Guild Care

Haviland House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 September 2017 and was unannounced.

The last inspection took place on 9 August 2016. As a result of this inspection, we found the provider in breach of Rregulation 18 (Staffing). We asked the provider to submit an action plan on how they would address this breach. An action plan was submitted by the provider which identified the steps that would be taken. At this inspection, we found the provider and registered manager had taken appropriate action and this regulation had been met. As a result, the overall rating for this service has improved from 'Requires Improvement' to 'Good'.

Haviland house is a purpose-built nursing home registered to provide accommodation and nursing care for up to 60 people with a range of care and nursing needs, including people living with dementia. At the time of our inspection, 58 people were living at the home. Haviland House is divided into five suites (known as 'households'): Angmering, Bramber, Clapham, Durrington and Elmer. Each suite caters for up to 12 people who are at different stages on their dementia journey. For example, people accommodated in Clapham are living with more advanced dementia and are less able to communicate verbally. Staff have different roles such as 'house leaders' who are in charge of the shift, management of care plans and risk assessment reviews. Staff who are 'home makers' ensure that people's care and support needs are met in a personalised way, together with other care staff. People are known as 'family members'. Each suite has a separate sitting room, dining area/room and kitchenette. There is a variety of communal areas within the home for people to access, including gardens. All bedrooms have en-suite facilities.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staffing levels were assessed based on people's care and support needs. Following the last inspection, the provider put plans in place to ensure that staff were allocated to each suite based on people's assessed care and support needs. Staff were on duty within each suite of the home and two registered nurses were on duty during the day and one at night. At the time of our inspection, agency staff were employed to cover any gaps in staffing. Staffing levels were sufficient and people's needs were met promptly. Safe recruitment practices were in place. People felt safe living at the home. Staff had been trained to recognise the signs of abuse and knew what action to take. People's risks had been identified and assessed appropriately and guidance was in place for staff on how to mitigate risks. Premises and equipment were checked regularly and emergency evacuation plans were in place should people need to leave the building in the event of an emergency. Medicines were managed safely.

We have made a recommendation to the provider about staff supervisions. Not all staff had received regular supervisions in 2017 and the registered manager looked into this issue following our inspection. Some valid

reasons had been provided where supervisions had not taken place, however, 13 staff had not completed supervisions recently. This had not impacted on the care people received. Staff meetings took place and some were used as group supervisions for staff. Staff had completed a range of training considered essential to carry out their responsibilities in line with their job role. Staff had also completed training on mental capacity and associated legislation and put what they had learned into practice. Catering at the home was managed by an external contractor which the provider had employed. People had a choice of what to eat at mealtimes and specialist diets were catered for. People were supported to maintain good health and had access to a range of healthcare professionals and services. The provider was in the process of changing much of their practice in relation to caring and supporting people living with dementia. Changes had been made to the environment and in the way staff supported people.

People received care from kind, warm and friendly staff who knew them well. People and relatives spoke positively about the caring attitude of staff. As much as they were able, people expressed their views about the way they wished to be cared for and were involved in decisions relating to their care. Staff knew people's likes, dislikes and preferences. People were treated with dignity and respect by staff.

Care was delivered in a person-centred way to meet the individual needs of each person living at the home. Care plans contained detailed and comprehensive information about people, their life histories and care needs to enable staff to support them in a personalised way. Activities were provided based on people's preferences. Some activities, such as occasional outings, were organised, whilst other 1:1 activities were more spontaneous between people and staff. People were observed to enjoy the activities they had engaged with. People and relatives knew how to raise any concerns they might have. Complaints were managed appropriately.

People and their relatives were asked for their views about the home through surveys and meetings. Responses were analysed and any actions arising dealt with. Feedback was positive. Staff felt valued in their employment at the home and commented that the management team was accessible and responsive. Staff were aware of the whistleblowing policy and who to contact if they had any issues to raise. Staff were asked for their feedback about working in a dementia care setting. Care provided at the home was monitored and measured through a serious of audits. Positive comments from relatives had been recorded.

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.

Staffing levels were sufficient to meet people's needs and staff were deployed flexibly. Safe recruitment systems were in place.

People and their relatives felt the home was safe. Staff had been trained to recognise the signs of potential abuse and knew what action to take.

Risks to people were identified, assessed and managed safely. Premises and equipment were regularly audited.

Medicines were managed safely.

Is the service effective?

