Care Quality Commission

Russettings Care Limited

Russettings Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 10 and 12 February 2015 and was unannounced.

Russettings Care Home is registered to accommodate up to 45 people with a range of needs, including people living with dementia and/or long-term health conditions. The service also provides a short-breaks and respite service. At the time of our inspection, there were 39 people living at the service. Russettings Care Home is a purpose built nursing home set in its own grounds and is situated on the edge of Balcombe village. People have their own rooms and some have en-suite facilities. There is a large communal lounge area, dining room and conservatory overlooking the grounds; a separate garden has been made accessible to wheelchair users.

The service has 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

Summary of findings

and associated Regulations about how the service is run. The service changed providers less than a year ago and the new registered manager started at the service in April 2015.

Risks to people had not always been assessed appropriately. Where risks had been assessed they had not been reviewed on a regular basis.. Where people were at risk of developing a pressure ulcer, there were inconsistencies in how the risks were assessed or managed. Accidents and incidents were recorded, but there was no analysis or monitoring system in place. The premises were undergoing refurbishment and there was a risk to people and staff because of the way the building works were managed and lack of environmental risk assessments.

People's medicines were not managed safely and Medication Administration Records (MAR) charts had not always been fully completed. The medicines trolley was left unlocked during a medicines round.

Staff knew how to recognise the signs of abuse and what action to take to keep people safe. Staffing levels were sufficient and the service employed agency staff to address any unplanned gaps in staffing. Safe recruitment practices were in place to ensure that statutory checks had been undertaken for new staff. People were protected against the risk of infection and staff demonstrated their understanding of infection prevention and control.

People were not always supported or encouraged to eat their meals. Some staff did not notice when people needed help and people were at risk of having little or nothing to eat. Where people had been identified as at risk of malnutrition or dehydration, they had not always been weighed frequently. Care plans did not always show what action had been taken to address people's dietary requirements or nutritional needs. Food and fluid monitoring and recording was inconsistent. People had access to healthcare services and professionals.

Staff completed an induction programme and had received all essential training, although not all staff had received dementia awareness training. They demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and the associated legislation and put this into practice. Staff received regular supervisions and attended staff meetings.

Care records were inconsistently completed and were not always person-centred as they lacked personal details about people. The registered manager was in the process of updating all care plans. Activities were organised on a daily basis and people were supported by staff to be engaged in these activities. However, it was not clear how much involvement people had in the planning of activities. Relatives and friends could visit people freely. Residents and relatives' meetings were held, but some people appeared to be unaware of them. Complaints were listened and responded to within a week and resolved within 28 days.

People were not actively involved in developing the service. There were some systems in place to monitor and measure the quality of care provided, however, these were not robust enough to drive continuous improvement. Where audits had been undertaken, they were not planned on a regular basis and where gaps or inconsistencies were identified, these had not always been addressed or acted upon.

Staff felt they were well supported and motivated to carry out their responsibilities. They felt that things had improved since the service had changed ownership. External agencies were contacted and worked in partnership with the service. People were cared for by kind, caring and compassionate staff and were involved in decisions about their care. They spoke highly of staff. As people reached the end of their life, they were involved in decisions about how they wished to be cared for. Staff were sensitive in their approach to end of life care and provided support to the person and their family.

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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected against risks because assessments were not completed accurately or reviewed regularly and staff were not taking appropriate action to protect people from the risk of poor care.

There were gaps in the recording of the administration of medicines, so that it was not clear whether people had received their prescribed medicines or not. The medicines trolley was left unlocked during a medicines round.

The service followed safe practices in relation to the prevention and control of infection. However, it was not clear whether some staff had been trained in processes for handling soiled laundry.

Staff knew how to keep people safe as they had been trained appropriately. There were sufficient numbers of staff and the service followed safe recruitment practices.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

People were not always supported to maintain a balanced and healthy diet to meet their needs. People who had been identified as at risk of malnourishment, had not been weighed regularly nor action taken to address the risk.

People had access to healthcare professionals and received ongoing healthcare support.

Staff had received essential training, although not all staff had undertaken dementia awareness training. Staff had regular supervision meetings and appraisals. The service complied with the requirements of the Mental Capacity Act 2005 and associated legislation.

Is the service caring?

