Acorn Health Care Limited

Acorn Lodge

Inspection report

Turners Hill Road
East Grinstead
West Sussex
RH19 4LX

Tel: 01342323207

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Acorn Lodge is a residential care home providing personal and nursing care for up to 40 people, the majority of whom have a diagnosis of dementia; some have mental health needs and frailty of old age. At the time of the inspection, 37 people were living at the home. The home accommodates people in one adapted building.

People's experience of using this service and what we found
Activities were not designed specifically for people living with dementia. Care was not always delivered in a person-centred way by staff. Some actions had been taken to arrange the environment in a way that was dementia-friendly.

Care people received was not consistently good. People were not always treated with dignity and respect.

There was a strong smell of urine in one part of the home which was persistent throughout the day. After the inspection, the manager sent us a copy of cleaning schedules and how the problem was being addressed.

Audits had not identified the issues that were found at inspection. Personal information about people was not always kept confidentially. Whiteboards in people's bedrooms charted detail about people's continence needs and whether they should be resuscitated or not. After the inspection, the manager informed us that these whiteboards had been removed pending a decision on how information should be managed in people's bedrooms.

Records relating to Lasting Powers of Attorney and the authority to make decisions with regard to property and finances or health and welfare were not always accurate. During the inspection, the inaccurate records were removed from people's care plans.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The management team understood their responsibilities in relation to providing the regulated activity. Staff felt supported by the management team. People and their relatives were complimentary about the home and the care provided.

Staff completed a range of training to enable them to support people in line with their care and support needs. They had regular supervisions and attended staff meetings.

People enjoyed the food on offer. They had access to a range of healthcare professionals and services. People were safe living at the home. Risks were identified, assessed and managed safely with guidance for

staff which was followed. Staffing levels were sufficient to meet people's needs. Medicines were managed safely.

Care plans provided detailed information about people, their likes, dislikes and preferences. People's wishes for the end of their lives were recorded in their care plans. Complaints were managed in line with the provider's policy.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at the last inspection
The rating at the last inspection was Good (published 5 January 2017).

Why we inspected
This was a planned inspection based on the previous rating.
We have found evidence that the provider needs to make improvements. Please see the Caring, Responsive and Well-Led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Acorn Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Acorn Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The registered manager was on leave at the time of the inspection. They were due to leave the service. A new manager had been recruited and was in the process of registering. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 13 people and seven relatives. We spent time observing the care and support people received. We spoke with two directors of the provider, the manager, deputy manager, a senior care worker and another care worker who was also the activities co-ordinator. We reviewed a range of records. These included four care records and multiple medication records. We looked at two staff files in relation to recruitment and supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
Following feedback, the manager sent us additional information in relation to issues that were discussed at inspection. This included actions that had subsequently been taken, two recreational and social activity care plans, cleaning schedules, and a list of additional evidence the provider felt met CQC's criteria for an 'Outstanding' rating.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The home provided a safe environment for people. People were protected from the risk of abuse by staff who had been appropriately trained.
- People and their relatives told us they felt the home was a safe place.
- Staff knew what action to take if they suspected any form of abuse. One staff member said, "It's our duty of care to make sure residents are safe in every area. Any hazard, we have to make sure the environment is safe for them. If the resident cannot express themselves verbally, we look at body language. If I see something, I will not keep quiet. I will go to the nurse in charge or the manager. If not them, then the local authority".
- The management team understood their responsibilities under safeguarding and the need to notify CQC of any abuse or allegations of abuse, in addition to informing the local safeguarding authority.

Assessing risk, safety monitoring and management

- People's risks were identified, assessed and managed safely.
- A visitor of one person explained their friend had become too unwell with dementia and now needed support in a residential setting. The visitor told us that they had not seen their friend for three months and told us they were, "overwhelmed" with the change in their friend and, "how well they looked". The visitor added that the person had now put on weight and felt they were not now at risk as they no longer lived independently.
- Risk assessments were detailed and relevant to each person living at the home. For example, one person was being nursed in bed to relieve a pressure wound that had developed. This person's risks had been assessed taking account of their double incontinence and the effect this had on their skin integrity. Advice and guidance had been sought from a tissue viability nurse who regularly assessed the wound, as did the nursing staff.
- Other risk assessments for people related to falls, access to call bells, smoking and activities of daily living.
- Personal emergency evacuation plans informed and guided staff on the actions and support required by people should the premises need to be evacuated in the event of an emergency.
- Staff were trained in fire safety and weekly fire drills took place. The fire alarm was tested on the day of inspection and staff went round to people to alert them that the alarm bell would sound and this was a practice.

