Care South

Sussexdown

Inspection report

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Date of inspection visit: 18 and 22 September 2015
Date of publication: 05/11/2015

Ratings

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

Overall summary

The inspection took place on 18 and 22 September 2015 and was unannounced.

Sussexdown provides nursing and care for up to 77 people with a variety of health and care needs. At the time of our inspection the home had full occupancy. The home is divided into three units: Princess Alexandra unit provides 20 places for people living with dementia, the Princess Alice unit can accommodate up to 34 people with residential care needs and the Douglas Bader unit provides nursing care for up to 23 people. Twenty-eight bedrooms have en-suite facilities. Sussexdown was built in 1925 and celebrates its 50th anniversary as a care home in October. The home is surrounded by extensive, accessible, landscaped gardens overlooking countryside. The main building has a sun lounge and library and communal areas include living and dining areas in each unit.

There was a registered manager 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.

People were protected from the risk of harm and staff knew what action to take if they suspected people were

Summary of findings

being abused. Accidents and incidents were reported and necessary action taken to minimise the risk of reoccurrence. People's risks had been identified and assessed appropriately. Information on how to look after people safely was provided to staff. Where people were at risk of developing pressure ulcers, there were guidelines in place for staff on their care and treatment. There were sufficient numbers of staff to care for people safely and meet their needs and the service followed safe recruitment practices. People's medicines were managed safely by trained staff. The provider had procedures in place to ensure that people were protected from the risk of infection.

New staff completed a three day induction programme and then went on to follow the Care Certificate, a universally recognised qualification. Existing staff had completed qualifications in health and social care. All staff followed a training programme which the provider had implemented in a range of areas of practice. Staff received regular supervisions which took the form of observed practice, however, not all these supervisions had been recorded, but staff were provided with verbal feedback. Staff knew how to gain people's consent to care and treatment and were aware of the requirements of associated legislation under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They put this into practice. People were supported to have sufficient to eat and drink and maintain a healthy lifestyle and had access to healthcare services. The premises at Sussexdown were designed in a way that reflected people's personal taste and to aid their mobility and independence.

People were looked after by kind and caring staff who understood them and how they wished to be cared for. People's spiritual needs were catered for and there was a separate chapel that people could access. A member of the clergy visited every week. People were treated with dignity and respect and, as they reached the end of their life, were looked after by staff to have a private, comfortable, dignified and pain-free death.

There was a wide range of activities on offer for people and they were also supported to follow their own interests and hobbies. Care plans were personalised and provided comprehensive information to staff about people, including their personal histories, likes, dislikes, social, cultural and religious preferences. In the main, care plans were reviewed regularly, but some plans had not been reviewed in line with the provider's policy. The registered manager was made aware of this at the end of the first day of inspection and consequently put an action plan in place to address this. The service routinely listened to and dealt with people's complaints to the satisfaction of the complainant, where the complaint was upheld.

The service was well led and people were involved in the development of the service; their feedback was obtained through an annual survey. Staff were also asked for their feedback by the provider and felt well supported by the registered manager. The service had a range of robust quality assurance systems in place to measure the quality of the care delivered and were improvements had been identified, action was taken. Following the inspection, the registered manager put action plans in place to address the issues raised by the inspection team. They worked in partnership with other agencies.

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?
The service was safe.

People were protected from the risk of harm and had their risks assessed. Risk assessments provided information and guidance for staff on how to mitigate the risk to people.

People were protected from the risk of infection and there were processes in place to control this.

There were sufficient numbers of staff on duty to keep people safe.

Staff were trained in the administration of medicines and medicines were managed safely.

Good

Is the service effective?
Some aspects of the service were not effective.

People were supported to have sufficient to eat, drink and maintain a healthy lifestyle.

Premises were designed and decorated to meet people's needs and in line with their personal taste.

Staff had received training on all essential aspects of care. New staff were required to complete the Care Certificate. Some staff took the lead in certain areas such as infection control and received additional training on this. They were then able to provide support and advice for other staff.

Staff received regular supervisions, although these meetings were not always regularly recorded. The registered manager had put plans in place to address this.

Consent to care and treatment was sought in line with the requirements of the Mental Capacity Act 2005 and associated legislation under the Deprivation of Liberty Safeguards.

Requires improvement

Is the service caring?
The service was caring.

