Caring Homes Healthcare Group Limited

Galsworthy House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook an unannounced inspection on 27 and 29 June 2017. At our previous inspection in May 2016 the service was rated as Requires Improvement and had four breaches of regulations relating to keeping people safe from risk and abuse, poor administration of medicines, insufficient monitoring of the service and lack of support to staff. We inspected against these breaches of regulation in January 2017 and the provider was meeting the regulations inspected. We carried out this inspection to see if the provider had continued to make sustained progress against the breaches we had previously found. At this inspection we found the provider was delivering a good service

Galsworthy House Nursing Home is registered to provide accommodation, care and support for up to 72 older people, some of whom have dementia. The service is split across three floors. The ground floor provides a service for people who need personal care, the first floor provides nursing care and the second floor supports people living with dementia. At the time of our inspection 53 people were using the service. The service was still undergoing a comprehensive refurbishment programme and the manager had purposefully left some rooms empty to provide additional space whilst the upgrade to the environment took place.

The home had a newly appointed manager at the time of the inspection, who was in the process of registering with the CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were safe at the home. The provider took appropriate steps to protect people from abuse, neglect or harm. Training records showed staff had received training in safeguarding adults at risk of harm. Staff knew and explained to us what constituted abuse and the action they would take to protect people if they had a concern. We saw that people were able to speak to the manager or deputy at any time.

Staff were familiar with risks people faced and knew how to manage these. We saw that regular checks of maintenance and service records were conducted to make sure these were up to date.

There were sufficient numbers of qualified staff to care for and support people and to meet their needs. We saw that the provider's staff recruitment process helped to ensure that staff were suitable to work with people using the service.

People were supported by staff to take their medicines when they needed them and records were kept of medicines taken. Medicines were stored securely and staff received annual medicines training to ensure that medicines administration was managed safely.

Staff had the skills, experiences and a good understanding of how to meet people's needs. Staff spoke about

the training they had received and how it had helped them to understand the needs of people they cared for.

The service had taken appropriate action to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed. DoLS were in place to protect people where they did not have capacity to make decisions and where it is deemed necessary to restrict their freedom in some way, to protect themselves or others. We saw and heard staff encouraging people to make their own decisions and giving them the time and support to do so.

Detailed records of the care and support people received were kept. People had access to healthcare professionals when they needed them. People were supported to eat and drink sufficient amounts to meet their needs.

People were supported by caring staff and we observed people were relaxed with staff who knew and cared for them. Personal care was provided in the privacy of people's rooms. People were supported at the end of their lives and had their wishes respected.

People's needs were assessed and information from these assessments had been used to plan the care and support they received. People had the opportunity to do what they wanted to and to choose the activities or events they would like to attend.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People told us they felt happy to speak up when necessary. From our discussions with the manager and deputy, it was clear they had an understanding of their management role and responsibilities and the provider's legal obligations with regard to CQC.

The home had policies and procedures in place and these were readily available for staff to refer to when necessary. The provider had systems in place to assess and monitor the quality of the service. Weekly, monthly and annual health and safety and quality assurance audits were conducted by the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were knowledgeable in recognising signs of potential abuse and the action they needed to take to report abuse.

Risk assessments were undertaken to establish any risks present for people who used the service, which helped to protect them.

There were sufficient numbers of skilled staff to ensure that people had their needs met in a timely way. The recruitment practices were safe and ensured staff were suitable for their roles.

We found the registered provider had systems in place to protect people against risks associated with the management of medicines.

Is the service effective?

Good

The service was effective. Staff had the skills and knowledge to meet people's needs and preferences. Staff were suitably trained and supported for their caring role and we saw this training put into practice.

People were supported to eat and drink sufficient amounts of their choice to meet their needs. Staff took appropriate action to ensure people received the care and support they needed from healthcare professionals.

The service had taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed.□

Is the service caring?

Good

The service was caring. We observed staff treated people with dignity, respect and kindness. Staff were very knowledgeable about people's needs, likes, interests and preferences.

People were listened to and there were systems in place to obtain people's views about their care. People were encouraged

and supported by staff to be as independent as possible.

