Mr & Mrs P A Hughes

Barchester Tower

Inspection report

31 De Cham Road
St Leonards On Sea
East Sussex
TN37 6JA
Tel: 01424 435398
Website: www.barchestertower.co.uk

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Ratings

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

Overall summary

The inspection was carried out on 23 and 24 November 2015 by one inspector, a specialist advisor and an expert by experience. It was an unannounced inspection. The service provides personal care and accommodation for a maximum of 22 older people living with dementia. There were 11 people living there at the time of our inspection and a further two people on respite for a short stay. Most people were not able to express themselves verbally due to their health needs.

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.

Staff were trained in the safe administration of medicines, however medicines protocols for PRN and topical creams were not in place and people's medicines were not always administered in line with prescribed guidelines.

Summary of findings

People were not always protected from the risk of cross infection. Hand wash facilities were not available in all toilets and bathrooms. Cleaning schedules required additional detail to enable effective monitoring and to ensure all areas of the home were regularly cleaned.

The premises were cluttered in places. This could pose a slip or trip hazard to people. Robust protocols were not in place to monitor the safety of the environment and address any shortfalls.

All fire protection equipment was serviced and maintained. However personal emergency evacuation plans were not in place for two people recently admitted to the home to support their safe evacuation from the premises in the event of a fire.

Robust protocols were not in place to manage people's pressure area care, weight, nutritional and pain management needs. There was a lack of adequate communication with some health care professionals around people's health care needs.

The lack of adequate protocols to monitor people's health needs; the lack of adequate communication with health care professionals; the lack of robust protocols to ensure the premises are safe and free from the risk of infection are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager carried out audits to identify how the service could improve. However they had not identified shortfalls we found during the inspection to continuously improve the quality of the service and care.

The registered manager sent annual satisfaction questionnaires to people, their relatives or representatives, however it was not always recorded what action had been taken in light of people's feedback.

Failure to adequately assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Funding arrangements were not in place for all people. We have made a recommendation that people are provided with the personal items they need until funding can be agreed.

People gave us mixed feedback about the food and drink available to them. The dining experience was not adequately adapted to the needs of people living with dementia.

We have made a recommendation about consulting people to ensure their food and drink preferences are met and to ensure that the dining experience meets the needs of people living with dementia.

We have made a recommendation about seeking specialist dietary advice to support optimum cognitive function for people living with dementia.

During lunchtime we observed people's walking frames had been placed out of people's reach. It was not clear whether people had consented to this practice. This practice could potentially reduce people's independence and restrict their freedom of movement.

We have made a recommendation about obtaining consent from people to remove their mobility aids to ensure people have lawfully consented to this restriction.

We have made a recommendation that 'All About Me' documents are completed to support effective handover with external health professionals in the event people are admitted to hospital.

We have made a recommendation that suitable signage and environmental items of benefit for people living with dementia are provided in line with current guidance.

We have made a recommendation that meaningful activities are developed and implemented for people living with dementia.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

There were sufficient staff on duty to meet people's needs. There were safe recruitment procedures in place which included the checking of references.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect.

People were involved in their day to day care. People's care plans were reviewed with their participation and relatives were invited to attend the reviews and contribute.

Summary of findings

People were able to spend private time in quiet areas when they chose to. People's privacy was respected and people were assisted in a way that respected their dignity.

Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

Staff's training was renewed annually, was up to date and staff had the opportunity to receive further training specific to the needs of the people they supported.

All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal to ensure they were supporting people based on their needs and to the expected standards.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit one.

The registered manager notified the Care Quality Commission of any significant events that affected people or the service.

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?

Requires improvement

The service was not consistently safe.

People's medicines were not always dispensed in line with prescribed guidelines. PRN and topical cream protocols were not in place to ensure people's medicines were administered as required.

People were not always protected from the risk of cross infection. Cleaning schedules required additional detail to enable the registered manager to monitor which areas of the home had been cleaned each day. Adequate hand washing facilities were not available.

The premises had not been adequately monitored to ensure a safe environment was maintained.

The registered manager had not completed personal emergency evacuation plans for all people at the home to record how people could safely evacuate the premises in the event of an emergency.

Is the service effective?

Requires improvement

The service was not consistently effective.

People gave us mixed feedback about the food and drink available. The dining experience was not sufficiently adapted to meet the needs of people living with dementia.

The registered manager understood when an application for DoLS should be made and how to submit one. People's walking frames had been placed out of people's reach at lunchtime. This practice could potentially reduce people's independence and restrict their freedom of movement.

There was a lack of signage on the premises and environmental adaptations to promote the independence of people living with dementia in line with current guidance.

Staff's training was renewed annually, was up to date and staff had the opportunity to receive further training specific to the needs of the people they supported.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

Summary of findings

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The was a lack of adequate protocols in place to monitor people's pressure area care, weight, nutritional and pain management needs, and a lack of adequate communication with some health care professionals to promote people's health needs.

There was a lack of meaningful activities available for people living with dementia.

The registered manager sent annual satisfaction questionnaires to people, their relatives or representatives, however it was not always recorded what action had been taken in light of people's feedback.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The quality assurance system in place was not sufficiently robust. The registered manager had not identified shortfalls in essential standards of care identified during the inspection. Service improvements plans were not in place to determine how required improvements would be addressed at the home.

The culture at the home was welcoming and there was a sense that staff genuinely cared for and respected people. The registered manager and owner were passionate about providing care to people in a compassionate and caring way.

