Woodean Limited

Sunhill Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 24 and 26 February 2016 and was unannounced.

Sunhill Court Nursing Home provides nursing care for up to 40 older people with dementia care needs and/or mental health needs. At the time of our inspection, there were 34 people living at the home. Sunhill Court Nursing Home is a large Edwardian building on the outskirts of Worthing and overlooks the South Downs. There are several communal areas – a large lounge, dining area and conservatory on the ground floor and a smaller lounge on the first floor. People have their own rooms and have access to a large garden at the rear of the property.

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

The last inspection took place on 30 June 2015. As a result of this inspection, we issued five Warning Notices in August 2015. We asked the provider to take action to address areas of concern relating to safe care and treatment, nutritional and hydration needs, good governance, dignity and respect and staffing. The provider was required to take appropriate action to meet these Warning Notices by 18 September 2015. In addition, we found the provider in breach of a number of regulations and asked them to submit an action plan on how they would address these breaches. An action plan was submitted by the provider which identified the steps that would be taken, the majority of which would be completed by the end of September 2015. At this inspection we found that the provider and registered manager had taken appropriate action to meet the Warning Notices and were now meeting required standards. However, we identified that further time and action was necessary to ensure the improvements continued and were embedded consistently into staff practice.

Some staff did not have a good understanding of safeguarding and how to protect people from the risk of abuse. Other staff were able to explain the different types of abuse and what action they would need to take. The provider had failed to alert the local safeguarding authority to a series of incidents that had occurred and had failed to notify the Commission.

Risks to people were identified and assessed appropriately. Care records contained guidance and information to staff on how to support people safely and mitigate risks. Medicines were managed appropriately, although the refrigerator did not work effectively and the packaging of some medicines was damp.

There were sufficient staff in place to meet people's needs, although a dependency tool employed by the provider to assess staffing levels based on people's needs, was out of date. There had been a high turnover of staff in recent months and there was a heavy reliance on agency staff, especially registered nurses, to

ensure staffing levels were safe. Robust recruitment practices ensured that new staff were vetted appropriately and checks were undertaken to confirm they were safe to work in a caring profession.

Improvements had been made to staff training and opportunities were available to staff. However, not all staff had completed the mandatory training and attendance by staff at training sessions was not consistently high, so some staff were not up to date with their training in specific areas. Staff received formal supervision and annual appraisals from their managers. Some staff, who did not have English as a first language, were unable to communicate effectively and people living with dementia may have found it difficult to understand them. All staff had a good understanding of the implications and requirements of the Mental Capacity Act 2005 and associated legislation under the Deprivation of Liberty Safeguards.

People had sufficient to eat and drink and were supported by staff to maintain a healthy diet. However, some staff did not understand how to approach people in line with their needs to enable them to enjoy the lunchtime experience. Other staff were empathic in their approach. Special diets were catered for and people's nutritional needs were assessed appropriately. Where needed, advice and guidance was sought from healthcare professionals. The environment was not always arranged in an effective way that was conducive to meeting the needs of people living with dementia.

The majority of staff had developed positive, caring relationships with people. However, there were occasions when staff did not communicate appropriately to meet the needs of people living with dementia. This may have been due to a lack of understanding by some staff and cultural differences. People's spiritual needs were catered for and they were treated with dignity and respect. As much as they were able, people were involved in making decisions about their care.

An activities co-ordinator was employed for three mornings a week and a programme of activities had been organised for people. People were engaged in these activities in a meaningful way and appeared to enjoy what was on offer. The provider hoped to be able to have more staff on duty to enable people to access the community and planned outings. However, some people cared for in bed lacked similar opportunities for mental stimulation.

Comprehensive, detailed care plans provided staff with information about people, their personal histories and how they needed to be supported and cared for. Staff did not understand the concept of person-centred care, although the provider had arranged for training on this topic.

The provider had a complaints policy in place, although no formal complaints had been received since the last inspection.

People were asked for their views about the service and regular residents and families' meetings were held. Staff were also asked for their feedback and felt that the registered manager was supportive. A range of audits was in place to monitor and measure the quality of care delivered.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was enough improvement to take the provider out of special measures.

We found a 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Some staff did not have a clear understanding of safeguarding and what constituted abuse. Notifications relating to abuse or allegation of abuse had not been received by the Commission. The local adult safeguarding authority had not been informed.

Medicines were managed safely.

Risks to people were identified, assessed and managed appropriately. There were sufficient staff to meet people's needs and safe recruitment practices were in place.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Mandatory training had not been completed by all staff. Some staff had limited English which affected their understanding in certain areas. However, staff had a good understanding of the requirements under the Mental Capacity Act 2005 and put this into practice.

Opportunities had been missed to adapt the environment in a way that supported people living with dementia.

Staff received regular supervision from their managers and an annual appraisal.

People had sufficient to eat and drink and had access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Some staff did not have a good understanding of how to communicate appropriately with people living with dementia. Overall, positive caring relationships had been developed between people and the majority of staff.

