

Bupa Care Homes (CFChomes) Limited

Dean Wood Care Home

Inspection report

Warren Road
Brighton
East Sussex
BN2 6DX

Tel: 01273987620

Date of inspection visit:
16 October 2017
18 October 2017

Date of publication:
24 November 2017

Ratings

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

Summary of findings

Overall summary

We inspected Dean Wood Care Home on the 16 and 18 October 2017 and the inspection was unannounced. Dean Wood Care Home is registered to provide accommodation and care, including nursing care for up to 80 people, with a range of medical and age related and chronic conditions, including arthritis, frailty, mobility issues and dementia. The service is divided into three floors. The ground floor provided care and support for people living with dementia. The first floor provided care and support to people with nursing care needs and the second floor provided to care and support to people with lower level care needs.

Dean Wood Care Home belongs to the large corporate organisation called Bupa Care Homes (CFChomes) Limited. Bupa provide nursing care services across England and have several nursing homes within the local area.

The service had a registered manager in place. 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.

At the last inspection undertaken on the 13 and 14 September 2016 areas of improvements were found in relation to staff morale, lack of staff supervisions and further work required to embed the provider's audits and action plans. Recommendations were made and at this inspection, we found improvements had been made. However, we identified new areas of care that needed improvement.

Systems and processes were in place for the provider to monitor compliance with the Health and Social Care Act 2008 (Regulated Activities) 2014. Audits were undertaken on a regular basis and the provider was able to demonstrate how audits were utilised to drive improvement. However, the provider's internal quality assurance framework was not consistently robust and further work was required to strengthen the provider's internal quality assurance checks. For example, shortfalls and omissions with documentation had not consistently been identified as part of the provider's internal quality assurance framework. We have identified this as an area of practice that needs improvement.

Positive relationships had been developed between people as well as between people and staff. There was a friendly, caring, warm and relaxed atmosphere within the service and people were encouraged to maintain relationships with family and friends. One person told us, "I'm very happy, I'm having a ball."

People were protected, as far as possible, by a safe recruitment system. Staffing levels were based on an assessment of people's individual care needs. Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported from abuse. There was a whistle-blowing procedure available and staff said they would use it if they needed to.

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

applies to care homes. Appropriate application to restrict people's freedom had been submitted. Staff had received training on the Mental Capacity Act 2005 (MCA) and worked in line with the principles of the Act.

People spoke highly of the food and said that they were able to make choices about what they had to eat. People received enough to eat and drink and risks associated with nutrition and hydration were managed effectively. People were supported to access the health care services that they needed.

The management of diabetes and catheter care was effective. Staff felt supported within their roles and staff morale had improved. The management team were dedicated to ensure staff's and people's voice was heard and acted on. Forums were in place for people and their relatives to give feedback on the running of the service.

People received care and support that was responsive to their needs. Care plans provided information on people's day to day care and people participated in a wide and varied range of activities. Regular outings were organised and people were encouraged to pursue their interests and hobbies.

Systems were in place for the safe storage, administration and disposal of medicines. People told us they received their medicines on time and in their preferred manner. A complaints policy was available and people and their relatives felt confident raising any concerns.

People were treated with dignity and their rights and choices were respected. Observations showed people being treated in a respectful and kind manner. People's privacy was maintained; when staff offered assistance to people they did this in a discreet and sensitive way. People confirmed that they were treated with dignity and their privacy was maintained. People's religious, sexual and spiritual needs were respected and upheld.

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 

Dean Wood Care Home was safe.

Staff had a clear understanding about how to protect people from abuse. People received the medicines safely when they needed them.

There were robust recruitment procedures in place and there were sufficient staff to keep people safe and meet their needs.

Risks associated with the environment were mitigated and risks associated with people's care were assessed, monitored and reviewed.

Is the service effective?

Good 

Dean Wood Care Home was effective.

People were happy with the food provided and were able to choose what they had to eat and drink.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

Staff had a good understanding of people's care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good 

Dean Wood Care Home was caring.

People were supported in a stable and caring environment. The staff promoted an atmosphere which was kind and friendly and staff had developed positive relationships with people.

Visiting was not restricted and people were supported to maintain relationships with people that mattered to them.