Barchester Tower

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 23 and 24 November 2015 and was unannounced. The inspection team consisted of one inspector, a specialist advisor with direct experience and knowledge of working with people living with dementia 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. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people living with dementia.

The registered manager had not received a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during the inspection. Before our inspection we looked at records that were sent to us by the registered manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports.

We looked at records which included those related to people's care, staff management, staff recruitment and quality of the service. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We looked at the activities programme and the satisfaction surveys that had been carried out.

We spoke with four people and three relatives to gather their feedback. We also spoke with the owner of the home, the registered manager, two members of care staff and one visiting health care professional. After the inspection we received written feedback from three health care professionals.

Requires improvement

Is the service safe?

Our findings

People who spoke with us said that they felt safe at the home. One person said they felt safe because the people and staff were nice. People said that they got their medicine at the right time. People said staff were available to help them. One relative said, "There is always staff around." Another relative said, "[My relative] is as safe as they are going to be anywhere."

People were supported to take their medicines by staff trained in medicine administration. Staff had their competency assessed by the registered manager. Records showed that staff had completed medicines management training. Medicine Administration Records (MAR) were in place where people had prescribed medicines to record that people had their medicines administered in line with their prescriptions. However where people had medicines prescribed as PRN not everyone was receiving this in line with those guidelines. One person's tablet dosage was marked incorrectly on their MAR. The MAR was recorded correctly for the first week of the prescription cycle but incorrectly for the subsequent weeks. This could result in the person receiving an incorrect dose of their prescribed medicines. In some cases where people were prescribed PRN medicines there was no PRN protocol in place to ensure people received PRN medicines in a safe way. Topical MAR were not in place where people needed topical creams applied. Cream was prescribed for one person, however there was no topical MAR chart stating where to apply this, in what quantity and at what times. Guidelines were not in place to ensure staff administered medicines and topical creams as prescribed to ensure people's health needs were met. Feedback we received from the provider's pharmacist supported our findings. The provider's internal medicines audit had not identified these shortfalls. Robust measures were not in place to ensure people received medicines safely and in line with their individually prescribed guidelines. Where people were not administered medicines as prescribed, the provider had not reviewed with the G.P. whether people still required these medicines.

There was a cleaning schedule in place, however this did not provide a detailed breakdown as to which areas of the home had been cleaned. There were no cleaning schedules for wheelchairs and commodes to record and monitor their cleanliness. One wheelchair in the communal area contained debris and required cleaning. This could pose a risk of infection to people. The registered manager told us the mattresses were regularly checked and replaced when required, however there were no records to demonstrate this practice took place. Cleaning duties were carried out each day. We observed a domestic staff member cleaning the home during our visit. We checked three toilets and all of them had not been flushed since being used and in one case had a dirty toilet seat. We asked how regularly toilets and rooms were checked for levels of cleanliness as the cleaning schedules did not provide this information. The registered manager told us that it was all staff members' responsibility to check toilets, however it was not clear how often staff checked these facilities. There was a lack of hand wash facilities in two of the toilets we looked at. There were no available hand wash products or paper towels to enable people and visitors to wash their hands. This could pose a risk of infection to people. We observed bath and slip mats were threadbare, for example in the second floor bathroom. This could pose a risk of infection to people.

We observed some people's bedrooms were cluttered with furniture and equipment. In one bedroom the floor was coming apart in places. We observed wires around the floor space and the environment was cluttered. There was equipment in the corridors to include a hoist that was not in service and a privacy screen. There was a wire hanging down from the wall near the kitchen with wires accumulated on the floor. People may have difficulties moving around safely or could be at higher risk of trips or falls. The slip mat in the second floor bath was threadbare and had fallen apart in places and could pose a slip hazard to people. The registered manager told us that water temperature checks were completed regularly before people received personal care. However there was no recorded evidence of regular checks to ensure safe water temperature levels were maintained. In one room the carpet guard was loose, although the room was not occupied at the time of our inspection. In another bedroom the sink unit was stained. One person had a large emergency exit sign on their bedroom door and a fire exit sign pointing to their door. A staff member said their room was not used as a fire exit in an emergency and that people would use the front door. This signage did not support the person's dignity and could cause confusion to people in the event of a fire. One relative said that there had been a

Requires improvement

Is the service safe?

strong smell of urine in their relative's room and we found the same concern in a person's room. This posed an infection risk to people and did not promote their dignity needs.

Personal Emergency Evacuation Plans (PEEP) were in place for most people. The PEEPs identified people's individual independence levels and provided staff with guidance about how to support people to safely evacuate the premises. Evacuation drills were completed every six months to support people and staff to understand what to do in the event of a fire. All staff had attended fire safety training and first aid training. The fire alarm was tested weekly and all fire equipment was serviced every six months. However the registered manager had not completed PEEPs for two people recently admitted to the home. In the event of fire, staff and emergency services personnel may not have access to information for all people to enable them to be safely evacuated from the premises.

The lack of adequate medicines management protocols, infection control protocols, environmental hazards protocols and lack of PEEPs for all people are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We observed one person did not have all personal items they required. Funding arrangements were not in place to enable staff to purchase items for them. The registered manager told us they had previously purchased personal items for them. They had made a referral to the Court of Protection for a Lasting Power of Attorney to enable the provider to oversee this person's health and welfare needs. They told us this was a slow process and they were awaiting this matter to be resolved.
The registered manager had referred their concerns to the local authority responsible for funding this person's care. However they had not raised a safeguarding alert to ensure the person's funding authority gave priority to this person's needs.