Good

The service was caring.

People were treated in a kind and compassionate way by caring staff. They were supported to express their views and were involved in decisions about their care.

People were supported in their end of life care and people had plans in place which gave information on how they wanted to be treated.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

Summary of findings

Activities were organised for people, however, they had little input in planning these. Some people were unaware that residents' meetings took place.

Care records contained incomplete information so that people did not always receive care that was responsive to their needs. There was a lack of personal information about people and care plans were not person-centred.

Complaints were responded to appropriately and resolved within 28 days

Is the service well-led?

Some aspects of the service were not well led.

People were not involved in developing the service and had not been asked for their formal feedback, although residents' meetings did take place.

The systems in place for monitoring the quality of the service were inconsistent and unfit for purpose as they did not identify shortfalls..

Improvements had been made and staff morale had improved under the new management.

The provider had sought advice and support from external agencies to develop the service and work towards a better quality of care provision.

Requires improvement

Russettings Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 10 and 12 February 2015 and was unannounced.

Two inspectors, a nurse specialist and an expert by experience with an understanding of older people undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

We observed care and spoke with people, relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spent time looking at records including 11 care records, six staff files, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. We contacted local health and social care professionals who have involvement with the service, to ask for their views.

On the day of our inspection, we spoke with eight people using the service, five relatives and two volunteers. We spoke with the provider, the registered manager, the head of care, two registered nurses and six care assistants. In addition, we spoke with a member of the dementia in-reach team and a dietician who were working at the service on the day we visited.

This is the first inspection since the service changed provider in March 2014.

Inadequate

Is the service safe?

Our findings

Arrangements for continually reviewing pressure ulcers were not safe. Risks to individuals, including environmental risks, were not managed appropriately. Six people were at high risk of developing pressure ulcers. One person had developed a grade 2 pressure ulcer. There was no wound care plan to inform staff how the wound should be managed. Pictures of the wound were not taken over time to measure progress of treatment and update any changes in skin integrity, nor was the care plan reviewed and updated. A Waterlow risk assessment was in place, but was not updated to reflect the current risk management of the person. Waterlow is a tool designed to assess people's risk of developing a pressure ulcer. It was observed that the same person had two skin bruises on the shin of the left leg. However, these bruises had not been recorded by staff and there was no body map or documentation within the care record. The turning charts for this person were inconsistently completed.

Insufficient action was taken to prevent the development of pressure ulcers. However, people at risk were provided with alternating pressure relieving air mattresses on profiling beds. There were turning charts for all people at risk, but some of these charts were not completed accurately. There were no monitoring systems in place to show the effectiveness of the air mattresses. Of the six pressure mattresses checked, only one was set at the right pressure. Some of the mattresses were left on 'static mode' which meant that these mattresses were not set to deliver alternating pressure as required. Two members of staff demonstrated good knowledge and skills on the prevention of pressure ulcers, but when asked about the mattresses, were unable to explain the mattress settings.

According to the provider's policy, the risk assessments within care plans were to be reviewed monthly, but the care records were not up to date to take account of people's changing needs. For example, one person had lost weight, but this had not been reflected within the Waterlow risk assessment. This meant that this person's current risk of developing a pressure ulcer had not been assessed accurately.

Risks to individuals were not managed so that people were protected. Arrangements for recording accidents and incidents were not sufficient to formulate a plan of action to ensure that similar events would not reoccur. For example, in September 2014, two people had more than two accidents each in the same month. The accidents and incidents audit showed the number of times an accident or incident happened to the same person and action taken, but there were no efficient monitoring or analysis systems in place.

Premises and equipment were not managed to keep people safe. An upstairs kitchenette provided a hot water machine so that staff and relatives could make hot drinks and snacks. However, this facility was freely accessible to everyone and had not been risk assessed for people who could be at risk of scalding water because they were unable to operate the hot water machine safely. One person had a freestanding heater in their bedroom and there was no risk assessment in place to show how the heater was to be managed safely to prevent the risk of burns.