People had built caring relationships with staff. Staff treated people with respect and recognised people's needs for privacy.

Is the service responsive?

Dean Wood Care Home was responsive.

People were encouraged to take part in activities to meet their social and physical needs and to reduce risks to them from social isolation.

People were satisfied with the support they received. The provider had appropriate arrangements in place to deal with any concerns or complaints people may have.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Good 

Is the service well-led?

Dean Wood Care Home was not consistently well-led.

The provider's internal quality assurance framework required strengthening. Shortfalls with documentation had not been identified internally as part of the provider's quality assurance checks.

The management team promoted an open and positive culture which focussed on people.

Staff morale had significantly improved.

Requires Improvement 

Dean Wood 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.

The inspection took place on the 16 and 18 October 2017 and was unannounced. The inspection team consisted of three inspectors, a specialist advisor with clinical experience of nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was last inspected in September 2016 where areas of improvement were needed in relation to staff supervision, staff not consistently feeling valued or supported within their role and embedding audits and action plans. The service was rated as 'Requires Improvement.'

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we looked at the previous inspection report and information that had been shared with us. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 10 people, six visiting relatives, an activity coordinator, three registered nurses, 10 care staff, the chef, the clinical lead and the regional director. The registered manager was away at the time of the inspection but we contacted them via email after the inspection. Some people had complex ways of communicating and most people had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about peoples' care and how the service was managed. These included the care records for 12 people, medicine administration record (MAR) sheets, six staff files, training matrix and other records relating to the management of the service. We observed care and support in the communal lounges and dining room during the day. We also spent time observing the lunchtime experience people had and the administration of medicines.

Is the service safe?

Our findings

People told us they felt safe living at Dean Wood Care Home. One person told us, "I'm extremely safe here." Another person told us, "I feel safe because if I press the button someone comes." A third person told us, "Yes I feel safe, they don't come charging in here without telling me who they are." People's relatives also confirmed they felt confident leaving their loved ones in the care of Dean Wood Care Home.

The risk of people receiving unsafe care and treatment had been assessed and actions implemented to mitigate any such risks. The provider had consulted nationally recognised guidance such as the 'Health and Safety Executive (HSE)' and the 'National Institute for Health and Care Excellence (NICE).' A large number of people required support from staff to move and transfer. Moving and handling risk assessments were in place which considered any physical, psychological and environmental hazards which might prevent a safe transfer. Consideration had also been given to individual tasks such as getting in and out of bed, if assistance was required, the necessary equipment and number of staff to aid a safe transfer. For example, one person required the support of a hoist with a medium sized sling and two staff members. Staff members had received practical training with moving and transferring and staff members confirmed they felt confident with the safe handling of people. During the inspection, we observed staff moving people with the support of a hoist. Staff clearly explained what they were doing and what was happening. For example, staff supported one person to transfer into a chair into the lounge. This was undertaken in a sensitive and dignified manner. Staff talked through the steps and explained what was happening throughout the transfer.

Management of pressure damage is an integral element of providing safe care to people living in nursing homes. We looked at the management of pressure damage throughout the home. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses and regular re-positioning. Input had been sought from the Tissue Viability Nurse where the person's skin integrity had broken down and nursing staff followed specialised wound care management plans. Documentation reflected that people's dressings were changed in line with the frequency recorded in their wound care management plan and wounds were healing. On the first day of the inspection, we identified a number of air mattress settings which were on the incorrect setting as noted in people's care plans (it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown). We brought these concerns to the attention of the management team and on the second day of the inspection, improvements had been made. Air mattress settings now included guidance on the setting itself which provided a visual prompt for staff when checking air mattress settings. On the second day of the inspection, air mattresses were on the correct settings.

Risks associated with wound care and nutrition were discussed at the management's weekly clinical risk meeting. This enabled the management team to have strategic oversight of any risks related to malnutrition, weight loss or newly acquired wounds. Clinical risk meetings also acted as a forum to monitor weight loss and ensure robust action was taken alongside monitoring the progress of any wounds and skin tears.