People's spiritual needs were catered for and they were treated with dignity and respect. People were encouraged to make decisions about their day-to-day care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People cared for in bed did not have sufficient mental stimulation. However, a range of activities was organised and available to people who were able to access these.

Some staff did not understand the concept of person-centred care.

Care plans provided comprehensive, detailed information about people and guidance to staff.

Complaints were managed in line with the provider's policy. No formal complaints had been recorded and informal complaints were dealt with straight away.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People and staff were asked for their views about the service. Regular residents and families meetings were held.

A range of systems was in place to audit and monitor the quality of care delivered.

Sunhill Court Nursing 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.

The inspection took place on 24 and 26 February 2016 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. The expert by experience at this inspection had expertise in dementia care.

This inspection was carried out to check that improvements to meet legal requirements, identified in five previous warning notices, had been made. This inspection also checked to see whether breaches of legal requirements made as a result of the last inspection on 30 June 2015 had been met.

Before the inspection, we checked the information that we held about the service and the service provider. This included the last inspection report 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 also examined the action plan that the provider had returned after the last inspection. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, relatives and staff. We spent time looking at records including seven 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 and spoke with four people living at the service and four relatives. Due to the nature of people's complex needs, we did not always ask direct questions. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the

provider, the registered manager, a registered nurse, three team leaders, three care staff and the chef.

Requires Improvement

Is the service safe?

Our findings

People were not protected from abuse and harm consistently, nor were they supported by staff who always knew what action to take if they suspected abuse was taking place. Insufficient action had been taken to ensure all staff had a thorough understanding of safeguarding and how to support people safely. Three of the six staff we spoke with had undertaken specific adult safeguarding training within the last year. Most were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team, should be made, in line with the provider's policy. However, three of the six staff could not discuss safeguarding issues with us in a meaningful way. Instead they all talked about issues relating to the Mental Capacity Act 2005, in which they had received recent training. One staff member told us mistakenly, "It [safeguarding] is about making sure people have a say in decisions". Another staff member said, "I think we shouldn't make decisions for people". An action plan from the provider, relating to risk management and concerns raised at the last inspection, stated, 'Training is [also] being revisited on safeguarding to ensure that all staff understand what might constitute a safeguarding concern'. This action had not been completed satisfactorily.

In one person's care plan, we read that there had been at least 16 occasions between April and November 2015 when they had exhibited challenging behaviour and had attacked, or attempted to attack, people and staff. Action had been taken promptly to address each incident and this person was seen regularly by an appropriate healthcare professional. However, each incident had placed people at risk of abuse and should have been notified to the local safeguarding authority for investigation. There was no evidence to show that this was done from the paperwork that the registered manager gave us relating to safeguarding issues at the home. In addition, each incident should have been notified to the Commission as they constituted abuse or allegation of abuse. We received no notifications and discussed our concerns with the registered manager and the provider at the end of our inspection.

The above evidence shows that people were not protected from the risk of abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, the provider contacted us by email to express their concerns that notifications had not been sent. They explained that a change from a paper based system to a new electronic system had meant that the registered manager had not received 'prompts' which were a reminder to complete the necessary notifications. The provider assured us that a system was now in place to prevent reoccurrence and that the person in question posed no further risk and had now settled at the home. The registered manager stated, "[Named person] is more settled now and I feel the risk is managed".

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with safe care and treatment. There were serious concerns that care and treatment was not provided in a safe way for people. As a result, we issued a Warning Notice in August 2015, which was to be met by 18 September 2015.

At this inspection, we found that sufficient steps had been taken and the provider was meeting the required

standards. Stained and loose carpeting had been replaced with laminate flooring on the first floor. A door to the staff living quarters on the second floor was secure and staff had been reminded of the need to keep the door closed. A thermometer had been placed in the conservatory to monitor the temperature during hot weather and the action plan stated that people would be moved to a cooler area and the windows opened if needed. Eighteen staff had been trained in moving and handling to ensure people were moved safely. We observed one person being moved by staff in a wheelchair and that there were no foot rests to support the person's feet appropriately. We brought this to the attention of the registered manager who told us that the wheelchair in use belonged to the person and their preference was to continue to use it. They had been made aware of the risks and lifted their feet clear of the floor as they were being wheeled back to their room.

Concerns had been raised at our last inspection relating to the management of pressure ulcers and wound care. The registered manager told us that no-one at the home was suffering from pressure ulcers at the time of this inspection. People's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for the purpose. One person's care plan recorded they were at high risk of developing pressure ulcers and they received nursing care in bed. A pressure relieving mattress was in use and adjusted to the correct setting and we asked staff about the absence of positioning charts. Positioning charts are used to record when staff physically turn a person in bed, thus relieving pressure on different parts of the body. We were told that this person did not require a positioning chart as they were able to turn independently; our observations of this person confirmed this.

At our last inspection, medicines were not managed safely and Medication Administration Records (MAR) charts had not always been completed appropriately and signed by staff. At this inspection, we were told that night staff checked MAR charts each day to ensure staff had signed each entry appropriately. We checked 10 MAR charts and found 'gaps' for one person of two medicines. Both medicines, which should have been administered at breakfast time the day before, were missing from the blister packs, but the MAR had not been signed by staff to show the medicines had been administered at that time. Later in the day, we looked at the MAR charts again and the gaps had been filled in by the agency registered nurse who had realised it was their oversight. The provider or registered manager may wish to evaluate the effectiveness of the systems for monitoring MAR charts.