Staffing and recruitment

- There were sufficient staff to meet people's needs. Where people were unable to use their call bells, staff carried out regular checks on them. For example, on the first floor, several people chose to remain in their

rooms. Staff made regular checks and signed when these had occurred. One staff member explained they had a chat with people and that they were happy. One person liked watching television in their room and another person enjoyed listening to audio books or having a book read to them.

● Staff felt there were enough staff on duty, but that it took time to explain working practices to new staff or agency staff. One staff member said, "If we have the permanent staff, it's fine because we know people. When we have agency, it takes time. Sometimes agency aren't trained in the same way and we have to show them".

● Staffing levels were assessed based on people's support needs and dependency levels.

● New staff were recruited safely. Staff files showed that all appropriate checks had been made before new staff commenced employment. These included checks with the Disclosure and Barring Service which considered the person's character to provide care. References were obtained and employment histories verified.

Using medicines safely

● Medicines were managed safely and audits were effective.

● People told us they received their medicines as prescribed. We checked one person's care plan, their health needs and their prescribed medicines; all were in order and their medicines were regularly reviewed by their GP.

● Registered nurses administered people's medicines and their competency to do so was checked.

● Medicines were stored in a medicines room on the ground floor and dispensed from a medicines trolley. Medicines that were to be taken 'as required' (PRN) were administered in line with the provider's policy. Medication administration records were completed to show why a particular medicine was administered and whether it was effective.

● Where people had a health condition, for example diabetes, their blood sugar was monitored and recorded, so the appropriate dose of insulin could be administered.

Preventing and controlling infection

● People were protected by the prevention and control of infection. Staff had completed training in infection control. Staff used personal protective equipment as needed.

● In one particular part of the home on the ground floor, there was a strong smell of urine which came from one person's room. The smell was evident throughout the day. We discussed this issue with the manager and directors.

● Other parts of the home were kept clean and smelled fresh.

● The manager stated that they undertook daily checks around the home and that no unpleasant odours had been detected.

Learning lessons when things go wrong

● Lessons were learned when things went wrong.

● For example, CQC was made aware of two issues which were raised anonymously. These concerns were shared with the local safeguarding authority, but were found to be unsubstantiated. As part of the investigation, the registered manager took action in relation to catheter management and care which was shared with staff; these were noted as minor concerns.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs

- The home had made some adaptations to meet the needs of people living with dementia.
- People living with dementia often find 'landmarks' around the home to be helpful to navigate their way around and promote independence and choice. These landmarks could be with clear signs where there is a good contrast between text and background. Some signage had been used, such as for bathrooms, toilets and bedrooms. Hand rails along corridors were of a darker colour. In line with best practice for people living with dementia contrasting colours could be used to help sharpen the environment and highlight areas such as floors, walls and stairs.
- For example, in the dining room we saw blue plates on blue trays, dark plates on dark mats, white plates on light mats. This lack of contrasting colours could make it more difficult for people living with dementia to eat independently. Whilst contrasting colours were available, staff did not use these on the day of inspection. For example, a white plate should be placed on a dark mat, so people can identify the edge of the plate and the mat.
- Rooms were personalised according to what people wanted. We saw pictures, stuffed toys and photos that people had chosen to furnish their rooms.
- All parts of the home were accessible. There was a lift and stair lift to the first floor and a ramp to the garden.

Ensuring consent to care and treatment in line with law and guidance

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 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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Consent to care and treatment was gained in line with MCA and DoLS guidance.
- People had been assessed where it was thought they lacked capacity to make specific decisions. One staff

member explained, "Generally when we do an assessment, we see if a person has capacity or not. People could have dementia or short-term memory loss, but they might still be able to express their needs and have capacity to make decisions. Someone with advanced dementia can't always do this, so staff act in their best interests".

● Some records relating to Lasting Powers of Attorney (LPA) were not always accurate. Where people have capacity, they may appoint a relative or another person of their choice to make decisions on their behalf. LPAs relate to property and financial affairs and/or health and welfare. Some relatives, or appointees, had given their consent when they did not have the appropriate LPA to do this. For example, one person's relative had an LPA with regard to property and affairs, but they had signed consent with regard to a medicines issue, which is a health and welfare decision.

● After the inspection, we received an email from the manager which stated that all consent forms had been removed from people's files where their relatives or appointees did not have the appropriate LPA to make particular decisions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

● Before people came to live at the home, their care needs were recorded and pre-assessments were completed.

People's care and support needs were discussed with relatives and professionals to ensure the home was suitable for them.