Systems were in place for the safe storage, administration and management of medicines and people confirmed they received their medicines on time. One person told us, "I get my medicines on time without fail. I can ask for painkillers. I have to ask the nurse." Another person told us, "They do medicines well, I have been given some more painkillers today." Care plans included guidance on whether people could experience pain and whether the person required a pain assessment. One person's care plan identified they could experience pain and were able to inform staff where the pain was and if they required pain relief. Medicines were administered by registered nurses or staff assessed as competent to do so and we observed staff following best practice guidelines. For example they encouraged people to take their medicine at their own pace. Once staff had confirmed the medicine had been taken they signed the Medicines Administration Record (MAR) straight away. MAR charts were clear and accurate and reflected that medicines were administered in accordance with individual prescriptions. They contained individual information and photographs to support safe administration.

Clear guidelines were in place for the administration of 'as required' medicines (PRN) outlining the reasons a person needed their medicine and how often it was to be given in 24 hours. Where people were prescribed antipsychotic medicines on a PRN basis, documentation confirmed they were administered on an ad hoc basis and staff members confirmed they would only be administered if all other steps had failed.

Policies and procedures were in place to support the safe administration and management of medicines. This included covert medicines (giving of medicines in a disguised form). Guidance by National Institute for Health and Care Excellence (NICE) describes covert medicines as giving people their medicines without them knowing. The guidance explains that 'The covert administration of medicines should only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005. However, once a decision has been made to covertly administer a particular medicine (following an assessment of the capacity of the resident to make a decision regarding their medicines and a best interests meeting), it is also important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed (as capacity can fluctuate over time).' Covert policies and protocols were in place alongside mental capacity assessments and best interest decisions which clearly reflected why the use of covert medicines was required.

Staff had an understanding of abuse and what action they would take if they had any concerns. They identified the correct safeguarding and whistleblowing procedures should they suspect abuse had taken place, in line with the provider's policy. They were aware that a referral to an agency, such as the local authority, could be made. One staff member told us, "I would always report (an abusive situation) to my manager." Another staff member told us, "We do get regular updates and training which is useful as it's always changing." Training documentation confirmed staff had received safeguarding training and the management team shared learning from safeguarding enquiries with staff members through the forum of supervisions and staff meetings. A member of the management team told us, "We are transparent and want to learn from safeguarding investigations. For example, following one safeguarding we have organised for end of life training and training on syringe drivers."

People were protected, as far as possible, by a safe recruitment practice. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults, completed by the provider. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Regular maintenance and environmental checks had been completed. Fire evacuation and emergency procedures were displayed around the service. Staff and people had access to clear information to follow in the event of an emergency, including Personal Emergency Evacuation Procedures (PEEPS). PEEPS included individual information about people and things which need to be considered in the event of an emergency evacuation. Including mobility, health, and the number of staff required to assist them. There was regular training for both day and night staff and evacuation equipment was located in the building in the event an emergency evacuation was required. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

Systems were in place to assess staffing levels. The provider used their own dependency tool titled, 'electronic care needs assessment tool.' A member of the management team told us, "Every month we complete this tool which considers people's nursing care needs, care needs and care banding. That then calculates how many hours of care they require per day. It then calculates the hours of care that we need per week." Documentation reflected that the service was providing over and above the assessed number of hours of care they had calculated. For example, the provider's dependency tool had calculated the service required 1203 hours of care staff per week, however, the provider was providing 1760 hours of care staff per week. Staff rotas were devised weeks in advanced and enabled staff to respond to requests to cover shifts before agency staff were requested. A member of the management told us, "We provide staff with a list of the shifts that need covering and staff put their names down against the shifts they can cover. Where shifts are unable to be covered with our own staff, we request agency and we have a dedication to ensuring we have the same agency staff for consistency." People and relatives felt staffing levels were sufficient. People told us that staff were busy but that they had to meet their individual care needs.

Is the service effective?

Our findings

People and visitors spoke positively about the home and the care and support provided by the team of staff members. One person told us, "The staff are ever so good. They know how to look after me." A visiting relative told us, "I feel confident in the skills and abilities of the staff."

At the last inspection in September 2016 we identified areas of improvement in relation to staff supervision. This was because a formal supervision strategy had not yet been fully established. Recommendations were made and at this inspection, we found improvements had been made.