We observed the registered nurse administering medicines to people at lunchtime. MAR charts were clearly printed and each had photo identification of the person and any known allergies; there were also photos of each medicine. The registered nurse cross-referenced the medicine, dose and time with the information on the monitored dosage system blister packs. The medicines trolley was locked at all times when unattended. The registered nurse washed their hands between each administration of medicines and ensured that people had taken their medicines before signing the MAR chart.

Medicines were stored in a locked drugs cabinet within a locked storage room. The registered nurse for each shift held the keys to the medicines storage room. A refrigerator dedicated to medicines storage was also in the room. The fridge temperature and room temperature were within recommended ranges to ensure the efficacy of the medicines; daily checks were made and temperatures recorded. The probe of the digital thermometer was placed inside a small, slightly rusty tin of petroleum jelly in the fridge. The registered manager stated that the pharmacist had advised this method as being effective to monitor the fridge temperature. However, the petroleum jelly tin was sitting in a small pool of water which suggested a degree of condensation within the fridge. There was also water on the bottom plate of the fridge where some antibiotic medicines and insulin were stored. The boxes for these medicines were damp. It is not advisable to store medicines on the floor of the fridge. We discussed these issues with the registered manager and later with the provider. They told us that a new fridge was to be ordered.

Registered nurses administered medicines and their competency was checked by the registered manager. A medicines policy provided guidance to staff on the safe administration, handling, keeping, dispensing, recording and disposal of medicines. Specimen signatures were on file for staff who were permitted to administer medicines as a means of identifying their signatures. Clinical observations were undertaken by the registered nurse to monitor people's blood sugar, blood pressure and pulse rates which indicated whether a person should be given a particular medicine or not. The registered nurse had a good understanding of what each medicine was for, however, they did not know how often people had reviews of their medicines undertaken. The registered nurse also stated that some people required medicines to be crushed or to be given covertly, that is without their knowledge. After the inspection, the registered manager told us that some people were already receiving their medicines covertly before they came to the home. Other people had a decision made at a best interest meeting, where the family, care staff and healthcare professionals discussed the options available.

We asked staff about their understanding of risk management and keeping people safe, whilst not restricting their freedom. One staff member said, "We always let people make decisions for themselves if they can. It can be risky, but we do". Another staff member told us, "If someone wants to do something and they have mental capacity, they can do it. We try to keep them safe, but it's up to them". Training was offered to staff in risk assessment and moving and handling. However, only four staff out of 24 had completed risk assessment training in 2015/2016. We were told that only registered nurses completed risk assessments. Generally care plans were reviewed regularly, but risk assessments within one care plan had not been reviewed recently and were due to be reviewed by October 2015; this had not been done. The care record stated that the risk assessment should be reviewed by this date and the assessment related to the person's risk to others, mental health, review of medicines and behaviour support plan.

We observed a door was left open to a bathroom where building work was in progress. We were told that the bathroom was not in use, however, people could easily access this room to use the toilet or washbasin. The maintenance staff/builders had left a ladder, spools of cabling and metal fitments in the bathroom which were a potential risk to people. We discussed this with the provider and the registered manager who stated they would lock the door whilst building work was in progress.

In one person's bedroom, the radiator was boiling hot and posed a potential risk of burns to anyone touching it. After the inspection, the provider explained that problems with the boiler had meant that some radiators had not been adjusted safely and, in this case, the radiator valve had been left fully open. The provider had not been aware of this fault and rectified this immediately after our inspection.

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with staffing. There were serious concerns that there were insufficient numbers of suitably skilled and competent persons deployed in order to ensure people's safety. As a result, we issued a Warning Notice in August 2015, which was to be met by 18 September 2015.

At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards. There were sufficient staff to meet people's needs safely as the number of staff on duty had increased. We asked staff about staffing levels at the home. One staff member said, "I think it's okay. We have enough staff to get to know people and spend time with them". Another staff member told us, "We definitely have enough time to cope". A third staff member said, "Staffing levels have massively improved over the last six months, it's much better now". Staff were deployed and used flexibly, so that people received support from staff promptly.

We looked at the staff duty rota covering the period from 23 January 2016 to 19 February 2016. The rota

showed staffing levels were consistent across the time examined, with between seven and eight care staff in the daytime and evenings. One of the care staff provided one-to-one care to a person. There were two registered nurses on duty during the day (including the registered manager) and one at night with four care staff. Kitchen, domestic, administrative and maintenance staff were also on duty during the day.

The provider made extensive use of agency staff during the period examined, particularly in reference to registered nurses. For example, 48 hours was provided by agency nurses in the week commencing 13 February 2016 and 58 hours for the week before. There was less use of agency care staff, with 114 hours being provided across the four weeks examined. Checks were undertaken with the Nursing and Midwifery Council to ensure that nurses were registered appropriately.

