New Century Care (Bognor Regis) Limited

Aldwick House Care Home

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced and took place on 16 and 17 February 2015. At our previous two inspections we found concerns with medicines management. At this inspection medicines, on the whole were ordered, given and recorded safely.

Aldwick House Care Home is a 32 bedded nursing home that provides care and support to older people with living with dementia and/or related mental health conditions and/or general care. At the time of inspection there were 27 people living at the home. The manager told us that everyone who was living at the home had a diagnosis of dementia and that this was their primary need.

During our inspection the manager was present. The manager had submitted an application to register with the Commission and this was being processed at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. Despite this, we found that risks to people had

Summary of findings

not always been managed safely. Immediate action had been taken when people sustained injuries but care plans and assessments were not always updated to reflect changes in needs.

Although the majority of people told us that they were happy with care they received we found that some people did not receive care and support that they needed to meet their individual needs. At times staff did not respond appropriately to people's individual needs. This included pressure area care and dementia care.

Staffs understanding of the Mental Capacity Act 2005 (MCA) and of the Deprivation of Liberty Safeguards (DoLS) varied despite having received training in these areas. People's representatives had not always been involved in decision making processes when people lacked capacity to consent and DoLS applications had not always been made to ensure people's human rights were upheld.

Most people said that the food at the home was good. There was evidence of people being offered choices in relation to food and drink but this did not include visual assistance that would have helped people living with dementia. Some people did not get help to eat their meal safely.

We heard staff speaking kindly to people and they were able to explain how they developed positive caring relationships with people. However, on occasions people were not treated with kindness and respect.

People said they were happy and comfortable with their rooms and we saw that they were attractively decorated with some personal touches including photographs and memorabilia. However, some elements of the environment didn't lend themselves to assisting the needs of people living with dementia.

People who lived at Aldwick House Care Home, relatives and staff told us that there were, on the whole enough staff on duty to support people at the times they wanted or needed.

Staff said that since the manager had been in post the support they received had improved. This had been provided both on a one to one basis and in groups. Training was provided during induction and then on an on-going basis. A training programme was in place that included courses that were relevant to the needs of people who lived at Aldwick House Care Home.

The manager had re-instated regular residents/relatives meetings in order to support people to express their views and to be involved in making decisions about their care and support. Records were in place that showed that where concerns or complaints had been raised, the manager had responded to these on an individual basis in writing. The findings from individual complaints were incorporated into the providers monthly complaints audit in order that trends could be identified and action taken if necessary.

People said that the home had been through a period of instability due to a lack of consistent management. The home had been run by three different people in the last twelve months. They said that since the end of November 2014 when the manager had been in post management of the home and the quality of service people received was improving. Everyone said that communication had improved since the manager had been in post and that a positive, inclusive culture was being developed. One relative explained, "Moral was low, staff left, everyone was talking about it. We saw a severe drop in the service. The manager has picked it up and things are starting to feel calm whereas they weren't before. People living here sensed all was not ok. Since the manager has been here staff seem happier. She has taken control. I think she is quiet realistic and honest. Never promises something if it can't happen. Residents and staff seem happier now".

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to people had not always been managed safely.

Staff understood the importance of protecting people from harm and abuse. Medicines were managed safely.

There were enough staff on duty to support people at the times they wanted or needed.

Requires Improvement

Is the service effective?
The service was not effective.

People's care needs were not always managed effectively.

When people did not have the capacity to consent suitable arrangements had not been made to ensure decisions were made in their best interests. Deprivation of Liberty Safeguards (DoLS) as applications to deprive people of their liberty had not been made. Therefore people's rights were not protected.

People were cared for by staff who received support to do their jobs. A thorough training programme helped staff to gain the skills and knowledge needed to care for people.

Inadequate

Is the service caring?
The service was not caring.

People were not consistently treated with consideration, dignity and respect.

People exercised choice in day to day activities throughout the day. Meetings were held so that people could express their views about their care and the home.

Requires Improvement

Is the service responsive?
The service was not responsive.

At times staff did not respond appropriately to people's individual needs.

People and their representatives had opportunities to give their views about the service they received. They felt able to raise concerns and the provider responded appropriately to any issues people raised.

Requires Improvement

Is the service well-led?
The service was well-led.

The quality monitoring systems were in the process of being reviewed to ensure that prompt action was always taken to address shortfalls in the quality of the service provided to people.