There were no rails along the corridors for people to hold on to which would have assisted if they wanted a rest from walking or felt a little unsteady on their feet. The registered manager told us that the previous owner had removed the hand rails and that these would be replaced as part of the refurbishment of the service. The provider was receiving support from an occupational therapist to ensure that adaptations and modifications to the premises were managed appropriately. There were no handrails on the inside of toilet doors to enable people to pull them shut easily. The red alarm cords, which people could pull to summon help, did not reach to the floor and therefore could not be reached easily if they sustained a fall. A door to one of the bathrooms, which was not currently in use, had been left unlocked. There were building works in progress, the flooring had been taken up exposing bare pipes and there was debris on the floor. This was a risk for people who were not physically prevented from entering an unsafe bathroom.

These matters were a Breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed so that they received them safely. There was some evidence of good practice in terms of medicines management, however, there were 12 unexplained gaps in the recording of medicines within the Medication Administration Records (MAR) in January and February 2015. MAR charts checked at the service showed gaps in the administration of some medicines and staff were unable to explain the reason for

Is the service safe?

this. It was unclear whether the medicines had been administered or not. The medicines trolley was securely locked in the treatment room when not in use. However, during the medicines round we observed on the morning of our inspection, one medicines trolley was left unattended in the lounge area without being securely locked. This meant that anyone passing the trolley could have helped themselves to medicines not prescribed for them and be put at risk. The registered nurse in charge of the medicines round demonstrated a good understanding of medicines administration and management, but was not able to give any reason why the medicines trolley had been left unattended.

These matters were a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled drugs were in use and were stored and administered in line with legal requirements. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and misuse of drugs regulations. Stock levels of medicines we checked were correct. Medicines that were required to be refrigerated were stored at an appropriate temperature. The medicines trolley on each floor were clean and medicines were arranged well for easy identification.

People were protected by the prevention and control of infection. Staff demonstrated their understanding of infection control and wore protective aprons and gloves when attending to people's personal care. Alcohol gel was available for handwashing. The environment was clean and tidy with no unpleasant odour in the corridors or rooms. Cleaning at the service was undertaken by an external contractor and there appeared to be no clear lines of communication between the cleaning staff and care staff, as each worked independently of the other. Minutes of staff meetings had identified that there could be a problem with cleaning on a Sunday as cleaning staff did not work on that day. The registered manager told us that any spillages that occurred, or urgent cleaning required when cleaning staff were not on duty, were attended to by care staff.

There was a separate laundry room and laundry was separated into blue, green or red bags. There were instructions on display to show how different items of laundry should be cared for and laundered. There was a large pile of clothing stacked up on the laundry room windowsill. This was clothing that was unlabelled and therefore could not be returned to the people it belonged to. The laundry assistant on duty at the time of our inspection found it difficult to answer our questions, as English was not her first language. It was not easy to ascertain whether she had a clear understanding about infection control and the laundering of soiled clothes or linen, although she pointed to red alginate laundry sacks and disposable gloves when questioned. The registered manager told us that infection control had been explained to the laundry assistant verbally by another member of staff who could communicate in her language and who had received appropriate training. Care staff told us that it was their responsibility to put soiled linen into a red bag. They would then take it to the laundry room or the laundry staff would collect it. The laundry room walls were not tiled, which made surfaces difficult to clean. The registered manager told us that this was work due to be done as part of the refurbishment programme.

People were protected from the risk of abuse. Staff recognised the signs of potential abuse and knew what to do if they suspected abuse was taking place. One member of staff explained, "We need to safeguard the residents from financial, physical or mental abuse, making sure they're ok". People told us that they felt safe and one person said, "I feel safe and I am happy here". Another person said, "I would ask a carer if I was worried".

There were sufficient numbers of suitable staff to keep people safe and meet their needs. Staffing rotas showed the hours worked by staff. The registered manager told us that they were advertising for an additional registered nurse and two care assistants. The provider employed agency staff when needed to maintain safe staffing levels and to cover staff sickness and other unplanned shortfalls to staffing. One member of staff told us, "Staffing levels have improved dramatically. We have high levels of sickness here, especially over weekends. The impact of sickness is on the residents. It takes away the personal time we have with residents". The registered manager acknowledged that staff would call in sick unexpectedly when they were due to work at the weekend and that this was being addressed.

The service followed safe recruitment practices. Staff had completed the necessary statutory checks to make sure they were safe to work with adults at risk. Two references were taken up before new staff commenced employment, including proof of identify and a full employment history.