People were looked after by kind and caring staff. Staff knew people well, their preferences, likes and dislikes and how they wished to be cared for.

Staff had been trained to support people at the end of their life to have a private, comfortable, dignified and pain-free death.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People were supported to pursue hobbies of their choice or to participate in a range of activities.

Care plans were devised in a personalised way that informed staff on people's individual needs.

Complaints were listened to and dealt with in line with the provider's policy.

Where needed, appropriate action was taken to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People and staff were asked for their views about the service and felt the service demonstrated good management and leadership.

The service had implemented a range of quality assurance processes to audit the standard of care delivered and took action when improvements were needed.

Sussexdown

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 18 and 22 September 2015 and was unannounced. Two inspectors and a nurse specialist undertook this inspection.

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 and staff. We spent time looking at records including 13 care records, four staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

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.

On the day of our inspection, we met and spoke with five people living at the service and two relatives. We spoke with the registered manager, the deputy manager, two registered nurses, eight care staff, two housekeeping staff, one maintenance staff and the activities co-ordinator.

The service was last inspected in September 2013 and there were no concerns.

Good

Is the service safe?

Our findings

People were protected from the risk of abuse and harm. Within the Princess Alexandra unit, which cared for people living with dementia, assessments had been drawn up which showed how people could stay safe and the measures staff should take to achieve this. Any visitors to the unit had to ring a doorbell and be met by a member of care staff, before being admitted. Staff knew what action to take if they witnessed something of concern and said they would report this to a senior member of staff and complete an incident report. Staff told us they had undertaken training in how to safeguard people at risk, however, some staff were unable to consistently demonstrate a comprehensive understanding of what might constitute potential abuse. This had no impact on the safety of people living at Sussexdown, as staff knew how to report any concerns to management. Staff were familiar with the provider's whistleblowing policy and who to contact if they had any concerns or issues.

Records confirmed that staff reported incidents and accidents. A root cause analysis, which is a method of problem solving used for identifying the root causes of faults or problems, had been undertaken and showed that actions had been taken to minimise the risk of falls from reoccurring overall. Risk assessments had been undertaken which identified the risk, with advice and guidance to staff on how to mitigate the risk. A member of care staff explained how they would document any accident or incident for a person and include this information in the care plan. Senior care staff would then review the risk assessment.

Risk assessments had been drawn up for people in a range of areas such as falls, nutrition and personal hygiene. Where people were at risk of falling out of bed for example, an assessment identified whether the use of bed rails would be appropriate. Some people did have bed rails and these were checked on a daily basis to ensure they were safely adjusted, however, this was not recorded anywhere. It would be useful to introduce a record of these safety checks to monitor this. Risk assessments were reviewed regularly every three months or earlier if needed.

People with pressure ulcers were cared for in accordance with the most recent National Institute for Health and Care Excellence (NICE) guidelines. Each person had a Waterlow risk assessment and score in place. Waterlow is a tool to assess people's overall risk of developing a pressure ulcer. Action was taken depending on the risk score. Pressure ulcers were graded according to a number of factors, but, in particular, to depth and size, with grade 3 and above pressure ulcers being reported as an incident. Professional support from a tissue viability nurse (TVN) was sought for people with a pressure ulcer of grade 3 or above. Currently, no-one living at the service had a pressure ulcer. However, a person with complex needs who required full nursing care, was admitted with a grade 3 pressure ulcer and this had been treated successfully, following advice from the TVN. Body maps, photos and charts recording progress over time were completed. Improvement to the pressure ulcer could be demonstrated so that the support of the TVN was no longer required.

Where people were at risk of developing pressure ulcers, inflated air mattresses were used to alleviate the risk. However, these mattresses were not always checked to ensure they were at the correct pressure and functioning correctly. It is usual practice to check the weight of a person and adjust the air pressure of the mattress accordingly. The deputy manager explained that the provider was about to introduce these checks. Following the inspection, the registed manager confirmed that these checks had been implemented. The maintenance staff confirmed that all mattresses were maintained safely and that the home supported this through training on equipment maintenance and safety checks. They also explained that the air mattresses were all from different manufacturers and therefore required different checks. There were no people with pressure ulcers identified on the day of our inspection.

Staff had been trained in moving and handling techniques. We observed one person being safely transferred from an armchair to a wheelchair using a stand-aid. The person was encouraged and reassured by staff during the process and the task accomplished safely and compassionately.