● People's care was continually reviewed to ensure the support they received was appropriate and current. For example, one person had poor teeth and required a fork mashable diet. A referral had been made to a dietician who, in addition to advising on diet, had recommended a food supplement. Staff assisted the person to eat well. This meant that the person's weight was maintained and their risk of malnourishment had been reduced.

Staff support: induction, training, skills and experience

● Staff completed a range of training relevant to their role and specific to people's needs. This included mandatory training on moving and handling, safeguarding, mental capacity, challenging behaviour and dementia awareness. Some training was delivered face-to-face and other training was accessed on-line.

● One staff member told us they found the training about dementia awareness useful. They said, "It's helpful to understand what dementia might mean to a person. You have to give people time to answer. One person will say 'no' to a drink when you ask them, but if you leave it, they will drink it".

● Staff were encouraged to study for additional vocational qualifications. One person told us they were studying for a Level 2 qualification in health and social care and were hoping to progress higher. The staff member said they were given time to study and felt supported. They said, "Everyone on the team is very encouraging".

● People felt that staff were well trained and equipped to do their jobs well. One person commented that the home suited them and that staff were well-trained to support their needs. We observed that staff had the necessary skills and were competent to support people effectively.

● Staff told us they received supervision with their line managers every two or three months and records confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to eat and drink enough to maintain a balanced diet.

● People told us they had a choice of menu at mealtimes. One person said they liked the meals and added, "The cook does a very nice chicken in sauce". A relative told us there was a lot of variety and choice with the meals on offer and were complimentary about the cook. They said they were particularly impressed with

the food made for the summer garden party.
● We observed the lunchtime experience and people chose where they preferred to eat their meal.
● Where people required assistance with their food, or were at risk of choking, staff provided appropriate support. We observed a member of staff reposition one person to make them comfortable before assisting them with their lunch. The staff member explained what was on the plate, assisted the person to put on an apron and then arranged the plate so it was close to the person. The staff member placed a drink close-by and then asked the person if they needed anything else before removing the protective cover from the plate of food. This was nicely done.
● We observed people had drinks readily available and staff offered drinks to people from a trolley which was wheeled around at various points during the day.
● Special diets were catered for and care records detailed any allergies or nutritional needs. For example, one person required a gluten-free diet as they were intolerant to gluten.

Supporting people to live healthier lives, access healthcare services and support
● People received healthcare support as needed from a range of healthcare professionals. Care plans showed that people had access to opticians, dentists, GPs and chiropodists for example.
● A relative explained the support their family member received from healthcare professionals. They told us the GP had visited last week about a particular health concern. The relative added that staff had organised a replacement pair of spectacles when the person had lost their original pair. A dentist had been visited following the loss of dentures, so a new set could be made.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity and respect.
- Care was not always delivered in a dignified or respectful way by staff to take account of people's needs, especially those living with dementia.
- We observed one person became quite upset having asked staff to assist them to the toilet. The person made two or three requests to staff for help. The delay in providing the assistance was caused because two staff were needed to fully hoist the person from their armchair to a wheelchair, before taking them to the toilet. However, no-one explained to the person that they might have to wait for staff to become available nor was any reassurance provided. We discussed this incident with the management team who assured us they would look into this further to prevent reoccurrence.
- At lunchtime, whilst some staff were engaged in conversation with people when assisting them with their food, other staff were task orientated. For example, we saw two staff supporting two people with their lunch, but the only conversation was instructional, such as, "Open your mouth".
- One person indicated to staff assisting them they did not want any more of their lunchtime meal. The staff member supporting them scooped up what was left on the spoon and held it up to the person's mouth, told them to open their mouth and fed them. They ignored the person's comment that they had eaten enough.
- We visited one person in their room on the first floor at 1.05pm. We observed the person had been incontinent and asked them if they would like us to summon staff help. The person indicated they would not. At this point a staff member entered the person's room to ask if they would like a drink; they did not notice that the person had been obviously incontinent . Five minutes later, we walked around the first floor to seek assistance, but no staff member was around. We then went to the ground floor and sought help. A member of staff was sent to change the person's clothes.
- We discussed this issue with the management team at the end of the inspection. In an email later, the manager stated that two hourly checks were made for people living on the first floor. There was an entry at 11.25am when the person was offered a drink and all was well. At 12.30pm, the person was given their lunch and they were not incontinent at this time. Staff said they would have noticed if the person was incontinent and would have supported them. Nevertheless, we observed the person had a wet patch at 1.05pm and the staff member who offered them a drink soon after did not spot that they needed a change of clothes.
- A noticeable odour on the ground floor was evident near one person's room throughout the day. The manager told us the person could leave wet and soiled clothing in the wardrobe and urinate and defecate on the floor. Since this was carpeted the odour could be retained. Staff were aware of these behaviours and checked the room regularly. Nevertheless, the smell could not have been pleasant for people whose rooms were in the vicinity. The manager sent us a copy of cleaning schedules which showed that people's rooms

were cleaned daily, or more often if required.