Requires Improvement

One aspect of the home was not effective.

Some staff had not received regular or recent supervisions. Staff had completed training in a range of areas considered essential to the job role. Staff meetings were held.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005, and associated legislation, and put this into practice.

People were complimentary about the food on offer and said they were given choices. Catering was provided by an external contractor employed by the provider.

People had access to a range of healthcare professionals and services.

The provider was in the process of changing various aspects of the home, including the environment and the way staff supported people living with dementia.

Is the service caring?

Good

The service was caring.

People were cared for by kind, friendly and supportive staff. People were encouraged to be involved in decisions relating to their care.

Staff demonstrated they treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their individual needs. Care plans provided comprehensive information and guidance to staff.

Some activities were organised, whilst others took place on an 'ad hoc' basis, such as people helping staff with housework.

People and relatives knew how to make a complaint and complaints were logged and managed appropriately.

Is the service well-led?

Good

The service was well led.

People and their families were asked for their views about the service provided and regular family and friends' meetings took place.

The home was undergoing change and developing the service provided for people living with dementia.

Staff felt valued and that the management team was approachable. People, relatives and staff said the home was well led.

A system of audits had been developed to measure and monitor the quality of care delivered.

Haviland House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 September 2017 and was unannounced.

Two inspectors, a nurse specialist and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, four staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

On the day of our inspection, we met with nine people living at the service and spoke with two relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the deputy manager, the shift organiser, an administrator, clinical lead, two 'house leaders', two 'home makers' and two support workers. Detail about these specific job titles are included in the overall summary and in the main body of this report.

Good

Is the service safe?

Our findings

At the inspection in August 2016, we found the provider was in breach of a Regulation associated with staffing. We asked the provider to take action because staff were not deployed in sufficient numbers to ensure people's care and treatment needs were met. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

Staffing levels were assessed based on people's care and support needs. Following the last inspection, the provider put plans in place to ensure that staff were allocated to each suite based on people's assessed care and support needs. One 'house leader' was allocated to each 'household' of up to 12 people. House leaders organised shifts, managed care plans and risk assessments and worked with the management team. Two registered nurses were on duty during the day and one at night. Four support staff, including a 'home maker', were allocated to each household during the day and two at night, plus a 'night manager'. If people's care needs changed, for example, if they were reaching the end of their lives, additional staff were allocated. At the time of this inspection, some 150 hours per week were covered by agency staff, including care and nursing personnel. We looked at the staffing rotas over a period of four weeks which showed that staffing levels were consistent across the time examined.

Staff were readily available when needed and knew people well, responding to people's body language and gestures where people had difficulty in communicating verbally. We observed one person who was moving around the home and used a walking frame. We saw that they appeared confused. Every time this person started moving around, a staff member was available to support them and reassured them by answering their questions. One person told us, "I just have to ask for help and a member of staff comes and supports me". People were supported in a timely manner and were not rushed. At lunchtime, we observed a member of staff asking a person if they would like to go to the dining room. The person responded they would, but did not move. The member of staff then asked the person if they would like a little time and the person agreed they would. The member of staff left the person for a couple of minutes, then returned and asked if they were ready to go for lunch. The person stood up and was supported to go to the dining room. They said, "I am never rushed, they go at my pace". We asked staff whether they thought there were sufficient staff on duty. One staff member said, "On this floor, the staffing is okay. On the other floors, not so much at the moment, but it gets worked out. There's no agency on here today. There's enough time to do everything. We have time to sit and talk to family members".

Another staff member said, "This unit [Elmer] has people with high support needs. Staffing can be a bit hit and miss. There are many people needing hoist care which is very time consuming. I feel this unit currently is a bit of a poor relation as the developments are focused on the other units. I do tell the manager; I will advocate for this unit". Another staff member told us, "There is always too much to do and yes, we are sometimes understaffed, but I cannot say that the home is ever unsafe". We observed there were sufficient numbers of staff on duty to meet people's needs and ensure their safety.

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had

completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting. One staff member told us that when they read the job description for the role they were applying for, they also telephoned the provider to check what the job involved before they applied.

