Assured Care Services Limited

# The Heathers

## Inspection report

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## Ratings

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| Overall rating for this service | Requires Improvement |

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| Is the service safe? | **Requires Improvement** |
| 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

The Heathers is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate up to 24 people in one adapted building. At the time of the inspection they were full. The home had six short stay beds. These beds were used by people who were transferred from the local hospitals for rehabilitation, prior to their returning home. The expectation was that the short stay people would stay at the home for six weeks but some of them stayed longer. At the time of the inspection one of these people had been resident at the home since January 2018.

We inspected The Heathers on 27 and 28 June 2018. The first day was unannounced. It was a comprehensive inspection. The last inspection had been on 15 February 2015. At that time we rated the service as Good.

People were happy at the home and felt that they received good care. There was a system of policies and audits in place. However, on review of the documentation we found some risk assessments had not been updated, to reflect changes in people's care needs and some of the people did not have essential risk assessments in place. Similarly, some of the care plans did not reflect the care people were receiving and some people did not have relevant care plans. The impact of this was minimised, as the staff knew the people under their care and the care each person required. However, this lack of up to date risk assessments and care plans, could potentially put people at risk, of receiving inadequate or inappropriate care. The management team were implementing changes, to improve the standard of the documentation. However, at the time of the inspection these changes had not insured that all people had contemporary and complete records. You can see what action we told the provider to take at the back of the full version of the report.

At the time of our inspection a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was based at the sister home and was not available on the day of the inspection. The day to day management of the home was the responsibility of the care manager. The home had a system of audits and quality assurance in place. However, these had not improved the quality of the documentation in regards to personal risk assessments or care plans.

There was a system in place for determining the level of dependency of the different people and thereby calculating the number of staff required. However, there was little flexibility within the staff numbers. On occasions when people's dependencies changed staff were very busy and it impacted on the ability of the care manager to complete the more administrative parts of their role, for example reviewing and updating the care plans.

There were environmental risk assessments in place and the home had been adapted to suit the needs of the people living there, with a lift between the different floors. The home was clean and tidy and was odour free and people enjoyed an enclosed garden. There was an infection control policy in place and we saw evidence of the use of personal protective equipment, including gloves and aprons.

There was a comprehensive training schedule for all staff. This included training on safe-guarding and the Mental Capacity Act (MCA). All staff received supervision and appraisals at regular intervals. There was a system in place for orientating and supporting any new member of staff. New staff had the appropriate checks, prior to starting work, to ensure they were appropriate for the job and could work within the care industry.

The staff were committed to keeping people safe and could tell us the principles of safe guarding. Similarly, 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. People were given choice within their daily lives, including how they wanted to spend their time and how they wanted to dress or decorate their rooms. People told us they felt happy in the home and were able to talk to the care manager about any concerns. They also told us they had good relationships with the staff and we observed people being treated with dignity and respect.

Staff were trained in the safe administration of medication. We witnessed people receiving their medicines in a safe and dignified manner. The medicines were kept appropriately and there was a system in place for the ordering and disposal of medications.

Any accidents and incidents within the home were reviewed to see if there were any lessons to be learnt. This was discussed at the regular staff meetings. There was also a complaints procedure in place, which was clearly displayed on the walls. People also received a written copy of this policy when they first arrived and they could request an audio version if they preferred. This was one example of how the staff aimed to make information more accessible to people, in compliance to the Accessible Information Standard (AIS).

There was an activity program in place and this had recently been increased, following people's feedback. Within the activity program each person received one to one time with the activity lead. This also enabled people to feedback about what they liked about the home and the activities and facilities on offer. People were able spend the day how they wanted. Visitors could visit within reasonable hours and were made to feel welcome.

The home had a chef during the working week but there was a meal delivery service at weekends. People told us they liked the food prepared by the chef but were less keen on the weekend food. This system was under review, following people's feedback. We observed a weekday lunch. We saw people receiving nutritious and tasty looking food and enjoying the meal time. There was ready access to fluids throughout the day and people, who were identified as being at risk of dehydration or malnutrition, were monitored, to enable changes to be identified and addressed.