Good

Summary of findings

The manager promoted a positive culture which was open and inclusive. The manager was committed to ensuring her knowledge and management skills were current. Staff felt well supported and were clear about their roles and responsibilities.

People, their relatives and staff were able to contribute their ideas about the service and they felt listened to.

Aldwick House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place on 16 and 17 February 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience who had experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the first day of our visit a pharmacy inspector also took part in the inspection process to specifically look at medicines management due to compliance actions that were set at the previous two inspections.

Before the inspection, we checked the information that we held about the home and the service provider. This included statutory notifications sent to us by the provider about incidents and 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 also reviewed comments that we had received from West Sussex County Council Adult Services and information of concern from members of the public. We used all this information to decide which areas to focus on during our inspection.

We spoke with eight people who lived at Aldwick House Care Home and five relatives. We also spoke with two care staff, a housekeeper, the chef, the area manager and the registered manager. The majority of people who lived at the home were living with dementia at different stages. Many of these people were unable to hold long conversations with us. We had to keep questions at a basic level that only required a yes or no response coupled with observing facial expressions and body language.

We observed care and support being provided in the lounges and dining areas. We also spent time observing the lunchtime experience people had. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included care records and medicine administration record (MAR) sheets for six people and other records relating to the management of the home. These included staff training, support and employment records, quality assurance reports, policies and procedures, menus and accident and incident reports.

Aldwick House Care Home was last inspected on 30 April 2014 when a compliance action was set for medicines management.

Requires Improvement

Is the service safe?

Our findings

People said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. One person said, "I'm not frightened". We saw that many people nodded and smiled as staff approached them and we didn't observe anyone showing fear or distress with any of the staff. A relative said, "I come in everyday not because I feel I have to but because Mum is my Mum but I know if I don't she is safe and well looked after." Another relative said, "I would know straight away if she was frightened of anyone, I only have to look at her face".

Although people told us they felt safe we found that risks to people had not always been managed safely. Risk assessments were in people's care records on areas that included moving and handling, falls, behaviour and skin integrity including pressure sores. Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. One person sustained an injury during the night. They were taken to hospital for treatment. Night staff informed the manager who was on call for emergencies. The manager went to the hospital to support the person and meet with their relatives. However, people's individual care and support records were not always reviewed when incidents occurred to help keep them safe and in some instances when they were reviewed they were not accurate. One person had two falls, one in December 2014 and another in February 2015. Their falls risk assessment stated they were high risk and this had not been reviewed following either fall. Their care plan stated they were assessed as a medium risk and this had not been updated to reflect the risk assessment rating of high risk. The care plan had been reviewed on 10 February 2015 but no changes had been made in reference to the level of risk or the fall in December.

We observed one person in the garden smoking. This person's records included a smoking risk assessment which said the person should always have one to one support when in the garden and that they were a high risk of falls. The person was not supervised in the garden. Therefore, they did not receive support to manage a known risk area.

Staff were able to describe how they supported people who were living with dementia and who at times needed support with behaviours. They told us, "We clear things around her, walk away and come back when she has calmed down, we don't use restraint". Both staff said that had training in managing behaviours. This person's care plan did not include any information about their behaviour, how staff should respond and no monitoring of triggers and/or behaviour to help staff assess helpful responses and positive actions and in the event of refusal, steps to take to support people who may refuse.

All of the above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. One member of staff explained, "Abuse can be physical, sexual and mental, physical and mental are the main ones as you can do a lot of damage to people". They told us the signs they would look out for were, "Agitation, lack of appetite, withdrawn or the opposite, if I were concerned I would go to the manager or CQC".

The manager was able to explain about when to report concerns and the processes to be followed to inform the local authority and the CQC.

Hoists were used where needed to ensure that people were moved safely and staff were able to describe safe moving and handling techniques. One member of staff said, "We use a sling and hoist and slide sheets, we don't pick people up, we check dates on the hoist to see if it has been checked and is up to date". Another member of staff said, "When they come in we are told what they can do, each person has a sling for transfers with their name on it, and manual handling training is done by the night nurse or in the home in Southampton". We observed two staff supporting a person to move safely from a wheelchair to an armchair in the lounge using a hoist. They did this safely and explained the process to the person, telling them what was happening and provided reassurance.