Guidance produced by the Skills for Care advises that 'effective supervision is important to all, whether a new care worker or the CEO of a multi-site national care organisation. Ineffective supervision can reduce productivity, increase absenteeism, create or prolong workplace conflict, damage the culture and for adult social care employers, impact the quality of care being delivered.' At the last inspection in September 2016 we found staff were not receiving effective and formal supervision. At this inspection, improvements had been made. A programme of supervisions and end of year reviews were now taking place. This provided staff with the forum to raise any concerns, queries or training needs.

Staff told us they were well supported and had received the training they needed to be effective in their role. When starting employment with the service, staff were subject to a robust induction programme which was based on the Care Certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. A member of the management team told us, "New employees receive a five day induction which includes mandatory training on moving and handling. They then shadow other care workers until they are deemed as competent to work alone. At that stage, then they are assigned a buddy who will then go through their personal development plan." One staff member told us, "It was really good. I wasn't new to caring but my previous role was working in the community. I shadowed staff until I felt comfortable." The introduction of the personal development plan was a new initiative implemented by the provider. A member of the management team told us, "The personal development plans are a new initiative we have implemented to help empower staff and help retain staff. It helps with career progression and identifying how we can support and enable staff to progress and develop their skills."

There was a full and intensive programme of training which included essential training for staff. Training included, care of a person with dementia, infection control and safeguarding. Registered nurses received ongoing clinical training which also maintained their continuing professional development. Clinical training included catheterization, PEG (percutaneous endoscopic gastrostomy), venepuncture (puncture of a vein), diabetes and wound care management. The training programme identified that a number of staff's training on moving and handling was overdue, alongside fire drill training. The registered manager confirmed that staff had received their mandatory training and they now required re-fresher training. Subsequent to the inspection, the registered manager provided confirmation of upcoming training dates scheduled for staff members.

People's changing health needs were reviewed on a regular basis and referrals were regularly made to healthcare professionals. The management team adopted a culture whereby staff understood that people's care needs can change on an hourly basis. One member of staff told us, "People's needs change so quickly, so it is important that we are aware of that." The service had links with a local GP surgery and GPs visited twice a week to provide support, guidance and assess people. Each person had a multi-disciplinary care record which included information when dieticians, SALT (speech and language therapist) and other healthcare professionals had visited and provided guidance and support. For example, we could see that people had access to opticians, district nurses, physiotherapists and social workers. One person told us, "The GP comes on a Tuesday and Friday. The dentist comes in and the optician for a regular eye check."

The management of diabetes, PEG (Percutaneous Endoscopic Gastrostomy) and catheter care was effective. Some people living with diabetes have an increased risk of disability, pressure ulcer development and hospital re-admission. Diabetic care plans were in place which included guidance on the signs of high and low blood sugar and the steps for staff to take. For example, one person's diabetes care plan included guidance on foot care and the actions required by staff to ensure adequate foot care was provided. Guidance was also available on the signs and symptoms of high and low blood sugars. One staff member told us, "If someone has a hypo (low blood sugars) they might present as unconscious, dizzy, confused, sweaty, toileting frequently. If someone has a hyper (high blood sugar levels) they may be thirsty, disorientated, unconscious, vision impaired. I would always check their blood glucose if they looked unwell." For people living with a catheter, guidance was available on when the catheter was last changed and the date for the next re-insertion. Catheter care plans were in place which included information on what to do in the event of the catheter being blocked or bypassing. Documentation also reflected that people were supported to have their leg bag changed weekly. Where people had a PEG tube inserted (internal feeding tube) documentation identified the rationale for the insertion and staff followed a feeding regime which had been formulated by an external dietician. On a weekly basis the PEG was advanced and rotated and this was reflected within documentation. Support was in place for people's weight to be monitored and MUST score (malnutrition universal screening tool) to be assessed weekly. Documentation confirmed that people were gaining weight and their MUST score had improved accordingly.

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. Staff members confirmed they had received training on the Act and throughout the inspection, we observed staff working in line with the principles of the Act. Staff gained consent from people and empowered people to make their own decisions. For example one staff member said to person, 'would you like a hot drink? Would you prefer tea or coffee? Would you like a biscuit with your drink?' Another staff member handed a person the TV remote in order for them to decide what they wished to watch on television.