Is the service responsive?

Good

The service was responsive. Assessments were undertaken to identify people's needs and these were used to develop care plans for people.

Changes in people's health and care needs were acted upon to help protect people's wellbeing.

People told us they felt able to raise concerns and would complain if they needed to.

Is the service well-led?

Good

The service was well-led. A manager and deputy were in place who promoted the good standards of care and support for people to ensure people's quality of life was maintained.

Staff told us they felt well supported by the manager and deputy who were approachable and listened to their views.

Staff understood the management structure in the home and were aware of their roles and responsibilities. We found there was a friendly welcoming atmosphere to the home and this was confirmed by people we spoke with.

Galsworthy House Nursing 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.

This unannounced inspection took place on 27 and 29 June 2017. It was carried out by one inspector, a specialist advisor who was a Chief Nursing Officer, with a background in elderly and end of life care and safeguarding adults 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.

We reviewed the information we had about the service prior to our visit and we looked at notifications that the provider is legally required to send us about certain events such as serious injuries and deaths.

Before the inspection we wrote to two local authority commissioners of services and the Impact Nursing team who support nursing and care homes in the borough to gather their views of Galsworthy House. We received a reply from one local authority and we spoke with a representative of Impact Nursing team during the inspection.

During the inspection we gathered information by speaking with 10 people living at Galsworthy House, eight relatives, the manager, the deputy manager, who was also the clinical lead, the two activities co-ordinators and 10 staff.

We observed care and support in communal areas in an informal manner. We looked at six care records and four staff records and reviewed records related to the management of the service.

Good

Is the service safe?

Our findings

During our visit we saw that staff and people got on well together in a friendly and relaxed atmosphere. Comments people gave us when we asked if they felt safe at Galsworthy House included "Yes, I do, I have friends here," "Oh yes, I have everything I need. I can't find a nicer place to live" and "I do feel safe with all the staff, if I didn't I'd tell my daughter." Relatives commented on the safety of their families "Yes, they are happy here. They [staff] just look after him so well and they've got the mat thing by the bed [sensory mat on the floor to sound if the person falls or gets out of bed]. There is always someone around to look after him," "Yes the staff are ever watchful. You don't see the staff sitting around, they are mindful of what might happen to people" and "My relative is immobile now and all the staff give them excellent attention, if they saw any trouble they would take action."

The provider helped to protect people from abuse. Staff were aware of and could explain to us, when prompted what constituted abuse and they knew the actions they should take to report it. Records confirmed staff had received training in safeguarding adults, although staff were unsure of what level of training they had received. We saw one documented incident where a staff member had spoken up about a concern they had witnessed and the prompt action the management had taken to ensure the person was kept safe from any further incidents occurring.

The service had policies and procedures in place to respond appropriately to any concerns regarding protecting people from possible abuse and these were readily available for all staff to read. When we spoke with the manager they were aware of procedures in relation to making referrals to the local authority that had the statutory responsibility to investigate any safeguarding alerts.

Risks were identified and the actions taken to mitigate those risks were clearly available. Risks to people were managed well and the manager and their staff demonstrated a good awareness of risks people faced and how to manage these. Staff were also able to describe how they would deal with incidents when they occurred. They described the escalation procedure, for example they would document the incident on a paper form and inform their immediate line manager. We were also given an example of how staff had learnt from any falls incidents. These incidents were dealt with on an individual basis, but also any incidents were aggregated at the end of the month to look at themes and trends and actions were identified to prevent them reoccurring.

Staff were able to describe the escalation process should a person become unwell and require hospital treatment. Staff had a good understanding of the Do Not Attempt Resuscitation [DNAR] orders that were in place for some people. We also saw good evidence of reassessment of several peoples DNAR status. This helped to ensure people's wishes were current and known to staff.

During the inspection we saw that each person while in their room had two call bells, one for their bedroom area and one for the bathroom to call for help if they needed to. Staff had risk assessed people's ability to press the call bell and had put in place other processes to ensure a person was safe if they were unable to press the bell, such as more frequent staff visits, having the bedroom door open with the persons permission

or encouraging them to spend time in the communal areas.