There were sufficient numbers of suitable staff on duty to keep people safe and meet their needs. People received timely support from staff to meet their needs appropriately and our observations confirmed this. For example, call bells were answered promptly. Staff were allocated across the three units of the home and, where possible, staff worked consistently in the same unit. Staffing rotas were drawn up six weeks in advance and records confirmed this. The home currently had vacancies for registered nurses

Good

Is the service safe?

and care staff and the registered manager had arranged to interview candidates for these posts. The registered manager felt that recruiting sufficient numbers of registered nurses was a challenge. She said, "If I can recruit registered nurses, I feel everything else would fall into place". The home was currently using registered nurses from an agency to make up the shortfall.

Safe recruitment practices were followed and records confirmed this. New staff had completed an application form, two references had been obtained, their identity checked and checks undertaken with the Disclosure and Barring Service to ensure new staff were safe to work in a caring capacity. Registered nurses all had up-to-date registrations with the National Midwifery Council.

People's medicines were managed so that they received them safely. Medicines were prescribed by a local GP and reviewed monthly or as required. A local pharmacy dispensed the medicines and provided medication administration records (MAR). Each person had their own dedicated medicines with some more general medicines, such as Paracetamol, being for communal use. The MAR charts had been completed correctly by registered nurses or staff who had been trained in the administration of medicines. The pharmacy audited the management of medicines on a six monthly basis, with the last audit in May 2015 and no issues were identified.

Observation of medicines being administered during the morning demonstrated that staff took care to ensure the correct medicine was administered to the right person. Any refusal of medicine was documented and re-administered following discussion with other staff on the most appropriate way forward. Medicines administered on the nursing floor were carried out by registered nurses; however, there was no assessment in place to measure the competency of the registered nurses in administering medicines. It is current best practice that all registered nurses have their competence to administer medicines assessed on a regular basis. This ensures they are aware of any changes in administration practice and also have a good understanding of medicines and their side effects. The nurse in charge explained that the provider was about to introduce medicines training and competence assessment for registered nurses. Following the inspection, the registered manager confirmed that all registered nurses had been observed and assessed with regard to their competency to administer medicines. In the Princess Alexandra unit, medicines were administered by care staff who had received appropriate training.

Covert medicines were observed to be administered to two people who had enteral (intestinal) tubes in place to assist with their nutrition. These people had mental capacity assessments in place, a best interest meeting had been held with relatives and health professionals and a management plan put in place within their care plan to ensure they received their medicine. A best interest meeting is where the provider consults with health and social care professionals, the individual and their relatives, to make a decision on the person's behalf in their best interest.

Homely medicines were written up for each person so that they could be administered as required (PRN). People were encouraged to self-medicate if they had capacity and this was appropriate for the person. The service assessed the risk when people wanted to manage their own medicines. This meant people were supported to be as independent as possible. For example, one person was provided with a lockable cabinet for safe storage of their medicines.

Storage facilities within the treatment room were suitable. Controlled drugs were stored in a separate locked cupboard within the locked treatment room and recorded in the register as required. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated drugs regulations. The controlled drugs register was checked by two registered nurses at handover on each shift. Controlled drugs were disposed of in accordance with policy in a suitable container. Medicines that were required to be stored between 2 – 8 degrees Celsius were stored in a drugs fridge and the temperature monitored daily. The environment supported the safe use of medicines within the home.

People were protected by the prevention and control of infection. The deputy manager took responsibility in this area to ensure that safe practices were followed. She trained and audited ten staff in hand-washing techniques each month and records from May to September confirmed this. The home was supported by a corporate clinical compliance co-ordinator from the provider. The general environment was visibly clean and discussions with staff confirmed they had adequate equipment, including

Good

Is the service safe?

personal protective equipment and supplies to provide appropriate, safe care. One person said there were, "good standards" of regular cleaning and another person told us they had, "a clean, tidy room". In the Douglas Bader unit, people were nursed in individual rooms without en-suite facilities, however, there was easy access to bathrooms available to meet people's needs safely. There were adequate supplies of dressings and other supplies such as continence pads. Clinical waste was disposed of appropriately and the bins for storing the waste outside the premises were locked.