People can only be deprived of their liberty so that they can 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 provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. Staff confirmed they had received training on DoLS and training records confirmed this. Staff members recognised the importance of enabling people to take risks whilst balancing this with the need to keep people safe and provide care in the least restrictive option. One staff member told

us, "Just because one person might be living with dementia doesn't mean they cannot take risks."

Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia. It also suggests making the environment as stimulating to the senses as possible to encourage people living with dementia to eat and drink. During the inspection, we spent time with people at lunchtime. Tables were neatly decorated with menus on display. For people living with dementia, they were visually shown the meal choices which empowered them to make their own decision. Music was softly playing in the background and where people required support this was provided in a kind and sensitive manner. People spoke highly of the food provided. One person told us, "The food is really very nice. You can have seconds if you want." A visiting relative told us, (Person) is really picky with their food but likes teacakes, if they won't eat, they do bring along tea cakes. (Person) has put on weight since moving in." Another relative told us, "The food is exceptionally good; I've been invited to stay for lunch quite often. I normally just make myself tea and help myself to biscuits." During the inspection, we observed that some people were supported to enjoy a late breakfast following a lie in. However one person was supported have their breakfast at 11.40am and then their lunch at 13.00pm. This meant there was very little time in-between the two meals. We brought this to the attention of the management team who were responsive to our feedback and discussed how improvements could be made to ensure a positive lunchtime experience for all.

Is the service caring?

Our findings

There was a friendly, homely atmosphere and people were cared for by staff that were kind and caring. People and relatives praised the caring approach of staff and told us that they were well cared for. One person told us, "All the staff are so willing and helpful, so nice it makes a difference." Another person told us, "I had a bit of a sore throat yesterday and today one of the carers asked me if I would like a drink of honey and lemon to help it."

The atmosphere in the service was calm and relaxing. A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. Signage was available throughout the service to help orientate people. Toilets were clearly visible and people's bedroom doors had their individual names on them. Throughout the inspection, people were seen navigating the service, making their way to their bedrooms or the toilet independently. The hallways of Dean Wood Care Home were dedicated to various themes. For example, one hallway included various film posters from the 1950s and 1960s. This helped to trigger memories and acted as a point of conversation for people and staff.

People confirmed that they felt that staff respected their privacy and dignity. One person told us, "They always knock before they come into my bedroom." Staff recognised the importance of upholding and respecting people's dignity. One staff member told us, "When supporting people with washing and dressing, I always ensure they are covered up and their dignity is respected." Systems were in place to ensure staff empowered people to remain as independent as possible. For example, plate-guards and adapted cutlery were utilised to enable people to eat and drink independently. Staff encouraged people to retain their independence with personal care. One staff member told us, "I always hand people the flannel and provide them with the opportunity to wash their own face."

People's bedrooms were spacious, in good decorative order and had been personalised, for example with photographs, art and items of memorabilia. One person's bedroom was decorated with memorabilia from their favourite football club. This helped to create a familiar, safe space for people. Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identity. For example, staff supported ladies to paint their nails and wear make-up. Ladies always had their handbags to hand which provided comfort and reassurance.

People's care records were stored securely in locked staff areas. Staff told us they were aware of the importance of ensuring personal information was only shared with the appropriate people. Care records were locked away on each floor of the service. Staff were discreet when discussing people's needs on the telephone or between themselves to ensure people's privacy was maintained at all times.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. They were able to say how they wanted to spend their day and what care and support they needed. The service had a roof terrace which was made available to people. One person was observed enjoying their

morning walk on the roof terrace. Staff recognised the importance of asking people what they would like to do and if they were happy. Where people were seen sitting in the communal lounges, staff ensured they had a hot drink and call bell to hand.

Friendships between people had blossomed while living at Dean Wood Care Home. People were seen sitting together and interacting. Staff told us about two ladies who had formed a strong friendship since moving into the service. Staff advised that they spent their days together joining in activities and sitting together in the lounges. One person told us how they had formed a friendship with one person and they now played cards twice a week.