At lunchtime we saw two staff woke a person who was sleeping in a lounge chair in order to go to the dining room. The staff tried to get the person to use their walking frame. There was a staff member either side of the person supporting them under their forearm and then the area manager entered the room and pushed the person up from under their bottom. The person did not want to get up. This was all done within seconds of the person waking up, staff

Requires Improvement

Is the service safe?

did not take the time to check what the person wanted before trying to get them up. It was also an unsafe moving and handling practice as the person was not prepared for the lift, and was resisting.

People who lived at Aldwick House Care Home, relatives and staff told us that there were, on the whole enough staff on duty to support people at the times they wanted or needed. A member of staff said, "Yes I think there are enough staff, same amount at weekends and most people are not in their rooms". A relative said, "Staff levels and consistency is important. The manager has done good work in this area". People told us that since the manager had been in post staffing had improved and agency staff were used to cover vacancies and shifts that permanent staff did not want to undertake. A member of staff said, "We haven't run short for quite a while now. When we say we are short they say – get agency".

Staffing levels consisted of five care staff and one nurse during the day from 8am to 8pm and three case staff and one nurse during the night. In addition to this domestic, cleaning, kitchen, maintenance and administrative staff were allocated to shifts so that care staff were able to focus on supporting people with their needs. An activity person worked four afternoons from 1pm to 5pm. The manager, who was also nurse qualified was supernumerary to the allocated staffing levels. Since the manager had been in post the deployment of staff in the building had changed to benefit people who lived at the home. Staffing was organised so that two care staff worked on the first floor and two on the ground floor and another staff member available to answer bells and work between the floors. The routine had been changed so that people in bed had breakfast first and then personal care. A staff member said this had helped because otherwise people in bed were having breakfast shortly before lunch time. The provider had a formal dependency assessment tool for deciding safe staffing levels but the manager had not used this since being in post. However, the manager showed us documentary evidence of pre-admission assessments that she had completed for people who wanted to move into the home but which she had declined. The manager explained, "It's not just about filling beds and finances". She explained that she had not offered some people a room at the home as she knew they would not be able to meet their needs and that staffing levels would not allow this. This showed a commitment by the manager to ensure staffing levels met people's individual needs.

Medicines were ordered in a timely fashion for continuity of treatment. There were systems in place for ordering and disposal of medicines. People's preferences on how they liked to take their medicines were recorded on the profile sheet at the front of each Medicine Administration Record (MAR) chart. We watched medicines being given to people. One person who preferred to wake up later in the morning was given their medicines after they woke up. A system for counting and recording medicines remaining in stock was not always filled in and was not always accurate. We counted a sample of medicines and compared amounts left against the expected amounts taking into account the amount administered. We found that for all medicine stocks we counted the amounts were correct. Hand written MAR charts were checked by a second person for accuracy before commencing their use.

Recruitment checks were completed to ensure staff were safe to support people. Four staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. The home had used agency staff to cover shifts. At the start of our inspection there was no documentary evidence for agency staff that confirmed that their employer had completed checks to ensure they were safe to support people. The manager acted upon this immediately and the required records were obtained by the end of our visit.

Inadequate

Is the service effective?

Our findings

The majority of people said that they were happy with medical care and attention they received. One relative said, "Back last summer we didn't think Mum was going to be here but they cared for her so well. Even at night they sat with her and nursed her. She's even better now than she was before, she's bubbly and talking". Another relative said, "Her skin started breaking down and they got onto it straight away. The dietician was involved too and there is such strong support". A third relative told us of concerns they had about the care their family member received in May 2014.

Although the majority of people told us that they were happy with care they received we found that some people's care needs were not managed effectively. On occasions people did not receive care and support that they needed to meet their individual needs. When spending time with one resident and their relative we observed that the person was scratching themselves incessantly. The relative got quite upset about it and told us, "She's supposed to have cream". At this point we rang the call bell which was out of reach of the person. The bell was responded to promptly and a member of staff came. The relative explained about the scratching. The member of staff said that the person should have had some cream in their room but none could be located so the member of staff said he would go and speak to the nurse on duty. After about 10 minutes a domestic was walking past so the relative mentioned it to her too. The domestic again said they would go and ask the nurse. After another 10 minutes the domestic came back and she couldn't find the nurse. The wait went on and after 20 minutes no one had come back to explain what was happening. By this time the resident had fallen asleep. The original member of staff who came to the person's room later told us that the cream had run out and was on order. At 6pm we visited this person again and found that their skin had not been creamed and that they were very distressed. Records confirmed that the person had not had cream applied to their body for a week. We observed a jug of juice was in the person's room but that they could not reach it. Due to the person being so distressed we called the manager who made arrangement for lighter bedding to be put on the person in order to try and alleviate their discomfort. We offered the person a drink from a cup with a lid and they were able to drink this independently. The manager told us that there were no over the bed trays that could be used in order that the person could access their drinks independently. Within 24 hours of our inspection we received written confirmation from the provider that informed us that they had been in contact with West Sussex Adult Services safeguarding team. They had indicated that the manager should investigate and act on any findings. The provider also informed us that measures had been put in place to ensure skin care was provided in a timely manner.