Assisted bathrooms were clean with appropriate equipment and cleaning procedures for equipment, such as hoists, were in place. Each person had their own hoist sling which was stored on the back of their bedroom door. These slings were numbered and a record of allocation kept in the nurses' office. Whilst staff reported that people's equipment such as commodes and hoists were cleaned using wipes following use, it was observed there were no wipes available in two out of the three sluices checked on the day of inspection. We brought this to the registered manager's attention and she said she would ensure that sufficient supplies of wipes were ordered to prevent this from occurring in the future. She also said that there were alternative means of cleaning equipment in place, should the stock of wipes be exhausted.

Cleaning staff were allocated to each unit and the cleaning equipment was kept in line with current guidance, with colour coded equipment used for different areas. The provider had a process in place for monitoring the cleaning of various areas within the home on a daily basis. The documentation allowed the cleaner to sign to confirm they had cleaned an area and then the supervisor would counter-sign. However, examination of the records for each month since January 2015 identified that the supervisor had completed the whole process retrospectively and that this appeared to be a tick-box process rather than a working document. We brought this to the attention of the registered manager who said they would address this as an action to be completed by 25 September 2015. Following the inspection, the registered manager had ensured that cleaning checks were undertaken on a daily basis by cleaning staff.

Requires improvement

Is the service effective?

Our findings

People had their assessed needs, preferences and choices met by staff with the necessary skills and knowledge. The registered manager had checked with the National Midwifery Council that all registered nurses employed were registered to practice. Nursing staff completed all essential training delivered by the provider and, in addition, could access further training delivered through links with local hospitals or hospices. For example, specific training in Parkinson's disease, diabetes, end of life care and verification of death. Nursing staff also had access to expertise such as diabetic and tissue viability nurses, dieticians, speech and language therapists and physiotherapists who were able to advise about the most recent guidance and practice. Two people received nutrition through a percutaneous endoscopic gastrostomy (PEG) into their stomach. The nursing staff were booked to attend a study day at Worthing Hospital on the care of people with PEG in situ.

New staff completed a three day induction programme organised by the provider and then went on to complete training in safeguarding, moving and handling, health and safety, food hygiene, first aid and infection control. Some staff completed administration of medicines training. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics, which the provider had introduced in accordance with national guidance. Existing staff had completed additional qualifications in health and social care, for example, National Vocational Qualifications (NVQ). One member of staff told us the provider had supported them to gain a level 2 qualification under the Qualifications and Credit Framework and they were being supported to progress to level 3. An occupational therapist who worked at the home on one day a week delivered training in moving and handling. Staff could also access a range of additional on-line training which the provider had recently subscribed to. Staff training was up to date and refreshed as needed and the training plan confirmed this. The registered manager said, "Training has improved as we used to rely on head office, but we can achieve more with online training".

Some staff took the lead in certain areas such as infection control and conditions such as diabetes, Parkinson's disease and dementia. These staff had received additional training and provided support and advice to other staff in their specialist areas.

Staff told us they had supervisions and annual appraisals and one staff member said they had an appraisal which they said was "constructive". Staff said their supervisions took the form of observed practice between three and six monthly intervals and they were given oral feedback. One person told us they received a written copy of one supervision. Without the evidence of recorded supervision, the provider could not readily demonstrate that staff were regularly supported to meet people's needs. In addition, written records provide an aide memoire to both the supervisor and supervisee and allows any discussions or actions arising to be formally documented and taken forward to the next supervision. We brought this to the attention of the registered manager. She said she would arrange to meet with senior staff and remind them of the process of recording supervisions by 25 September 2015. They would also be required to update a central log so that the registered manager could check to see that supervision meetings had taken place.

Handover meetings in the Douglas Bader unit took place between shifts at 7.45am, 1.45pm and 7.45pm. Handover sheets were completed which showed a list of people, their room numbers and space for staff to write notes. Allocation sheets were completed by the registered nurse in advance of handover and identified who was caring for specific people and the tasks to be completed. For example, people who had healthcare appointments and any changes to their daily care plan. Discussion with two staff confirmed that handover meetings took place. This ensured that people's needs were continually assessed and they received the support they needed from care staff on a daily basis.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice. All staff had either completed training on MCA or were booked to complete this training. One member of staff explained their understanding of the MCA meant they, "Give people dignity to make their own decisions, don't assume, always ask". Another member of staff told us, "You have to assume everyone has capacity to