Staff had a good working relationship with other health care professions. People were helped to access health services as required. If appropriate, the staff referred people to a local scheme, which provided specialist support and advice for people as they approached the end of their lives.

The staff were proud of the homely atmosphere within the home and people told us that they felt well cared for.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities 2014). You can see what action we told the provider to take at the back of the full version of this report.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The home was not consistently safe.

Personal risk assessments were not always in place or accurate.

There were appropriate recruitment systems in place. There was a system for calculating required staffing levels. However, on occasions, care documentation was not completed due to time pressures on the care staff.

Staff had a good understanding of safe-guarding and were aware of how to report signs of abuse or neglect.

Medicines were administered safely and according to guidelines. The home was clean and staff were aware of infection control measures.

### Is the service effective?

**Good**

The home was effective.

People had ready access to support and advice from health care professionals. The premises were adapted to suit people's needs.

People were given choice. Staff worked within the principles of the Mental Capacity Act (MCA).

Staff received relevant training and had regular supervision and appraisals.

People were supported to eat and drink. However, the food at the weekend was supplied by a catering company and was not enjoyed to the same extent as that provided by the chef during the week.

### Is the service caring?

**Good**

The home was caring.

People were treated with kindness and compassion.

People were given choices and independence was encouraged.

People were treated with dignity and their privacy was maintained.

## Is the service responsive?

**Requires Improvement**

The home was not always responsive.

Care plans did not always reflect people's current needs and some people did not have their care needs documented.

There was an activity programme in place.

There was a complaints procedure in place.

## Is the service well-led?

**Requires Improvement**

The home was not consistently well-led.

The management team had an action plan to address the omissions in care documentation. However, at the time of the inspection this had not ensured that all people had a complete and contemporary set of care records.

There was a registered manager in place.

There was a positive culture within the home and people told us they felt well cared for.

There were systems in place for gathering feedback from people within the home.

# The Heathers

**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 comprehensive inspection took place on 27 and 28 June 2018. The first day of the inspection was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some information about the service, what the service does well and improvements they plan to make. We also reviewed the information held about the service and notifications we had received. A notification is information about events which the service is required to send us by law.

Throughout the day we observed interactions between staff and people within the home. We spent time talking to nine people. We also spoke with four visiting relatives, the care manager, the area manager, the deputy, the chef, the activity lead, three care staff and three visiting health care professionals. We observed the lunchtime meal and the administration of medications. We also looked at five care plans, four recruitment files and files related to staff training, accidents and incidents, the record of complaints, maintenance files, audits and the policy folder.

Requires Improvement

# Is the service safe?

## Our findings

People told us that they felt safe in the home. One person stated, "I feel safe because someone is around all the time," with another stating, "I get very good care here." However, during the inspection we reviewed documentation relating to the different people, including risk assessments and care plans. Not all risk assessments had been completed and some were out of date. The home had a set of policies detailing when risk assessments should be completed. These stated that some assessments, including the falls assessments and the risk of developing pressure area damage, should be completed within two days of admission. One person had been admitted in January 2018. They did not have any risk assessments in place, even though they had fallen five times since admission. The care manager informed us that there had been risk assessments but these had been deleted in error from the computer a few weeks previously and had not been rewritten. Another person, who had been admitted on 17 May, did not have an assessment related to their risk of developing pressure area damage. Another person had become less mobile the previous year and was now being hoisted between the bed and the chair. The personal emergency evacuation plan (PEEP) did not reflect this change. It therefore did not have the correct information about how this person would be evacuated, from the building, in the event of an emergency.

The home did not always have enough staff. This had been flagged as an area of potential concern from data we collected prior to our inspection. There was a system for determining the care needs of the different people within the home but it was apparent from comments from staff that sometimes they were very busy. As the home had short stay people the dependencies varied from week to week. The management team updated the dependency scores each time there was a new admission, or discharge, or if someone's condition changed. However, on occasions the staff were very busy. One member of staff told us, "It's alright when the bells don't go." They went on to comment, "Sometimes it's manic especially when there are four bells going at a time." This feeling was echoed by other members of staff. Some people in the home commented about the staff numbers. One person told us, "Things have changed a bit over the last three years, the staff have to work so hard now." Another told us, "They could probably do with a few more staff." During our inspection it was apparent that the staff were busy. It was also evident that the care manager was regularly helping with the care needs of the people and did always not have enough time to complete the more administrative tasks. This was evident in the lack of up to date care plans and risk assessments. The home worked closely with their sister home, which was within the same care group. When they were understaffed someone from the other team would cover. This system of cross-cover meant that they did not often use agency staff, improving continuity of care. This was appreciated by the people within the home with one commenting, "There is a solid core of staff. They all know me by name." We discussed staffing levels with the care manager and they agreed that this is an area that needs to be kept under review.