We asked people if they felt safe living at Haviland House. One person said, "I feel very safe" and another told us, "I am very happy here". Relatives also said that they felt their loved ones were safe. One relative explained, "We know Mum is safe and that is important to us". Another relative said, "The last home my wife was in was very good and we worried that we would not find anywhere as good, but we have been lucky; this home is better. As soon as we looked around the home, we got the feeling that this was the right place and we have not been disappointed. She receives the best care and support". People were protected from avoidable harm by staff who had been trained to recognise the signs of abuse. Staff we spoke with knew what action to take if they had any concerns about people's welfare. One staff member told us, "It's putting in place the safety of each person and taking into consideration how far along they are with their dementia. I might need to report something. I would look for bruising, markings, a scratch from a nail or side effects from medication. I would go to the house leader with the concern. I would need to write it down and do an incident form". Another staff member said, "I would go to the house leader and not discuss it with anyone else. I had safeguarding training as part of a refresher a few weeks ago. It was face to face training with a discussion of scenarios". The staff member explained their understanding of different types of abuse and was able to discuss these.

Risks to people were managed so they were protected and their freedom was supported and respected. We observed people being supported to do as much for themselves as they could. People who moved independently were encouraged to do so, whilst people who required support received this from staff. People were supported to take risks appropriately. We observed one staff member monitoring a person as they used their walking frame to visit the toilet. The staff member encouraged them and reassured them that they were doing well. One person said, "I am supported to do as much for myself as I can".

People's risks had been identified and assessed appropriately. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments provided guidance to staff on how to support people safely. We looked at a range of risk assessments in relation to the use of bed rails, moving and handling, skin integrity, the environment and accidents and incidents. We undertook some random checks on air mattresses which were used to provide support for people at risk of developing pressure areas. Three of the six mattresses we checked were set incorrectly and we discussed this with the registered manager. In addition, two foam mattresses were 'bottomed out' and required replacement. We discussed these matters with the registered manager who had rectified these issues by the end of our inspection, by ensuring that settings were accurate on pressure mattresses and new mattresses procured where needed. Mattresses were not consistently checked as part of the home's audit, but the registered manager told us that these checks would now be completed when resident's care plans were reviewed each month.

Some staff were unaware of the location of emergency equipment, for example, defibrillators which are used in the event of cardiac arrest. One suctioning machine was old and not compatible with responding to some situations in that it was dependent on an electricity supply. The registered manager was aware of the location of relevant equipment and told us they would remind staff of these. Some staff had been trained in the use of emergency equipment. For example, one staff member said, "We do 'resus' and 'defib' as part of

first aid training, but not everyone does the three day course". Staff were aware of the action they would take, for example, if a person collapsed. The same staff member explained, "I would hit the emergency bell and I would check consciousness. I would put the person in the recovery position. I would check for bleeding and call for the nurse. Afterwards I would fill in an accident form and inform the next of kin. I would make sure the other residents are okay and that my colleagues are okay too". Accidents and incidents were reported as needed.

Overall, premises and equipment were managed to keep people safe. An inspection had recently been completed in relation to fire safety. The registered manager told us that they had been advised that flammable materials, including pictures and photos on display, would need to be removed from corridor walls. The registered manager said they were querying this with fire safety professionals, as many care homes have notices and pictures on corridor walls. Personal emergency evacuation plans (PEEPs) had been completed for people, should these be required in the event of the home having to be evacuated. Staff had completed fire safety training. One staff member said, "We test the fire alarm weekly and we have done fire training. The residents have PEEPs and there's always a fire warden on shift. Every nurse's station has a 'walkie-talkie'. I know about the evacuation process and where the assembly point is". Audits had been completed in relation to the safety of the premises. Moving and handling equipment was seen to be in good order, with appropriate slings and slide sheets in use.

People's medicines were managed so they received them safely. The registered manager told us that the administration of medicines by registered nurses could be a timely exercise, so they were in the process of training senior staff to help out with the administration of medicines. Training was organised with a leading pharmacy. The majority of medicines were stored in medicines trollies, but in the Clapham unit, medicines cabinets had been installed in people's bedrooms, and medicines were kept securely. The registered manager told us there were plans to install medicines cabinets in each bedroom, which would mean medicines were readily accessible and quicker to administer. We looked at a selection of Medication Administration Records (MAR) which had been completely appropriately. Overall medicines were ordered, stored, administered and disposed of safely. Medicines audits were in place and the majority of incidents recorded were in relation to staff forgetting to sign the MAR to confirm that people had received their prescribed medicine. The registered manager told us that when omissions occurred, the person responsible was contacted immediately and asked whether the medicine had been administered and to sign the MAR.