Is the service effective?

do what they want to do". Where people were unable to make an informed decision, capacity assessments had been completed to prove this and were documented in people's care plans. Where needed, Deprivation of Liberty Safeguards (DoLS) applications had been completed and sent to the local authority. DoLS protects 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. Some authorisations had been granted by the local authority, but the majority of DoLS applications had been received by the local authority, although decisions had not been made. Some people had made arrangements for Lasting Power of Attorney to be put in place. This gave their relatives, or other people they appointed, the right to make decisions on their behalf about their finances, health or welfare. The necessary legal documents had been completed appropriately and copies were held on people's care plans or in the provider's office.

Physical restraint was not used with people who might display behaviour that challenged. One member of staff explained, "It's about knowing people. You know who will get upset and why and most of the time it's because they want company".

People were supported to have sufficient to eat, drink and maintain a balanced diet. One person told us, "The food is good. The cooks are really good". The Food Standards Agency had awarded a rating of 5, which is the highest rating for food hygiene standards. Food was prepared in the main kitchen of the home and meals transported to the other units via a heated trolley. The food was then kept hot in a 'satellite kitchen' based in the unit and people's meals were served individually by staff. A large dining room was situated in the main building, with a three course meal being served at lunchtime. People chose what they wanted to eat on the day. In the Princess Alexandra unit, care staff brought a choice of meals to the table, so people could see whether they fancied the menu choices on offer. People were asked what they wanted to eat and on the day of our inspection, one person indicated that they did not want any red cabbage. Having made their choice, this person then had to wait over 10 minutes before their lunch arrived. Even then, their original choice of vegetarian sausage had been exchanged for gammon. They said they did not want their lunch as they had not asked for it, but staff encouraged them to eat what was offered and they seemed happy with the alternative choice.

We observed staff supporting people at lunch time and checking food preferences with people, what they would like to eat, the portion sizes and whether people wanted any more. There were mixed opinions about the food on offer. One person said that they, "Did not like the food" and that nearly all meals did not have a very good taste". They added, "I try to guess what the food is". However, another person thought the meals were of "high quality". Drinks were freely available throughout the day and drinks were brought round for people during an activities session in the Princess Alexandra unit. This session had been planned to encourage people to be as physically active as possible, but the weather was warm and sunny, so staff encouraged people to have a drink.

People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The provider had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. People's weights were recorded and monitored on a monthly basis. One person had lost a significant amount of weight between August and September (4.8kg). In addition, the MUST had not been completed since July 2015. We discussed this with the senior care staff, who informed us that they would rectify this. They told us that this person had been extremely unwell and that they were giving them a fortified diet in an attempt to make up the weight that had been lost. Other weights for people and MUST assessments had been completed appropriately. One person who had lost weight also had difficulty in swallowing. The Speech and Language Therapist had been asked to visit and recommended a suitable pureed diet and nutritional supplements to maintain the person's weight. We recommend that all MUST assessments are reviewed on a monthly basis when people are weighed, to ensure that any fluctuations in weight have been monitored and appropriate action taken.

People were supported to maintain good health and had access to healthcare services. Staff were aware of people's health needs and called in the GP and other health professionals as required. Referrals had been made to professionals such as dieticians, speech and language therapists and physiotherapists and their recommendations had been included in the care plans.

Requires improvement

Is the service effective?

Staff explained they had training in how to recognise changes in behaviour, how to respond and how to escalate any concerns. The GPs visited weekly. This showed that people's health needs were being met.

Twenty-eight bedrooms had en-suite facilities and all bedrooms in the Princess Alexandra unit had en-suite facilities, that included a toilet, washbasin and shower. Each floor had a wet room and assisted bathroom in the main house. Besides individual bedrooms, there were areas throughout the home where relatives could meet with their family members in comparative privacy. People's rooms were personalised and they were encouraged to bring their own furniture and pictures. The Princess Alexandra unit, which cared for people living with dementia, had been furnished in such a way as to provide a feeling of home. For example, one part of the unit had a fireplace with ornaments on the mantelpiece, television and armchairs, which made it feel like a living room. The unit was in the process of being redecorated and contrasting colours and carpets had been used to good effect, enabling people to find their way around the unit. One person told us that a yellow door indicated this was a toilet. There were 'memory boxes' outside people's rooms which contained photos and memorabilia that had particular significance for them. There was an outside area with seating, which was easily accessible to people, with a circular walk and sensory garden.