People had individual personal emergency evacuation plans (PEEP), relating to their mobility, communication skills and other relevant information that could be needed in an emergency. Staff were aware of the fire emergency plans and these were kept up to date. The fire alarm was tested weekly and fire drills were conducted regularly. The provider had arrangements in place to deal with emergency situations to help ensure continuity of service.

We saw that the service had contracts in place for the maintenance of equipment used in the home, including the fire extinguishers and emergency lighting. A food standards agency inspection in March 2016 gave the kitchen a rating of five, where one is the poorest score and five the highest score.

Throughout the inspection we saw staff were available, visible and engaging with people. People and relatives commented on the number of staff saying "Yes there are enough staff, including weekends. I have a call bell I can ring and staff always come," "We had a problem a couple of weeks ago with a lack of staff [the problem was explained to us] but that was sorted out," "When my relative steps on the sensor mat and it goes off they [staff] come quickly," "Yes I think so I've never seen them looking understaffed" and "I don't specifically count but staff numbers seem to be reasonable. A while back they did seem to be a bit short, one Sunday there was only one staff in the dining room attending to four people who needed help with their lunch but not now, there are more staff." Staff felt there were enough numbers of staff to meet the needs of people. Staff told us sickness and annual absences were covered and when needed agency staff were brought in to ensure sufficient staff were on duty to support people. Staff rotas we looked at confirmed what we were told by the manager.

We looked at four staff member's personal files, including three staff who had been recruited in 2017 and saw the necessary steps had been carried out before staff were employed. This included completed application forms, references and criminal record checks. These checks helped to ensure that people were cared for by staff suitable for the role.

Medicines were administered safely and managed well at the home. People spoke positively about the medicines they received and the attention staff had taken if medicines needed to be changed. We also heard from relatives who said any previous concerns they may have had were being resolved.

The home had recently undergone an audit by the supplying pharmacy and any concerns found had been actioned by staff. All medicines were stored in locked cupboards and medicines that needed to be kept cool were stored appropriately in a refrigerator and we saw records that the temperature of the refrigerator was checked and recorded on a daily basis. The medicines trolleys were also locked and attached securely to a wall.

Following a medicine round the Medicine Administration Records [MAR] were checked for any gaps or omissions of medicine received and checked if they were coded with the appropriate code as to why the medicine had not been given. Specimen signature forms were present in the medicine folders and also by the controlled drug cupboard to help identify who had administered the medicine. The controlled drugs [CD] book was completed correctly, with no errors or omissions. We audited a small selection of medicines and found them to be correctly stored and within the use by date.

We observed that medicines were being administered correctly to people by staff trained in medicines administration. A medicine competency assessment was completed on all staff who administered medicines every six months and we saw examples of the competency framework that was used. The checks

we made confirmed that people were receiving their medicines as prescribed by staff qualified to administer medicines.

Good

Is the service effective?

Our findings

People were cared for by staff who received appropriate training and support. People's comments about staff included "They [staff] are very nice people, they are good, you can ask anything of them, some of the nurses have been here sometime" and "Yes staff are alright." Relatives commented "Yes, they know what they're doing; they don't run around like headless chickens. They are just calm and steady, they just get on and do" and "Yes, I see them in action, I see the way they treat people and I'm full of admiration for them."

Staff had the skills, experiences and a good understanding of how to meet people's needs. Staff felt that they had the knowledge and skills to carry out their roles and responsibilities. The home employed a trainer who trained people classroom style two days a week and two days of practical and observational training while staff worked with people. The trainer also engaged in staff supervision sessions so additional training needs could be identified and actioned. Staff told us and records confirmed that they had recently undertaken training in manual handling, dementia awareness, fire awareness, information governance, safeguarding vulnerable adults, infection prevention and control. One care worker told us "The training is good and the trainer always insists that we do the training."

Staff also completed the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Details of the Registered Nurses [RNs] registration details, Nursing Midwifery Council [NMC] PIN numbers, were recorded and there was a process for revalidation of the RNs as to who would be there confirmer for revalidation.

