpleasant odours. Care staff recognised the importance of

preventing cross infection. They wore clean uniforms, had access to antibacterial soap and regularly washed their hands. Soft furnishings, beds and bed linen were in good condition.

People's safety was protected and promoted by staff who knew the needs of people. The acting manager had ensured that lessons were learned and improvements made when things had gone wrong. Records showed that they had carefully analysed incidents and accidents so that they could establish how and why they had occurred. We noted that actions had then been taken to reduce the likelihood of the same thing happening again. These actions included considering the need to refer people to specialist healthcare professionals who focus on dietary needs. Agency staff were always paired with an experienced carer who was employed by the service. We observed this during this inspection. A relative also confirmed that when agency staff are used, they are always paired up with a permanent staff member.

Good

Is the service effective?

Our findings

At the last inspection in December 2017 we rated this key question as requires improvement. We found two breaches of Regulation. We found the provider failed to ensure that staff received the training they needed to meet the needs of people. Some staff did not have regular supervisions as defined by the provider's policy. The provider had failed to ensure that care and treatment was provided to people with the consent of the relevant person. We made requirements for this to be addressed and the provider sent us an action plan.

At this inspection, we found improvements had been made and both regulations were now met, resulting in the rating being changed to, 'Good'.

The acting manager maintained a spreadsheet record for training in courses completed by staff which the provider considered as mandatory to provide effective care. This allowed the acting manager to monitor when this training needed to be updated. These courses included food hygiene, fire safety, first aid, health and safety, infection control, moving and handling, equality and diversity and medication. Additional training had been completed by nurses and health care assistants in specific conditions such as epilepsy, gastronomy, tracheotomy, diabetes, fluids and nutrition and acquired brain injury. Staff received on-going refresher training to keep their knowledge and skills up to date.

Nurses and senior staff had completed an awareness course on the National Early Warning Score (NEWS) to support nursing staff pick up early warning signs of deterioration in health. A nurse told us how the NEWS chart was used for people and the positive impact this had to prevent unnecessary hospital admissions. A senior health care assistant told us, "It shows (NEWS chart) normal and abnormal observations. We can do blood pressures if needed and we can also do saturations. On the NEWS chart, white is normal, red is abnormal and amber is something to be aware of. If we do any blood pressures we take them back to the nurses as they need to know what it is." This demonstrated staff awareness of the actions they needed to take to ensure people's health needs were met. However, we found these charts were not always fully completed, which we have commented on in the key question, is the service well-led.

Staff knew how to care for people in the right way. Although the provider did not offer specific training in regard to learning and physical disabilities, staff demonstrated a thorough understanding of people's individual needs. Care plans provided sufficient guidance on people's individual learning and physical disability needs. An example of this was that care staff knew how to provide clinical care for people who lived with medical conditions. Other examples were that care staff knew how to correctly assist people who experienced reduced mobility or who needed help with their nutritional needs.

Staff had an induction when they started employment with the organisation which involved them completing the Care Certificate. The Care Certificate is a national qualification designed to give those working in the care sector a broad knowledge of good working practices. Inductions included areas such as the geography of the home, communication systems, policies and procedures. There was also a period of shadowing more experienced staff.

Without exception all the staff we spoke with told us that teamwork was positive and morale was good. Staff received three supervisions in a 12-month period, with the acting manager or clinical lead. Notes of supervision meetings confirmed this. This was in line with the providers supervision policy. Staff told us they found supervision meetings helpful. We reviewed records of staff supervision which stated that the focus was clearly on staff welfare. It was evident staff could raise issues of importance to them. The staff we spoke with confirmed this.

Records demonstrated other ways staff were supported. This was through staff monthly meetings. Minutes of these discussions demonstrated staff discussed people's needs, activities, changing policies and procedures, safeguarding, organisational learning and training needs. Without exception, staff told us this worked for their service and that the acting manager had an open-door policy and they could talk to them anytime they needed to. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Appropriate DoLS applications had been made, and staff acted in accordance with DoLS authorisations and conditions were being met. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

Staff had received training of the MCA and DoLS. Our observations confirmed staff promoted choice and acted in accordance with people's wishes. A member of staff told us, "It's about if someone has the capacity to make decisions. It depends on what decisions they are making. It can be about health, their needs or personal things. Some people can make some decisions but not on a grand scale, such as what clothes they would like to wear. We have best interest meetings and peoples have a DoLS. It's all taken into account." We found that a person had been recently given medical advice to encourage weight loss, the person told us they were in full agreement with the weight loss plan it had not been imposed on them. We observed staff giving this person options at lunchtime of what they would like to eat.

