Balcombe Care Homes Limited

Aldersmead Care Home

Inspection report

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Ratings

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

Overall summary

The inspection was carried out on 24 August 2015 and was unannounced.

Aldersmead Care Home can accommodate up to 38 people. It is registered to provide nursing and personal care to older people and people living with dementia.

There were 34 people living at Aldersmead Care Home at the time of our visit. There was a registered manager, who was present on the day of our visit.

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.

The accommodation was over three floors with two lifts. The building was well maintained and decorated to a good standard. We found inconsistencies in staff providing a caring and respectful approach with people.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS protects the rights of people ensuring if there are any restrictions to their freedom and liberty, these have

Summary of findings

been authorised by the local authority as being required to protect the person from harm. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

The home had taken steps to make sure that people were safeguarded from abuse and protected from risk of harm. Staff had received training in how to safeguard adults and knew what action to take in the event of any suspicion of abuse.

Medicines were managed and stored appropriately. Staff received regular training and their competency in giving medicines was assessed, to ensure people received their medicines as prescribed.

Risks to people's safety were assessed and managed appropriately. Assessments identified people's specific needs, and showed how risks could be minimised.

Regular environmental and health and safety checks were carried out to ensure that the environment was safe and that equipment was in good working order.

There were systems in place to review accidents and incidents and make any relevant improvements as a result.

People's needs had been assessed to make sure that there was enough staff on duty during the day and night to meet people's individual needs.

People's health needs were assessed and monitored. Health records were written in an accessible way. People were supported to have a balanced diet. Staff understood people's likes, dislikes and cultural preferences.

New staff received a comprehensive induction, which included specific training such as Dementia Awareness, End of Life, Parkinson's Disease, Wound Care, Palliative Care, Pressure Sore Awareness, Choking Prevention, and Compassion Awareness.

Staff were trained in areas necessary to their roles and completed additional specialist training such as how to communicate effectively and support people to make sure that they had the right knowledge and skills to meet people's needs effectively.

Each person who lived in the home had a different way of communicating their needs. Staff understood how to communicate in a personalised manner with each person who lived in the home.

Staff spoke with people in a respectful manner, treated them with kindness and encouraged their independence.

People's care, treatment and support needs were clearly identified in their care plans and included people's choices and preferences. Staff knew people well and understood their likes and dislikes. Clear guidance was in place to identify the triggers and action to take when people displayed behaviour that may challenge themselves or other people.

People were offered an appropriate range of activities, which included in-house activities and trips in the community. People were supported to keep in contact and visit friends, family members and people who were important to them.

Staff understood the aims of the home were motivated and had confidence in the management of the home. One employee stated 'Great manager, on top of everything'.

Systems were in place to review the quality of the service and included feedback from people who lived in the home, their relatives and staff. Improvement plans were developed where any shortfalls were identified to make sure that improvements were made and sustained.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this 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?

Good

The service was safe.

Staff knew how to help people to stay safe and identify where people might be at risk.

Staff understood people's needs and risk assessments ensured they would know how to ensure their safety.

There were sufficient staff to meet people's needs.

The service followed safe recruitment practices.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff were well trained and received a thorough induction when they started work.

They received regular supervision and training.

Staff had a good awareness of issues of consent and the requirements of the Mental Capacity Act 2005.

People had good access to health care in the community and from the nurses at the home.

Is the service caring?

Requires improvement

The service was not always caring.

We observed inconsistencies in how people were treated with dignity and respect.

The records for people on an end of life plan demonstrated that discussions had taken place between the person, those close to them and a care team about how best to support them and what best care might look like in the future when their health declined.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs. Staff were knowledgeable about people's support needs, interests and preferences, in order to provide personalised care.

People had opportunities to access the local community and had activities and interests to occupy them when at home.

Summary of findings

Information about how to make a complaint was available to people and staff knew how to respond to any concerns that were raised.

Is the service well-led?

Good

The service was well led.

The service had effective quality assurance and information gathering systems in place.

The registered manager had frequent direct contact with people who use the service and their relatives, and with staff members. They were therefore able to seek and receive frequent feedback.

There was a system of checks and audits in place to assure the quality of service provided. Each tier of the management and supervisory hierarchy played a role in making sure this happened.

Aldersmead 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 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.