We asked how safe staffing levels were established by the provider. We were told the provider used a formal tool to assess the changing needs of people and calculated staffing levels accordingly. The tool in use was 14 years old and did not contain up-to-date information concerning current best practice methods of assessing staffing levels. In addition, we found no evidence of how it was used at the home. The registered manager told us that staffing levels were assessed based on people's care and nursing needs. They said, "We are looking at residents more realistically and how behaviour might change. Staff levels are all based on individual needs". One person said, "There never seems to be enough staff, but they come quickly if I use my call bell".

There was a high turnover of staff and we looked at a list of all employees and their employment starting dates. Of the 31 staff members on the list, the majority of whom were care staff, 15 had joined within the past 12 months. The registered manager acknowledged that the majority of staff had left since our last inspection, but felt they now had a stable group of staff in place. Staff files showed that safe recruitment processes were in place. Checks had been made with the Disclosure and Barring Service to ensure that new staff were safe to work in the care profession. In addition, two references were obtained from previous employers before staff commenced employment. Checks were also undertaken to ensure that overseas staff had the required documentation in place and the right to undertake paid employment in the UK. Whilst some staff were qualified as nurses in their own countries, they were employed as team leaders to deliver personal care at this home. The registered manager explained that the role of team leader had been newly created and staff took on additional caring responsibilities which allowed registered nurses to concentrate on delivering nursing care.

Requires Improvement

Is the service effective?

Our findings

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with staffing. There were serious concerns that there were insufficient numbers of suitably qualified, competent, skilled and experienced persons to meet this regulation. As a result, we issued a Warning Notice in August 2015, which was to be met by 18 September 2015.

At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards. Generally, people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. One person told us, "The staff seem well trained, I'm very happy with it all". We spoke with staff about their experiences of induction following the commencement of employment. One staff member told us, "It was wonderful. The staff helped me a lot in induction. They made me feel at home. I worked with another staff member until I felt okay to work on my own".

We spoke with staff about the training opportunities on offer. One staff member said, "I haven't been here that long, but I've done a bit of training". Another staff member told us, "The training is good and I like it because I can care for the residents better".

We examined the 2015 staff training plan. The provider had made improvements and training was available for staff in the following areas: infection control, health and safety, moving and handling people, fire awareness, safeguarding vulnerable adults, first aid, food hygiene, equality and diversity, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), understanding dementia, communication in dementia, record keeping, risk assessment, pressure sore prevention, death, dying and bereavement, care of people with diabetes and falls prevention.

Attendance at these courses was not consistently high. For example, of the 24 staff members recording on the training plan, only 13 had attended a dedicated safeguarding course in either 2015 or 2016 (see further information in the 'Safe' section of this report). Nine had attended infection control training in the same time period and six staff had undertaken training in pressure sore prevention. In explanation of this, it was noted that a number of staff members were relatively new to employment with the provider, but this did not fully explain why some training had not been completed by other staff, unless it had been assessed as not being required to undertake their caring duties. Therefore, although further training had been implemented to equip staff with the knowledge and skills to care for people's needs, further work was required to ensure this training was completed by all staff, according to their roles.

We asked how staff were formally supervised and appraised by the provider. All of the staff we spoke with had received recent, formal supervision or a yearly appraisal. One staff member said, "The manager is really good and they will always listen". Another staff member told us, "Yes supervision is there. I will go and speak to the manager if I need to in between". Staff records confirmed that staff had supervisions with their line manager and matters discussed, together with action points, were written up. Staff had at least six supervision meetings per year. In addition, observations were also undertaken by senior staff, to monitor

staff delivering personal care. Staff meetings were held, and formally recorded, with the most recent taking place on 13 January 2016.

Of the six staff members we spoke with, three did not have English as a first language. We observed their spoken English was limited and they sometimes found it difficult to make themselves understood because of a lack of vocabulary. Staff sometimes misunderstood questions and we rephrased questions in a different way to try and help staff in answering our questions. As some staff did not have a working knowledge of English, this could have implications when these staff were supporting people who lived at the home, the majority of whom were living with dementia or had a sensory impairment. Clear and effective communication between staff and people is essential. In the action plan submitted by the provider following the last inspection, it stated, 'We will support our non-English speaking staff to undertake English speaking courses'. We raised our concerns with the registered manager at the end of our inspection and they confirmed that staff were being supported to improve their fluency in English through attendance on appropriate courses.

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with consent to care and treatment. We asked the provider to take action because care and treatment was not always provided with the consent of the relevant person in line with legal requirements. 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.

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. We asked staff about issues of consent and about their understanding of the MCA. Some of the staff we spoke with had undertaken recent training in this area. All had a good understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Care plans recorded where people had given consent in particular areas of their care, for example, they gave consent to the use of bed rails. Care plans contained assessments of people's capacity to make decisions.

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 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. The registered manager had applied for DoLS authorisations for 14 people living at the home, some had been authorised by the local authority and some were still in progress. Some staff members could tell us about MCA and DoLS for the people they were supporting. One staff member told us, "We need to make sure we act in people's best interests". Another staff member said, "Sometimes people can have mental capacity for a time then it goes. I try to make use of that time to get them to make decisions, like what they want to wear".