There was a system of background checks and processes to ensure that new staff had the appropriate skills and could work within the care industry. This included an interview and reference checks, along with checks of their identity and home address. They also had a system for completing a Disclosure and Barring Service (DBS) check. This was repeated at regular intervals to ensure that staff members remained suitable to work within the care industry.

Staff were aware of the principles of safe guarding and they could talk through what they would do if they felt something was unsafe, or a person was at risk. They had received relevant training. One member of staff told us the training was, "Very useful." There was a safe-guarding and whistle blowing policy in place. Another member of staff reassured us, "If I see something or hear something, I would say."

The home had an electronic system for managing medicines. We witnessed a medicine round and saw people being given their medicines in a caring and dignified manner. The electronic system highlighted if any medicines had been missed in a daily report. Any discrepancies were seen to be investigated promptly. Medicines were stored safely and appropriately. There was a robust system to ensure new medicines were requested in a timely fashion and if medicines were no longer required they were returned to the pharmacy. There was a small number of staff who could give the medicines and they had received appropriate training to ensure they were competent. The staff also reviewed the effectiveness of medications with one relative telling us, "Mom was prescribed some meds that really didn't suit her, the care staff were aware of this and got them changed."

The home was clean and staff were seen to use PPE (Personal protective equipment), for example gloves and aprons. There was a both a daily and monthly cleaning schedule and they had a regular audit by West Sussex County Council. There were instructions in the staff areas detailing the correct technique for hand washing and infection control was part of the mandatory training schedule. The home had an outbreak of diarrhoea and vomiting earlier in the year. The care manager explained the procedures they had followed to minimise the risk of other people or staff becoming unwell. This included isolating those affected, reducing visitors to the home and ensuring any equipment used was washed appropriately to reduce cross-contamination. A visiting health care professional advised us they, "Haven't seen any bad practice," in regard to infection control.

There was a system in place to record and review any incidents or accidents that happened within the home. One staff member told me, "It's important not to leave things to happen again." If someone fell the manager looked for trends and sought ways of reducing any risks. One person had been moved to a different room following a fall. The new room was on the ground floor, enabling staff to respond quickly if the person rang their buzzer, or if the alarm from the pressure sensor mat went off.

There were environmental risk assessments in place. The Heathers employed a maintenance person who completed regular reviews of the home. They also worked with outside agencies to ensure that the hoists, lifts and appliances were assessed at regular intervals along with the utilities. Reviewing the maintenance logs there was a three-month period when the weekly flushing of little used outlets was not documented. There had been a gap in employment when the original maintenance person had left and the new one had started. We were informed that during this period some of the checks had been carried out by the care manager. The new maintenance person had resumed the regular checks and was able to evidence that these were now happening at appropriate intervals.

Good

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can 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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLs). We checked whether the care home was working within the principle of the MCA. The MCA requires providers to submit DoLs applications to a supervisory body for authority to deprive someone of their liberty. The home had made some DoLs applications but these had not yet been processed. The care manager and staff were aware of the principles of the MCA and had completed relevant training. They also had close links with a mental health nurse who worked in the sister home and could ask for advice and support as necessary.

During our inspection we saw care staff ask for consent before helping people. At lunch time we heard one member of staff ask, "Do you want me to cut that up for you?" rather than presuming and just doing it. One member of staff described how they would assist people. They stated, "Ask the person, talk to them and ask for their consent."