In the Princess Alexandra unit, the activities and events for the week ahead were written up in marker pen on a whiteboard in one of the communal areas. However, there were no visual references or pictures to enable people to easily understand what was happening. In addition, the dates were confusing for people living with dementia. The first day recorded was Monday 14 September through to Thursday 17 September. We inspected on Friday 18 September, but the date displayed was Friday 11 September, followed by Saturday 12 and Sunday 13 September. We were told that the board was updated weekly, rather than on a daily basis. We were also told that people in the unit would often rub off the writing and the use of pictures would not have been suitable, because some people would then remove them. Following our inspection, the registered manager said they had arranged for a more accessible and visual board to be put in place.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People were consistently positive about the caring attitude of the staff. One person told us, "Care staff are very good. I ring the bell and they do their best to get to me". Another person said they were encouraged to stay in touch with their friends and added, "I love it here, the view is gorgeous". People were supported by staff who demonstrated kindness and respect, compassion and dignity. One member of staff told us, "If a person declines care, I sit down and discuss it. I may need to walk away and come back later" and added that another member of care staff might have more success using a different approach. During the activities session in the Princess Alexandra unit, staff noticed that one person appeared to be feeling cold. The staff member immediately brought a blanket for the person and helped them to be wrapped up cosily. Another member of staff was observed to chat with a person about their teddy bear, which they were cuddling.

A relative whose family member had been at the home for some months was very positive about the care delivered and the staff. They explained that they lived nearby and visited most days. Theytold us that the, "social events arranged always include the family. Recently we had a concert in the garden and we all ate fish and chips for supper whilst we listened to it".

Staff knew the people they cared for and supported, including their preferences and personal histories. One member of staff explained how they got to know people by asking questions. They said people were happy to talk about their lives and that family photos were particularly useful to encourage conversation. They said, "I know people. You need to know people to achieve things. There's a particular lady who likes golf. It's about knowing what makes people tick". The same member of staff enjoyed caring for people living with dementia and said, "It's like you make 20 new relationships every day". The registered manager had received feedback on the Princess Alexandra unit. She said, "I know the in-reach team have told staff and me that it's got a good reputation".

People's spiritual needs were supported and a member of the clergy visited every week. Sussexdown also has a separate chapel which people could use for worship or quiet contemplation. The chapel was sometimes used for memorial services when people had passed away.

People were supported to express their views and, as far as possible, to be actively involved in making decisions about their care, treatment and support. In the Princess Alexandra Unit, where people needed more help to express their views, they were supported by their keyworker, who co-ordinated all aspects of their care. One member of staff said, "If they don't have toiletries, I'll tell [named senior care staff] to pass it on to the family. I'd listen to people regardless. People will tell me what they want".

Staff treated people with dignity and respect. We observed staff knelt down and spoke with people at eye level, rather than standing over them. Staff made sure that, when delivering personal care, people's bedroom doors were shut. Before lunch, people were asked by staff if they wanted to go to the toilet; this was done in a very discreet and sensitive manner. One person refused and staff said they would come back later. At lunchtime in the Princess Alexandra unit, people were given discreet serviettes to keep their clothes clean, rather than more conspicuous clothes protectors.

Information about people, including care plans, in one part of the home were not always treated confidentially. For example, a list of personal care tasks that included people's names, showing which staff had completed which job, was posted on a noticeboard in a communal area. In addition, care records were stored in an office with the door left open, so that anyone could have walked in and looked at the files. We brought this to the attention of the deputy manager. She immediately removed the list from the noticeboard and said she would talk to staff about the need to keep sensitive information in a confidential way. The open door to the office where the care records were stored was immediately closed and secured.

People were supported at the end of their life to have a private, comfortable, dignified and pain-free death. Some people in the residential unit may move to the nursing unit, to receive nursing care. A number of people had a 'Do Not Attempt Resuscitation' (DNAR) form in place. These had been completed appropriately and, where they were able, people had given their consent to this. Staff were able to explain the process for completing DNAR forms and what the policy was in relation to acquiring consent for this. Staff knew which people were subject to a DNAR to ensure they would know what to do in the event of cardiac arrest.