On another occasion we were talking to a person who lived at the home who said, "I've got tummy ache I need the loo". We called over a member of agency staff whose first language was not English. The member of staff asked the person what they needed and the person said, "I want to go to the loo". The member of staff did not check the person's response and did not appear to understand what the person was asking. We had to intervene twice before the member of staff responded appropriately to the persons request to go to the toilet.

Two people had pressure wounds. There were no care plans or photographs and measurements of the wounds that could be used to monitor that people were receiving effective treatment. NICE guidelines were not being followed for effective wound care management. The nurse on duty told us that they were going to write the care plans that day. They could not explain why they had not been written by the nurses on duty who identified the wounds on the days they developed. This meant that people's needs were not being assessed, planned and delivered effectively.

Other people had care plans in place for identified needs that had been reviewed monthly. Some plans were detailed and informative and gave good information for staff to follow to meet people's needs. Most review comments said 'no changes'. However we found several examples of where care plans had not been reviewed and updated or accurately reflected people's needs or the care that was delivered. One person's care plan stated that they were living with dementia (vascular) and anxiety. Their care plan stated they suffered short term memory loss, communication difficulties and depression. The plan had been reviewed monthly but not updated since November 2013. Support identified included that the person should be encouraged to take part in activities as this was important in the treatment of dementia. However, the activities care plan dated November 2013 stated 'it would

Is the service effective?

be updated as we learn more about X and her interests'. Although the activities care plan had also been reviewed monthly it had not been updated with any further information about the person in over a year despite the care plan being aimed at preventing isolation and getting to know the person. Two people were prescribed 'when required' medicine for epilepsy. Neither had a protocol or care plan in place that described how the medicine should be used if the person had a fit.

Most people said that the food at the home was good. We observed the lunchtime experience. Lunch was organised by using coloured trays for people who required assistance and those who did not. This helped ensure people retained independence or received support if needed. Most people had their lunch in the lounge and dining area. The dining area afforded minimal seating in proportion to the number of people who lived at the home. This meant most people were served their lunch on individual tables in the lounge area. We saw one person whose table needed pulling closer to them in order that they could manage their meal more effectively. Staff did not notice this and as a result they ate very little of their meal. We observed another person who was struggling to eat and their fork was empty when they put it in their mouth. Staff occasionally prompted the person as they passed but the person did not start eating for some time. There was a long gap of 15 minutes before the person started to eat by which time their lunch appeared cold. This meant that some people did not have the assistance they required to enjoy lunch in a timely way. One person who was being cared for in bed was not supported to eat safely. Their care plan stated 'Should not be put to bed if he has food or fluids in mouth' and 'should be sat upright'. This person was lying in bed when the meal was served and staff did not attempt to put them into a safe position for eating their meal that was being given by a relative. We drew this situation to the attention of the manager who immediately made arrangements for the person to be positioned appropriately. Other people were able to eat independently and appeared to be eating well.

All of the above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Within 24 hours of our inspection the provider informed us that 'Full wound care audit has been commenced – all care plans, wound record charts will be audited and reports acted on. With the specific issues identified by CQC an incident form has been completed and investigation commenced to ensure lessons learnt and any other development needs of staff identified'.

People told us that they were happy with the support they received to maintain good health. A relative said, "Dads not too well at the moment but this is the first time in two years so that says a lot about how well they look after him". Staff looked at people's body language and facial expressions to help decide if people who could not tell us due to their dementia were in pain. There was a formal, nationally recognised pain assessment system in place that staff used to ensure people received pain relief medicines when they needed them. One person with a pressure wound had a care plan in place and other records that demonstrated this was being managed effectively. A referral to the tissue viability nurse had been made and a pressure relieving mattress was in place. The person told us that that they were happy with the care they had received to manage the wound and that their needs had been met.