People were not always treated with dignity and respect. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A 'dignity tree' had been placed in the entrance hall with paper leaves affixed; this was an activity in response to a recently organised 'dignity week'. People and relatives had written various comments about the home and staff, describing the latter as 'kind' and 'caring'.
● We observed staff knocking on people's doors and waiting for a response. One staff member explained how they would always knock on people's doors before entering and say their name. They told us they would chat with people and explain the reason for calling on them. The staff member said they would wait for people to consent before providing any personal care, shut the door and draw the curtains. They added, "Some people are independent and some people want to wash themselves whilst others need help".
● Two people shared a bedroom and had done so for many years. Staff told us that one person used a commode. At night, a screen was placed across the room to afford people privacy.

Ensuring people are well treated and supported; respecting equality and diversity
● People were treated well and supported appropriately by staff who understood people's diverse needs.
● People's religious needs were respected. For example, staff were reminded to inform one person when a member of the clergy came to visit so they could choose whether to attend the religious service at the home. This person could also speak German fluently, so one staff member spoke this language with them.
● Staff told us of one person who was Jewish and prayers were delivered in Hebrew as the person passed away. This had been important to them.
● Staff knew people well and how to support them. Contact by staff with people was observed to be kind, warm and caring. Staff had time to spend and chat with people.
● We overheard the new manager introducing herself to one person in their room and the conversation that followed. This was done in a sensitive, appropriate manner.
● A relative told us they could not fault the home and particularly praised one member of staff. The relative felt staff knew how to care for people and they did this with a smile. Another relative was enjoying tea with their family member. They told us, "The home often sets up tea and biscuits for us here in this spot". They added they had no concerns and felt their loved one was safe, well-fed and looked after.

Supporting people to express their views and be involved in making decisions about their care
● People were encouraged to express their views and to be involved in decisions about their care.
● We observed staff asking people what they would like to do and how they wanted to spend their day. For example, on the day of inspection the weather was very warm and a number of people chose to go out in the garden.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Activities were not designed in a way that took account of people's interests or, where relevant, their dementia.
- The National Institute for Health and Care Excellence (NICE) guidelines for dementia, published in June 2018, state that a range of activities should be offered to promote wellbeing that are tailored to people's preferences. Interventions should be offered to promote people's cognition, independence and wellbeing. The guidelines recommend activities such as group reminiscence and personalised activities to promote engagement, pleasure and interest. Staff should be advised on planning enjoyable and meaningful activities.
- One member of staff explained they had recently been asked to plan and organise activities for people and that they would be receiving training on this. In the meantime, they had tried to look at things people might like to do by exploring online, including how technology might benefit people. However, they were also engaged in caring duties during the day. For example, after breakfast they would be in the lounge until noon, with activities starting after 9am. We saw that some people were colouring during the morning. One person was given a colouring book and felt-tip pens, even though they told us they did not enjoy colouring. This person did not engage with the activity offered.
- Another person was given a 'rummage box' which was full of different types of lace and ribbons. However, the colours were all similar, with shades of white and peach, and had knotted up into a huge ball, so the person struggled to sort them out. At one point we saw the person trying to eat the end of a ribbon until staff noticed and intervened, removing the box from reach. The staff member then gave the person a biscuit to eat. Later this person was touching and feeling the tablecloth. A staff member kept smoothing down the tablecloth. We suggested the tablecloth be removed so the person could feel its texture and fold it up. This was done and the person appeared happy. However, later two staff members removed the tablecloth from the person's hands and returned it to the table. After the inspection, the provider told us that the colour and arrangement of the lace and ribbons were not relevant, since the person enjoyed the feel of the fabric.
- After the inspection the provider told us of a sensory room that was available. We were not made aware of this room during the inspection to be able to assess the impact this facility had on people's wellbeing.
- After the inspection, the manager sent us copies of two recreational, leisure and social activity care plans. These provided information about people's past lives and their interests. Whilst one plan stated the person enjoyed the activities on offer, the other plan provided little insight. For example, this person had lived abroad, enjoyed European holidays and was interested in knitting, quilting and sculpture. However, their weekly planned activities were identified as hand massage, lights and music, the reading of current affairs and music therapy. These planned activities were not personalised and did not reflect the person's interests or preferences.

We recommend the provider seeks advice and guidance from a reputable source on the provision of activities for people living with dementia.