Requires Improvement

Is the service effective?

Our findings

We looked at the supervision matrix and saw that not all staff had received regular supervisions with their line managers or supervisors in 2017. This did not impact on the care that people received from staff. We discussed the lack of supervisions with the registered manager who investigated our concern that, according to the matrix we looked at, 32 members of staff had not had a recent supervision. Some valid reasons were provided after the inspection as to why some staff had not received regular supervisions, however, the registered manager agreed that 13 staff had not completed supervisions recently. Three of these staff had transferred to the home from another of the provider's other services. Some staff had attended staff meetings which were used as group supervisions. A staff member said, "We do little group supervisions which are minuted. Staff can raise concerns. They can come to the manager or deputy manager or the nurse on duty". We looked at the records which confirmed this.

We recommend that the provider reviews all outstanding staff supervisions and that these are completed at regular intervals for all staff in line with the provider's policy.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles. One person said, "The staff are very good, nothing is too much trouble". Another person told us, "The staff know me and how I like things done; they are lovely". We asked new staff about their induction when they commenced employment. One staff member explained that as part of their induction they completed training in moving and handling, health and safety, dementia care, care practice, safeguarding, mental capacity, infection control and person-centred care. They completed four shifts shadowing experienced staff, then their practice was reviewed and if this was satisfactory, they then worked more independently. This member of staff said they had completed one probationary review with their house leader and that they could discuss everything about their role as part of this review. Another staff member told us they had completed their appraisal in April 2017 and that weekly house leader meetings took place with the registered manager, when a range of issues were discussed. A third staff member said they had recently had a change of job role and were becoming used to a new way of working. They said, "It's a brilliant way to express things we're good at. It's a nice thing for residents. It's person-centred; you get to know people properly and learn how they tick. It's really special and exciting; any change is a good thing. We've had the support and the training is ongoing. The training is quite detailed".

Staff completed training in a range of areas including dementia, equality and diversity, fire safety, first aid, food hygiene, health and safety, medicines, Deprivation of Liberty Safeguards, moving and handling, infection control and safeguarding. Registered nurses completed additional training such as end of life care. The administrator told us that, as part of their induction, new staff committed to training sessions and were signed up to these. Training was also being rolled out to provide staff with further information about supporting people living with dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We observed staff seeking consent when supporting people. For example, staff asked people if they would like to move to the dining room before they supported them to do so. They would then ask the person they were supporting where they would like to sit. One person explained, "The staff always ask me if I would like help". We asked staff about their understanding of MCA and DoLS. One staff member said, "I never assume that people don't have capacity to make decisions. It's about whether they can make informed decisions. They might not be able to make decisions about their medication, but can make decisions about what to wear". A second staff member told us, "The MCA is to not assume that people don't have capacity. It's taking the fewest steps to restriction. It's allowing people to do what they can without restricting them. Most people have DoLS here as they are locked in. It's about anywhere where we are depriving them of their liberty. People have either got a DoLS or it's pending". Capacity assessments had been completed for people as needed. The registered manager told us that applications had been made for DoLS where required, but that the local authority had only authorised two so far.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. Catering at Haviland House was outsourced to an external contractor and meals were provided 'in house' from staff employed by the external contractor. We observed people having their lunchtime meal in the dining room of the Angmering suite. People we spoke with said the food was good. One person said, "The food is very good and we always have a choice". We saw one person decide they did not want the main dish on offer and was asked if they would like an omelette instead, to which the person agreed. They were then asked what they would like in their omelette and given a choice of fillings. Once the order had been placed with the kitchen staff, the person was then told their omelette would take about five minutes to cook. They were also asked if they would like some vegetables to go with their omelette, which was agreed to by the person. Gravy boats were placed on tables so people could help themselves. We saw a member of staff going around the tables asking people if they would like help to pour the gravy. A relative told us, "The food is good. Mum enjoys her meals". People who preferred to have their meals in their rooms could do so.