Staff celebrated people's successes and special events. For people's birthdays, their bedroom door was decorated with banners and balloons. During the inspection, staff celebrated one person's birthday. People gathered in a communal lounge all wearing glittery hats with tambourines and along with staff sang happy birthday.

People's equality and diversity needs were respected and staff were aware of what was important to people. One staff member told us, "People have religious contacts once a month on a Sunday, or once every two months. We can facilitate it more frequently and we can arrange Sunday mass if wanted." People's care plans included guidance on people's religious and spiritual needs and the level of support required to meet that individual need. One person told us how the local Priest visited them once a week. Another staff member told us that as Harvest was approaching, they would be holding a church service to celebrate the Harvest festival.

People were treated with kindness and compassion, as individuals, and it was clear from our observations that staff knew people very well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Observations demonstrated that staff had spent considerable time getting to know people, their life history and personal preference. A member of the management team spent time engaging with one person enquiring about their morning whilst having a joke about their search for a boyfriend.

People told us they were able to maintain relationships with those who mattered to them. During the inspection, visitors visited throughout the day and people also enjoyed going out for the day with their loved one. Visitors told us that they were made to feel welcome and could visit at any time.

Is the service responsive?

Our findings

People received support that met their needs and was personalised to their individual choices and preferences. One person told us, "I'm well happy with everything." Another person told us, "I'm very happy, I'm having a ball."

People and their relatives felt involved within the care planning process and involved in decisions about their care and treatment. Senior staff undertook detailed assessments with people before they started to use the service to establish the level of support they required and their choices and preferences for how this was provided. This helped the management team make sure staff could provide the care and support the person wanted in their preferred way. This information was used as a base for people's care plans. One person told us, "I was involved in my care plan when I moved into the service."

Care plans covered a range of areas including; sense and communication, lifestyle, moving around, personal care, going to the toilet and mental health and well-being. Care plans considered what the person could do for themselves and the support they required from staff. For example one person's sleeping care plan identified that the individual preferred their bedroom light off and liked their door to be shut. However, support required from staff included regular checks at night as they were unable to use their call bell. Care planning and documentation included an overview of the person's care needs titled 'my day, my life, my portrait'. This included a brief overview of the following areas of care; 'what's important at this time, what does a normal day look like, sense and communication' along with other areas of care. This provided staff with a personalised overview of the person's care needs and what was important to them.

Guidance produced by the Social Care Institute of Excellence advises that 'good communication is a fundamental aspect of providing good nursing care.' The management team and staff recognised the importance of communication and how good communication enabled them to provide responsive care. For example, every day at 10.00am, the management team and heads of department held a meeting to discuss any clinical needs, the plans for the day ahead, any concerns and whether anyone needed a GP visit. These daily meetings enable staff to communicate and share important information which enabled staff to provide responsive care.

The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for all people, particularly those living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. The service employed dedicated activity coordinators who provided a range of activities seven days a week. One activity coordinator told us, "The activities are planned a week in advance. We hire a mini bus once a month for planned trips and another activity coordinator takes people out on smaller trips in their car. They go to the beach, garden centres and various other places. We have lots of clubs and recently people asked for a model and scrabble club. Other clubs include poetry and art. We also have a documentary and film club." During the inspection, we observed people attending a documentary club alongside the poetry club. One person told us, "I like the poetry club, it keeps my mind stimulated." A variety of singers also visited during the inspection and people spoke highly of the singers advising it was important that they got the best seats

before the singer arrived so they could enjoy it.

People spoke highly of the activities provided. One person told us, "Something happens every day. Seated exercise and music therapy. I went on a trip to Stanmer Park." Another person told us, "I normally join in with whatever is going on." A third person told us, "We have entertainment outside on the roof terrace. I like the singers/players. I don't go for all of it." A visiting relative told us, "There are plenty of activities and there are no restrictions on taking Dad out."

Guidance produced by Social Care Institute for Excellence advises that older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility or income. Social isolation and loneliness have a detrimental effect on health and wellbeing. Some people preferred to stay in their bedroom due to preferences or health reasons. Staff were mindful of this and activity coordinators visited people in their bedrooms providing one to one activities. For example, the activity log for one person who remained in their bedroom noted that they enjoyed poems being read to them from their childhood. Documentation confirmed that during one to one activities with the activity coordinator they spent time reading poems to the individual. Another person preferred to stay in their bedroom and read their books and poems. As staff walked past they engaged with the person and Inspectors spent time with the individual learning about their favourite poems. People's lifestyle care plans clearly reflected their hobbies and interests and these interest were utilised when undertaking one to one activities with people.