This inspection took place on 24 August 2015 and was unannounced.

The inspection was undertaken by an adult social care inspector, an inspection manager and an expert by experience with expertise in caring for older adults. 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, we reviewed the information we held about the service and service provider. This included the 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.

The registered provider had completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

We contacted a medical practice and Sussex Community NHS Trust for their views. We used all this information to decide which areas to focus on during our inspection.

Some people could not talk with us about their experiences of living at the home and we spent time observing how they were cared for and treated by staff. 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.

We spent time looking at records including six care records, four staff files, the staff training programme, staff meeting minutes and rotas, medication administration record (MAR) sheets, risk assessments and other records relating to the management of the home.

On the day of our inspection, we met with five people living at the service and five visitors of whom one was a relative and four were friends. We observed people as they engaged with their day-to-day tasks and activities.

We spoke with the registered manager, maintenance person, two senior care staff, a cleaner and two registered nurses.

The service was last inspected in May 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe at Aldersmead Care Home. One person said, "I feel safe".

A relative told us their husband, "was safe, staff are caring and seem very nice". Another relative said the "bedroom always looks safe and tidy. When you walk in here, it smells lovely and clean. There are no trip hazards you can see".

An external health professional said, "The residents of Aldersmead always appear very well cared for, happy and relaxed. I never witness any bad practice and feel particularly impressed by the way, staff approach, in particular, those residents who suffer from dementia. The care home is a safe environment for the residents to live in with plenty of variety of activities to keep them entertained. I would certainly recommend the care home as a place that provides an excellent service."

Another external health professional said "The home seems to provide safe service, they ask for advice and help appropriately from relatives and health care professionals and been very welcoming to myself, and patients appear well cared for."

All staff were trained to recognise potential signs of abuse or neglect, which would ensure that this risk was monitored and reported upon swiftly if necessary. Staff were able to describe various types of abuse, recognise signs of potential abuse and knew what action to take if they suspected abuse was taking place. One member of staff stated 'If their behaviours changed I would notice'. Another member of staff told us that they would first report any concerns to the nurse in charge or the registered manager.

One member of staff did not mention that the local authority should be contacted in relation to concerns but understood they could whistle blow to the Care Quality Commission. Staff understood that the registered manager would share raised concerns with the safeguarding team and/or Care Quality Commission if needed. Staff attended appropriate safeguarding annually and this topic was also covered comprehensively through induction for new staff. Aldersmead Care Home operated in in line with the requirements of Sussex Safeguarding Adults Policy and Procedures 2015. A copy of this policy was on display in the office, which was easily accessible.

The company had a 'whistle blowing' procedure to enable staff to share their concerns in a safe way. Staff who chose to whistle blow were encouraged to shed light on poor practice and protected to do so.

Risks to individuals were managed so that people were protected from harm.The risk assessments provided a clear action plan for staff on how to manage risks to people and how often they should be reviewed. Various risk assessments were in place and updated monthly including assessments for the use of bed rails, moving and handling, wheelchair use, nutritional needs, falls, pressure area management.

The care plan guidance was clearly linked to the risk assessments.

For example, a person had been assessed using the Waterlow tool as at risk of pressure damage. This is a tool that assists in assessing a person's risk of developing a pressure ulcer. There was a care plan in place to guide staff in supporting good skin integrity such as regular repositioning, using a propad cushion, skin monitoring and regular mattress checks.

There was a catheter care plan in place for some people to ensure this was managed safely and effectively. There was a clear plan for staff on how and how often to empty the catheter and how to keep the area clean. This helped to reduce the risk of urinary and other infections.

We observed there was significant weight loss recorded on a weight chart for one person between May and July 2015. The MUST (Malnutrition Universal Screening Tool) tool indicated a change in malnutrition risk but the care plan had not been updated to reflect this change in need and what actions staff should take to support good nutrition. We spoke with the registered manager about this. Although the documentation was not consistent, the registered manager was aware of the weight loss and had sought a dietician referral through the GP. Interventions such as fortified meals were used and the weight loss had slowed between July and August.

Accidents and incidents were recorded for people and, if needed, a body map was completed to show any physical harm that they had sustained. These were then handed over between shifts.

Good

Is the service safe?

Accidents and incidents were reported promptly to the registered manager who also took any necessary action. This system encouraged the team to reflect on previous accidents and incidents and prevent similar ones.