Staff told us they were fully supported by the manager and deputy manager. Staff received one to one supervision every two months plus an appraisal. Records we looked at confirmed this. Staff meetings were held monthly and we looked at the minutes of the last two staff meetings held.

The provider had taken appropriate action to ensure the requirements were followed for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. DoLS protects people when they are being cared for or treated in ways that deprive them of their liberty. People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

We saw that staff encouraged people to make their own decisions and gave them the encouragement, time and support to do so. One person told us "It's up to me when I get up and go to bed no one tells me to go to bed." A relative commented "Staff are watchful and know my relative, the care is 'person led' if he feels a bit sleepy so they leave him to sleep." Where people were not able to make decisions, best interests decisions were made for them with the involvement of their relatives and the relevant healthcare professionals, where

necessary. The outcomes of the assessments and the applications under DoLS were recorded on each person's file and were available to inform staff.

We also saw several re-applications where the DoLS had lapsed and the evidence of delays by the processing authority, due to an increase in the number of DoLS applications. These delays and the accompanying emails were documented in people's files. We spoke with a visiting assessor who confirmed that there were delays in processing re-applications but the local authority had taken positive steps to address these concerns.

Many of the people at Galsworthy House were independent with some aspects of their care and mobility, and we saw that the provider ensured that any restrictions on people's liberty were kept to a minimum. For example people were not restricted in their movements or where they wanted to go within the home. However we did see that the second floor of the home which was mainly occupied by people with dementia was poorly lit and all the doors and walls were the same creamy/beige colour. Although each room had a memory box outside of it and these were filled with items of importance to people and could aid a person in remembering which was their room, we observed several people being unable to find their own room. Staff said the lighting had been reduced because of the extreme heat that day and this along with open windows and fans was helping to keep the area cool. Staff agreed the decoration of the walls and doors was not dementia friendly and they were hoping that the current refurbishment of the building would address this problem. In the meantime they had added colourful items to people's doors to help people to recognise where they were and alleviate any distress they may have. We recommend that the provider reviews the decoration of the service to ensure the needs of people with dementia are considered.

One person's room we looked at had a climbing plant from the outside of the building growing through the open window, their window was propped open with a glass jar and water was on the floor of their bathroom. Although the person was unable to mobilise independently these may have caused a hazard to staff assisting the person. We spoke with the manager about this and the issue were rectified immediately. The manager told us they had also check all the rooms to ensure windows were not being propped open with glass jars.

During the current refurbishment works, some areas of the home had restricted access to ensure people's safety but this was being kept to a minimum. On our second day we saw the changes to the garden and patio areas at the rear of the building were almost completed and secure fencing had been installed. The area was accessible and safeguards were in place to ensure people's safety. The front door of the home lead onto a busy road and was locked with a key pad code. Staff told us relatives were given the code to the door and could visit at any time. People were also given the code so they could come and go as they wished. People who were subject to a DoLS for their own protection could also go out but would need to be accompanied by staff or relatives. These measures helped to protect people when going out alone.

People were supported to eat and drink sufficient amounts to meet their needs. One person said "We have a coffee machine with hot chocolate and tea in the café and can get a drink when we want to." When we arrive we saw a resident making themselves a coffee and taking two cups to their room. Staff offered to help but help was declined. Throughout the two days we saw people and their families and friends using the café, which had hot and cold drinks and snacks available.

People commented about the meals "I used to doing my own cooking and I like food presented nicely, if it's not I complain," "You get a choice, sometime the chunks of meat are to big but the food tastes nice." Relatives commented "They serve a very good freshly cooked three course dinner and the breakfast is porridge and scrambled eggs. Our relative has put on weight," "The food is quite nice and you get choices

and assortments" and "The food is fine, you get generous portions. Staff are always watching who isn't eating and help them if needed."

Staff completed a Malnutrition Universal Screening Tools [MUST] and monitored people's weight, as a way of checking a person's nutritional health. We also saw evidence of food and fluid charts being completed correctly. Staff said they knew who was on a special diet, for example diabetic, soft, through the person's care records and through daily discussions at staff handover meetings. Staff said they also knew who needed help with eating and drinking and we observed people being helped to eat and drink.