Requires improvement

Is the service effective?

Our findings

People were not always supported to have sufficient to eat, drink and maintain a balanced diet. Menus were planned on a four weekly cycle and were changed during the summer and winter months. Special diets were catered for. We observed one person whose lunch had been cut up, placed on a tray and put in front of her on a table. She spent time looking at the food, picked up her knife and fork and put them down again. She appeared to be confused and started calling out, but no staff came over to find out what was the matter. After 15 minutes, we went to seek help from care staff. A further five minutes elapsed before a member of staff came to assist this person with her lunch. By this time, the food was cold and the person ate a small amount, with help from staff. A dietician who was also visiting on the day of our inspection advised that finger foods should be provided so that the lady could help herself. A sandwich was provided and the lady immediately started to eat. In this person's care record, an assessment stated, 'Resists food. Requires full assistance to eat and drink. Risk of aspiration'. The care plan was accurate, but the care provided by care staff did not meet her needs. Records of this person's weight showed she had lost 5kg between November and December 2014. At teatime later in the day, we observed this lady enjoying a drink of hot chocolate which she drank quickly. The care plan showed that she enjoyed milky drinks. However, after the hot chocolate had been consumed, care staff took the empty cup away and did not offer her another drink. This person was at risk of malnourishment and her nutritional needs had been assessed accurately, but they were not addressed in practice.

During the lunchtime meal, there was a variety of drinks on offer including lemonade and fruit juice. One person requested cranberry juice which was handed to them by a member of agency staff who would not have been aware what medicines this person was taking. This posed a potential risk for the person if they were taking Warfarin as there is medical evidence to suggest that cranberry juice increases the effects of this drug.

The majority of people who were sitting in the lounge area, were encouraged to eat their lunch in the dining room. Many people required two members of care staff to support them to be hoisted from an armchair to a wheelchair, then be taken into the dining room. The whole process took a while to complete, with the result that people who were sat down waiting for their lunch earlier, were sat there for a couple of hours or so. Care staff were on hand to assist people with their meals, but we observed that some people who were not encouraged by staff to eat, ended up with cold food. We discussed this issue with the registered manager as the lunchtime experience might be handled more sensitively for people with two lunchtime sittings, rather than one, which took time to complete.

One gentleman said that he did not wish to go into the dining room, so lunch was brought to him on a tray in the lounge area. He said that he did not want the food on offer, sausage plait. We observed that the food was taken away, that no alternative food choice was offered by staff or thought of bringing the food back later to see if the person had changed their mind about eating. No encouragement was offered by staff to see whether the person might eat a little bit of lunch later, so that he ate nothing.

Nine people had been identified as being at risk of malnutrition and dehydration. The provider's weight monitoring policy stated that these people should be weighed weekly, but none of the nine care records we looked at included weekly weights. Where people's weights had been recorded, there was no plan in place to show what action had been taken when people had lost weight. Care plans for eating and drinking for people identified as at risk had not been updated, evaluated or reviewed. Staff reported that they relied on handover meetings to provide them with updates on people who required extra assistance with eating and drinking. None of them suggested they would look at the care plans to gain updated information. Care staff appeared to have little understanding of the significance of reporting weight loss and felt this was a job for the registered nurses. Fluid charts were completed for some people, but entries were not always consistent and there were gaps in the recording of entries. Three different fluid charts showed that the person had their last drink of the day at 12.00 hrs, 13.00 hrs and 15.00 hrs respectively. There was nothing else recorded after that time. There was no evidence to indicate that staff had been trained in the effects of malnutrition or dehydration, which put people at risk.

Feedback from a healthcare professional stated that regular observations such as weight recording and Waterlow assessments had been sporadic, but that this area was improving.

Requires improvement

Is the service effective?

These matters were a Breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people were supported to maintain good health, had access to healthcare services and received ongoing healthcare support. Three people said they could ask to see a doctor. One said, "The doctor was here yesterday and I saw him". We asked them, "What would happen if you asked to see a doctor and a staff member said that a doctor's visit was not necessary. Would you still get a visit?" The person's response was, "Yes, if I said I wanted the doctor, I think I would get a visit". Another person told us, "I have my own podiatrist and I arrange for them to visit every ten weeks. That suits me well". Another person said that they saw an optician and visited the 'eye clinic'. Care records showed that there was involvement of external professionals, for example, referrals to a dietician. General practitioners were involved in the management of ailments such as urine infection, chest infection and medication reviews.