Staffs understanding of the Mental Capacity Act 2005 (MCA) and of the Deprivation of Liberty Safeguards (DoLS) varied despite having received training in these areas. One member of staff said, "MCA makes you think more about what you are doing and different approaches when people can't make a decision. I do trial and error, if they can't say what they like, you might have information to try something else of if not just try it, also I coax and encourage and try to build up trust". They gave me an example of how they had encouraged someone to have a bath and said, "Now she loves her bath". Another staff member told us how important it was to keep the external doors locked; they did not know what DoLS was. The manager told us that one of the nurses employed at the home completed MCA assessments for people. The manager said, "No one is restrained". When asked about the use of bed rails the manager had not identified these as a possible restraint. There were bedrail benefits assessments in place for people but they did not include consideration of people's mental capacity to consent to their use or of best interest decision making processes having been followed in line with the MCA. We were informed that restraint, freedom of choice and consent would be discussed with staff within their next supervision. Within 24 hours of our inspection the provider supplied documentary evidence that further MCA training was going to be provided to all staff.

Inadequate

Is the service effective?

People's representatives had not always been involved in decision making processes when people lacked capacity to consent. One person had a DNACR which stated they did not have the capacity to consent. It also stated the person had no relatives so it was signed and agreed by staff and the GP. However, the care plan for the person stated they had two relatives and that they should be kept informed of any changes and were involved in the person's care. The person's care plan also stated that they lacked capacity to make decisions regarding on-going treatment and end of life care and their relative should be involved in any decisions regarding this. The person had a mental capacity assessment regarding their medication regime and this concluded that a best interest meeting was required as the person lacked capacity. However, the best interest meeting section was not completed so it was not evident this process had been concluded. This meant that the persons representatives had not been involved in the decision making process regarding treatment and therefore was not able to act on their behalf.

We spoke to the manager about how they had responded to the changes in requirements for DoLS assessment and application in light of a recent Supreme Court Ruling. They told us that when they came into post some applications had been made by the previous manager. The manager had carried out an audit of applications but had not progressed beyond that. The manager was aware of the recent changes and described these as, "Just because someone appears to be settled doesn't mean they don't require a DoLS application". However they accepted they needed further information and help to understand the DoLS system. The manager had completed some DoLS training but they said this was "basic" and aimed at care staff. They said, "I am going to book myself and the nurses on the manager level training". The manager said they had also asked for help from a DoLS team assessor who visited a person at the home and they had agreed to help them. The manager said there were 14 applications that still needed to be made". Of the applications that had been made by the previous manager, two had been rejected and this was because the person had capacity. Another person was recorded on the audit as having capacity, but a DoLS had been previously authorised. The manager said the person did not have capacity. It was apparent that the information available about people's DoLS status needed to be thoroughly reviewed so the manager could be confident that applications were made appropriately and urgently to ensure people's human rights were upheld. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was evidence of people being offered choices in relation to food and drink but this did not include visual assistance that would have helped people who were lived with dementia. We heard one member of staff ask a person what they wanted for lunch but everyone else was served a meal directly. One person was served a different meal of their choosing and asked for champagne. They were served some orange looking champagne in a wine glass and were very happy with this. One person who wasn't eating was asked by a member of staff if they wanted anything else. Although the intention was good, an open ended questions for someone who lived with dementia can be confusing. People were offered a choice of juices and water with their lunch.

Lunch was a choice of chicken curry and rice or sausage casserole with potatoes and vegetables. Pudding was a currant sponge or cheese and biscuits. There was a vegetarian option available and we saw that a person was given this in line with their dietary preferences.

Care plans included information about people's dietary needs and malnutrition risk assessments. Food and fluid charts were completed and weight recorded. Care plans included people's food likes and dislikes, food allergies and appetite and whether vegetarian and/or diabetic. Staff understood how dementia could affect people and their food needs. A member of staff said, "Some people talk about food all the time and other people have forgotten they've eaten, we have lots of finger food – there is always a sandwich or fruit, for example when X is not eating, she loves custard creams and a milkshake".

Within 24 hours of our inspection the provider wrote to us and informed us of actions they had taken to address the shortfalls in management of people's dietary needs. These included diet preference files reviewed, observations of mealtime experiences, supervision of kitchen staff regarding diet textures and management of meal time delivery and clarification of responsibilities for recording and escalating fluid and food intake concerns.