Care plans contained information on people's food preferences, their likes, dislikes, the food consistency and type of drinks they preferred so staff had the necessary information to support them appropriately with their nutrition. One person's care records stated a specific way of supporting the person at meal times. The information was useful to support the management of the person's nutritional care plan. A choking risk had also been identified for this person and there was information available for staff on the emergency management of choking. This information helped to ensure people were supported appropriately with their nutrition.

We noted that a menu was displayed in the main entrance but not in the dining areas. Staff told us this was because the printer was not working and A5 paper for the menus was not available. Staff saw the visual aspect of the menu to be important to people especially those with dementia who may have become uninterested in food or eating. Staff had requested the printer to be repaired as soon as possible.

People were supported to maintain good health and have appropriate access to healthcare services. We saw evidence in the people's care records of people being referred to and receiving access to other healthcare services, for example the GP, who visited the home on a regular basis, speech and language therapist [SALT], occupational therapist [OT], tissue viability nurses [TVN], and a podiatrist. Staff told us that they could also access the local NHS Nursing Impact Team, who support care homes with nursing needs and training. We also saw evidence of referrals to hospital specialist and the appointments attended.

Good

Is the service caring?

Our findings

People were supported by caring staff. One person commented "They do anything I want them to do, I'm happy," "Staff are all very nice. Sometimes when staff are new they call you darling or honey, I don't like that and say so. I liked to be called by my name." Relatives commented "The minute we came here I knew this was the place for us," "Staff always ask her [relative] what she wants to do, they laugh and joke and treat her as an equal," "Our relative is asked if she wants anything which is a general feature with all the staff always asking, I don't see anything forced on people. The staff are remarkable, they make people feel dignified" and "Staff just do everything, they ensure our relative is in clean clothes and clean and tidy, we've never seen him unkempt or unshaven. The first thing they did when he came here was get his hair cut and a chiropodist came to see him."

We observed staff engaging with people throughout the day in the communal areas and calling people by their preferred name. We saw staff treating people in a respectful and dignified manner. Two relatives of people who were non-verbal told us "Staff never do anything without chatting to them. I see my relative smiling a lot at staff and that tells me a lot about their care" and "Yes they do talk to her and she responds quite cheerful with them." The atmosphere in the home was calm and friendly. Staff took their time and gave people encouragement whilst supporting them. The knowledge staff had of people as individuals gave them the opportunity to care for people in the most effective way.

People were supported with their spiritual needs. We observed on day one of our visit a small group of people of differing nationalities and faiths listening to a talk by a visiting religious minister. They had brought pictures to enhance the talk and people joined in with the discussion and the singing. On our second day a visitor from another religious denomination was visiting and meeting with people in both small groups and individually.

Care plans showed that people had been asked which gender of staff they would like to help them with personal care. There was evidence in the care records around people's privacy and dignity and how to maintain it by closing curtains when giving personal care. Bedroom doors also had privacy notice to be used when personal care was being given. We observed staff knocking on doors before entering and saw interactions between staff and people which were kind and considerate. Staff also told us that "Relatives appreciate what you do for their relative," "It's a caring place and we put the people at the centre of what we do" and "This place feels homely."

A communication sheet had been introduced following a previous CQC inspection to ensure conversations with relatives were recorded. One person's relative gave an example of good communication between the different relatives over the person's care and they also spoke highly of the care at the home.

People were supported by staff to make decisions about their end of life care. We saw in people's care files that those people who wished to had made an advanced care plan and this had been discussed with their family if appropriate and agreed to by the person. One person clearly told us "I don't want to be resuscitated and I don't want to be sent to hospital. I want to end my life in my room." Two relatives commented "She

[relative] has made it clear she wants to be treated here and not go back to hospital" and "Our relative has made a DNAR and does not want to go to hospital." The actions the provider had taken helped to ensure people had the end of life experience that they wanted, in the place they wanted it to be.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home and care was planned and delivered in response to their needs. Assessments detailed the care requirements of a person for daily living, including general health, medicines, hearing and vision, dietary needs, communication, sleep, continence and mental health. People's records included information on the person's background which enabled staff to understand them as an individual and to support them appropriately.