We recommend that the provider ensures people have the personal items they need until funding can be agreed.

Policies and procedures were in place to inform staff how to deal with any allegations of abuse. Staff were trained in recognising the signs of abuse and were able to describe these to us. Staff understood their duty to report concerns to the registered manager and the local authority safeguarding team. Records showed staff had completed training in safeguarding adults and that safeguarding policies were discussed in staff meetings. Contact details for the local authority safeguarding team were available to staff if they needed to report a concern. There was a whistleblowing policy in place. Staff told us they would not hesitate to report any concerns they had about potentially poor care practices.

There was an adequate number of staff deployed to meet people's needs. The registered manager completed staff rotas in advance to ensure that staff were available for each shift. There was an on-call rota so that staff could call a manager out of hours to discuss any issues arising. Our observations indicated that sufficient staff were deployed in the service to meet people's needs. The staff told us that there were sufficient numbers of staff on shift to meet people's needs. We observed the staff were not rushed, carried out their tasks in a calm manner and were able to spend time talking with people. As staff covered additional shifts in case of sickness no agency staff were used.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks to ensure staff were suitable. Staff were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured that staff were of good character and fit to carry out their duties.

The premises were kept secure and were protected from inappropriate access. The front gate had an alarm so that staff were made aware of and responded to visitors. There were no key-pads or locks to restrict access within the house other than for cleaning cupboards, the kitchen and restricted areas containing hazards. Portable electrical appliances were serviced regularly to ensure they were safe to use. All equipment that was used to help people move had been regularly serviced. The bathrooms were equipped with aids to ensure people's safety. Handrails were in place. People were escorted when they needed to use the stair lift to access other floors. The service had an appropriate business contingency plan that addressed

Requires improvement

Is the service safe?

possible emergencies such as fire, gas or water leaks. It included clear guidance for staff to follow. The registered manager and the provider were available during out of hours to respond to any emergencies.

Records of accidents and incidents were kept at the service. When incidents occurred staff completed physical injury forms, informed the registered manager and other relevant persons. One incident occurred where someone had a fall. The person used a walking frame and staff ensured they assisted the person when walking at all times. The registered manager ensured a hand rail was installed in the hallway to support the person to walk in communal areas. Risk management measures were taken to reduce the risk of incidents occurring.

Care records contained individual risks assessments and the actions necessary to reduce the identified risks. The risk assessments took account of people's levels of independence and of their rights to make their own decisions. One person had a risk assessment in place to support them to safely use the stair lift to get downstairs. The person needed support from two staff members and support to walk to the lounge using a walking frame. We observed these control measures were in place when the person was supported by staff to use the stair lift.

Requires improvement

Is the service effective?

Our findings

People's needs were assessed, recorded and communicated to staff effectively. People said the staff were experienced and well trained. People said they were looked after properly. One person said, "Staff are really good." Another person said, "They [staff] all seem to be doing some training at the moment." A relative said, "I think its fine." Another relative said, "They [staff] absolutely look after X the way I like."

People had different opinions about the food provided at the home. One person said, "The food is quite good." Another person commented, "The food is ok." A relative said, "I think the food is very good, appropriate for their age." Another relative felt that the food was, "Pretty good" but that their relative didn't get enough to drink. One person said that staff occasionally asked them about the food and they sometimes get more. One person said, "I don't like it, it's too plain." We observed that people were not offered teas or coffees after the meal. A member of staff said that they would be offering these refreshments during the afternoon. There was no fresh fruit for people to access at different times of the day, should they wish. We looked at the four weekly menu, it was not clear which week or day the meal represented. We observed there was no menu or picture prompts in the dining room to remind people what was on the menu for the day. This could prove confusing for people living with dementia and did not support their understanding of what was available to eat. The registered manager showed us a book of photographs of food in the kitchen that they used to support people to decide on meal options that they chose each morning. The clock on the wall had stopped and did not show the correct time. This did not support people living with dementia to be orientated to place and time. The registered manager said that if there was nothing on the menu the person liked, the cook would change things to suit people's needs. There was not a choice of main meal however an alternative meal was cooked when people preferred. For example one person requested to have fish and their needs were accommodated. People were supported by staff with eating and drinking when they needed encouragement.

We recommend the provider reviews the dining experience to ensure it is adapted to meet the needs of people living with dementia.

We observed lunch being provided. The meal was freshly cooked, well presented and looked appetising. It was hot and in sufficient amount. Condiments were available. People were able to have second helpings and various drinks as they wished. A choice of water or lemon juice was offered to people and this was refilled as needed. People's allergies, dietary restrictions and preferences were displayed in the kitchen. Some people had liquidised foods and other people had plate guards to enable them to eat their meals independently and with dignity. One person said, "That was a very nice dinner, thank you." People acknowledged when asked by staff that they had enjoyed the meal.