One person told us, the food was "excellent" and there was a good choice of food given. They went on to tell us that they had "homemade porridge" made daily. A second person told us, if they do not "like want is on the menu they can request something else." Another person told us they had "struggled with the recent hot weather" and consequently was "drinking a lot more." The provider had supported the person to have their own drinks to keep cool. Another person told us, the food was "Absolutely lovely."

Two relatives told us, they were very happy with food and meal service provided at The Granary.

We were present at lunch time and saw that the meal time was a relaxed and pleasant occasion. The dining tables were neatly laid and people were offered a choice of dishes. Meals were attractively presented. The service had an excellent pictorial menu plan which showed varied, nutritious and balanced meals. People were offered a choice of food and were asked in advance what they wanted to eat which was recorded for the kitchen staff to follow.

Stocks of food included fresh vegetables and fruit and the chef told us dishes were homemade from fresh ingredients. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

People's nutritional needs were assessed and care plans recorded when people needed support with eating and drinking. When people had assessed needs with eating and drinking, referrals were made to the GP, dietician or Speech and Language Therapist (SALT). Copies of SALT reports were included in people's care records so staff knew the type of support people needed. People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnutrition. The acting manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST). This is a tool designed specifically for this purpose. Some people's food and fluid intake was monitored, which was recorded and showed people had sufficient to eat and drink. People's weight was monitored and recorded. The care plans, monitoring charts and information in people's rooms was accurate and reflected the care we observed,

People's needs were assessed before they used the service. This involved meeting with the person and completing a needs assessment, by gathering information from them and any relevant health and social care professionals. We looked at recent records which showed a wide-ranging needs and preferences assessment had been carried out, including the person's capacity to make their own decisions. It was apparent the person had been involved with the process and had signed in agreement with the outcomes of the assessment. People were encouraged to visit the service, for meals, activities and short stays. This was to actively support the ongoing assessment process and provide people with the opportunity to experience the service before moving in.

Records showed that the acting manager's assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the acting manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included care staff had important information about a person's care so that this could be given to ambulance staff if someone needed to be admitted to hospital. This ensured that a person's experience of the transfer between services would be more positive with staff who knew their individual needs. People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians.

The Granary had clinical multi-disciplinary health meetings (MDT) which were held weekly where the acting manager, clinical lead or a nurse and GP would attend, to discuss people's health needs. We found records around these meetings could be more detailed to fully document the outcome of discussions. We fed this back to the acting manager who agreed with our comments. The acting manager told us, she would review

how information was recorded for these meetings.

People told us, they were involved in decorating their bedrooms and communal areas, by choosing the colours of wall paint.

Feedback from one health care professional from a funding authority told us, their view of how effective the service has been. A continuing healthcare manager told us, 'The environment itself is new, very well equipped and well maintained.'

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. There was sufficient communal space in the dining room and in the lounges. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

Good

Is the service caring?

Our findings

At the last inspection in December 2017 we rated this key question as requires improvement. We found one breach of regulation. People were not treated with dignity and respect at all times. We made requirements for this to be addressed and the provider sent us an action plan.

At this inspection, we found improvements had been made and the regulation was now met, resulting in the rating being changed to, 'Good'.

One person told us, "[Staff] are kind, compassionate yeah, yeah they know me." Another person told us, "Yes happy, it's nice, lots of people come and see me. Always nice to me (staff). Very happy here."

We observed the way staff and people interacted and the care that was provided. Our observations showed that people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. We saw interactions were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

We observed the lunchtime experience for people. Food was individually plated, was attractive and served hot. Food looked excellent and good portion sizes. Dining ambience was pleasant with adapted cutlery, protected clothes, table cloths and a choice of cold drinks was available. Support was given to people who needed it and alternative choices were offered if food was not eaten. Support with eating was correctly paced with good interaction.

We saw that the service ensured that people were treated with kindness and that they were given emotional support when needed. Care staff were informal, friendly and discreet when caring for people. We witnessed positive conversations that promoted people's wellbeing. Staff spoke with people as they went about their work and spent time with people who were cared for in their rooms. We observed staff kneeling to speak with people, stroking their arms and backs and calling them by their names. Staff were patient and attentive listening to what people were trying to say. We observed one person sleeping and their head fell forward, staff immediately got up and repositioned the persons head so that they were comfortable.