There was a comprehensive programme of training for staff. This covered areas relating to general care, for example pressure area management and confidentiality, and topics related to the care of specific people, for example dementia training and the management of diabetes. The staff felt the training was accessible and informative. One member of staff stated, "You have to do it (training) because it changes; nothing stays the same." New care staff were enrolled on the Care Certificate. The Care Certificate outlines 15 standards for health and social care workers to follow. It is aimed at people who are new to a caring role and introduces them to the required skills and knowledge with the aim of promoting care which is compassionate, safe and of a high quality. Some of the more experienced staff were also completing Regulated Qualifications Framework qualifications (RQFs), previously known as National Vocational Qualifications (NVQs). This is a work based qualification which recognises the skills and knowledge a person needs to do a job. There was a period of orientation for new staff, as well as a probationary period. During their orientation they met with the care manager, on a weekly basis, to ensure they were working to the required standard and had the required support. There was also a system of appraisals and supervisions for all staff. This enabled the staff to be monitored and supported as necessary. The care staff acknowledged that these were happening regularly and stated that they found them beneficial.

The staff were aware of the dietary needs of different people and people who were at risk of weight loss were monitored and referred to the GP for advice, if required. The chef had a system to identify different people's food preferences and any dietary requirements, for example a diabetic diet. During the week the home had a regular chef. However, at weekends they had meals supplied by an outside catering company. These were then reheated and served up by the domestic and care staff. The difference between the weekday meals and the weekend meals were noted by the people within the home. One person told us, "I don't like the food at

the weekends. The chef doesn't work weekends," and another stated, "When the chef is on the food is lovely. He doesn't work weekends and the food is not so good." The care manager told us that the use of a catering company at weekends was under review, as they were aware that people were not as satisfied with the food available at the weekends.

We observed a weekday lunch. The food looked nutritious. There was quiet conversation at some tables, with one person being overheard telling their neighbour, "He's a good cook that man." One of the carers was seen to go between the people offering support and encouragement. The meal was unrushed and people were seen to enjoy the food. The tables were set with table cloths and had the weeks menu on them. The home had pictures of the different dishes to help people decide what they wanted. The menu was on a four-week rotation and following people's feedback some new options had been tried. During the week the people could choose their meal the day before. However, at the weekend food needed ordering two to three days in advance, although we assured people could change their choice if they wanted to. During the week people were offered a choice of a main meal or an alternative, which included omelettes, jacket potatoes and sandwiches. One member of staff told us, "All given a choice of what they would like to eat." There was a vegetarian in the home and they told us, "They try. I have lots of baked potatoes," although this lack of variety did not seem to bother them unduly. The home was in the process of reviewing the weekend arrangements and had held a residents meeting to gain feedback. People had access to drinks throughout the day and there were jugs of juice in the lounge to keep them hydrated.

People had ready access to health care professionals. People who were admitted into the short stay beds had regular reviews by a social worker and occupational therapist during their stay. The home also used an electronic system, for communicating with health care professionals, for this group of people. This system allowed for observations, for example a blood pressure, to be entered and relayed directly to a clinician for review. During the inspection we met three visiting health-care professionals who all spoke well of the relationship they had with the home. It was evident that nursing and medical care was sought if required. We were informed by one health care professional that the home was "flexible and adaptable," and another told us they "always get the correct equipment." Technology was used within the home to help with people's care needs.

The premises met the needs of the people, although there were some areas within the home which required re-decoration or modernisation. There was a list of improvement works with timescales as to when the work would be completed. There was an accessible garden, which people were seen to be enjoying. There was also a communal lounge, conservatory and dining area. There was a lift for those on the upper floors. People had personal belongings in their rooms and on each door, was a framed display of things that were important to the person. We were told these were chosen by the different people and included pictures of pets or significant places. The home had WIFI and the manager described how the lap top could be taken into the different rooms, so that daily records could be updated with the person. There was also an electronic call bell system and staff were happy to try new electronic devices, with the aim of improving care given, for example the electronic medicine charts and the system which relayed information to health care professionals.