Staff told us they were committed to delivering person centred care and that they knew people well. Observations demonstrated that staff worked hard and Inspectors observed genuine warmth and affection between staff and people. Activity logs completed by the activity coordinators demonstrated that they knew people well and were committed to delivering person centred care. For example, the notes for one person reflected their passion for chocolate and animals, especially dogs.

Guidance produced by Age UK advises on the importance pets bring to older people. Dean Wood Care Home recognised the importance that animals brought to older people and had made links with the organisation Pet Pals who brought animals into the service on a regular basis. A member of staff told us, "We regularly have Pat dogs come in and we encourage visitors to bring their dogs into the service."

People and their relatives said they felt listened to, their views were taken seriously and any issues were dealt with. One relative told us, "I have got better at voicing my concerns. (Person) had a special toe brace and I found that it was not being put on. I spoke to a carer and it's not a problem anymore." Another relative told us, "Any problems are normally resolved easily, if not I speak to (member of the management team), she's always approachable." The provider had appropriate arrangements in place for dealing with people's complaints or concerns if these should arise. The provider's complaints policy was clearly displayed in communal areas. It contained information about how and to whom people and/or their representatives should make a formal complaint. Records showed when a concern or complaint had been received the registered manager had conducted an investigation, provided appropriate feedback to the person making the complaint and offered an apology, where appropriate.

Is the service well-led?

Our findings

People and their relatives confirmed they felt involved in the day to day running of the service. People told us that there were various forums within the service whereby they could make suggestions and improvements, including 'resident meetings.' Staff spoke highly of the management team and felt staff morale had improved within recent months. Despite people's praise for the management team, we identified areas of care which were not consistently well-led.

At the last inspection in September 2016 we identified areas of improvement in relation to staff not always feeling valued or supported within their role. A further area of improvement was also identified in relation to embedding audits and action plans. Recommendations were made and at this inspection, we found improvements had been made.

Systems were in place to assess and monitor the quality of the service. This included weekly, monthly, quarterly and annual audits and reviews for safety, security and health care. Following each individual audit, any actions or recommendations were added to Dean Wood Care Home 'home improvement plan' (HIP). However, despite systems in place to assess and monitor the quality of care, we found a number of shortfalls had not consistently been identified or where shortfalls had been identified, improvements had not yet been embedded or sustained. For example, we identified some shortfalls within care documentation. Care plans were subject to regular audits; however, a number of discrepancies with recording had not consistently been identified as part of the provider's internal quality assurance checks. For example each person had a 'consent care plan' in place which considered their ability to make day to day decisions. During the inspection we observed staff working in line with the principles of the Mental Capacity Act 2005, however, documentation regarding people's capacity was often contradictory. One person was deemed to have capacity over a decision yet the capacity assessment recorded that they were unable to weigh up the information or retain the information. Yet, they had been assessed as having capacity. Failure to weigh up information or retain information means that an individual lacks capacity in line with the principles of the Mental Capacity Act 2005. We found this was a consistent theme within recording around mental capacity.

Each person had a range of documentation in place, these topical medicines records. We found a range of discrepancies with people's topical medicines records. For example, one person was prescribed a barrier cream which was required to be administered daily. Documentation reflected that it was not being applied daily. A recent internal audit by the provider in October 2017 also identified this shortfall, however, the desired improvements required time to be embedded and sustained. The provider internal audit also identified that a number of daily notes were task oriented instead of written from a person centred perspective. This shortfall required time for the desired improvements to be embedded. However, a number of other shortfalls had not consistently been identified by the provider. Where people had a catheter in place, documentation failed to reflect whether the person consented to their catheter being changed by the nursing staff. Staff told us how one person's capacity could fluctuate but they always gained consent from the person and recognised to ask them about changing their catheter in the morning when they were more lucid. However, documentation did not reflect that. People and their relatives told us they felt involved in their care, however this was not consistently reflected within the care planning process.