Staff received training as part of their induction which continued throughout their probationary period. Staff received essential training in safeguarding adults at risk of abuse, moving and handling, infection control, food hygiene, health and safety and first aid. A spreadsheet showed recent training that had taken place and training that was planned. One member of staff told us about the training she had received since joining the service in August, in mental capacity, Deprivation of Liberty Safeguards (DoLS), safeguarding adults at risk, infection control and dementia awareness. The registered manager told us that staff were trained to at least Level 2 in Health and Social Care and were encouraged to progress to Level 3. One member of staff commented, "We have loads of training, lots of choices, almost too much training". Staff felt there was sufficient training and plenty of opportunities to undertake a health and social care qualification.

The registered manager told us that staff had not received dementia awareness training with the last provider and that this was now being rectified. Some staff related well to people who lived with dementia, made eye contact and sat or knelt down next to people when communicating with them. Other staff stood over people and did not appear to speak very clearly, or even to speak at all to people, especially when they were assisting them to move using a hoist. The registered manager had sought advice from the local authority's Dementia Inreach Team who had been visiting the service over several weeks and were supporting staff in their understanding of dementia care.

Staff had regular supervision meetings and support from their line managers. One member of care staff told us that she received supervision every two or three months, that any issues could be discussed. She said that they would look at the last supervision meeting notes and discuss any actions arising and whether these had been addressed. Staff told us that they received regular supervisions and yearly appraisals and felt well supported by management. Another member of staff said that the registered manager and deputy manager were very accessible and added, "The owners are very nice and very approachable". Staff meetings were held every couple of months and minutes of meetings confirmed this.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant requirements of the Mental Capacity Act 2005 (MCA) and put this into practice. One member of staff talked about mental capacity and said, "People who are unable to make their own decisions". She went on to say that she was in the process of completing DoLS applications for some people. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm.

People's human rights were properly recognised, respected and promoted and the service was meeting the requirements of DoLS. The registered manager had received advice on this from the local authority to ensure legal guidelines were followed. Where people were unable to make big decisions independently, best interest meetings were organised. This is where staff, professionals and relatives would get together to make a decision on the person's behalf. People were also able to attend these meetings if they wished. Care plans showed that mental capacity assessments had been undertaken for people and the service recognised the different levels of decision making.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People said that staff were kind and helpful, although one person thought that staff were sometimes too busy to stop and have a chat. She said, "I love conversation and would really like to have time with staff for this. I do have visitors, but there is no time to talk with staff. It's a long day if you don't see anybody to talk to". We observed people were treated with kindness, respect and empathy by most care staff. When a person on the first floor needed help and rang their call bell, two care staff went to find out what the person wanted. The staff knocked on the door prior to entering. They did not rush the person, but gently and kindly attended to their needs. Staff were interactive, polite and communicated with people in a respectful manner. The majority of staff communicated well with each other and worked together effectively.

We observed the registered nurse administering medicines and she waited patiently whilst one person swallowed their medicine. She gained the consent of the person and called them by their preferred name with a smile. Staff demonstrated a good understanding and knowledge of people's preferences and choice.

One member of care staff was observed asking a person at lunchtime if she could manage to eat their lunch unassisted. When this person appeared to be struggling with their meal, the member of staff did not immediately take over, but was sensitive to their needs. She said, "Shall I bring a chair and sit next to you in case you would like some help?" The staff member then sat down next to the person, waited a little longer and then said, "Do you think you would like some help?" to which the person replied, "That would be nice". We observed staff assisting people to walk to the dining room at lunch time and chatting with them as they went. When people expressed a preference to eat their lunch in the lounge area, then their request was acceded to.

One person in the lounge area became ill. Staff responded immediately and pressed the emergency call bell and a registered nurse arrived within seconds. The person was treated with dignity and respect and spoken with reassuringly by care staff. People sitting near the person were gently moved away to give the person who had become ill privacy and space. At the same time, a new person arrived by ambulance with paramedics; she had come in to the service for a short break. Care staff welcomed her and immediately got this lady a drink. The registered nurse, having checked that everything was all right with the first lady who had been unwell, then went to meet the lady arriving at the service and undertook an initial assessment. There was no sense of panic whilst all this was happening. Staff acted swiftly and appropriately and were calm and comforting with people.