When we asked people and relatives if they had been involved in the writing of the care plans we received a mixed response. "I don't think I have one, I can't remember," "I've not seen one, but it would be useful to see," "Yes, we helped with it, with [name of senior care worker] but we haven't got a copy of the care plan" and "Yes we did but I don't think I have a copy." We commented to relatives that a care plan is a living document and people who the care plan relates to should have access to a copy and they could speak with the manager about this.

The care records that we reviewed were generally good. The system for recording care needs was logical and the care records were on the whole completed well. Assessment sheets and care plans were pre-printed and we saw there were some gaps as not all of the 'boxes' in the care records had been completed. For example under care plans/risks identified, history of hypotension or hypertension, medicine risks, social interaction, sitting position adjustments these and other similar boxes were not ticked. We asked staff about this and they told us where the statement did not apply to a person they did not tick the box but staff agreed the space to write 'not applicable' or N/A would be helpful and would make it clear that this was not an area of concern for this person.

We found some of the paperwork had been photocopied from its original source and the printing had faded making it difficult to read. We also found some amendments to records, words or sentences crossed out which were not signed by the staff making the change. There were other entries which were not always dated and timed. This made it difficult to identify who had made the entry or change. We were advised by the specialist advisor [SPA] who accompanied us on the inspection that it is good practice for student nurses and care assistants entries to be countersigned by the registered nurse supervising them. The SPA spoke with staff about these issues at the time of the inspection.

Care plans contained information and guidance to help staff know about how people's care and support needs should be met. The information included how a person would like to be addressed, their likes and dislikes, details about their health history, career and past life. The manager told us that people's care plans were developed using the information gathered at the person's initial assessment.

We saw evidence in the care plans of staff considering people's needs in the future, for example a person was identified as not having breathing problems, but staff had assessed the person might be susceptible to chest infections due to their immobility, so a care plan had been generated specifically for that. Moving and handling assessments were completed in the care records and care was planned based on the assessment and reviewed monthly. We saw evidence of falls and bed rail assessments being carried out and evaluated

monthly.

Assessments of people tissue viability and Waterlow scores were recorded and preventative action taken. The Waterlow score consists of several factors, a person's build/weight, height, visual assessment of the skin, gender/age, continence, mobility, and appetite, and any special risk factors. These results are brought together to assess a person's risk of skin damage [tissue viability].

Pressure relieving equipment was used in the prevention of pressure ulcers. Pressure relieving mattresses were in place and there was a process in place for daily checking of mattresses. However, the records did not record what setting the mattress was on and we found one person whose mattress setting was between 90kg – 100kg, the setting relates to the person's weight. The person actually weighed 36kg, so the setting was above what it should have been. We reported this to the manager and action was taken immediately. The nurse informed us that the mattress was faulty and had been changed and in future records would show the expected setting for each person using a pressure reliving mattress. We saw that turning charts were in place and were completed by staff, although there were some gaps mainly during that daytime when residents were sat out in chairs and it wasn't clear if residents were helped to relieve pressure during those periods.

We also saw evidence in the care records of a person's communication, comprehension and cognition skills being assessed and care plans to address any areas identified were developed. Personal hygiene assessments were carried out and care plans developed to the person specific hygiene needs. Oral assessments were also carried out on people and evaluated monthly. Continence assessments were also carried out and care plans put in place to meet people's needs. However, we noticed that there didn't seem to be a regime in the care plan as to how, when and if the patients were encouraged to use the toilet.

Other areas, for example, sleeping and occupation needs were also assessed and care planned accordingly. We noted an example of a person who wanted to attend her local Church for Mass with her daughter, which was facilitated by staff. We also noted a sleep observation record being used for one resident. The level of assessments and care planning we saw helped to ensure people received the care they needed.

There was a programme of activities delivered by two activity co-ordinators. We observed people engaged in individualised activities including reading books or the newspaper, jigsaws, art work and listening to music. In one longue a recording of a classical event was being shown. Where activities were taking place we saw and heard good interaction between staff and people.