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with meeting people's nutrition and hydration needs. There were serious concerns that people were not always supported to have sufficient to eat, drink and maintain a balanced diet. As a result, we issued a Warning Notice in August 2015, which was to be met by 18 September 2015.

At this inspection, we found that sufficient steps had been taken and the provider was meeting the required

standards. We observed people eating their lunchtime meal in the dining room. Tables were laid with cloths, with cutlery being handed to people once they were seated. The dining room was a 'through room' connecting the conservatory to a quiet sitting area at the front of the home. Staff, and people who wanted to leave their dining tables, were walking through regularly during the lunchtime period. We observed one person was shouting out in a manner that was quite alarming whilst the medicines trolley could not be manoeuvred easily as another person was being moved through in their wheelchair. The atmosphere was quite busy and noisy with staff speaking and trying to engage people's attention who they were supporting to eat. In several cases we noted that some people had more than one member of care staff helping them, whilst two other people did not receive much support with their meal and had fallen asleep. At the end of the meal, their plates were about to be cleared away. However, one member of staff gently put their arms around one person's shoulders and softly spoke to them to see if they wanted to try any more food. They offered to help, with the result that the person then ate and finished off the meal in front of them.

We observed one member of staff supporting a person to eat their food. They placed a large quantity of food onto a very large spoon which they then placed in the person's mouth. However, a further spoonful of food was placed in the person's mouth before they had finished the previous mouthful. This member of staff was quite insistent and forceful with the person who, in the end, refused to open their mouth, shook their head and said, "No, no, no", but the member of staff persisted saying, "Open your mouth, well done". However, another staff member engaged different tactics, spoke kindly and softly with the person and encouraged them to eat, without rushing them. Staff offered choices of juice to people at the table and also asked people if they needed their food cutting up. One staff member said, "You need me to cut it? I'll cut it into small pieces, just tell me when it's enough". People were offered a choice of a jacket potato or another alternative if they chose not to have the main meal on offer, vegetarian curry. We heard one member of staff say, "[Named person] would you like some more cheese on your jacket potato? I love lots of cheese on mine, would you like some more?" Throughout the day, we observed that people always had a drink within reach and staff offered people drinks during the morning and afternoon and at mealtimes. People had mixed views about the food on offer. One person said, "The food's all right, but the curry was a bit tasteless". Another person said, "I don't like the food, but you get used to it".

Care plans showed that people had been assessed against the risk of malnourishment through the use of a tool dedicated for the purpose, the Malnutrition Universal Screening Tool (MUST). People's risks had been assessed appropriately and, where people had been assessed as at high risk, they were weighed more frequently. Where needed, appropriate advice and guidance had been sought from healthcare professionals, such as the dietician. One person's care plan had detailed information about their nutrition and stated, 'My weight and BMI are unstable at present and I require full assistance to eat and drink … I require support to maintain choice and eat a healthy, balanced diet. I require x 1 carer to assist with all meals and snacks. Please offer me snacks between meals. Weigh me weekly and record'. Some people were encouraged to increase their calorie intake through the use of a nutritional supplement, such as Fortisip. There was a vast quantity of nutritional supplements kept in cupboards in one of the storerooms. One box of Fortisip had an expiry date of November 2015. The issue of the large quantity of supplements stored and used within the home was discussed with the registered manager. They said the supplements were useful to have in stock when people were not able to manage an adequate diet.

We spoke with the chef about special diets for people and they told us that food was prepared to meet a range of needs, including diabetes and soft or pureed diets. The registered manager told us that they routinely had to wait 26 weeks for a speech and language therapist (SALT) assessment to be carried out when there were concerns about people's swallowing or aspiration of food. Urgent requests for a SALT assessment could be done within six weeks. In the meantime, soft or pureed foods were given to people to prevent risks such as choking. We spoke with care staff about people's nutritional and hydration needs.

They had a good knowledge of people they were looking after and two staff told us they had previously undertaken training in dysphagia (difficulty in swallowing) management. The provider did offer training in diet and nutrition, but only seven staff members had undertaken this in 2015 or 2016 according to the training plan.

The above evidence in relation to people's nutrition and hydration demonstrated that, although improvements were made to ensure that people had sufficient to eat and drink to meet their needs and preferences, further improvements were needed to embed these changes and ensure a consistent approach by staff in supporting people with their eating and drinking.

People confirmed to us that they received support from a range of healthcare professionals. One person said, "I have had a doctor yes, they got one for me. It's reassuring to know there's a nurse on duty". Another person told us, "I have had my hair done today. I don't have any 'footwork' [referring to chiropodist] but I know it can be sorted here". Care plans documented when people received medical input, for example, from a dentist, chiropodist, optician, GP or district nurse.