As people were reaching the end of their life, the deputy manager explained they would involve the GP, the

Good

Is the service caring?

palliative care team and any other relevant professionals. Some staff had received end of life training and specialists from the local hospice supported this. Staff had received training in recognising deteriorating conditions and how to monitor vital signs and in the administration of oxygen if required. As people became more dependent, their care plan was reviewed more often. The registered nurse gave an example of contacting the local hospice for advice about pain relief for one person. The hospice provided an out-reach service and were able to visit and recommend what medicines the GP should prescribe. There was an advanced care plan and the person and their family had been involved in discussions about power of attorney, resuscitation and whether to involve any community nurses, such as the palliative care team. All this information was documented.

Good

Is the service responsive?

Our findings

In the Princess Alexandra unit, people were supported to follow their interests and take part in social activities. They were supported by staff in a way that promoted their independence. People were encouraged to join in with the music and some were dancing with staff. One member of staff was 'dancing' with one person in an armchair at their level and the person appeared to enjoy this. Pom-poms were given out and people were waving and shaking these in time to the music. At the end of the session, people were invited to participate in another activity and asked to think of a man's name beginning with the letter A, B or C and so on. People were positively encouraged by staff and, when they could not think of a name, were given clues. We spoke with the activities co-ordinator and observed people accessing other activities in the main building at The Drop Inn. There was a variety of activities on offer which prevented social isolation and provided mental stimulation for people. People could also pursue their own interests. There were also opportunities for 1:1 activities with activity staff such as hand massage. One person said there were, "Enough activities to pick, whether you want to attend or not". A member of staff said that it could be a challenge, "Keeping people entertained as a group and trying to keep everyone happy, but we have a person that's trained to do activities every day". Sussexdown is licensed to sell alcohol and a bar was open at lunchtime and in the evenings, so that people could enjoy a drink in relaxed surroundings. People also had access to a hairdresser or barber who visited the home.

People received personalised care that was responsive to their needs. The care plans were devised using a corporate template and used throughout the provider's homes. Care plans were divided into sections allowing easy access to people's information as required. The care plan templates were regularly reviewed and revised. They prompted staff to assess, plan, evaluate, record and review people's care as required. Care plans followed the activities of daily living such as communication, personal hygiene, continence, moving and mobility, nutrition and hydration, breathing, pain control, sleeping, medication and mental health needs. The care plans were supported by risk assessments and these showed the extent of the risk, when the risk might occur and how to minimise the risk. A review of care plans in the Douglas Bader unit identified that people's care and treatment was planned and delivered in a way that was intended to ensure their safety and welfare. People's social history, likes, dislikes, social, cultural and religious preferences, as well as end of life care, were included in their care plans.

Care plans in the Princess Alice unit were required to be reviewed on a quarterly basis, however, there were occasional gaps to these regular reviews. Some care plans in the unit had also not been reviewed as regularly. We brought this to the attention of the registered manager who put together an action plan to address the shortfalls. The action plan stated that all outstanding reviews to care plans would be updated by the end of October 2015 or before.

In the Princess Alexandra unit, an initial assessment of people's needs was undertaken in areas such as communicating, thinking/decision making, sensory, breathing, continence, mobility, sleeping, moods, relationships, staying safe, eating and drinking, personal hygiene and pain and wounds. The assessment was put together in a person-centred way. A person-centred approach focuses on the individual's personal needs, wants, desires and goals so that they become central to the care process. The information in the initial assessment formed the basis of the care plan. Care plans were reviewed on a monthly basis and care records confirmed this.

Daily records were completed for day and night shifts and provided a satisfactory account of how people's needs had been met. For example, they showed the assistance people had been given with their personal care, whether they had eaten and drank well, what their mood was like and if they had taken part in any social activities. The records allowed staff and the registered manager to monitor people's progress and respond to any changes in their needs.

The service routinely listened and learned from people's experiences, concerns and complaints. Sussexdown had guidelines for staff on the management of informal complaints which stated, 'Try to resolve and record. If unable to resolve, escalate to registered nurse, senior carer, community team leader, deputy or home manager'. The complaints policy stated that complaints were acknowledged within four working days and resolved within 28 days. In 2015, six complaints had been received in the year to date. Records showed that complaints were investigated and corrective action was taken to the satisfaction of the complainant, where the complaint was found to be upheld. Any patterns or trends within

Good

Is the service responsive?

complaints were analysed. Compliments were also recorded and acknowledged. For example, a thank you letter had been received from the Royal Air Forces Association following a Dutch Day Reunion in June 2015.