Records indicated that two people had anxiety which could result in distress. We observed staff interacted effectively with people with in a calm, friendly manner. Throughout the inspection the atmosphere was relaxed and there was no evidence of people experiencing distress.

People's privacy, dignity and independence were respected and promoted. We observed people being supported to eat independently. We found a care plan that promoted a person making their own drinks. Where people were able, they were supported to purchase personal items from the local community. We observed a staff member explained to a person they were going to put 'lip balm' on their lips and told them "Don't be scared" and gently wiped the excess away. This demonstrated the kind and unique way that each

person was treated at the service.

We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We saw care staff knocked and waited for permission before going into bedrooms, toilets and bathrooms.

We found that people could speak with relatives and meet with health and social care professionals in private, if this was their wish. In addition, care staff assisted people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made which ensured that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff. Records showed that care staff had been given training and guidance on the importance of maintaining confidentiality and we found that they understood their responsibilities in relation to this matter.

We looked at whether people's communication needs were taken account of and how staff sought accessible ways to communicate with people in relation to decision-making. One person had a specialist item of equipment that enabled them to communicate with staff through 'eye gaze.' This equipment enabled the person to send and receive emails and to write. Although this person had a severe disability, communication from staff was kind, patient, caring and personal and, from what we saw, the person appreciated this. The person was attended to by staff who clearly knew the person, they adjusted their head and communicated with them through the persons eye contact. We observed the person tell staff what their care needs were, which staff responded to without delay. Another person had a communication application on their mobile phone and a further two individuals communicated with pictures, which we observed staff used.

People told us they could make day to day choices and were involved in the delivery of their care. A relative told us, "We are both involved with [person's] care plan. I am very happy with [person's] care, they [staff] have been amazing in getting [person] better from their hospital discharge. They [staff] are all approachable, always willing to listen." We observed a nurse requesting to check a person's saturation levels. They asked the person what finger they wanted the nurse to use. The person offered a finger and the nurse reported back to the person, "it's really good you're doing really well." Records demonstrated that care staff had sensitively asked people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night. People were asked if they would prefer a bath or shower. Whether people wanted to be supported with having a wet or electric shave. Records demonstrated that choices were being met and documented.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in December 2017 we rated this key question as requires improvement. We found one breach of Regulation. The provider had failed to ensure that people using the service had care or treatment that was personalised specifically for them. We made requirements for this to be addressed and the provider sent us an action plan.

At this inspection, we found although improvements were made in this area, further improvements were needed to ensure every person felt listened to and received care in a personalised way.

People did not always receive care that was responsive to their individual needs. Feedback from two health care professionals told us their views of how responsive the service had been. A nurse assessor told us, 'Whilst this support (from agreed funded care package) is generally being provided as evidenced by paperwork received, we do have concerns about the quality of support being provided and when observed, although the support was with the individual there was, at times, very little worthwhile engagement, often resulting in the individual spending lengthy periods of time alone in central areas watching TV. Our conclusions, based on this particular individual would be that it is not effective despite repeat reviews, now on a monthly basis, repeat recommendations are not being actioned, therefore the service is not responsive enough to the needs of this individual.'

A continuing healthcare manager told us, 'The clinical feedback and documentation has been comprehensive and I have felt very well informed regarding peoples' needs and progress. The placement has been very good at keeping in touch with me a however this has not been so good since the previous manager left (in June).'

We found care plans varied in personalisation, some being very personalised and others continued to lack personal detail. Three care plans associated with supporting people to express their sexuality were in a uniformed format, lacking information personal to this area of need. One person's care plan for epilepsy lacked detail with regards to what seizure type the person experienced and their personal history around epilepsy. For another person their spiritual care plan stated, 'Staff should respect my spiritual needs and my religion'. The care plan did not state what religion the person chose to follow. It also stated, 'Please give me choice to decide whether I should go to church and involve my family in the process'. There was no evidence of this happening. For another person, we found their weekly schedule did not detail any activities for the afternoons Monday to Sunday. Their social care plan did not indicate how this person liked to spend their afternoons, and what stimulation the person was being offered. In the activity folder each person had a profile of their interests, hobbies and likes, but these were not reflected in their weekly activity timetables.