Good

# Is the service caring?

## Our findings

The staff were caring and people were treated with kindness and compassion. One person told us, "I love all the staff here, they do a grand job," whilst another described the carers as "very nice and kind." The staff told us they tried hard to make the home feel welcoming. One said, "We like to keep a happy, homely atmosphere." We observed the staff interacting in a friendly and personal way. One member of staff described how they, "Have a banter with the residents, which they enjoy." Another told us, "They are more than well cared for, they are pampered." One of the visiting health care professionals stated that some short stay people had opted to stay long term. They stated, "This is a good reflection," of the home, commenting on the caring attitude of the staff.

From talking with staff and from our observations it was clear that the staff knew people well. At lunchtime we observed one carer going from person to person, addressing them by their preferred names and offering comments or encouragement. The staff could tell us things about each person, from their background, to their family and their individual preferences. One member of staff told us, "You get to know them by talking to them." Another told us how they would recognise if one of the people was unhappy, stating, "Anybody who looks withdrawn we need to find out why."

People were offered choices and had a degree of flexibility within their daily routines. One member of staff told us, "Sometimes (named person) doesn't like meal times at lunchtime, so we give it to her later." Comments from the different people also reflected this. One person told us, "I go to bed at 6.00pm and get up at 4.30am. I shower twice a week. That's what I like." Another person commented, "I get up when I want and I go to bed quite late." People could also decide how they spent their day. One person told us, "I go out and about, I have no restrictions. I just have to write it within the book." Another person went out every day with their family. Members of staff discussed how they offered people choices for example by asking, "What would you like to wear today?" and similarly described how people could choose whether to join in activities. This was seen during the inspection with some people joining in the activities and others preferring to stay in their rooms. One person was seen to go outside to smoke, which was important to them. One of the relatives commented, "Compared with the other care home Mum was in this is much better. They bring Mum out to smoke and are never too busy to help."

People were treated with dignity. The staff told us how they gave personal care whilst respecting people's privacy. One told us, "The door is always shut when you're giving personal care." Another told us, "Some like to stay with their door open; but still knock." We saw this in practice with people knocking on doors and asking permission before helping people with their physical needs.

Care records were kept securely, with electronic devices being password protected. People's personal information was protected. Staff were aware of the need to protect people's personal information and maintain their privacy.

Staff treated everyone with the same respect. They were adamant that they would not discriminate against anyone within the home. One member of staff, when asked, stated, "Don't discriminate against anybody,"

and was able to list protected characteristics, including race, religion and sexual orientation. There was a recognition of people's spiritual needs and a priest visited regularly and delivered communion to those who wanted it. One person described how they had attended church weekly prior to coming into the home. They told us they no longer felt able to attend church but found the regular contact with the priest very important to their well-being.

Staff were welcoming to people's friends and family. One member of staff stated, "Whoever comes through the door is welcome." Another told us they knew the regular visitors and they, "Always offer them a cup of tea." During the inspection we saw visitors arrive at different times and be made welcome by the staff.

Requires Improvement

# Is the service responsive?

## Our findings

During the inspection we reviewed people's care documents. Some people did not have care plans and some of the care plans which were present did not reflect the care being given. The home's policy stated that everyone should have full care plans within a week of admission and that care plans should be reviewed and updated on a four to six-week basis. If they were at low risk of change it was documented they could be reviewed three monthly. Two of the records we checked had no care plans. One of them had been admitted six weeks before the inspection and the other had been admitted in January. As before, we were informed that the person admitted in January had previously had care plans but they had been accidently deleted from the system a few weeks prior to the inspection. There was an initial assessment for these people, which detailed their background and health and care needs on admission. As this information had not been incorporated into care plans it was not possible to determine, from the paperwork, the care these people required, or to ascertain if their needs had been reassessed since their admission. The notes we reviewed, relating to long-term residents of the home, did not have care plans that reflected their current health needs. One person had developed a wound and they were less mobile than previously. The change to their mobility had not been recorded, meaning that the care plans relating to movement, daily care and elimination were not up to date. Another person had also deteriorated in health and mobility. They had a care plan which specified they required daily monitoring of their blood sugar. This had not been done since February 2018. Staff told us the GP had decided it was no longer required but the care plan had not been updated to reflect this change. The care plans related to mobility, daily care and elimination were also inaccurate, due to the change in the person's mobility. We queried these discrepancies with the staff. They could tell us about the support each person needed and the care each person required but acknowledged that this was not always reflected in the documentation. As the staff knew the different people the impact of this was reduced. However, if there had been new staff or agency workers this lack of information may impact on the person receiving personal care, which reflected their individual needs.