Good

Is the service well-led?

Our findings

Where they were able, people were actively involved in developing the service. People met with new staff as they were shown around the home. People were asked for their feedback through surveys and action was taken on any suggestions or comments received. In 2014, 23 responses were received from people. With regard to staffing and care, 100% agreed they were treated with dignity and respect. In terms of quality of life, 81% of people agreed they were happy living at Sussexdown and 82% of people were satisfied with the service overall.

Volunteers supported the work of the home and organised reunions for ex-air service personnel and through a range of fundraising activities. Some volunteers were involved with the home on a regular basis, for example, helping out at mealtimes. The home was involved in the community and recently entered the gardens for 'Storrington in Bloom' receiving a merit in the community category. Some people helped with the upkeep of the garden.

The service demonstrated good management and leadership. Staff knew and understood what was expected of them. Staff demonstrated respect for their managers and staff confirmed they were involved in the day-to-day activities of the home. Staff thought communication was good, that they were "all family" and covered for one another. Staff attended social events in their own time, for example, BBQs. Staff said they felt supported. One member of staff said they could always ask senior staff and that they were "flexible". Staff were aware of the provider's whistleblowing policy and where to access this if they needed to. People were supported by staff who had the confidence to question practice and report any concerns about the care offered by colleagues and other professionals. Staff told us they would speak with senior staff if they had any concerns. The provider had systems in place to encourage openness and transparency.

A staff survey was completed in April 2015. This asked staff for their feedback on national pay, communications and culture, staffing levels, facilities, uniform and equipment. Staff were also asked if they felt everyone was 'living the values' [from the provider]. Overall the feedback was positive. One of the care staff felt proud, "That I go home at the end of the day and know I've helped people, making people smile". The registered manager felt proud of the relationship she had with staff and said, "I empower the staff to do a good job and give them the confidence and knowledge to do the job". She added, "I'm approachable, they can talk to me and I get things done".

The service had a range of robust quality assurance and governance systems in place to drive continuous improvement. Where improvements had been identified, action was taken to address any shortfalls. The registered manager audited 10% of the care plans on a monthly basis. We checked the audits for April, May and June. The audit monitored completion of records and also evaluated the care delivered. The registered manager also monitored the completion of all supporting documentation such as food and fluid charts, hourly observation records, hourly turning checks and daily plans for people. The registered manager was aware that audits had not always been regularly completed after June 2015 due to a temporary absence from her management duties and had put together an action plan to address this shortfall. All care plans were to be reviewed and updated by the end of October 2015 or before. After the inspection, the registered manager sent us copies of audit reports in areas such as health and safety, infecton control, medicines, hand hygiene and completion of people's daily records. These audits identified any areas for improvement and stipulated dates for completion; all audits were now complete and up to date.

The provider carried out four monthly medicine audits on 10% of the medication administration records (MAR) and the last audit was completed in September 2015. Results of the audit were fed back to staff via regular meetings or more immediate information was given at handover meetings. There was an Infection Prevention and Control policy in place, which included guidelines for the management of infection outbreaks such as Clostridium Difficile (C. diff), guidelines for isolating and reporting and the notification procedure for reporting Methicillin-resistant Staphylococcus aureus (MRSA) both of which are virulent bacterial infections. The provider carried out infection control environmental audits quarterly. West Sussex County Council also carried out an audit in February 2015 and the home scored 79%. There was an action plan in place to address the areas of concern and issues were addressed by April 2015.

Good

Is the service well-led?

An audit completed in April 2015 on health and safety prompted staff, 'Remember to obtain written consent if people have capacity'. In moving and handling, the audit informed staff, 'Remember to check care plans each day in case the moving and handling plan has changed'.

The home operated the 'Butterfly Approach to Dementia Care' which is about person-centred care and acknowledges that people living with dementia have a different reality to others. The home delivered care and support in an empathic way to meet this approach.

The service worked in partnership with other agencies. The registered manager was a member of the West Sussex Care Management Forum which runs free quarterly events for care providers. The registered manager told us, "I'm proud of the reputation we have with the local community and the good relationship with hospitals and GPs".