We found although the provider had followed the principles for making best interest decisions and staff were following the principles of the MCA, care plans lacked information relating to the outcomes of MCA assessments and DoLS authorisations. This lack of personal detail in these care plans could mislead staff, agency staff that are not familiar with the outcomes may not know the person well.

A relative told us, "[Person] needs stimulation that doesn't happen." We looked at one person's communication passport which stated that the person was unable to verbally communicate but could make their needs known through body language and facial expressions. It stated that if the person grinded their teeth, it meant they were bored. We observed the person grinding their teeth for 30 minutes. The staff present did not offer any form of activity or stimulation in response to the person communicating they were 'bored'. The acting manager told us, people could go out if they wanted to use the mini bus. However, we did not observe this offered to anyone during our visit.

These issues were a continued breach of Regulation 9 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014 as the registered person had failed to provide person-centred care for every person.

We noted that care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for a person to meet their spiritual needs by attending a religious service. A relative told us, "[Person] prays in their room, nothing is imposed. They [staff] put a sign on [persons] door to say they are praying." Examples of personalised care plans we viewed, was a mobility care plan, which demonstrated the person had been involved in completing the care plan. It stated, 'I will choose to get out of bed every few days and will need support to transfer to my wheelchair or mobility scooter. I don't usually like to go outside, but I would like you to ask me. Respect my response if I decline.'

Each person had a Disability Distress Assessment Tool (DisDAT) which described physical or vocal cues that would alert staff to how a person was feeling. We found these to be personalised and informed staff of when the person may be in pain or unwell.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

We viewed a 'Things I like to do' document which stated, 'I enjoy gardening, I like to grow flowers of any kind and would like to grow some vegetables' and 'I would like to get some raised and start some gardening projects. I would like to get a bird feeding station for outside my bedroom window'. We spoke with the person and found these interests had been supported. The provider had allocated part of the garden for the person to grow their flowers. Records demonstrated a bird feeding station had been purchased and the person was frequently supported to watch the birds feeding.

Since our last inspection, the provider had appointed an 'Involvement and Engagement Manager.' The manager was in the process of reviewing the activities within the home. Looking at what was already in place and seeing if they matched the needs of the people supported, moving away from the larger group activities and looking at the needs of the individual. We found the impact of this was positive for people, although time was still required for this area to be fully embedded.

During our inspection we observed staff engaged appropriately with people and enhanced their well-being. Within the complex of The Granary, there was salt cave and two hydro pools. We observed people using the salt cave during our visit. A salt cave, has dry salt air which is more powerful than moist air. The negatively charged ions in salt improve health and mood. Inhaling the particles which can reduce inflammation and mucus in the lungs, improving respiratory conditions. People told us, they enjoyed using this area.

People were supported with specialist equipment to engage in meaningful activities. We observed people

used a sensory room which was on site. The room had an interactive floor screen. People told us they enjoyed using this area and could watch movies in the sensory room from a wall projector. Records demonstrated this happened on a weekly basis. One person enjoyed watching Disney movies. We observed other people being supported to leave the grounds for a walk. People were encouraged to sing and clap along with music. Families could come as they pleased and meet their relatives at the service.

There were photographs displayed throughout the home of activities which people had participated in. There was an activities planner on the main information board so people and their relatives could see what they could join in with. Activities were documented and recorded for each person. If people did not want to join in there was a reason recorded. The activities offered at the home allowed for the opportunity of social inclusion and engagement.

People had been supported to enjoy their interests and hobbies that were important to them. We saw one person was supported to visit their local fishery pond / activity park in Horsham, another person was supported to visit Guildford Bridge and another person enjoyed visiting a superstore for a hot beverage and cake. Two people enjoyed going out together to the local cinema and were supported to do this at least three times a month. A group of people were supported to have a three-day trip on a canal boat in September 2018. People told us they really enjoyed this and all had an interest in boats.

Records we viewed, photos we observed and relatives confirmed that external entertainers also visited on a weekly basis. Entertainers were booked from knowing people's individual likes and interests such as a theatre group performing a play, a quiz night and a person whose interest in horse shoes, organised a horse shoe competition for their home. Records confirmed Tribute Act entertainers were booked monthly, which were age related and in line with what people enjoyed listening to.

Before moving to the home people had initial assessments completed to ensure the service could fully support their needs. These assessments were used to shape people's care plans. The care plans were regularly reviewed by staff, nurses and the acting manager.