This lack of individualised care plans is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 which requires clear care plans, which include goals and review dates, be developed and made available to all staff.

From 1 August 2016 all providers of NHS care and publicly funded adult social care must follow the Accessible Information Standard (AIS) in full. Service must identify, record, flag, share and meet people's information and communication needs. The home had an accessible information standard and the staff sought to overcome barriers to communication. They could tell us how they would use accessible information to try to ensure everyone was able to express their views or make choices. We were shown picture cards that were used to help people, who were hard of hearing, to understand conversations about care. They also had audible copies of both the statement of purpose and the complaints procedure. The staff told us how they would help people with communication difficulties. One mentioned a course they had completed which, "Asked how we would communicate with different people." They could list different strategies like picture cards and sign language. However, once more, communication needs were not fully reflected in the care plans of the different people.

Staff received information from the hospital detailing who they would like to admit into the short stay beds. The staff reviewed this information, prior to admission, to ensure they could fulfil the care needs of each person. If they had questions or concerns, about the care the person required, they would ask for more information. They told us that on occasions they had declined an admission as had felt they were not able to offer the support the person needed. If someone was moving into one of the long stay beds they were encouraged to visit for a day prior to moving in, to check if they were happy and comfortable within the home.

There was an activity programme and this was displayed prominently throughout the home. During the inspection we observed people enjoying a game of dominoes together and there was colouring and reading materials in the lounge. We asked people for their view of the activities available. One person told us, "I like the activities, I join in." with another stating, "I like living here, there is entertainment." However, some people preferred not to be involved in the activities. One told us, "I'm happy not to join in. (Activity Lead) comes in to see me and leaves me a quiz." The activity lead was seen to be a core member of the team. They worked three days a week and when they were not available had arranged for an external entertainer to visit. There was a specific budget for entertainment. The activity lead produced a monthly report detailing the activities that had happened and who had participated in the different events. This reflected the comments made by the people and staff, with evidence that people enjoyed different things or preferred not to participate. The report also showed that the entertainment was being reviewed with the people within the home. There was mention that they had not liked one entertainer and that, following this feedback, they would not be rebooked.

The activity lead mentioned trips outside of the home. They commented, "Nearly every day I'm here I take someone out." This often involved taking them to the local shops. This was commented on by the visiting health-care professionals. They told us that one of the short stay people had not had appropriate clothing when they had transferred to the home from the hospital. The activity lead had bought the person clothes and on another occasion, had sourced white goods for a person, prior to them returning home. However, the activity lead also mentioned that they had been unable to arrange group trips recently as there was insufficient carers to accompany them. This was discussed with the manager and staff. When asked if they would have the flexibility to take a person out regularly, for example to church, we were told they would, "Find a way, somehow," but they acknowledged that this would be challenging with the present staff numbers.

The complaints procedure was prominently displayed on the walls in the corridors. It was also included in the "Welcome pack," which was hanging in the entrance hall and given to each new person when they came to live in the home. We saw evidence that complaints were reviewed and responded to. Each complaint was documented and an action plan was formed detailing steps that would be taken to address the complaint. People told us they felt able to talk to the manager about any issues. One person said, "I have never made a complaint but if I did I would speak to (Names senior staff)."

Staff delivered end of life care. If people were felt to be nearing the end of their life they were registered with the End of Life Care Hub (ECHO). ECHO provides a twenty-four-hour telephone service, with the aim of improving the co-ordination and delivery of end of life care in the local area. This enabled care staff to seek specialist support and advice when people were nearing the end of their life. Preferences regarding care at this time was discussed with the people alongside their family members, if felt to be appropriate. One relative confirmed this, stating, "We have discussed DNR (Do not resuscitate)." Some of the people also had anticipatory medicines available. These are medicines used to manage symptoms that may develop when people approach the end of their lives.