People were supported with eating where they were at risk of malnutrition. One person had been referred to a Speech and Language Therapist (SALT) for an assessment of need. There were guidelines in place for staff to follow to include supporting the person with thickened drinks. One person had their food crushed as it was easier to swallow. Staff supervised the person whilst they ate, they prompted them to slow down and made sure they paced their eating to reduce the risk of them choking. However, the person's care plan did not detail the importance of position when supporting the person with drinks to minimise the risk of choking. Food prepared for people was fortified with cream, butter and dried milk powders. However, the specialist advisor identified there was a heavy reliance on dairy products which can result in making people more lethargic. They advised that giving people living with dementia the best chance of cognitive function included supporting them to have foods that enhance brain activity. Food such as omega fish oils, fresh fruit and vegetables can help promote people's well-being particularly in the form of fresh juices and smoothies. Holford, P (2004), Alzheimer's and dementia: the nutrition connection, Primary Care Mental Health 2004;2:5-12 and Peter Morgan-Jones, Emily Colombage, Danielle McIntosh, Prudence Ellis. Don't give me eggs that bounce, Published by Hammond Care Media.

We recommend the provider seeks further specialist advice to support the dietary needs of people living with dementia.

The Mental Capacity Act 2005 (MCA) 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

Is the service effective?

needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Related assessments and decisions had been properly taken. The registered manager had submitted applications to a 'Supervisory Body' for authority to lawfully restrict people's freedom in their best interest and were awaiting the outcome of applications submitted. The provider had properly trained and prepared their staff in understanding the requirements of the MCA in general, and the specific requirements of the DoLS.

Staff sought and obtained people's consent before they helped them. One staff member told us, "I explain things using not too many words. I limit information and use short sentences and key words to help people to understand." Another staff member discussed how they sought consent from people with non-verbal communication. When they asked people if they wanted to have lunch they would make eye contact with people and observe their body language. They would stroke the person's hand to get their attention and using eating gestures to help people to communicate whether they wanted to have a meal. They said sometimes they wrote things down for people and used picture prompts. Staff told us if people did not want to eat they could eat at another time. When people declined to do something, for example when they did not wish to get up or go to bed, their wishes were respected and staff checked again a short while later to make sure people had not changed their mind. During lunchtime we observed that people's walking frames had been placed out of people's reach. It was not clear whether people had consented to this practice. This practice could potentially reduce people's independence and restrict their freedom of movement.

We recommend the registered manager seeks consent from people to remove their mobility aids to ensure people freedom of movement is not restricted.

People's wellbeing was promoted by regular visits from healthcare professionals. A GP visited when people's health needs changed and reviewed people's medicines when needed. A chiropodist visited people to provide treatment and an optician and a dentist visited when required. District nurses visited people regularly when they needed to provide treatments such as dressings. People were supported with their health needs when they became unwell. Emergency services had been called when necessary. People said that if they were not well a doctor would be called. A relative said that their loved one saw the doctor regularly. Records about people's health needs were kept and information was communicated to staff. There was a transfer sheet designed to support people to communicate their health needs if they went to hospital and there was an 'All About Me' blank document in the registered manager's office. However transfer sheets were not completed in people's care files to support them in the event they went to hospital.

We recommend the registered manager ensures effective handover with health professionals in the event people are admitted to hospital.

We completed a tour of the home to observe whether adaptations to the premises had been made to support the needs of people living with dementia. People's bedroom doors had their names in a large font and some had pictures of the person on them and others had pictures of things that they enjoyed from their past. This supported people living with dementia to find their rooms and promoted their independence. There were no obvious dementia specific adaptations to the home relating to signage or enhanced lighting to help people find their way around. The communal walls in the home were all painted cream, which may make it more challenging for people to orientate themselves to different rooms in the home. There was no menu information or picture prompts in the dining room to remind people what they had chosen to eat that day. The clock was not working in the dining room, which may confuse people and not support their orientation to the relevant time of day and support promotion of their routines. Staff said that the use of pictures, textured items and displays were a 'work in progress' to support optimum cognitive functioning and sensory stimulation for people living with dementia. Staff were keen to develop the environment for people living with dementia.

Requires improvement

Is the service effective?

We recommend that the registered manager seeks information on and provides suitable signage and environmental adaptations for people living with dementia in line with current guidance.

Care plans for people living with dementia included guidance on how to encourage people and staff to communicate effectively with each other. Care plans were written to reflect people's abilities and were personalised to their specific assessed needs and preferences. An example of this was, 'I am able to communicate my needs, however, due to my dementia and poor hearing I am unable to hold a conversation and need people to speak slowly and clearly when talking to me and to allow me time to answer.' We observed staff followed this guidance, ensured they talked clearly to them and checked that they understood what was said. Updates concerning people's welfare were communicated between staff at handover meetings to ensure continuity of care. For example, information about people's individual health, moods, behaviour and appetite was shared by staff when a new shift of care workers took over. Each care plan had an 'at a glance' summary of people's care needs for ease of access and understanding by the staff team.

Staff had appropriate training and experience to support people with their individual needs. Staff had a comprehensive induction and had demonstrated their competence before they had been allowed to work on their own. Essential training included medicines management, fire safety, manual handling, health and safety, mental capacity and safeguarding. This training was provided annually to all care staff and there was a training plan to ensure training remained up-to-date. The registered manager needed to attend a refresher course for manual handling to update their train the trainer qualification. They had missed the last session for legitimate reasons and were due to refresh this training at the next available opportunity. They were awaiting new training course dates to be provided by the local authority. This system identified when staff were due for refresher courses. Staff received regular supervision to discuss work related matters and development needs.

The registered manager was due to implement a new induction programme called the 'Care Certificate' training for all new staff that joined the service. This is based on an identified set of standards that health and social care workers adhere to in their daily working life. It has been designed to give everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care. The Care Certificate was developed jointly by Skills for Health, Health Education England and Skills for Care.