Generally, staff felt that there were sufficient numbers of suitable staff to keep people safe and meet their needs. One member of staff said, 'There is a high turnover of residents which means people's needs are always changing. This can sometimes pose a challenge but staffing levels can be flexible and they sometimes have extra staff come earlier or later in the day to help during busy times.'

Another staff member said 'Everyone gets on quite well together'. 'It's enough. It's a good number.'

We asked about the staffing levels and staff skill mix as there were people who had been assessed as requiring high levels of staff support to keep them safe. The registered manager had assessed people's needs and used this information to identify the number of staff needed.

There were seven care staff who worked in the morning, five care staff who worked in the afternoon and two care staff who worked overnight. In addition to this, there were two registered nurses who worked in the morning, one registered nurse in the afternoon and one registered nurse who work overnight.

The registered manager was also a registered nurse who worked shifts when needed.

The registered manager said there were no nurse vacancies but there were 4 night carer vacancies, which were currently being covered by internal, or agency staff. Agency staff were rarely used but when they were, we were informed regular staff were used.

Our observations were that there was enough staff to support people in the home to ensure their care and treatment needs were met and for people to go out in the community. The duty rota matched the staffing levels that we saw on the day.

Safe recruitment practices were followed. Most of the core number of staff had worked at the home for a number of years. Two staff had commenced employment within the last four months.

Disclosure and Barring Service (DBS) checks were undertaken to ensure that new staff were safe to work with adults at risk. Staff files showed that two references had been sought and employment histories checked before new staff commenced employment.

Medicines were managed so that people received them safely; there was good hand hygiene during administration. The registered nurse administering medicines knew which service users were able to say whether they wanted pain relief and asked people as much as possible. If people refused this medicine, their wishes were respected and recorded appropriately on the medication administration record (MAR).

The policies and procedures relating to medicines were updated in 2014 and we observed that the nursing staff acted in accordance with these internal policies and with safe administration practices.

Staff received training in the administration of medicines and this was refreshed annually.

There were two medicines trolleys, which were kept in locked rooms when not in use. When in use they were closed and locked when the nurses stepped away. There was one main medicine room on the top floor, which was locked when not in use. Controlled Drugs were safely stored in a separate locked cabinet secured to a wall. There was also a small refrigerator for medicines, which needed to be kept refrigerated.

Although the refrigerator temperatures were recorded regularly, they were not reviewing the room temperature where the medication was stored.

The medicines room was at the top of the house with a window and therefore could get hot on warmer days. This was not being checked. We spoke with the registered manager about this who said they would start to do this.

There was a medication care plan in place for each person that explained what each drug was prescribed for and any adverse signs and symptoms that staff needed to look out for when administering people's medicines.

Medicines were audited monthly and the registered manager undertook spot checks.

The premises appeared clean and tidy and smelled fresh.

Good

Is the service safe?

We were informed there had been a recent change in the cleaning staff and there were now three cleaners. A staff member said they were 'thorough' and 'It's a big job but they do keep it clean'.

One of the cleaners said 'it's useful when there is a third cleaner' as it allowed them time to undertake deep cleaning tasks.

There were daily cleaning checklists that were completed. The registered manager also documented spot checks, which indicated when the cleaning staff had missed anything or needed to redo anything.

Staff followed safe practices so that people were protected against the risk of infection. Staff wore protective gloves and aprons when delivering personal care or food preparation. They knew how to wash their hands effectively before and after delivering personal care to people and were trained in this.

The registered manager carried out regular environmental and health and safety checks to ensure that the environment was safe and that equipment was fit for use.

These included making sure that the water was maintained at a safe temperature, that fire equipment was in working order, that the risk of a potential fire occurring had been minimised, that electrical and gas appliances at the home were safe and that infection control protocols were being followed.

The maintenance person was responsible for several areas of maintenance and health and safety including: general upkeep of the premises, routine checks (water temperatures, environmental risks, Legionella risks, equipment, beds and mattress pressures, fire systems, boilers, portable appliance tests, and other general health and safety audits), as well as responding to maintenance issues as they arose.

Staff had a communications book where they could write in any maintenance issues that needed attention and this was checked through the day, meaning areas that required attention did so in a timely manner. These checks and responsiveness to maintenance issues ensured a safe premises for people, staff and visitors.