The provider supported people to express their views and, from our observations, people were involved in making decisions about their care, treatment and support. Some people seemed unaware that they could be involved in planning their care, but one person said, "They have a great team here and they try very hard". Another person said, "They work hard, are very caring in sometimes difficult circumstances". A member of care staff told us, "You learn something new about people every day" and went on to say that she was a 'dementia friend', an initiative of the Alzheimer's Society. She said she was finding out more about being a dignity champion which meant she believed ensuring dignity and respect for people who used care services was a cause worth pursuing. A healthcare professional was asked for her feedback and responded by email saying, 'My team often comment on the caring nature of the care staff within the home that they have witnessed'. She added, 'The care staff appear to enjoy their work and this is reflected in their caring approach'.

People were supported at the end of their life to have a private, comfortable and dignified death. Some people had end of life plans in place and, where they were able, had been involved in decision-making. There were 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms in some people's care records and these had been completed correctly in line with legal requirements. Where possible, people and their relatives had been consulted in the completion of these forms. One member of care staff said, "We do as much as we can and provide support to the individual and their family".

Requires improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs and care records were not always completed to reflect this. The registered manager told us that she was still catching up on care records and acknowledged that some care plans had gaps in the recording of information. The provider had taken over a service where care records had not been completely appropriately in the past. One senior member of staff referred to the service and said, "It's got a lot of potential and needs a lot of work, things pulling up to scratch, but nothing is not achievable". A member of care staff said, "We want care plan training to understand these. Care plans do help, but can be confusing". She said that many of the care plans had been completely re-written and were new and told us that she would be involved in drawing up risk assessments as part of the care planning in the future. One of the registered nurses said that people and their relatives were consulted before a care plan was written. However, evidence in care records did not reflect this as most had not been signed by the person or their relatives.

Care plans had not always been completed consistently. For example, in one care plan there was a safety assessment and consent form for bed rails, but this had not been signed or dated. It was difficult to track the accuracy of information to ensure that people's most up-to-date care needs were being met. Some care records had been reviewed monthly in line with the provider's policy, but others were not. For example, one care plan, including the risk assessments, was last reviewed in July 2014, another was last reviewed in September 2014 and two other care plans were last reviewed in August 2014. Staff said they relied on communication at handover between shifts to gain information about how people wanted to be looked after. None of the care staff we spoke with said they used the care plan to inform them of the care delivery. They felt the care plans were the domain of the nursing or management staff and they were not involved in changes or updates to care plans. Feedback from a healthcare professional stated that care plans were in the process of being updated into a new format to adopt a more person-centred approach.

Care records we looked at showed little in the way of life histories to build a person-centred approach. Staff knew people well, their preferences, choices and interests, but there was no evidence to support this within people's care records. Given the significant use of agency staff, there was no pen portrait within care records to facilitate personalised care at every interaction.

These matters were a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An activities co-ordinator planned activities at the service and something was planned every day of the week. For example, beauty treatment sessions, reminiscence, chair exercises, arts and crafts. On the day of our inspection, two young ladies were dressed in American forces costume and were singing songs from the wars. People were engaged in this activity and supported by staff to be involved. There were limited opportunities for people to participate in community activities, unless their relatives took them out. One person told us, "I think I went out some time ago, but no, I've not been to the village [Balcombe]. I don't know where that is". The registered manager said that it was difficult to manoeuvre wheelchairs outside the service as country roads nearby were narrow and unsafe. Another person told us, "I did go round the garden when the weather was warm, but it's too cold now". People were very reliant on activities that were organised for them within the service. However, there appeared to be no consultation on what people would like to do. People were supported and encouraged to maintain relationships with people that mattered to them. One person said, "I went to be with my family on Christmas Day. They came and drove me there. It was so lovely to be in their home".

Residents and relatives' meetings were held, although some people were not aware of them because they had not seen notices advertising them. Thought might be given to having separate meetings to really encourage residents to come together to discuss issues that mattered to them. People should be asked what they wanted to discuss and supported to include items on an agenda. Many people were capable of making a meaningful contribution at residents' meetings, whilst others who were less able needed support to do so.