In a dining room in the Durrington suite we observed five people having their lunch. They were offered apple or pineapple juice to drink. We saw that condiments were not freely available and that salt was kept in sachets in a cupboard, but people were not asked if they would like salt or pepper on their food. Food was served from a hot trolley which was wheeled into the dining room from the kitchen. One person preferred 'finger foods' and this was catered for. Whilst we were told there were two choices of the lunchtime meal, only one main meal was plated up for the majority of people, who were not asked what they wanted. However, staff seemed to know what people liked or preferred. Staff told us that some people lived with type 2 diabetes, so their diet was adjusted to meet their health needs. For example, an alternative on the day we inspected was stewed apples instead of trifle and diabetic jelly was also on offer. Some people preferred vegetarian meals and these were catered for. We asked staff whether other people's special dietary needs were catered for. One staff member said, "There is one person who has thickener added to fluids and has a pureed diet and there are people living with type 2 diabetes on this suite. The kitchen are aware of dietary requirements. When we collect the trolley, we tick it all off and run through it. There's a list in the kitchen of people's dietary requirements".

Staff told us that one person was asleep during lunch and added that they would not be able to keep the

food hot for them, so they would offer a sandwich, with a trifle to follow, when they woke up. However, other staff told us that hot meals were available to people 24 hours a day if needed. Menus were planned with the external contractor and meal times were organised according to set times when catering staff were on duty. Food and fluid charts were seen for people on Durrington suite. These recorded the amount of food eaten, fluid intake and totals were recorded. Staff told us that these totals were recorded into people's care plans each day and records confirmed this.

Drinks were on offer to people throughout the day. We observed a drinks trolley being wheeled around at 3.40pm. People were offered a choice of drink with a biscuit or coffee cake. Biscuits, fruit and popcorn were placed around the home, so people could help themselves to a snack whenever they wanted. Small kitchenettes based within the suites enabled staff to help people to have a drink whenever they wanted. People we spoke with said there were always enough staff on duty at mealtimes, to assist them with their meals, as needed.

People were supported to maintain good health and had access to a range of healthcare professionals and services. A GP who attended people at the home was asked for their feedback about the management of people's health needs. They stated, 'We see people either with one of the managers or a registered nurse. They are always very well prepared and informed of all the patients [people] and any issues that need to be addressed. They have an excellent knowledge of all the patients. It is very well organised and they have a list of problems that need addressing that is faxed over to us the day before we visit. The staff on all the suites appear to be caring and know their patients well. They will always call the surgery if they have any concerns. In my opinion, this is a very well led dementia care home that offers an excellent level of care to the patients'. However, another healthcare professional felt differently and wrote in their feedback, 'Every time I have been to the home, there is an air of no-one knows what is happening. The registered nurses only appear to do medication and it is the 'health care assistants' who appear to run the wards [suites] and when someone is off, no-one knows'.

We asked staff about the action they would take if people became unwell. One staff member said, "The GP comes every Tuesday. If we need a GP before that we can contact them. There's a nurse on site at all times. We can ring 111 if we are unsure. We have a first aid kit in the office and another in the kitchen. There are also defibrillators available". Records we looked at confirmed that people had access to healthcare professionals as needed, including GPs, dentists, opticians and chiropodists.

The registered manager told us they were in the process of changing much of their practice in relation to caring and supporting people living with dementia. This included the way the environment was organised to include changing of colour schemes and the arrangement of communal areas. For example, there were plans to change one of the large lounges and organise it as a 'village hall' with films shown on a large screen. Spaces in other parts of the home would be created to include a beach hut with boat, a summer house and a pub or tea shop. The provider had invested significant funds to change the way the home was organised and was receiving ongoing advice and support from an external organisation that had expertise in the management of dementia. For example, staff did not wear uniforms or badges and suites were organised into 'households'.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed staff providing support to people in a caring way. Staff demonstrated that they knew how people liked to be supported by interacting with them when invited. One relative said, "Mum has only been here two weeks, but the staff already know how she likes things done". People and relatives agreed that staff were caring. One person said, "The staff are very good" and another told us, "The staff are marvellous. They take very good care of me". A third person told us, "The staff can't do enough for me, I am very impressed". A second relative said, "The staff are very good and look after Mum very well. They are very caring and cannot do enough". We observed several instances throughout our inspection of staff's caring and compassionate attitude with people. Staff were patient when listening to people and gave them the time and space they needed. For example, one person appeared to be disorientated in one of the sitting rooms. Staff reminded the person they were in the sitting room and asked them what they would like to do. The person was asked if they would like to go to their room and was reminded of their room number. Staff then gently guided the person to their room, with their agreement. We observed another person who was feeling unwell and was invited by a staff member to sit in a comfy chair. The staff member stayed with them and comforted them until they felt a little better. We observed another person helping staff in the serving of drinks and the staff member told us they would then go and help fold the clean laundry up. Staff had time to spend with people and we saw one staff member reading with a person.