Documentation was in place for the recording of incidents and accidents which were subject to a monthly audit. Documentation reflected that a number of falls without injury were occurring at the service. For example, where people were found on the floor. The monthly audit considered the timing of the incidences and documentation confirmed that most incidences were occurring between the time of 14.00pm to 20.00pm. A member of the management team told us, "Based on this analysis, we have implemented a twilight shift. This involves a staff member starting at 17.00pm and working to 22.00pm." The management team were also in the process of completing a falls toolkit which further analysed the location of falls and the times and the plan was to create an action plan based on these findings. However, the toolkit was not yet completed. Measures were beginning to take place to analyse incidence and accidents, however, this required strengthening. For example, incidences and accidents from September 2017 reflected that most incidences and accidents were occurring on the ground floor. There was no root cause analysis of why this might be and there was no action plan in place to identify how improvements could be made to mitigate the risk of future incidences and accidents. Some staff members raised concerns over the high number of incidences due to concerns with staffing levels and being unable to consistently monitor people's whereabouts. During the inspection, we observed that staffing levels were sufficient in meeting people's needs. However we brought these concerns to the attention of the management team who were responsive to our feedback and agreed to focus further on incidences and accidents.

A range of systems were in place to monitor compliance with the Health and Social Care Act 2008 (Regulated Activities) 2014. However, these systems were not always consistently effective in identifying shortfalls with documentation. Where shortfalls had been identified, the desired improvements required time to be embedded and sustained. These shortfalls had no direct impact on the quality of care that people received. People received care that they required and the provider was responsive to our feedback. However, we have identified this as an area that requires improvement.

At the last inspection in September 2016 we found that the culture of the service required improving. Staff morale was low and staff felt that they were not valued as employees. Improvements had been made. A member of the management team told us, "We've worked really hard to address the culture of the service and it has been a challenge. Staff were using terminology such as 'feds' and we have worked hard to address that and pull staff up on terminology and we now feel that things have significantly improved compared to three months ago. I've been empowering staff and giving them a voice in order for them to feel supported and valued. Always, thanking the staff and recognising their achievements. Culture within the service has come on significantly."

Staff members confirmed that they found management approachable and valued as an employee. A member of the management team told us, "Management are supportive, if I raise issues then they will respond. When I carry out my supervisions I want to support the team, listen to their views and needs and offer training if they need it." Staff meeting minutes reflected that staff's views were listened to and action was taken based on their feedback. For example, the staff meeting minutes from September 2017 reflected that the results of the staff survey were discussed alongside recognition and rewards for staff. A recent initiative implemented by the provider to improve morale within the staff team and staff retention was the implementation of the staff pay banding. A member of the management team told us, "To improve morale, we've implemented this pay banding which encourages staff to move up the banding which they achieve through training and through doing so, they are paid more. This encourages staff to meet their supervision targets, take more responsibility and commit to the company for longer."

The service had a strong, visible person centred culture which was good at helping people to express their views so they understood things from their points of view. A member of the management team told us, "We empower people here to have a voice, so that we can understand things from their perspective." Regular

'resident' meetings were held on a regular basis and provided people with the forum to raise ideas or feedback any concerns. People told us that they attended 'resident' meetings and found them very helpful. One person told us, "I was encouraged by (member of the management team) to go to the residents meetings. They answered any concerns." People's feedback was used to drive improvement and improve the overall quality of care. For example, people had requested more trips out and that was now taking place. Recent feedback included healthier desserts. This was passed to the Chef and action taken.

At the last inspection in September 2016, improvements were identified in relation to the provider's audits and action plans. This was because a range of audits had only just been implemented and the provider was unable to demonstrate the effectiveness of these audits. At this inspection, improvements had been made. The provider was now able to demonstrate how audits had consistently been undertaken every month to drive improvement. On a monthly basis the provider's regional director visited the service and provided a RAG rating based on the findings of their audit. Documentation reflected that between the periods May to August 2017, the RAG rating of the service improved which demonstrated the effectiveness of some of the provider's internal audits. For example, the action identified from one audit included the implementation of a poetry club. On the inspection, we observed a number of people attending poetry club identifying that the proposed action had been met.