Each person had a personal emergency evacuation plan (PEEP), which set out the specific physical and emotional requirements that each person had to ensure they were safely evacuated from the home in the event of a fire, during the day and at night.

Good

Is the service effective?

Our findings

An external health professional said "The care they provide is effective and good quality. They are responsive and flexible and are able to provide good end of life care."

Staff had effective support, induction, supervision, appraisal and training. Staff had supervisions six times per year in line with the provider's policy. Staff records confirmed this.

Issues such as policies and procedures, people staff supported, learning and development, aspirations and goals were discussed. Following each supervision, action points were identified and followed up at subsequent supervision meetings.

A member of staff said, "I have supervisions regularly every couple of months".

People received effective care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities. Training was delivered both in-house and through distance learning. Examples of training topics included Infection Control, Safeguarding of Vulnerable Adults, Health and Safety, First Aid, Fire Safety, Manual Handling, Dementia Awareness Mental Capacity Act and Equality and Diversity. End of life care training was completed in conjunction with a local hospice.

The records showed that cleaning staff were invited to attend much of the same training as care staff so there was a shared responsibility for the well-being of service users. For example, the records indicated they had attended safeguarding awareness, Mental Capacity Act / Deprivation of Liberty Safeguard training, infection control, first aid, fire safety, Control of Substances Hazardous to Health, Health and safety and dementia awareness.

Staff were also able to undertake qualifications in health and social care. One member of staff told us that they had completed a National Vocational Qualification Level 3 in Health and Social Care and hoped to proceed to Level 5. These are work based awards that are achieved through assessment and training.

In the staff room there was a calendar of all the training being delivered on a rolling basis so staff could plan to attend.

Staff said 'I feel I'm very well trained and am given possibilities by the management to improve.'

Team meetings were held quarterly, the last one being on 14 July 2015. The next one was planned for September 2015. These were an opportunity for staff to contribute agenda items for discussion, such as staffing levels, training, suggestions on how the service could perform better and discussing policy updates and implementations. The minutes reflected discussion and learning points for the service to be effective.

An example of this was a complaint made about the food. Discussion was minuted about the lessons learnt and what practice was going to change to ensure this did not happen again.

A member of staff said 'It's a good opportunity to have your say.'

Applications had been completed appropriately for people under the Deprivation of Liberty Safeguards (DoLS). DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Staff understood the relevant requirements of the Mental Capacity Act (MCA) 2005 and were able to put what they had learned into practice. One member of staff referred to people's capacity to make decisions and said, "We are always asking [for consent]. Everybody has the decision of when to get up. People can make decisions where they are able such as what to wear and what they want to eat. Everything about the daily routine they are making choices."

There was a 'making decisions support plan'. This plan was in people's care records. This plan included guidance for support staff on how to effectively communicate with the person with day-to-day decisions. Because staff followed the principles of the MCA, people's decision-making was maximised so they had control over their lives and their rights were protected. Staff had training in areas specific to people's care needs and safety, knew how to meet people's needs and respond to any changes.

The registered manager understood the principles of the Mental Capacity Act 2005. She explained the circumstances

in which best interest meetings had been held with relevant professionals and relatives to make a decision on people's behalf, when they had been assessed as lacking the capacity to do so.

People were supported to have sufficient to eat, drink and maintain a balanced diet. Menu choices were depicted pictorially and written on the notice board so that people could understand and make decisions about what they wanted to eat and drink.

Prior to the lunch meal, the tables were nicely laid and there was a menu on each table with a list of food choices for the lunch and dinner meals. This was useful for people who may have memory impairment so they could make their choices on the day.

A member of staff said 'We can offer something different, if someone wants something else to eat'.

Some people had a soft food diet or their food was blended. Advice had been sought from a speech and language therapist in line with good practice.

A staff member said 'We would call the dietician for advice on people's food and nutrition when needed'.

They monitored people for any swallowing difficulties and sometimes used food charts to keep track of what people were eating.

A recent care review for one person noted that there was continued SALT (Speech and Language Therapist) involvement and the diet was working well.

We observed people having their lunch and they were asked what they wanted to eat. The

lunchtime experience was relaxed and unhurried.