People were supported to express their views and were encouraged to be involved in decisions relating to their care. Not everyone we spoke with could remember if they had been involved in their care planning, due to their health conditions. Those that could, confirmed they were involved. A relative told us, "We were all involved in planning Mum's care". We observed staff supported people to be as independent as possible where people were able to do something for themselves. For example, we saw some people could walk to the toilet on their own and that a member of staff observed them to ensure they were safe.

We asked staff how they knew about people's likes, dislikes and preferences. One staff member explained, "Each person has their own profile on their door in their room so we know what they like and so we can offer them choices. We offer choice with meals and with activities. We ask people what they want to do. Some people want to stay in bed. We give people a choice with their clothes and two options. We don't want to confuse people". We asked a staff member what they would do if a person refused personal care. They said, "I would come back and try again; I would try a different approach. They may want a male carer. They may want a bath instead of a shower".

We observed staff were respectful with people at all times and treated them with dignity and respect. Staff always spoke with people, bending down to their level and ensuring they were facing the person they were talking with. One person said, "I have travelled all over the world, stayed in some of the best hotels and the staff here are some of the best as far as treating me with respect". We observed one member of staff request information from another staff member, who was supporting a person with a massage. The second staff member asked if they could be excused for a moment and followed the first staff member out into the hallway. Information was passed on, out of earshot of everyone else, then the second member of staff

returned to the person they were supporting. We asked a staff member about maintaining people's dignity and they told us, "It's making sure you are speaking to them and that they are happy with their care. It's closing doors and windows and making sure they are covered up when personal care is given".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans provided detailed information about people in a person-centred way. The essence of being person-centred is that it is individual to, and owned by, the person being supported. A person-centred approach to care focuses on the person's personal needs, wants, desires and goals so they become central to the care process. People's needs take priority.

We asked people if they were involved in reviewing their care plans, but the majority could not recall whether they were or not. A relative said, "We are kept up to date with everything that changes and we have regular family meetings; in fact, one has been arranged for today". A member of staff told us, "Our focus is on meeting the needs of the people we support; this takes priority over everything else".

Role titles for staff had been changed to encourage a less institutionalised approach. One of the roles for staff was that of 'home maker'. A member of staff explained, "My role is to make sure residents are happy, as close to what they have at home. Care is personalised to each family member [person living at the home]. Each person has a personal profile. If they are not used to hot food, they can have finger goods, like at home. One person has a mashable diet and finger foods because he doesn't like to chew, he finds it hard". This staff member added, "There are no routines. People can stay in bed and have a lie-in. They have a choice of food and drinks and what to wear. They take the lead role in their care". A second member of staff, when asked about person-centred care, said, "It's making sure that everything is individualised and not treating people the same. It's about supporting them in the personal way they need to be supported. We ask friends and relatives and we ask them to complete 'Our Life' book, so we have that in place and we just build on it". Staff were allocated to people as their keyworker which meant they took responsibility for ensuring people had toiletries and clean clothes and liaised with relatives regarding their family members' needs.

Care plans were detailed and provided guidance to staff in areas such as moving and handling, nutrition, skin care, continence, behaviour, wound care and end of life. Care plans were recorded electronically, reviewed monthly and records completed daily by care staff. One staff member told us that they had access to people's care plans and that they had read them as part of their induction when shadowing shifts. They added that they read through them at intervals to update themselves adding that the care plans reflected people's needs well. We asked staff about their knowledge of people who lived at the home. From our conversations, it was clear that staff knew people's care needs and personal histories well, which enabled them to provide individualised care in line with the information held in the care plan. We asked one staff member how they would manage people who displayed behaviour perceived as challenging. They told us, "[Named person] can present with behaviour that challenges. They are on a behaviour chart, but their behaviours are not frequent enough to warrant a separate care plan. Something happens once or twice per week; it's more verbal. They prefer some staff members over others".