Staff were able to articulate how to deal with informal complaints and said that they would try and deal with the complaint there and then and they were also able to describe how they would escalate complaints. Most of the staff we spoke with had not been involved in any written complaints and said they would be dealt with by the manager of the home.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People and relatives told us they knew who to make a complaint to and said they felt happy to speak up when necessary. One person said "I have complained about the food and it was changed." Relatives commented "We've written to the provider management team but you don't usually get a response" and "We would complain locally to the manager or deputy and they would sort it out."

Records showed that many of the complaints received focused around the refurbishment of the home. People and relatives felt they did not have sufficient information about the plans, the time scales and the disruption it would cause to the home. However relatives told us they did have confidence that the new

manager would deal with their concerns promptly. This was evidence in the records we looked at that showed the manager had dealt with recent complaints promptly and to the satisfaction of the majority of the people using the service.

Good

Is the service well-led?

Our findings

People who lived at Galsworthy House knew who the manager, deputy and staff were by name and could freely chat with them at any time. People were positive about the staff and managers. One person said "I see the deputy every day and the manager pops in."

Staff at all levels spoke positively about the home management and told us 'We are very well supported by the home managers and our immediate line managers.' Staff commented in a similar way that "The home was getting back to normal now following a time of uncertainty about the management of the home." "It is a lovely, caring and friendly place to come to" and "This is a good place." One member of staff commented "The clinical lead on the middle floor is just super and helpful." Staff told us the current managers were very approachable.

The service was led by a new manager who had only been in post for three months when we inspected. They were supported by an experienced deputy manager, who was also the clinical lead. People and relatives commented and our own observation showed there was a good visibility of the management team within the home. This helped to ensure that the management team were fully aware of what was happening within the service and were available for people when needed.

The manager told us they were here to encourage staff to do well, to reassure them by talking to them and being available. They were encouraging staff to speak up and report any incidents and they would be actioned and the manager gave us an example where this had occurred recently. They said they wanted to hear staff ideas, so they could try them and evaluate the results. They wanted to empower staff to make decisions and be welcoming to new staff, so everyone's experience of work was good. They told us about six team building days they had held recently and we saw the outcomes of a two day session held in April 2017. Staff were encouraged to put forward their ideas to make working and living at Galsworthy a positive, happy experience.

From our discussions with the manager and deputy it was clear they had an understanding of their management role and responsibilities and the provider's legal obligations with regard to CQC including the requirements for submission of notifications of relevant events and changes.

Staff told us about the different meetings that took place at the home. They said that they had flash meetings as and when it was felt that there was something that needed discussing or working out and they gave the example of a flash meeting taking place during the recent hot weather, to ensure measure were put in place to help keep people cool and hydrated.

Staff also told us about more formal team meetings between the management and the staff, which were recorded so that staff not able to attend were aware of what had been discussed. Meetings also took place with the maintenance team, the clinical nurses and also health and safety meetings.

Through the Caring Home Care Awards 2017, the deputy manager and clinical lead at Galsworthy House

won the 'Registered Nurse of the Year' award, for her dedication to the care and well-being of people. The home also had a monthly "Caring Stars" award. Staff were nominated by people living at Galsworthy, relatives, visitors and staff, those that won each month were then put forward for a national award. The scheme had been running for three months and so far one nurse and two care workers had received the "Caring Stars" award. The provider also has a long service award for staff working more than 20 years with the company.

Systems were in place to monitor and improve the quality of the service. This included surveys to gain feedback from people, relatives and staff about the quality of the service that was being delivered and to identify areas for improvement. We saw the results of the staff survey in 2016; the number of returned questionnaires was poor which prompted the provider to organise the team building days to gain staff views. People and their relatives did not receive a formal survey in 2016 because several meetings were held to discuss the refurbishment plans and this gave an opportunity for people to give feedback to senior management. The manager and deputy also said they were available at any time to speak with people and relatives and could act on any comments they received.

We looked at the maintenance records and saw that weekly and monthly audits were conducted, including infection control, water temperatures, fire risk assessments and health and safety of the home. Certificates of inspection for gas, water, passenger lifts, personal hoists and electrical safety were all up to date. Where changes needed to be made action plans were developed and action taken to ensure people, visitors and staff were kept safe within the home.