● After the inspection, the manager sent us a list of outings that had been organised for people. These included lunch out at a local pub, visits to a garden centre and to the Bluebell Railway.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans recorded people's life histories, likes, dislikes and preferences.

Care plans were written in a person-centred way and provided detailed information and guidance to staff. For example, information was provided about people's personal hygiene, oral hygiene, continence and behaviours.

● People were encouraged to maintain relationships with their families and friends. Visitors were made to feel welcome at any time.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Communication care plans had been devised for people. These documented people's hearing and visual needs and how they communicated. For example, one person was able to express themselves verbally but could become frustrated if staff asked them to repeat themselves. Staff were advise to sit with the person, to make eye contact and to talk in a moderate tone. Staff were also advised to offer the person one piece of information at a time and to avoid asking too many questions.

Improving care quality in response to complaints or concerns

● Complaints were managed in line with the provider's policy.

● Complaints were logged and outcomes were recorded. The complaints policy was available to people in an audio format or in large print if required.

● People might share a complaint with their relative who would them inform the management team. For example, one person had complained they could not reach their call bell at night and this had been addressed.

End of life care and support

● People could live out their lives at the home, if this was their wish.

● No-one was receiving end of life care at the time of the inspection.

● People's end of life wishes and preferences were recorded for staff to follow as and when needed.

● 'Do Not Attempt Cardio-pulmonary Resuscitation' forms had been completed for some people. These showed that people, their relatives and healthcare professionals had been involved in decisions not to resuscitate them if they experienced a cardiac arrest.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- A system of audits had been implemented, but some audits were not always effective in driving improvement. Audits related to areas such as food hygiene, health and safety, infection control and care plans.
- Some audits had not identified the issues we found at inspection. For example, the inconsistency of records in care plans relating to consent and the noticeable smell of urine, particularly on the ground floor.
- Some records confirmed that a relative, or other person appointed, had a Lasting Power of Attorney (LPA), but a copy of the relevant LPA was not held on file. This was discussed at feedback on the day of inspection.

- An audit regarding choice and equality stated that people could practice what activities they liked in the home. This was not in line with what we found at inspection.
- Information of a confidential nature in relation to people's personal care and support was on display on their bedroom walls.

Audits were not effective in identifying issues to drive improvement. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- All the above was discussed with the management team at inspection and we have included the responses received from the management team and actions taken after inspection in this report.
- Notifications which the provider/registered manager were required to send to us by law had been completed.
- Staff meetings took place and dates were planned for the year ahead. One staff member explained that staff meetings were also used as training opportunities. Staff were always thanked by the management team and encouraged in their work. Any areas for improvement would be shared and ideas listened to on how these should be addressed.
- The registered manager was on leave at the time of the inspection. They were due to leave the service. However, a new manager had recently commenced employment and was in the process of registering with CQC.
- The home worked in partnership with others. The deputy manager was a member of West Sussex Partnership in Care and had recently won an award in relation to dementia care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Personal information about people was not always kept confidentially or in a sensitive way. We saw that details about people's care and support needs had been recorded on large whiteboards which were on display in their rooms. For example, information relating to people's continence care and whether or not they should be resuscitated had been recorded and was clearly visible when we went into people's rooms or from the corridor.

● We discussed this issue with the management team at the end of the inspection. The manager sent us an email after the inspection which stated that all the whiteboard charts had been removed from people's bedroom walls. The manager stated the management team would discuss what information was needed in people's bedrooms and how this should be managed to maintain people's dignity and privacy.

● Although we found issues in relation to dignity and respect and the provision of person-centred activities , relatives were complimentary about the home.

● The provider had organised a family support group that met every few months and prepared relatives for when people came to the end of their lives.

● In a recent audit, a family survey confirmed that 90 per cent were happy with everything. One relative had commented, 'Excellent service and help as always. Dad is well-cared for. Thank you from all of us'.

● The provider explained how they would support anyone with protected characteristics, such as people who had particular sexual preferences. Staff had completed diversity training to aid their understanding and care plans included people's preferences in this regard.

● Staff felt supported by the management team. Staff spoke of the organisational values and the importance of being kind to people and keeping them safe. One staff member said, "It is a rewarding job" and felt the management, "were doing their best". Another staff member told us they enjoyed working at the home and that their working hours could be organised flexibly. They said, "You can communicate with [named provider]. If I have a concern, I will express it and they will act if needed".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The management team understood their responsibilities under duty of candour. They explained the need to be open and honest and to inform relatives of any incidents or accidents happening at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect by staff. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective in auditing the service to improve the quality and safety of the services provided or to drive improvement. Regulation 17