In our last report, we recommended, 'that the provider utilises best practice guidance to ensure that the design and adaptation of the service supports the orientation of people living with dementia'. Opportunities have been missed to adapt the environment in a way that might help people living with dementia to navigate around the home. For example, people's doors had no objects of reference, memory boxes or photos. Objects of reference are items that have particular significance for an individual. The day's menu choices were written up on a whiteboard and placed on top of the piano in the dining room. The information was not displayed in a way that supported people living with dementia to easily understand it. Basic information was written up, for example, the teatime/supper choice read, 'selection of rolls'. This would have been difficult for many people to understand and pictures or photos of food could have been used to good effect to aid people's understanding. However, we observed that some improvements had been made, for example, a daily newspaper which described historical events and reminiscence was in use to engage people living with dementia in meaningful conversations about the past. There was a hat and scarf stand in the entrance hall so people could try on various hats and scarfs and a large tank of tropical fish for people to look at. A small room off the dining area was still available for people to access if they chose, however, apart from an alternative place to sit and some pictures on the walls, there was little to engage and stimulate people. This room was mainly used by staff to access the computers and update people's care plans or daily records.

Requires Improvement

Is the service caring?

Our findings

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with dignity and respect. There were serious concerns that staff did not always treat people with dignity and respect to meet this regulation. As a result, we issued a Warning Notice in August 2015, which was to be met by 18 September 2015.

At this inspection, we found that some improvements had been made, but the provider was still not meeting the required standards overall.

One member of staff appeared to lack understanding about people's reality. When one person became anxious during the lunch meal because they thought a family member was coming to see them, the staff member only directed the person back to the task of eating and did not respond to their worries. However, a short while later, another member of care staff approached and the person said, "I don't want anything yet, I want my husband". To which the second member of staff responded, "When he comes, he'll be coming in that way there and so you'll see him straight away". This member of staff was very calm in their approach and immediately the person's mood changed and she became relaxed and reassured. There was a mixed level of understanding by staff in how to approach and communicate appropriately with people living with dementia.

We observed another situation when two care staff were assisting a person to walk to the conservatory after lunch. They were very calm and gentle as the person was taking very small steps. One male member of staff, who was supporting the person closely behind, whispered in their ear and said, "Come on handsome, you can do it, just these little steps, it's our secret". This may not have been an appropriate conversation to have with a person living with dementia.

Apart from the above incidents which may be related to cultural differences of staff and understanding of dementia, it was clear that staff knew people well and supported them appropriately, with dignity and respect. The provider had made specific training available to staff on equality, diversity and inclusion. However, only seven staff out of 24 had completed the training at the time of our inspection. One person did not know if they had a choice of whether male or female staff provided their support and said, "I usually only have girls to do my care. I don't recall being asked".

People and their relatives felt that positive, caring relationships had been developed between people and staff. One person said, "The girls are very nice. I don't think much of the men – they talk too much for my liking!" Another person told us, "I prefer to sit alone for my lunch, it's the only time I really go out there. I'm the only one here who isn't here for medical reasons. I'm only here because of my age and there's no-one else to chat to. A couple of the girls do, I'm quite close to them. Other than that I watch the box and read". A third person said, "I would recommend it. It suits a lot of people, but there are lots that are screaming mad. I miss conversation and sensible people. They just stare at you, there's no conversation. The girls don't have a lot of time, they have a lot to do". However, there were positive comments from people which included, "It's very nice here" and "Yes, everyone seems kind". Feedback from relatives and visiting friends

was also positive. One comment was, "[Named person] has only been here a couple of months. He's got a nice room and he's safe. He gets showered regularly and is always clean and shaven". A friend visiting the home told us, "This is the first time we've been to visit [named person] and we'd like to say immediately as we walked in, it was a very nice atmosphere and the staff are all very nice".

As much as they were able, people were supported to make decisions about their care. These usually related to day-to-day decisions such as what people wanted to wear, how they wanted to spend their time and food/drink choices. We observed that people were smartly dressed in appropriate clothing for the time of year. Female residents had their hair styled by a visiting hairdresser. We asked staff how they supported people to maintain their dignity and privacy. One staff member told us, "We give people choice in what they want and give them time to make decisions". Another staff member said, "We always knock when we go in someone's room" and our observations at inspection confirmed this. At lunchtime, we observed some staff members did not always check with people whether they wanted to wear a protective covering to keep their clothes free from food spillages.

People's spiritual needs were recognised and catered for and a church service was held at the home on 11 February. A relative spoke movingly of the caring nature of the home and staff as their family member had passed away recently. They spoke highly of the care and said, "She had the most wonderful care and attention. I've also watched how staff relate to everyone else". They added that staff were very attentive and all the family felt they were well looked after too. The family had agreed that their family member should continue to stay at the home and not be moved into hospital. The relative said that, in line with their wishes, the staff had arranged for a priest to visit and deliver the Last Rites, a Catholic sacrament which a person can receive at the end of their life. The relative had visited the home to pick up their family member's belongings and a member of staff handed them a picture that their family member had recently drawn, which obviously meant a lot to them.