People received effective support from staff that had been trained to help them to maximise their independence and increase their quality of life. Staff had completed training in dementia care. Our specialist advisor reported, 'The registered manager and owner are both knowledgeable and passionate about supporting people living with dementia. They are receiving additional dementia training for their staff from the local in-reach team. The staff are communicating with people living with dementia and clearly know people well. People's levels of emotional wellbeing are good.'

Staff were confident when describing what they needed to do to support people living with dementia. Staff told us, "I reassure people and remind people about their families coming to visit them. I sit with people and keep them company and answer any questions they have. I give people options and ask people whether they would like to do things. I take time to get to know people." Staff were satisfied with the training and professional development options available to them. Staff were supported to achieve further qualifications in social care. Staff received formal annual appraisals of their performance and career development. They were well supported through regular supervision and staff meetings.

Good

Is the service caring?

Our findings

People told us they were satisfied with the way staff cared for them. People said, "Staff are very kind." Relatives said, "Staff seem to be caring. They are patient and are aware of individual needs" and, "Staff talk to X. They understand what X is saying. They understand X's specific needs. They are caring, capable and experienced. They treat people as individuals." Staff said, "I have time to talk to people. One person likes me to brush their hair and likes to talk about when they were married" and "I can have one to one time with people and pamper them. People like having their nails done." Staff told us about how they engaged with people living with dementia. One person told them they lived through the war, drove lorries and did people's laundry. They talked to the person regularly about this to encourage stimulating conversation. Another person had been in the army. Staff bought them a book about the army to engage them in their interest and used knowledge about their life story to prompt conversations with them. This supported and prompted meaningful conversations between people and staff.

Staff supported people in a caring way. We observed staff took time to stop and talk to people. They knew people well using their knowledge of people to inform their conversations with them. Staff ensured people were involved in conversations and activities and respected when people declined to join in. People were not calling out during the course of the day and there was a homely atmosphere. Written feedback received from a health care professional read, 'Staff appear caring to people.' One health care professional wrote, 'I have no concerns for the care they provide. Each person appears to be cared for in a holistic and individual manner with particular attention to people's individual needs."

We spent time in the communal areas and observed how people and staff interacted. The staff displayed a polite and respectful attitude. Staff provided care in a kind and sensitive way. One person who needed help using the stair lift to come downstairs was assisted by staff. Staff ensured the person's pace was respected. Staff demonstrated a caring, respectful and patient approach. They gave the person instructions in a calm and reassuring way and thanked the person when they followed instructions to keep them safe. They encouraged the person whilst they were going down the stair lift saying, 'Almost there'. When they reached the ground floor they support them to stand and hold their walking frame in their own time. Staff spent one to one time with people if they needed company or reassurance. A person who was unwell and who remained in their room was visited several times during the day and was asked whether they needed anything or company. There was a friendly and appropriately humorous interaction between staff and people. During lunchtime we observed staff crouch down to people's eye level to talk with them and encouraged people to eat. One staff member acted promptly when someone asked to be moved nearer the dining table to eat their meal. They checked that the person was ok and was more comfortable. One staff promptly found a tissue for someone who needed support to ensure their personal grooming needs were met whilst eating.

People said they were treated with dignity and respect. One person said that staff always knocked before entering their room. All staff knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. We observed the registered manager went to check on someone who spent their time in bed. The person was slightly distressed. The registered manager lightly stroked the person's arm to reassure them and reminded the person who they were. They started talking about the person's family and that they were coming to visit and the person visibly calmed and appeared reassured by this conversation. Staff told us about how they promoted one person's dignity. They told us sometimes they declined support with personal care. Staff said they tried to encourage them by saying they would feel better for it and they would find some fresh clothes together and then have a cup of tea and watch television as this was something they liked to do. This supported and encouraged the person to maintain their personal care needs with dignity.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were encouraged to dress, wash and undress themselves when they were able to do so. Staff told us, "When I support people with personal care. I put people at ease. I ask people what they can do themselves. I prompt people and help them when they need it." Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Some people preferred to remain in the lounge or their bedroom. Information about

Good

Is the service caring?

the service and its facilities was included in the service user guide which people received when they came to the service. The procedure to follow about how to complain was provided to people and visitors and displayed in the entrance.

People were involved in their day to day care. The registered manager and people discussed and agreed on a contract with clear terms and conditions before they came into the service. This included arrangements for their information to be shared with visiting health care professionals when necessary, according to Data Protection Act 1998 requirements. People's care plans and risk assessments were reviewed monthly, which was intended to ensure they remained appropriate to people's needs and requirements. People's relatives were invited to participate in the reviews with people's consent.

People's end of life wishes were recorded in their care plans when they came to the service. People had end of life care plans in place. Staff discussed with people their preferred place for end of life care and this had been recorded in their care plans. The district nurses supported staff when people were nearing the end of their life. Written feedback received from a health care professional read, 'The manager appears to be devoted to providing high standards of care and the staff are particularly good at liaising with other services to enable people to end their lives in an environment where they know and trust the staff rather than having to move to alternative accommodation if their medical condition deteriorates. The staff also appear to have a good rapport with relatives which enables end of life planning to enable people to have choice at end of life. Staff appear to always inform relatives of any appropriate information.'

Requires improvement

Is the service responsive?