People told us there were always activities available, some of which were organised on a 1:1 basis. We observed one member of staff moving around the sitting room spending a few minutes with everyone in the

room. They sat with one person and talked about the book the person was looking at. This staff member then asked another person if they would like to have a walk around the garden and supported them accordingly. In another part of the home, people were having a manicure and chose the colour of nail varnish they wished to be applied. The registered manager explained that staff could interact with people in short bursts and said, "People are getting on with their lives and not dictated to by routines". Activities could also relate to housework. For example, when one staff member went to organise drinks for people in one suite, one person was helping them to hand out cups of tea. Another staff member said, "There is a lounge downstairs. We do singing, put the horse racing on and we had strawberries and cream the other day. At weekends, women have their hair and nails done. Men play board games. There is a drive on Mondays and Wednesdays to take people out for a drive up towards Pulborough and Steyning. There's an activities schedule in the office. One person likes her nails to be done and another likes to talk about cricket and football. We keep a record for the family to see. People have their diaries in their room with the activities recorded". A third staff member said, "The back garden is enclosed and safe. We've got a summerhouse being built and we have a greenhouse. Some people water the plants. We try to make it possible for them to go out as much as possible. The balcony doors open up". The staff member added, "People like the board games and books. We have bought a fish tank and people will help to clean it out. People can go over to socialise with people on other suites; they are encouraged to move around".

We observed people engaging with various activities in the Angmering suite. One person was enjoying playing pitch and putt around the sitting room. Another person was helping a member of staff with tea.

People we spoke with said they knew how to raise a concern, but had not had cause to do so. A relative confirmed what they would do if they wished to make a complaint and said, "On the odd occasion I have raised an issue or asked for something for my mum. It was dealt with, without fuss and always with a 'can-do' attitude". We looked at complaints received during the year. Eight complaints had been recorded which included how the complainant was updated as the issue was investigated, together with the outcome.

Good

Is the service well-led?

Our findings

People and their relatives were involved in developing the service. Meetings had taken place to update everyone as the home adopted a change of approach to supporting people living with dementia. We asked people if they were asked for their views about the home and they all confirmed they were and that they felt listened to. One person said, "I am asked for my opinion all the time and I am listened to". A relative told us, "We visit at least twice a week and are often asked for our views". Family and friends' meetings took place and records confirmed this. Family surveys had been completed which analysed the responses of 20 relatives or friends. Feedback related to how well the home met people's needs, whether this was personalised and overall how satisfied relatives and friends were with the service. Feedback received was positive.

We asked people whether they felt the home was well led. One person said, "The manager is always available and she is very approachable" [referring to the person in charge of the suite]. Another person told us, "The manager is lovely". A relative felt, "The management is very good, approachable and willing to listen. The manager sorts things out without fuss".

We observed staff during our inspection and they all appeared relaxed and happy working in the home. One person said, "The staff always have a smile on their faces". Good relationships had been developed between staff and the management team and they were supportive of each other. Staff we spoke with felt valued and told us there was an open door policy at the home. One staff member said, "I find the manager approachable. I can knock on his door. He is more approachable than other places I have worked and he was present at some of my training. The house leader is great too, she takes on concerns". Another staff member said, "It's an amazing place to work, everyone is so nice. It feels like you're coming to work with family and I feel very included. The managers make sure I'm okay. I can knock on the manager's door and he has an open door policy". Staff were asked for their feedback with regard to working in a dementia care setting and whether they felt respected and valued. The majority of responses were positive. A healthcare professional expressed concern in their feedback in relation to the home undergoing a period of change and lack of stable leadership in the past. We observed the registered manager was visible and knew people who lived at the home. He spoke passionately about his vision for the future of the home and was actively involved in developments to provide quality care for people living with dementia.

We asked staff whether they were aware of a whistleblowing policy and how they would raise any concerns they had. One staff member said, "It's raising a concern between you or management or staff. The policy is in the folder on the suite. I would speak to the house leader, head of nursing or management". Another staff member explained, "It's where you whistle blow about something confidentially that you are uncomfortable with. There's a confidential phone line. I would contact the deputy CEO, she would be my port of call".

The care that was provided at the home was measured and monitored on a regular basis through a system of audits. Where accidents and incidents had occurred, these were analysed for any emerging patterns or trends to prevent reoccurrence. Checks were made in relation to housekeeping and audits completed in health and safety, safety of premises and the environment. Care records were sampled to ensure they were

completed appropriately. A 'resident of the month' scheme ensured that each aspect of every person's care and support was reviewed, including the environment they lived in. We saw that 13 compliments had been recorded. We read, 'We really appreciate the care, attention and deep concern we see from Haviland staff; a place where we feel our father has a quality of life'. Another relative had written, 'I would like to praise every member of staff that I've met involved in Mum's care'.