Requires Improvement

# Is the service well-led?

## Our findings

People told us they were happy in the home. One person stated, "I like it here, I'm very happy with it all," and another person told us, "I couldn't live anywhere better." However, the home was not always well-led. There was a comprehensive list of policies and audits in place and a framework for governance. The policies were reviewed yearly and covered a range of topics from the recruitment checks, to standards related to hydration. The audits aimed to check tasks were being completed at appropriate intervals. They also employed an external auditor to complete audits. However, despite there being quality assurance and audit systems in place these were not always effective. Records such as the risk assessments and care plans were not up to date and did not reflect the current needs of people.

The home had a registered manager. The registered manager was not based in the home and was not available at the time of the inspection. The care manager informed us that they contacted the registered manager through emails, or over the telephone and they visited the home every few weeks. We were informed that the management team had identified that the varying needs of the short stay people was impacting on the ability of the care manager and deputy to complete some of their duties. They had consequently reviewed the distribution of tasks. This had led to their recruiting of a new administrator. Some of the other tasks, including MCA and DOLS assessments, maintenance checks and staff training and supervision had also been delegated to other people within the organisation. However, although they had identified the issues, at the time of the inspection, the actions they had taken had not ensured that the care documentation was up to date, or reflected people's current needs.

The provider had not ensured that good governance had been maintained. Therefore, the above areas are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care manager was responsible for the day to day running of the service and was the person who the people within the home knew by name and referred to. The area manager also had a role in overseeing the home and was familiar to the people within the home. The people we spoke with thought highly of the care manager and felt that the service was well-led. One person, when referring to the care manager, advised us, "(the care manager) is excellent, nothing is too much bother." Another person told us, "If I have a problem I can go to them," and another described them as, "Very easy to talk to." This was echoed by the visiting health-care professionals who described the care manager as, "really approachable."

The staff worked well as a team. One member of staff told us, it was, "Not good for residents if you haven't got a good team." Another told us, "It's a good place to work," and "we all get on well." This sense of team extended to the care manager with the staff describing them as, "very supportive" and "easy to talk to."

There were twice yearly staff meetings, where information was shared and incidents were discussed. The staff felt these were at appropriate intervals with one telling us the meeting were, "as regular as they need to be." One member of staff had missed the last meeting but told us how the care manager had spoken to them directly, to ensure they had the relevant information. The care manager also attended the daily handover to ensure that they were aware of changes within the home and could share new information

outside of the formal staff meetings.

The views of people were sought on an individual basis. Previously there had been regular residents' meetings but these had stopped two months prior to the inspection, after feedback from the people within the home. One staff member explained, "They talk to the residents…get feedback that way." When asked, the people told us they received questionnaires but there was a general lack of interest in having formal meetings, supporting the evidence that meetings were stopped, following feedback from people. We would recommend that this is kept under review as different people may find regular resident meetings beneficial. People were involved in some of the decisions around the home, with the care manager giving the example of them choosing wall paper and soft furnishings.

The home worked closely with outside organisations. This was evident in the management of the short stay people. One of the health care workers, who helped with these people, told us that their "working relationship is very good." They also discussed the success of the program describing the staff as "driven," during the initial pilot. They commented favourably on the way the staff approached challenges associated with getting people home. They stated that the staff had, "Gone outside the box," on occasions, giving the examples of sourcing white goods for one person and buying clothes for another.

The care manager was aware of their responsibility under the Duty of Candour and there was a policy in place detailing steps to be followed, if required. The Duty of Candour is a regulation that providers must follow. This regulation requires providers to be open and transparent and sets out specific guidelines to follow if things go wrong with care and treatment.

The care manager was keen to develop the home and mentioned ways of staying up to date with developments and changes within health and social care. They mentioned accessing information from the Department of Health and reading guidelines published by National Institute of Clinical Excellence (NICE) when reviewing their policies. They also attended the West Sussex Forum, which is a chance for networking with other homes within the local area. Staff had also joined in the National Care Homes day, welcoming the public into the home. They also mentioned activities within the home which aimed to raise funds for local charities. On one occasion they had a 'cupcake Day,' with people helping to decorate cakes and they also had an annual summer fete.

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<br><br>The provider had not ensured care plans were available to staff involved in providing care.<br>9(3)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not assessed, monitored or improved the quality and safety of the services provided<br>17 (2)(a) |