We undertook an observation of people and staff as they engaged in baking a cake during the morning. Six people were engaged in the activity and everyone was asked if they had a drink to hand or if they wanted one. People were asked by the activities co-ordinator if they would like to wear an apron or not to prevent spillage of the sponge mixture onto their clothes. Throughout the activity, the co-ordinator engaged with people in a meaningful and inclusive way. For example, people were invited to test the consistency of the cake mixture after they had stirred it and whether it was ready to go into the baking tin. People were also asked whether they knew what temperature the oven should be set at and how long the cake should be baked for. At the end of the activity, when everyone had finished having a turn at stirring the mixture, the staff member said, "Shall we pop it in the oven? Once it's cooked, you can have a taste". People were positively engaged with the activity and appeared to be enjoying themselves. After the baking activity, people were asked if they would like to play cards and some people chose to engage in a game where they turned over cards and tried to find a matching pair. The card game was explained to people beforehand and everyone joined in the game. Staff talked with people at eye level and drinks were offered to people throughout.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with person-centred care. We asked the provider to take action because people did not always receive care and treatment that was appropriate, met their needs and reflected their preferences. 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.

The provider had engaged the services of an activities co-ordinator who worked at the home three mornings a week. We were told that the hours would be increased in the following month. The registered manager explained that, once they had completed recruiting permanent staff to the home, this would enable people to go out into the community with a member of care staff. Some people had already been asked what sort of thing they would like to do. One person said they would like to visit a particular pub for a drink, whilst others chose to go out for a coffee or on a shopping trip. One person told us, "I've not been outside for two and a half years. I don't want to be shown around the garden, I want to have a look at the sea". One relative referred to the time care staff had to spend with people and explained, "He likes to chat and socialise and he can go out with a carer, but they can't really spend much time taking him out as they've lots to do inside". A range of activities was organised for people and we observed people enjoying a giant game of snakes and ladders, a quiz and armchair exercises on the second day of our inspection. People could also engage in a gardening group which was organised by two ladies who visited the home. Clothes parties were organised twice a year and people could buy new clothes, including underwear and sleepwear, which the organiser brought to the home.

An activities programme was displayed on a noticeboard and, whilst it was difficult to ascertain whether people's particular hobbies and interests were catered for, people appeared to be engaged and enjoy the activities that were organised for them. Some of the armchairs in the conservatory were positioned in a way that enabled people to enjoy the views across Findon Valley and the South Downs in the distance.

People who were cared for in bed did not always have sufficient mental stimulation. For example, we observed one person was in bed staring at a blank wall. According to the care plan in their room, this person, 'Loves rock and 70s' music'. By mid-afternoon, this person was observed alone in a quiet corner. They became tearful and said, "It's not fair, have I done something wrong?" We reassured the person and summoned a member of care staff. The care staff came promptly and calmly and sympathetically explained to the person that their spouse would be visiting later. Therefore, although the provider and registered manager had taken steps to improve the provision of activities for people, further improvements were needed to ensure that the needs of all people were considered in the planning of future activities.

Care records were kept electronically and contained detailed information about people's needs and guidance and information to staff on the way people should be supported. We looked at seven care records in total and 'tracked' the care that two people received. For example, one person was diagnosed with Alzheimer's disease and other complex needs. We looked at the care they received in relation to their nutrition, skin integrity and possible means of communication. The care record included risk assessments

relating to pressure ulcers, risk of falling and nourishment, as well as a completed Do Not Attempt Resuscitation (DNAR) form and DoLS application. We observed this person during the day of inspection and that they were lying on a pressure mattress, facing the wall. Their heels and elbows showed no signs of redness and the skin was intact. Their toes and fingernails were well cared for and their mouth, eye and hair care also appeared well attended. We spoke with the registered manager about this person always being in bed facing a blank wall. They reported that an occupational therapy assessment had been recently carried out and there was the possibility, if funding could be found, for a custom-made chair to be provided. This would enable the person to be moved from bed to chair and position them in such a way that they would not be in danger of slipping to the floor. This person's life story was written-up in a folder kept in their room. It showed that the person had always enjoyed singing in a choir. We spent time singing to them and there appeared to be an immediate response, as the person had tears in their eyes. This person might benefit from one-to-one support in activities to provide mental stimulation. We recommend that the provider looks at opportunities to engage with people and provide 1:1 support for people at risk of social isolation.

A stool chart was also kept for this person, but entries were not always completed and therefore could not be relied upon for accurate information. For example, there was no record of any bowel activity between 1 – 18 February. The registered manager said they were always 'chasing' care staff to accurately document details on the charts in people's rooms. We observed this person was offered food and liquids throughout the day, but staff did not appear to sit the person upright prior to helping them to eat; this was not good practice and could have placed the person at risk of choking. After the inspection, we discussed our concerns with the registered manager. They told us that this person was physically unable to sit upright safely and advice had been sought from an occupational therapist. Options were being considered, including a custom moulded seating system that would enable the person to be supported appropriately. Staff completed daily records electronically to show the care that people received, including food and fluid recording. Summaries of people's care needs were printed off as hard copies and these were kept in people's rooms to provide instant updates for staff. When people's care needs changed, care plans were updated.