Staff supported people to eat, where needed. We observed a resident discussing dessert options because they had some food intolerances. The person asked for yoghurt, which was not on the menu but given to them anyways. This was an example of choice and taking a person's individual needs into account in relation to their food.

The notice board advertised that hot and cold drinks and snacks were available throughout the day. We observed people asking for food and drink outside of lunchtime which were acted on and provided. Visitors could have meals with residents.

People's care plans gave clear written guidance about people's health needs and medical history. Each person had a health action section, which focused on their health needs and the action that had been taken to assess and monitor them.

For example, diabetes needs were recorded as part of the nutrition and hydration care plan and included a clear statement of food preferences.

The health action plan included details of people's skin care, eye care, dental care, foot care and other specific medical needs. These plans were written in a way which helped people to understand their content and be involved. For example, for a person with a specific health care need, information and pictures were used to explain their condition and the medicines they needed to take to keep them in good health.

A record was made of all health care appointments including why the person needed the healthcare visit and the outcome and any recommendations. People's weights were recorded monthly so that prompt action could be taken to address any significant weight fluctuations. In addition, each person had a "Hospital Passport".

This provided the hospital with important information about the person and their health if they should need to be admitted to hospital.

The home had links with health care professionals, including the chiropodist, dentist, psychiatrist, speech and language therapist and community learning disability team. These professionals were used for advice and support about specific medical and health conditions affecting people to ensure they were given effective support.

Requires improvement

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. Although we observed positive, caring interactions between people and staff, we also observed examples where people were not always cared for in a compassionate, attentive and person-centred way.

During our visit we observed poor interactions including one person who had their hand outstretched to a staff member. The staff member did not appear to notice this and walked by without acknowledging the person.

Another person was in the path of another resident. A staff member pulled the person's wheelchair out of the way quickly without speaking to the person or explaining why they were being moved.

One person was observed not having any staff interaction for a 40 minute time frame. The person was sat in a recliner and was withdrawn. When refreshments were served they were not supported to eat or drink with everyone else although we could see there was a beaker of drink left beside them.

We fed this back to the registered manager at the time of our visit.

Staff did not consistently treat people with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast, we observed several examples of caring and respectful interactions between staff and people.

We observed that a radio was on in a bedroom, and a resident stating they were scared because they thought someone was in their room. We informed a staff member who turned the radio down. The member of staff offered the person reassurance and explained it was the radio. The staff member said that the person liked the radio on but that the noise could distress them too. Later in the afternoon the person was observed sitting with a care assistant, they were much more relaxed. The staff member was massaging the person's hands with cream.

We observed a member of care staff holding another person's hand and said to the person they felt cold, the staff then asked if they wanted a blanket and a cup of tea.

We observed a person using the quiet lounge to read the newspaper and a care assistant ask if the lighting was sufficient as the light over the person's head was not working. The staff member then pulled the vertical blinds back to allow more light into the room and asked the person if they would like the television turned off, to which they agreed. The member of staff turned the television off for the person and gave them the remote control.

People's privacy were respected and promoted.

Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice.

A member of staff said that when they supported people with their personal care they, 'Always introduce ourselves' another stated they 'Ensure that doors and windows are closed when providing personal care' and 'Knock on people's doors before entering'.

They added it was also important to ensure people had the privacy they needed and that they had their own space.

One person said 'people [staff] knock and wait before entering my room. I have a door I can lock' which demonstrated that they could maintain their privacy if they wished.

Aldersmead Care Home have been piloting the Proactive Elderly Person's Advisory Care Plan (PEACE) in collaboration with West Sussex Partnership Trust. People on an End of Life Plan had designated care co-ordinators who worked with them for continuity. This was aimed at individuals with life limiting illnesses. The records demonstrated that discussions had taken place between the person, those close to them and a care team about how best to support them and what best care might look like in the future when their health declined. Examples of this were care and treatment for infection and support around nutrition. It also evidenced the person's views on whether being admitted to hospital would be beneficial or detrimental.

Aldersmead Care Home has also achieved the Six Steps accreditation for End of Life Care. This accreditation means the home have developed an awareness and have knowledge of End of Life Care.

Requires improvement

Is the service caring?

We observed the people using the service and their families had assigned dignity champions whose role was to monitor the practices in the team and report/undertake corrective action when staff failed to adhere to good working practices. Families were involved in this process.