Staff said that they completed an induction at the start of their employment that helped equip them with information and knowledge relevant to the care sector they

Is the service effective?

were working in. One member of staff said, "Seniors do induction, we go through the call bell system, emergency numbers, orientation to the home and the policies and procedures. Then new staff shadow the senior for at least a couple of days. Staff have some training before they go on the floor such as; safeguarding, manual handling and infection control". A newly appointed member of staff confirmed that they had a full week's induction that included shadowing to "See how staff deal with residents and to ask questions". Training was provided during induction and then on an on-going basis.

Staff were trained in areas that included health and safety, fire safety, food hygiene, and moving and handling. Refresher training had been arranged for January to March 2015 for food hygiene, safeguarding of adults and record keeping in order that staff kept their knowledge up to date. A training programme was in place that included courses that were relevant to the needs of people who lived at Aldwick House Care Home. A member of staff told us, "I have had training in medicines, HIV (because someone had this), dementia, challenging behaviour, DoLS, blood pressure and taking bloods and catheters, palliative care and end of life". They had also completed an NVQ 3 in health and social care. The member of staff said, "If you want any non-mandatory training they will put you on it".

Staff said that since the manager had been in post the support they received had improved. Of the 35 staff employed 23 had received a formal, one to one supervision meeting. Supervision that had taken place was specific to the role of individual staff. Nursing staff had received supervision about monitoring and prevention of pressure ulcers. This had included observations of their practice. Domestic staff had received supervision about good infection control measures. Staff had not received an appraisal but the manager had a plan in place to address this by June 2015. The manager had also re-introduced staff meetings as another form of support for staff. These included a 'topic of the month'. In January 2015 this was infection control.

Requires Improvement

Is the service caring?

Our findings

On occasions people were not treated with kindness and respect. Two members of staff walked into people's bedrooms without knocking although doors were closed when undertaking personal care. We saw one person was calling out and clearly slipping down in his chair. We alerted staff who came to assist the person using a hoist. One of the members of staff said to the person, "You've got a slippery bottom. Now stay and no moveys". This was said firmly. On a second occasion a different person said to the same member of staff, "It's very rough care here" and the member of staff replied, "Oh I hope not". There was no exploration of why this person had said this or of how they were feeling.

On another occasion whilst hoisting a person we didn't hear staff explaining or reassuring the person despite the person wincing. Neither member of staff noticed this then the person said, "My back". Again staff did not respond. The person then told the staff, "My back hurts". Staff responded, "What your back" removed the sling and walked off.

We observed one person in a wheelchair calling out to staff for ten minutes, "When am I going" and "Where am I going" then "Do you want me to come that way?" and then "Come and get me". Staff walked past the person and did not respond to them. The area manager came along and asked staff what was happening and a staff member then responded to the person's questions and told him he was going to bed.

All of the above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On other occasions we heard staff speaking kindly and in a polite manner to people. Comments included, "Hello how are you today", "Would you like me to help you" and "Would you like me to cut up your food for you". Some staff were observed smiling at people as they went about their roles. One person told us, "All the staff are very nice and very patient". A relative said, "Her wellbeing is fantastic here". Another relative said, "They are 100% caring". Staff were able to explain how the developed positive caring relationships. One member of staff said, "We are like a family; we treat residents like they are our family – if there is a problem we all help out". Although staff talked about caring for people, we did not see many active examples of this in practice. We did not see any care staff sitting and chatting with people, apart from when people were being assisted at lunch and this varied.

One member of staff was very bubbly and of extrovert character and people responded to her presence positively. She briefly burst into song and was very engaging with people which they seemed to enjoy particularly as there were no other forms of occupation or stimulation in the lounge at the time. She did however call people "darlin" a lot of the time very loudly and we often heard "alright darling" as she approached people but people seemed to appreciate human contact with her as they smiled at her in response and no one appeared unhappy with this term of address.

Variable efforts had been made to promote people's dignity. Some people needing their hair washing or brushing and some gentleman needed shaving. Greater attention to detail had been given to other people. Some people were seen wearing colour co-ordinated shirts and cardigans and non-slip footwear. Several people were wearing clean reading glasses and many ladies had their nails painted.

Staff were able to explain how they promoted people's privacy, dignity and rights to confidentiality.

A staff member said, "When I go in I wash the person's bottom half and keep their top covered and tell them what I am doing, and vice versa. When we take them to bed we always shut the door and speak to people quietly about going to the toilet, it's the way that you talk to people". On confidentiality they said, "If they talk to you on a personal level you have to work out whether it needs to be mentioned, I would act on information about harm and if the person wasn't happy".