Care plans demonstrated people had been consulted with them about how they wanted their personal care delivered. Overall care plans were being reviewed monthly to make sure that they accurately reflected people's changing needs and wishes. Other records confirmed that people were receiving the personal care they needed as described in their individual care plan. This included help with managing a number of on-going medical conditions, washing and dressing and changing position safely.

People were being supported with assistive technology to help them use a computer to communicate. People had their own landline and tablets for contacting friends and relatives. One person told us they skyped their relatives on their tablet. Another person had their own laptop to keep on top of local news which was a keen interest of theirs. A person had a mobile with a communication app, that connected to a voice-controlled intelligent personal assistant service. We found this enabled people to become more active in expressing their choices and making decisions.

People had their own specialized equipment for eating such as angled spoons and plate guards which meant people were enabled to be independent.

People were supported appropriately when they wanted to raise a complaint. There was a comprehensive complaints procedure in place at the home. This was available to people and their relatives. We reviewed the complaints log for the service and the actions taken. The acting manager addressed all complaints within the designated timescales and acted where required. Lessons learned were acted upon and shared

with staff during meetings and supervisions.

At the time of our inspection no one received end-of- life care. Staff had received training in end-of-life care and the policy showed that end of life care plans would be put in place for people if this was a requirement. This meant information would be available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in December 2017 we rated this key question as requires improvement. We found one breach of regulation. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. We made requirements for this to be addressed and the provider sent us an action plan.

At this inspection, we found improvements had been made and the regulation was now met. We found although improvements were made in this area, further improvements were needed in relation to record keeping.

Feedback from one health care professional from a funding authority told us, their view of how well-led the service has been. A nurse assessor told us, 'Initially when our individual moved into the service approximately a year ago, we were very impressed with the opportunities that were available to this client, however the then manager has left and there has been a significant decline. Further, the service currently has an "acting manager" and although she appears very kind and concerned about our client, does not appear to be appraising staff as required and identified as evidenced in omissions in paperwork.'

Our findings regarding gaps and forms not always being fully completed supported this professionals view. The provider used the National Early Warning Score (NEWS) to support nursing staff pick up early warning signs of deterioration in health. We reviewed NEWS charts from 16 June to 21 September 2018 and found they had not always been fully completed. People's vital signs had been recorded four times a day as assessed as needed, however the total NEWS score had not always been recorded at the bottom of the chart. The pulse, temperature and alertness were also not recorded on one date during this time.

We reviewed fluid charts from 16 June to 21 September 2018. Fluids had not been totalled on four of these days. The recommended daily amount was not indicated on these charts. We reviewed a person's bowel monitoring chart from 8 March to September 2018. The records indicated in March, there was a period of six days and nine days of no bowel movement. In May there was a period of seven days and in June 10 days of no bowel movement. In July we found there was a period of seven days and then five days of no bowel movement. Records were unclear what action had been taken in response to this and what action was being taken to keep the person safe. We spoke to the acting manager who provided sufficient evidence that GP involvement had been sought and medication reviewed for the management of this, but records in relative to this person's bowel management were not complete and contemporaneous. These were areas of needed improvement.

Other forms of monitoring that we found had been fully completed were in relation to mattress checks (for pressure and skin care), PEG regime's and catheter records. Quality assurance systems were in place that included audits by the acting manager and provider. We checked if the monitoring systems ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. Systems included: finances, medicines management, accidents, activities, housekeeping, health and safety, falls, infection prevention and control and care plans. We noted examples where shortfalls

had been identified and addressed. The peripatetic manager carried out compliance visits on behalf of the provider; this involved ensuring the audits were completed and actioned. The role of a peripatetic manager supports managers in their role and moves from service to service offering advice and guidance.

The acting manager collated information relating to the running of the service which they shared with the provider through regular reporting. This covered everything from admissions, safeguarding, maintenance of the building, to incidents and accidents and care reviews. This information provided oversight of what was happening within the service and contributed towards plans for the continual improvement of the service.

At the time of our inspection the service did not have a registered manager in post. The last registered manager left in July 2018. The provider had put measures in place to ensure the service had adequate management support whilst they were recruiting a new manager. During the inspection the chief operating officer, operational director and acting manager were present in the service.