Examples of feedback from the dignity questionnaires completed in March 2015 said 'staff can be in and out too quick', 'I can't always hear staff knocking at my door' and 'sometimes people knock and walk in without waiting for a reply".

This feedback was then used in a team leader meeting where it was discussed and an action plan put together to feed this back to staff.

A family and resident questionnaire was then completed in May 2015 which showed these issues had been resolved.

People's needs were recognised in terms of their cultural or religious beliefs. One person was supported in their particular beliefs and lifestyle by visiting church twice a week and had a vicar visit the them each Wednesday for communion and prayer. Care plans sampled reflected each person's beliefs so this need was catered for where possible.

People were supported to express their views and were actively involved in making decisions about their care, treatment and support, as much as they were able.

A person who was unable to read their care plan said 'carers read me my care plans and I will tell them if I agree or not. The staff are lovely and treat me nicely. They knock on my door and make sure my room is nice'. People's abilities to express their views and make decisions about their care varied. To make sure that all staff were aware of people's views and opinions, they were recorded in people's care plans, together with the things that were important to them. At the front of each person's care plan there was a 'This is Me' page, it recorded the persons likes and what made them feel anxious, for example one person liked specific music and a particular type of food, but they could also become anxious and unsettled.

The staff supported people to maintain contact with friends and relatives. This included helping people to send friends and relatives cards, to speak to them on the phone, and to arrange home visits. Staff positively supported friendships that people had outside the home.

A care plan stated 'I can make choices whether to join in activities. I am a social person and I have a lot of friends and contacts outside of the home'. The plan then went into detail of who to contact and when so that they could maintain friendship and family ties. This was also evidenced in the visitors' book.

Staff told us they supported people to look after their own personal care such as washing and cleaning their teeth independently, taking their cups to the kitchen and using the toilet.

Examples of this were also observed on our visit. One care plan said 'I can brush my dentures and keep them cleaned'; 'I can rinse my mouth out and run the tap to fill my cup with water'.

On the day of our visit staff communicated with people in an appropriate manner according to their understanding. We heard one member of staff speaking in a steady and quiet voice to a person who could become anxious. The staff member communicated with the person in a soft voice, to direct this person to the activity in hand and helped them to remain calm.

People living at the service who had verbal communication skills were included in meetings to review their care.

Some people were able to indicate their preferences through speech and physical gestures.

Each person had a communication profile, which gave practical information in a personalised way about how to support people who could not easily speak for themselves. The profiles gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, and angry or in pain. They also contained information about how staff should respond. For example, one person's communication profile explained that if a person was anxious they would need staff to gain their eye contact and distract them by being taken to the 'memory lane' for a 1:1 reminiscence.' The communication was then meaningful and gave reassurance.

Staff ensured they gave people as much freedom as it was safe to do so. We observed a number of people walking around their home with staff keeping a discreet eye on the person so that they could see them at all times, but did not always follow them, to make sure they had their own personal time.

Requires improvement

Is the service caring?

When staff spoke about people they focused on the positive aspects of their character and described their enjoyment in supporting people to get the most out of their lives. People were involved in their care plan according to their understanding and abilities.

Good

Is the service responsive?

Our findings

One person stated, “nurses and carers are all kind, they will make me tea in the middle of the night”.

An external health professional said, “The staff do appear caring and certainly senior staff have been in post for some years and thus enable continuity and are able to respond well in a crisis. They are responsive to patients and relative needs”.

Another health professional said, “As a visiting professional, I can safely say that I always look forward to visiting Aldersmead. If I have to raise any concerns about a patient's treatment, they are always listened to and acted upon promptly.”

The home had received compliments; a card read ‘I offer my sincere thanks to you and all the staff at Aldersmead’, ‘The sensitive approach of staff that was given was truly appreciated’.

Another said ‘food is excellent’, ‘I thank the staff, and they are worth their weight in gold’.

We observed an activities coordinator in the room playing table games with three people and there were other people sat in chairs in the room.

Staff came in and out of the room numerous times to offer support.

We observed someone from the kitchen also came around to offer people drinks and snacks.

Staff interacted in a positive way with people, holding someone’s hand or putting a hand on their shoulder to offer re-assurance. Staff were supporting one person to look at pictures and a book.