Our findings

We observed staff spending time talking with people in the lounge. One member of staff sat with someone to look at photos. The person showed joy when they recognised themselves. The staff member had a good knowledge of the person's family and background and talked to them about this. They then moved on to talk with another person and spent time with them. One relative said, "They [staff] talk and listen to [my relative]." Written feedback we received from a health care professional read, 'We have been delivering workshops in the home on several aspects of dementia care and we generally have had 3 to 4 care staff attending. Our impression of staff is that they are very keen to learn and willing to take forward ideas such as the life story work.' Life story work is an activity which involves reviewing a person's past life events and developing a biography. Life Story Work enhances the care provided to older people particularly those living with dementia. Benefits include promoting individualised care, improving assessment, building relationships and improving communication, between people, their families and staff.

We reviewed the care plan for one person who had a recurrent pressure sore. The registered manager had contacted the district nursing team for support and the person's pressure sore had been regularly dressed. When we asked at the beginning of the inspection if anyone had any pressure sores or skin breakdown, the registered manager informed us that no one had these needs. The district nurse who came to dress the wound on the day of our inspection said the person had a grade 3 to 4 pressure sore. The person's care plan for skin integrity did not refer to the pressure sore as both the registered manager and owner were unaware that it was as severe as the nurse had advised us. There was no picture record of the wound or body map in the person's care file to review how the wound was progressing. It was not clear what measures were in place to reduce the risk of further skin breakdown. The Waterlow assessment was incorrect for this person. A waterlow assessment determines the level of risk for a person of developing a pressure sore. The person's care plan did not reflect their needs. The person had a pressure relieving mattress in situ. When we checked the mattress setting it was set incorrectly for the person's weight. This did not provide the necessary pressure relieving benefits to the person. The registered manager said that the district nurse had put the setting on and they assumed this was right. The communications between the registered manager and district nurses were not effective in providing up-to-date information about the person's pressure sore needs. After the inspection the registered manager contacted the practice nurse who agreed to visit the following day to review the wound, redress it and discuss how they communicated information about people's care needs in future.

We reviewed the nutritional assessment for this person as they had lost a significant amount of weight. This assessment was not accurately completed as the person's weight had not been accurately recorded. The person's care plan did not reflect any action taken to address this weight loss. When observed the person was adequately hydrated and the weight loss may be reflective of their end of life needs, however this had not been identified within their care plan. In three out of four cases we found concerns around significant weight loss for people in a relatively short time frame. The registered manager was using the Body Mass Index (BMI) as an indicator as to whether the person's weight was at a safe level, rather than using the required Malnutrition Universal Screening Tool (MUST). MUST is a 5 step screening tool to identify adults who are at risk of malnutrition. It also includes management guidelines which can be used to develop a comprehensive care plan for people. This weight loss and the required nutritional needs for those people were not reflected in their care plans. The nutritional risk assessments had not been reviewed or updated to reflect this weight loss and there was no additional detail as to what action staff had taken in response to people's change in needs.

The registered manager had previously referred one person to the dietician for a nutritional assessment and advice due to concerns about their weight loss. The person had experienced considerable weight loss over a month period and subsequently had a fall and sustained an injury. Our specialist advisor reported that significant weight loss of this type in older frail people can result in loss of muscle mass which can increase the risk of falls and of people sustaining fractures. The dietician did not conduct an assessment for this person as the registered manager had not sent all of the required information as part of the referral. The dietician requested additional information was sent to them. However, the registered manager agreed instead with the G.P. to prescribe the person fortified supplements. The person subsequently gained a little

weight. However the person did not receive a full assessment of their dietary needs from a specialist as needed. There was insufficient detail in the person's care plan to reflect how staff should monitor and respond to the person's weight loss.

Staff knew people well, they had all worked at the home for a considerable amount of time and the registered manager was able to describe how they assessed people for pain. However, this was not recorded in people's care plans and there was no evidence of a pain assessment tool being used to determine people's pain level. People may not receive adequate pain relief as appropriate assessment tools were not in place.

The lack of adequate protocols to monitor people's pressure area care, weight, nutritional and pain management needs, and the lack of adequate communication with some health care professionals are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We observed that people were supported to take part in some daily activities. Activities included knitting, jigsaws, skittles, soft ball games, crosswords and reminiscence work. We observed one person doing a word search, another person was looking at a photo book and another person was doing a jigsaw. People's daily notes read, 'Doing some knitting', 'Reading magazines and doing crosswords', 'Declined to play skittles' and 'Watching a gardening programme.' We read that one person had helped staff to prepare supper, which created a homely environment and meaningful occupation for that person. People had recently enjoyed a 'Mad Hatter' party. People had dressed up and staff invited their family to come along. There were photos on the walls of people enjoying the party and having fun. The owner was arranging a party to celebrate thirty years since the home opened that coming weekend.

The owner of the home told us that people could go out if they wanted to, but that people were not interested in this. However, one person said they would love to go out but it did not happen. It was not clear whether staff regularly asked people whether they wanted to go out. These conversations were not recorded to establish they took place. Although only a few people were involved in activities, people said they could make their own choices about how they spent their day. One person said, "I like doing puzzles", and we observed them doing a puzzle during our visit. There were limited activities taking place, particularly activities which supported meaningful engagement for people living with dementia.

Our specialist advisor reported that people nearing the end of their journey with dementia were at higher risk of social isolation, particularly those people who spent most of their time in their bedroom sleeping. One person's care plan contained a confusing statement, 'Staff need to be aware that X will only do what they would like to and at times prefers to sleep". This was then followed in another part of their care plan with the statement, 'Staff are to discourage X from sleeping too much during the day.' It is accepted that as people deteriorate with dementia they sleep for short periods after mental stimulation and cannot sustain prolonged concentration. However when an activity is something a person loves or loved doing, this can lead to increased speech and cognition and significantly enhanced wellbeing. Records showed that staff checked on people who stayed in their bedrooms during the day. However records stated, 'Asleep' or 'Awake'. The records did not provide information on any meaningful engagement staff had with people when they visited them in their rooms.