One staff member told us, "The support from Helen (acting manager) is brilliant. There is also an acting clinical lead. They are really approachable". Without exception staff were positive about the support they received from the acting manager. The acting manager was described as being very hardworking and very helpful.

The acting manager had a clear understanding of the important events that they must notify, by law, the Care Quality Commission (CQC) about. The records we hold about the service confirmed this.

The management team in place included the acting manager and a clinical lead. The staff rota had been arranged to ensure there was always a manger/senior or clinical lead on duty to provide leadership and direction. There was an administrator providing additional management support. We found the managers had an 'open door' policy that supported ongoing communication, discussion and openness.

Care staff told us there was a 'zero tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the acting manager if they had any concerns about people not receiving safe care. They told us they were sure that any concerns they raised would be taken seriously by the acting manager so that action could quickly be taken to keep people safe.

The service's philosophy of care, vision and values was reflected within the written material including, the guide to the service, staff induction and policies and procedures. There was a welcoming and friendly atmosphere at the service. We observed numerous positive interactions between people who used the service, staff and managers. Staff spoken with expressed an understanding of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job descriptions and a code of conduct, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates.

We noted that each shift was led by a nurse and senior health care assistant. We heard them discussing the personal care needed that day by each person who lived in the service. We then noted that this discussion was reflected in the tasks we saw care staff being asked to complete. In addition, we were present when the care staff met to hand over information from one shift to the next. We noted the meeting to be well organised so that detailed information could be reviewed in relation to the current care needs of each person.

People who used the service, their relatives and staff were engaged and involved in making improvements. Documents showed that people had been invited to attend joint residents' and relatives' meetings at which

they had been supported to suggest ideas about how the service could be improved. We noted examples of suggested improvements being put into effect. An example of this was changes that had been made to the menu so that it better reflected people's changing preferences.

Compliments received about the service were shared with staff and used as examples of good practice. Staff were praised when they received positive feedback from people and they were proud that people's relatives had taken the time to write thank-you cards. Any feedback received was recorded and regularly reviewed by the acting manager and the provider.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent to people with the last being in May and June 2018. We noted they expressed satisfaction, in areas of staff attitudes and quality of care. Where issues were identified, people stated that they were listened to and those issues were resolved in a timely manner.

Information was available to people and visitors in the hallway of the service. These included the provider's Statement of Purpose and an area to give feedback / make suggestions. This facilitated communication channels between people and the service's management.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating at the service.

The provider was aware of CQC guidance of 'Registering the Right Support.' (CQC's policy on registration and variations to registration for providers supporting people with learning disabilities.) They understood the principles of the guidance and required more time to embed the principles of person centeredness. In response to evidencing how the provider can provide person centred care they had recently signed up to 'The Driving Quality Code' (The code was developed following the Winterbourne review that identified abuse within learning disabilities at Winterbourne View. The government and many other organisations that support people with learning disabilities are taking action to make sure that this never happens again.) The Code has a particular focus on people with challenging behaviour who have longstanding and complex support needs but can be applied to all people with learning disabilities, including those who have autism. The Granary had signed up to the Driving Up Quality newsletter from the site, and the acting manager had access to the website with a link to the self-assessment. The self-assessment guide includes what 'good' and 'bad' looks like in each area of the Code. We will not be able to assess the impact of this recent action until we next inspect the home.

In July the provider started having 'Manager Briefing workshops' which are delivered monthly. We saw sufficient evidence that these occurred in July, August and was arranged for September 2018. The focus of these meetings was to have open discussions / workshops to consult and engage with managers within Sussex Health Care to discuss shared organisational learning from the safeguarding's and CQC inspections. Consequently 'Weekly Communication' documents are sent to all staff to improve and challenge good practice. In July, an agreed template and agenda was created by managers at a 'Managers Briefing' to adopt a standard approach to ensure organisational learning was imbedded in the providers locations. The agenda included: safeguarding updates, DOLS/MCA – updates, audits & action plans, lessons learned (location), training, policy of the month, staff feedback, company updates, organisational learning and suggestions box. We will not be able to assess the impact of this recent action until we next inspect the home.

Records demonstrated the service worked with other organisations to ensure people received a consistent

service. This included those who commissioned the service, safeguarding and other professionals involved in people's care.

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 9 HSCA RA Regulations 2014 Person-centred care These issues were a continued breach of Regulation 9 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014 as the registered person had failed to provide person-centred care for every person.