Staff were dancing to the music with people and orienting them with the date and time. We observed one person became restless and agitated and a staff member offered to go for a walk with them, which they seemed to enjoy.

People’s needs were assessed before they moved into the home. Where the local authority funded a person’s care, an assessment was obtained from the funding authority so that a joint decision could be made about how people’s individual needs could be met. These assessments formed the basis of each person's care plan.

Care plans contained detailed information and clear directions about all aspects of a person’s health, social and personal care needs to enable staff to care for each person.

They included guidance about people’s daily routines, communication, well-being and activities they enjoyed. Each person had a one-page profile so staff could see at a glance what was important to the person and how best to support them.

One member of staff explained, “We evaluate their support plans and risk assessments”.

Care records showed people were assessed before they moved in by the registered manager. Care records were reviewed at least monthly by a registered nurse or key worker. (A key worker is someone allocated to a person who works with them on a 1:1 basis.) Care plans were updated when needed with the information being shared with staff in the communication book and during handovers of shifts.

A staff member stated ‘you can pick up on what residents need, it’s all in there’. Another staff member stated ‘Everything is written [in the care plan], very useful’ and ‘If anything changes, it’s updated.’ The care plans recorded people’s preferences and assesses risk such as choking.

For choking risks, useful guidance was written in the care plan and displayed in the kitchen.

Formal review minutes with the residents documented that the registered manager and key workers usually attended with people’s families. Reviews occurred within the first month following admission, and then three to four monthly thereafter. Records showed that the plans were evaluated monthly.

Reviews took into account new information and significant changes such as health, medication and diet changes.

There was a ‘resident’s plan of care review form’ for one person’s care which recorded the person’s views on their care and their preferences.

Each person was supported by a keyworker who co-ordinated all aspects of their care.

Relatives kept in touch with people and were supported by staff in this; this was reflected in the daily notes.

Information about people’s daily routines, likes, dislikes and preferences were contained in their care plans, which

Good

Is the service responsive?

were written in a person-centred way. Detailed guidance was in place for staff to support people who presented behaviours that could result in harm to themselves or other people. The specific behaviours that the person might exhibit were clearly listed, together with the appropriate response that staff should take and information about what could trigger the behaviour.

People's well-being was discussed at staff meetings, reviewed by the registered manager and health professionals were involved as needed.

Information about what activities people liked to take part in were recorded in their care plans. During our visit to the home people were occupied watching what was going on and spending time with their visitors. People were asked throughout the day if they wanted to do activities.

Activities for the day were planned and a reminiscence session was run by an external person, who visited every other week. The previous reminiscence session had been themed around the 1960s and 1970s focusing on the passing of Cilla Black. This reminiscence session during our visit was general, focusing on things around the home. For example, whether people remember parquet flooring and how they used newspaper as underlay for carpets. The person leading the session encouraged residents to reflect using their senses of sight and smell.

We observed the activities coordinator match the activity to the ability and preference of the residents that chose to participate. We saw people supported to paint. Some people were playing dominos. Others were reading newspapers, doing crosswords and watching TV. Floor and table top games organised by the activities coordinator.

There were two notice boards, which gave residents and visitors information such as the date and the weather forecast that day. The board was used to inform residents on a range of topics of interest that included helpful advice and information.

People's concerns and complaints were encouraged, explored and responded to in good time.

A member of staff said that they recorded complaints and compliments, which were kept in a folder dedicated for this purpose. Staff said that if a person told them something was upsetting them, they would try to resolve things for the person straight away. If they could not do so, they would report it to the registered manager.

Another staff member said formal complaints go to the registered manager who records her actions. Sometimes staff had supervision to discuss any practice issues, which may have been raised as part of a complaint.

The home had a complaints procedure which included the contact details for the Care Quality Commission. The registered manager made a record of any complaints, together with the action they had taken to resolve them. There had been 14 complaints in 2015 and the way they had been responded to was in line with the provider's policy.

Good

Is the service well-led?

Our findings

An external health professional said, "I believe the home is well led and consistent in its approach to patient care."

Another external health professional said, "I always look forward to visiting Aldersmead because the care team, led by Pauline, is very well managed".

Staff members said "She [registered manager] has plenty of time for residents', 'She [registered manager] is very involved with residents and is supportive of staff', 'Great manager, on top of everything' and 'Matron is always asking us [about additional training]. She wants us to improve our skills.'