Since the manager had been in post staffing had been reviewed and a male member of staff was allocated to each shift in order that people received care from staff whose gender they preferred.

The manager had re-instated regular residents/relatives meetings in order to support people to express their views and to be involved in making decisions about their care and support. During these people were asked their views on areas that included staff, meals and activities and action was taken to address points raised. People had said that they wanted named, key staff allocated to people who lived

Requires Improvement

Is the service caring?

at Aldwick House Care Home in order that they had a point of contact they could go to when they wanted to discuss their family member. This was in the process of being put in place at the time of our inspection. The manager had arranged for guest speakers such as Age Concern to attend the residents/relatives meetings who were able to offer advice and information about care and support people could receive. This demonstrated that the manager was committed to empowering people to be involved in making decisions about their care and welfare.

Requires Improvement

Is the service responsive?

Our findings

At times staff did not respond appropriately to people's individual needs. We observed one person in garden having a cigarette. After five minutes they started to knock on the patio door to come back in. No one came to the person's assistance despite a member of staff sitting right by the door. After 20 minutes we became concerned that the person who was still intermittently knocking had not been attended to and was outside in the cold. We drew this to the attention of the nurse on duty who was the only member of staff around at this point. The nurse was undertaking the medicines round and the medicines trolley from where the nurse was working was in direct eye line of where the person outside was. The nurse then went and assisted the person back inside. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Within 24 hours of our inspection the provider wrote and informed us 'We are speaking to all staff on duty on the day of the inspection to raise our concerns about this incident, and expectations going forward. The Home Manager and nurses are reviewing the care plan and will ensure staff are aware of the prescribed care'.

People told us they were happy and comfortable with their rooms and we saw that they were attractively decorated with some personal touches including photographs and memorabilia. The bathrooms were clean and attractive and where there were some steps there was an alternative ramp section for access. There was a big faced clock in the lounge and a date and weather board that helped orientate people living with dementia.

However, some elements of the environment didn't lend themselves to assisting the needs of people with dementia. Throughout the corridors was a busy spotty carpet and one person was seen confused and attempting to pick up the spots from the carpet. People's names were on their bedroom doors but phased into a darker colour making it difficult to read. One person did not have their name on their door and as they came along the corridor they were struggling to read the names on the doors to find their own. **We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.**

During the first day of our inspection we did not observe any structured stimulation or /activity taking place. The television was on and one person had some large Duplo bricks in front of them. A couple of people were looking at magazines. We did not observe any input for people being nursed in bed or any attention to any sensory stimulation apart from televisions being on. Relatives said that activities were provided and one said that their family member particularly enjoyed the gardening and the flowers. We were informed that activities took place on four afternoons per week and these included painting, quizzes, exercise and singing. On the second day of our inspection a visiting entertainer was at the home who confirmed that daily entertainment was offered to people. People were observed joining in a reminisce session that was enjoyed by all.

Efforts were made in response to people's religious and cultural needs. Two people told us that they were practising Catholics and we saw their rosary's being worn. We observed a person asking when they would have mass and they were informed this would be happening on Thursday. A staff member confirmed that mass was available two times per week and said, "Another church comes in for someone; if someone wants to go to church then we will arrange this with either the activities worker or care staff". They went on to tell us about a person living in the home that was Polish and said, "We have Polish nurses so they are able to explain their needs when they talk in Polish".

People said that since the manager had been in post improvements had been made to involvement in decisions relating to peoples care and treatment. A relative said, "There's no set time to discuss care plans as such but I can ask at any time, staff are very approachable and they're buzzing to tell me what she's been doing when I arrive." Another relative that the manager had introduced regular relatives meetings which helped people to keep informed. They said, "It's much better now, the manager has got an agenda going and we get minutes via email". A third relative said, "We are going to have a keyworker system so we can go to a named person to discuss minor issues. Families asked for this at the relatives meeting and the manager is sorting".

The home's complaints procedure was displayed at prominent points throughout the building in order that people could refer to this if needed. At the entrance of the

Requires Improvement

Is the service responsive?

home, we saw that there was information displayed regarding the fees, service user guides and contact details for the Commission so that people could make contact if they wished to share information about the service they received. There was also a suggestions box that people could use to raise issues anonymously if they wished.

Records were in place that showed that where concerns or complaints had been raised, the manager had responded to these on an individual basis in writing. The findings from individual complaints were incorporated into the providers monthly complaints audit in order that trends could be identified and action taken if necessary.