The service did routinely listen and learn from people's experiences, concerns and complaints. Complaints were responded to within seven days and resolved within 28 days. A copy of the complaints procedure was displayed in the reception area. There were no complaints from people using the service on file and people told us that if they

Requires improvement

Is the service responsive?

wanted to make a complaint, they would talk to staff. One person told us, "If I don't like something, I tell them. It's a lot of money [referring to fees], so I tell them and usually it gets sorted out". A relative told us, "You can always ask the owner. He's often about and he really listens and does want to know. He says he wants to know so he can improve things, so we would always go to him and he does take us seriously". A member of care staff said, "I speak to the person, reassure them and they can write it formally. Most informal complaints can be dealt with quickly".

Requires improvement

Is the service well-led?

Our findings

People were not actively involved in developing the service. People were unaware of how they could make their voice heard in terms of suggestions or improvements at the service. Two people thought they might have heard about the relatives and residents' meetings, but they could not remember attending any. They said they had not been asked to complete any formal feedback to ask for their views, for example, through a questionnaire. Residents and relatives' meetings had been organised and, where people and relatives had attended, their feedback was positive.

There were some systems in place to measure the quality of the service. The registered manager had identified that robust systems were not in place when she took over as manager. For example, there was no training plan and staff did not receive regular face-to-face or supervision meetings. Progress has been made, but there were still gaps in record keeping and auditing. Care records and associated risk assessments were not reviewed in line with the provider's policy. Accidents and incidents had been recorded, but there was no analysis of the reoccurrence of accidents that people had sustained or lessons learned. Medication audits had been undertaken six times during 2014, however, these had not identified or explained why there were gaps and inconsistencies within the MAR charts. There were audits that looked at staff training, infection control, wound and pressure sores, but these appear to have been completed on an 'ad lib' basis rather than being factored into a system that ensured they were undertaken at regular times throughout the year. Audits had not identified areas for improvement or actions to be taken, for example, in wound care management.

These matters were a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When asked about the vision and values of the service, the registered manager said, "Treat everyone as an individual. Keep them safe, secure and happy and give them a sense of purpose. For staff to be happy and work as a team. We all have the same objectives, we're here for the residents".

Staff felt well supported and motivated in their work. One of the registered nurses said, "The new manager is trying to make the home better and is very supportive". A care assistant said, "Our manager is very good". Staff meetings were held every couple of months and records confirmed this. A member of care staff told us that they had separate team meetings as well as staff meetings which all staff could attend. A member of care staff felt that there had been massive improvements since the new owners had taken over and said, "Staff morale was very low with the previous owner. Things are getting a lot better". She added, "All the staff generally get on very well. If I'm happy and having fun it reflects well on the residents". Staff were aware of the whistleblowing policy, knew how to raise a complaint and who to contact. The registered manager told us, "We've mentioned it [complaints policy] at staff meetings and put a copy on the noticeboard in the staff room".

The provider had sought support and advice from external agencies and was acting on this. When asked for their views via email, a healthcare professional said, 'The home manager is relatively new to post. She is keen to effect change in some areas of the home, but at times it appears that changes are not communicated efficiently among the staff team'. The registered manager felt that promoting person-centred care and involvement of the staff was the biggest challenge at the moment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider was not carrying out, collaboratively, with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. The provider did not design care or treatment with a view to achieving service users' preferences and ensuring their needs were met. The provider did not enable and support relevant people to understand the care or treatment choices available to the service user and to discuss, with a competent healthcare professional or other competent person, the balance of risks and benefits involved in any particular course of treatment. Regulation 9 (3) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not protect service users against the risks associated with the unsafe use and management of medicines. Regulation 12 (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 How the regulation was not being met: The provider did not provide service users with suitable and nutritious food and hydration which was adequate to sustain life and good health. The provider did not, where necessary, support service users to eat or drink. Regulation 14 (4) (a) (d)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider did not assess, monitor and manage the risks relating to the health, safety and welfare of service users and others who may be at risk. The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user. The provider did not maintain records relating to the management of the regulated activity in relation to audits and reviews and action plans in response to risks and incidents. Regulation 17 (2) (a) (b) (c) (d)