Staff were receiving support and teaching sessions from the Sussex Partnership NHS Foundation Trust for Care Homes In-reach team. This service provided staff with information on best practice in dementia care. Staff said they intended to purchase new resources such as books, games, knitting and crafts. They were looking to introduce new 'rummage boxes' and to develop a 'reminiscence box' and life story books for people to trigger memories and promote discussions. There were plans in place to develop new activities specifically for people living with dementia, however there was no record or service improvement plan to determine when these measures would be achieved. At the time of our inspection there were limited specific activities in place designed to socially engage and stimulate people living with dementia. A member of staff was completing some training before taking on the role of activities co-ordinator. They discussed some creative ideas about ways to engage and support people living with dementia in meaningful occupation and activity. Written feedback received from a health care professional read, 'Staff appear caring to people and would like more ideas about activities.' Staff had a willingness to learn about and implement new activities however they had not been fully implemented at the time of our inspection.

Requires improvement

Is the service responsive?

We recommend that the registered manager develops meaningful activities for people living with dementia and further develops staff knowledge to meet people's needs.

People attended resident meetings to discuss aspects of the service and give feedback about how the service should be run. Recent records read, 'All residents like the new flooring which was chosen by X' and 'All residents say they are happy here.' 'People enjoy the new cook's food.' Surveys were sent to people, relatives and visitors so they could give feedback and develop the service. The last survey was completed in April 2015. People had requested the menu was changed to reflect seasonal food choices. The registered manager acted on people's preferences and changed the menus. However not all feedback we received from people about the food provided was positive. Some people were satisfied with the food and drink available and other people said this did not meet their preferences.

We recommend the provider regularly consults with people and their relatives to ensure their preferences are met.

The registered manager told us about one person who had a recent fall and needed to go to hospital. Whilst in hospital the person declined to eat and was not thriving in the environment. The registered manager worked with the hospital and health care professionals and arranged for the person to come home. Whilst at home the person received support from a physiotherapist. The registered manager knew the person well and since they had come home they had been encouraged to eat and work with the physiotherapist and were closely monitored by staff. They were also visited by the district nurse to monitor for any associated health risks. The person had made significant progress and was able to walk around the home with their walking frame and one staff member supporting them at all times. The person's relative told us, "When X came back from hospital they were smiling when they arrived at the home. They felt like they were coming home. They feel cared about and staff are brilliant with them." The person received consistent co-ordinated, person-centred care when they used different health care services.

Each person's needs had been assessed before they moved into the service in respect to their morning, afternoon, evening and night-time care. This ensured that the staff were knowledgeable about their particular needs and wishes. One relative's comments from a survey read, 'I have no issues with the service. When discussing [my relative's] admission the contact was very good. I have been satisfied with all aspects of their care. Individualised care plans about each aspect of people's care had been developed to include people's likes and dislikes, needs and relevant risk assessments.' Staff said, "I create conversations with people. One person used to like to knit their clothes, they used to be a receptionist and also worked for a writer in their past. We provided them with different colour wools, they particularly like the colour purple so we got that colour wool for them. I engage in conversation with people about what they enjoy in their life." Relatives said they were encouraged to give information about their loved ones to help the staff better understand people needs and preferences. This promoted staff understanding of how to respond to each person's care needs and wishes.

People's bedrooms reflected their personality, preference and taste. For example, some rooms contained articles of furniture from their previous home and people were able to choose furnishings and bedding. One person had recently chosen the colour scheme for their bedroom. They chose colours that reminded them of their previous bedroom at their home. People were offered choices and options about the support they received. One person wanted to have a lie in each morning and staff changed the staff shift handover time to meet the person's request. People's care plans were personalised and reflected people's past life, hobbies and preferences. The documentation in the care plans was entitled "My life so far" which recognised that people still had a life to lead.

People said they could have visitors at any time of the day and all visitors were made to feel welcome. People were encouraged and supported to develop and maintain relationships with people that mattered to them. This information was written into people's care plans and staff supported them to do this.

The complaint policy was available to support people to understand how to make a complaint. The registered manager showed us the complaints procedure. People were provided with a brochure about the service when they came to live there and there were posters available to explain to people how to make a complaint. No complaints had been recorded since our last inspection.

Requires improvement

Is the service well-led?

Our findings

There was an open and positive culture which focused on people. People generally thought the atmosphere was good. One person said, "It's a happy place." People knew the registered manager and saw them about the home. A relative said that when their loved one had an accident the registered manager handled it well. One person said, "They [staff] would do their best to help me." Relatives said that the service their family members received was, 'About the best that could be done for them.' People and members of staff were welcome to come into the office to speak with the registered manager at any time. The registered manager told us they saw the owner of the home all the time and got the support they needed from them. The staff we spoke with were positive about the support they received from the registered manager. One staff member said, "The manager has been here for years and is very approachable."

The registered manager carried out regular audits to monitor the quality of the service. There were monthly audits of medicines, infection control, staffing levels, staff training and the home environment in place. The registered manager had completed two night shift audits to monitor essential care standards were being met by night staff. They recorded no issues of concern from these visits. The registered manager completed monthly audits of people's care files to check records such as care plans and risk assessments were accurate, reviewed, updated appropriately and fit for purpose.