Care plans contained information about people's communication, continence, daily life, emotional support, medical needs, nutrition, pain, personal care and sleeping patterns. People told us they were happy with the care they received. One person told us, "I choose when to get up and go to bed. I just ring and they come". However, another person said, "I have a shower twice a week, but I would like one every day ideally".

We asked staff what they understood by the term, 'person-centred care'. A person-centred approach focuses on the individual's personal needs, wants, desires and goals so that they become central to the care and nursing process. One staff member told us, "I think of these people, they are like my children". Another staff member said, "I ask my staff to think they are looking after their own mother and father. This is not a factory". A third staff member we spoke with did not understand the term 'person-centred care' and could not describe it to us. A fourth staff member told us, "Some of the new staff – they don't understand that you don't need to do everything for everybody. Because we have more time now, we can make sure staff know what people can do for themselves and let them do it". According to the records we looked at, the provider did not offer any specific training to staff on person-centred care, although the action plan stated, 'All staff will receive training on person-centred care including dignity, respect and ways to approach and speak to residents and these will be reviewed'. Therefore, we found that improvements had been made to the way people's care had been planned, reviewed and carried out, but further improvements were needed to ensure consistency of staff understanding and approach.

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with complaints. We asked the provider to take action because complaints received were not always

investigated and proportionate action taken in response. 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.

The provider had a complaints policy in place which stated, 'It is our policy that all comments, suggestions and complaints are dealt with quickly and effectively'. Complaints would be acknowledged and investigated within 28 days of receipt and a meeting was offered to the complainant to discuss any issues or concerns. The provider had a recording system in place to ensure that complaints would be fully investigated in a timely manner. No complaints had been recorded and staff told us that usually any concerns were raised informally with them or the registered manager and dealt with straight away.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in June 2015, we found the provider was in breach of a Regulation associated with good governance. There were serious concerns that there were no effective systems or processes in place to meet this regulation. As a result, we issued a Warning Notice in August 2015, which was to be met by 18 September 2015.

At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards. One person told us, "I've had letters from head office asking me if I'm all right here". People and their relatives were involved in developing the service and their views obtained at 'families and representatives' meetings. We looked at the minutes relating to the last two meetings held in November 2015 and January 2016. These showed that various items had been discussed, such as the suggestion of forming a committee of families, to include a staff representative and a resident representative. Activities for people were discussed and a suggestion was made that volunteers might be enlisted to help with activities such as gardening, a film club or photography club. Other suggestions discussed were a 'tea dance' and access to the Women's Institute.

People and their families were also asked for their feedback through a formal questionnaire; the last survey had been completed in May 2015 and showed that 20 responses, out of 38 requests sent out, had been received. Most responses were positive, such as, 'The staff are kind and compassionate, patient and work hard' and 'I have complete faith that my relative is in very good hands'. Some responses related to activities and a programme of events for people. As a result, a programme of activities was posted on a noticeboard at the home and sent out monthly to relatives. In addition, families and representatives' meetings had been instigated, to be held every two months.

Staff confirmed to us that the registered manager operated an 'open door' policy and they felt able to share any concerns they might have in confidence. One staff member felt the registered manager was, "a very good leader and has time for everyone". They added that their opinions were respected and gave an example of reporting their concerns about one person who had been coughing. As a result, their observation was listened to and acted upon. We asked other staff about the management of the home and one staff member told us, "The manager is really good and is fair too". Another staff member said, "I can always talk to my manager if I have problems with my staff". We asked staff about the vision and values of the home. One staff member said, "I think we are much better. We have a good team". Another staff member told us, "I'm new, but I think it's very good here. I've learned a lot". A third staff member said, "I hope to stay here because I like it a lot" and a fourth staff member told us, "I think we try to give people a good life".

A range of audits had been put in place relating to people's care plans and these included information on consent to care and treatment, life story, personal emergency evacuation plan and bed rail audit. Other audits had been implemented including infection control, medicines, health and safety and a hoist and sling audit. The provider had drawn up an action list of actions to be completed and this was reviewed and updated regularly, showing which actions had been completed and which were outstanding. A pharmacist

had completed an advisory visit in January 2016. No significant issues were identified.

Staff were asked for their views about the service and nine responses had been received. The comments recorded were not overall positive, but the registered manager explained that the majority of staff who were unhappy about their employment at the home had since left. A whistleblowing policy was in place. One member of staff told us, "It's really enjoyable, I'm quite happy to work here. If I have an idea, it's discussed with my manager".

We asked the registered manager to explain their view of the culture of the home. They said, "We've tried to move away from a culture of 'we're here to look after you' and try and promote independence". They added that the focus was on, "Family friendly orientated personalised care, caring from the heart". The registered manager felt they had worked very hard on the action plan and taken a lot of advice from the local authority Care Home In-reach team, who had been supporting them since the previous week.

It was evident that significant improvements had been made across all areas of the home since our last inspection. As indicated in our report, further improvements will be required to ensure good practice and consistency of care is embedded and sustained across the organisation.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment. Systems and processes had not been established to prevent abuse of service users. Regulation 13(1)(2)