Good leadership inspired staff to provide a quality service. This was demonstrated through information being provided to staff which covered CQC's key lines of enquiry under the areas of 'Safe', 'Effective', 'Caring', 'Effective' and 'Well Led'.

The registered manager had addressed each of these domains in a Quality Assurance Development Plan dated 29 April 2015. This was audited weekly by the registered manager and quarterly by the operational manager.

There were effective systems in place to regularly monitor the quality of service that was provided. Each month aspects of care were audited such as medication, care plans, health and safety, infection control, fire and equipment. Having these robust systems supported the registered manager to identify areas that required attention.

During the visit, we observed a pile of daily care records/ observation records on a table in the dining room/ conservatory as staff sat here in the afternoon to update them. However, there were periods where these records were left unattended for periods of time, which left people's personal information at risk. One resident picked up one of the records and started to flip through it, thinking that it was a magazine. This was brought to the registered manager's attention during the visit who stated they would address the issue with the staff on duty.

Information about accidents and incidents were analysed by the operations manager monthly, so that any trends or patterns could be identified and action could be taken to reduce the occurrence of any of these events.

The operations manager visited quarterly to check that all audits had been carried out. They completed an improvement plan, which set out any shortfalls that they had identified on their visit.

This plan was reviewed at each visit to ensure that appropriate action had been taken.

During their visit, they looked at records, talked to people and staff and observed the care practice in the home. A detailed report was produced about all aspects of care and treatment at the home.

The report highlighted that some care plans and risk assessments needed updating, the registered manager then responded to this.

The next audit showed this action had been taken within an adequate timescale and they were completed to a good standard.

The annual audit tool, for 'Safe' covered the training plan to ensure staff training was up to date in safeguarding. This was reflected on the training schedule observed. Monthly auditing of care plans and risk assessments ensured they were up to date and relevant and risks were being managed and balanced. These audits were looked at as part of our visit.

The registered manager used this section of the tool to ensure DoLS applications had been made to the local authority upon completing individual capacity assessments to see if they were needed. Other areas audited and reviewed covered staffing levels and recruitment, infection control, medicines, staff training and the issue of quality questionnaires.

Similar audit systems had been developed for 'Effective', 'Caring', 'Responsive' and 'Well Led' which monitored areas for improvement and identified actions to be taken.

The home had a whistleblowing policy and staff knew what to do if they had any concerns. One member of staff confirmed they had read the policy and guidelines on whistleblowing and said that the registered manager would be their first port of call or, failing that, the area manager.

The aims of the service were displayed at the home and on the company's website. The registered manager was able to speak fluently of them and described providing high standards of care in the safest possible way. The registered

Good

Is the service well-led?

manager said 'I try to be fair, open, honest and if I don't know the answer, I will say. The people living here have a right to be treated as adults, be treated fairly, listened to and responded to.'

Staff said that there was good communication in the staff team that they worked well together and staff meetings were regularly held. Staff said that they enjoyed their jobs and supporting people in their care. Minutes of these meetings showed discussion around CQC changes had occurred, safeguarding was a regular topic for discussion as was health and safety and lessons learnt from complaints and questionnaire feedback. The last meeting was on 14 July 2015.

The views of people who lived at the home were sought at individual monthly keyworker meetings and at residents' meetings. The last residents' meeting was on 6 March 2015 and occurred twice a year. The residents' views on future ideas for the home were asked. In response there was a cream tea afternoon, those that wanted to be part of the gardening did so and a visit to another home was arranged for lunch and for a social gathering.

Some residents had been documented as saying 'food is sometimes cold'; this was followed up in another meeting with the catering staff to ensure this did not happen again. Another stated 'food is good; if I am hungry I am offered snacks'. During the residents' meetings, maintenance, laundry and nursing care were also discussed.

The views of people's relatives were sought through annual questionnaires in May 2015. These records sampled were complimentary.

As a result of feedback received from questionnaires, the following areas were raised and responded to by the registered manager: an activity coordinator was requested to offer more stimulation, which was actioned. More activities were suggested such as a pampering session, music session, memory books implemented and more visits to the pub supported – this was reflected on the notice board and daily records showed these were happening.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not consistently treated with dignity and respect. Regulation 10 (1)**