The owner of the home completed a monthly service visit to review service quality issues. This included an inspection of the premises, observations of staff practice and discussions with people about their experience of the home. They completed an action plan which identified any actions for the registered manager to address prior to the next visit. However, we identified shortfalls in the quality of care delivery as part of the inspection. We identified shortfalls in the assessment of people's care needs to include their nutritional needs, pressure area care and medicines management. Infection control and environmental safety measures were not sufficiently robust and the premises required further upgrading and adapting for the needs of people living with dementia. These shortfalls had not been identified as part of the provider's quality assurance process.

Staff recorded incidents and accidents when they occurred. However one person had two falls which resulted in them sustaining an injury. There was no evidence of falls analysis and actions agreed to prevent further falls. One person had recently returned from hospital following a fall where they sustained an injury. Their moving and handling and falls risk assessments had been updated after the fall, however there was no evidence of a falls analysis to review ways that falls of this type can be minimised. The registered manager had not consistently analysed records of incidents which took place to review any patterns of incidents. This meant that effective control measures may not be in place to reduce risks to people and the likelihood of incidents reoccurring.

We observed that the home environment was worn and could benefit from an overall scheme of refurbishment. One health care professional wrote, 'We feel that the environment is tired and could be improved on. In the time we have been there they have already made improvements to the communal lounge area.' Relatives commented in the last survey that the home could benefit from updated décor. The provider told us that bedrooms were repainted when people vacated them. The flooring had recently been replaced in the living room. They said they were due to replace the flooring in communal areas at the beginning of the new year. The provider's maintenance policy stated, 'The manager should ensure that a decorating budget is in place to facilitate the timely and appropriate re-decoration of areas in need throughout the year. Budgets for repairs, renewals and maintenance are set and managed by the manager.' However, the owner told us the refurbishment programme was 'budget led' and there was no schedule in place to determine when future refurbishments would take place. However, after the inspection the provider sent us a refurbishment plan. The owner told us that necessary maintenance work was completed at the home. However they told us we needed to check invoices to see that maintenance work had been completed. A maintenance audit was not in place to demonstrate which maintenance issues had been addressed and whether any maintenance issues were outstanding.

The service was a member of the Care Homes Association (CHA) and received regular updates on policy changes and latest developments in care home best practice. The provider had purchased training materials endorsed by the CHA. The provider was working with the Sussex Partnership NHS Foundation Trust for Care Homes In-reach team which

Requires improvement

Is the service well-led?

provided them with information and teaching sessions on best practice in dementia care. At the time of the inspection this work was on-going. Staff told us about ideas they had to develop meaningful activities for people living with dementia, yet some of these ideas were yet to be implemented in practice. The registered manager kept informed with latest development in the delivery of health and social care in order to improve their service. However, there was no service improvement plan to determine when the changes would be implemented at the home.

The registered manager told us that they spot checked staff providing care to people to ensure they maintained essential standards of care delivery. However these spot checks were not recorded to demonstrate they took place and what action was required where any shortfalls in staff care delivery may be identified.

The lack of adequate audits to identify shortfalls in care delivery and service quality, and the lack of service improvement plans to address shortfalls are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

The provider discussed the challenges they faced in ensuring people's fees were paid in a timely way from people's funding authorities. They told us about cases where people's fees had not been paid for a significant period of time. The provider told us they had discussed these concerns with representatives from people's funding authorities. In some cases they had made referrals to the Court of Protection to review how decisions should be made in respect of people's finances, in their best interests. However they told us this was a lengthy process. The Court of Protection was set up under the Mental Capacity Act 2005. It can make decisions as to whether people have capacity in relation to particular decisions, appoint or remove people who make decisions on people's behalf and makes decisions relating to Lasting Power of Attorney. Although the provider had made some effort to resolve these problems they had not made formal complaints to people's funding authorities to ensure people's financial matters and payment of fees were prioritised. A lack of fees paid had a direct financial impact on how the provider could effectively manage the operational running of the home and the financial viability of the service.

The service held a current Food and Hygiene Certificate at the highest possible rating level of 5 on 24 November 2015. We observed the kitchen was clean and well maintained.

The culture of the home was welcoming and the staff were focused on the people they care for and there was a sense that staff cared for and respected people. The registered manager and owner were passionate about providing care to people in a compassionate and caring way. Staff told us about their vision and values. They told us, "I want to make people feel comfortable, promote their independence and encourage people to do as much for themselves as possible." The staff took action to make sure the philosophy of care was promoted in practice.

Staff team meetings were held regularly to discuss the running of the service. Staff contributed to the agenda and were able to speak freely. Records of these meetings showed that staff were reminded of particular tasks and of the standards of practice they were expected to uphold. Staff talked about people's care and support needs in these meetings. For example an incident had occurred where someone fell between the gap by their bed. This led to the person's bed being replaced for a more suitable design and the bed was moved to a more suitable position to reduce the risk of falls and this had been implemented.

The registered manager consistently notified the Care Quality Commission of any significant events that affected people or the service. Records indicated the registered manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment had not been consistently provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— A assessing the risks to the health and safety of service users of receiving the care or treatment; B doing all that is reasonably practicable to mitigate any such risks; C ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; D ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; E ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. G the proper and safe management of medicines; H assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; I where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes were not adequately established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. C maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; E seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services F evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e)