Good

Is the service well-led?

Our findings

People confirmed that the home had been through a period of instability due to a lack of consistent management. There had been three changes in management in the past twelve months. They said that since November 2014 when the current manager had been in post management of the home and the quality of service people received had started to improve. One member of staff explained, "We've been through a year of uncertainty, no proper management and staff inappropriately promoted we are just starting to get back on an even keel as nobody knew where they were, it's more stable now". A relative said, "Quality dropped due the three changes in manager in a short period of time. The manager is working hard to bring it up to scratch. She is very approachable and we have seen improvements recently". The manager said that the provider supported her to undertake her role and that they had been honest about the issues when she was recruited. She explained, "There is always someone on the end of the phone for advice. I knew how difficult this job was going to be. I was under no illusions. I've made changes and the company have supported me fully".

Everyone said that communication had improved since the manager had been in post and that a positive, inclusive culture was being developed. One person said, "Since the manager has been here the morale has improved, she's got more staff in and she's really got to know the residents". A relative said, "Before I would have given this place two out of ten. Now I would give it seven out of ten. It's on the up and morale is much better". Relatives said that they were always made to feel welcome when they visited. Regular relatives meetings had been introduced that supported two way communication.

Staff were able to explain the vision and values of the service. One member of staff explained, "To promote choice, dignity and independence and to make the home as pleasant and homely as possible for each individual and their individual needs". Another member of staff said, "To help them, make them feel comfortable, some people will spend the rest of their lives in here we want them to be happy". A third member of staff said, "The key challenge is to do your job to the best of your ability and to make things more comfy and homely and then I can walk away knowing \I have done my job to the best of my ability". The vision and values of the service were on display at the entrance to the home. The manager said that she had not yet started to discuss these formally with staff but was planning to incorporate these into the staff supervision sessions that were planned. The manager stated, "They are critical. We all need to be clear in what we are doing and why".

Staff said that the manager was approachable and open to suggestions. Staff meetings took place where staff could raise issues and discuss service provision. Staff also discussed the needs of people at the handover sessions between shifts. One member of staff said, "Yes I feel able to be open and staff meetings are useful and the manger attends". Another said, "The manager is approachable and I can say what I think to them". A third member of staff said, "We talk about what needs to change in handover, for example that's when we talked about changing the way the breakfasts were done". The manager had printed off a copy of the provider's whistleblowing policy and displayed this prominently where staff could see it. This demonstrated that the manager was open to people raising concerns and encouraged people to question practice.

The manager had been in post since November 2014. Prior to this she had managed other nursing and dementia care homes. The manager held a nursing qualification and obtained the Registered Managers Award in 2006. The manager said that to ensure her knowledge was up to date she attended courses run by the Registered Nursing Home Association. These included attendance at a recent course about forthcoming changes to legislation relevant to the running of the home. Records confirmed that further training was booked to take place in March 2015. The manager also attended a manager's forum in January 2015 run by West Sussex Partnership in Care. The manager said of this, "Networking is good". This showed that the manager was committed to ensuring her knowledge and management skills were current.

The manager explained that she had completed a number of audits and prioritised actions based on risk. As a result of a bed rail audit new mattresses were purchased that were compatible for use with bedrails and reduced the risk of entrapment. There were an abundance of audits and action plans in place completed by staff, the manager and representatives of the provider. These included cleanliness, mealtimes, activities, staffing, the environment, care needs, accidents, complaints, wound care and records. Auditing was being looked at by the provider's quality team and a new system was being drafted. As a result of the feedback

Good

Is the service well-led?

we gave at the end of our inspection the manager and provider took action and within 24 hours put plans in place to address the issues identified. These included additional weekly monitoring visits by the area manager, the home being placed on the 'Quality Watch List' in order that senior management would have oversight on a weekly basis and an internal audit and review of behaviours and culture changes in relation to meeting people's needs. The prompt action showed a commitment for improvements to be made to the quality of service people received.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9(1)(a)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of service users.** **The registered person had not taken proper steps to ensure each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user and planning and delivery of care and treatment in such a way as to meet service user's individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 18(1)(a)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to care and treatment.** **The registered person had not ensured suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17(1)(a) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Respecting and involving service users.**

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not, so far as reasonably practicable, made suitable arrangements to ensure the dignity of service users. The registered person had not ensured service users were treated with consideration and respect.