New Century Care (Bognor Regis) Limited

Aldwick House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 2 and 5 May and was unannounced.

The last inspection took place on 25 and 26 February 2016. As a result of this inspection, we found the provider in breach of two regulations, one relating to safe care and treatment and the other associated with the need for consent. We asked the provider 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. At this inspection, we found the provider and manager had taken appropriate action and these regulations had been met. As a result, the overall rating for this service has improved from 'Requires Improvement' to 'Good'.

Aldwick House is registered to provided accommodation and nursing care for up to 32 people with a range of healthcare needs, including a diagnosis of dementia. At the time of our inspection, 30 people were living at the home. When capacity was available, the home also offered short breaks or respite for people, providing care on a short-term basis. Aldwick House is a large detached, older style property, with accessible gardens, close to the town of Bognor Regis and the coast. Communal areas include a large lounge and dining area with a conservatory. All rooms are of single occupancy, apart from one, where two people have shared a room for a number of years. There were plans to replace the lift in the near future.

The manager came into post at the home in January 2017 and was in the process of becoming registered. 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.

Supervision meetings for some staff had lapsed since the last registered manager left employment and the new manager had started. The manager was aware of this and had identified it as an area for improvement. People and relatives liked the meals on offer, however, arrangements within the home made it difficult for some people to eat independently. Staff were not always positive towards making the mealtime a sociable experience for people.

Staff had completed a range of training and attended staff meetings to ensure they had the skills and guidance necessary to support people effectively. Staff were encouraged to study for qualifications, such as diplomas in health and social care, and new staff completed the Care Certificate, a universally recognised qualification. Consent to care and treatment was sought in line with legislation. People received support from healthcare professionals and had access to healthcare services.

People and their relatives felt Aldwick House was a safe place to live. Risks to people had been identified and were assessed appropriately. Guidance was in place for staff on how to manage risks. Staff had been trained to recognise the signs of potential abuse and knew what action to take. Staffing levels were

sufficient to meet people's needs and there were plans to increase staffing levels. Safe recruitment systems were in place. Medicines were managed safely.

Positive, warm and friendly relationships had been developed between people and staff. We observed positive interactions between staff and people. People and their relatives were encouraged to express their views in relation to their care. People were treated with dignity and respect. At the end of their lives people were supported to have a comfortable, dignified death.

A range of activities was provided for people from an activities co-ordinator employed by the home and an external entertainer who visited each weekday. People were also provided with individual support where they chose not to be involved in group activities. The provider had put in place a strategy to improve the way people living with dementia were supported and cared for. Care plans provided detailed information about people's care needs and guidance to staff on how they wished to be supported. People and relatives felt confident that any concerns or complaints they had would be addressed appropriately.

People and their relatives were involved in developing the service and regular meetings took place. Questionnaires had been sent out to obtain people's feedback. The home was well managed and good leadership was evident. Staff spoke highly of the new manager, who felt that they now had a sound staff team in place. Relatives were complimentary about the care their family members received. A range of systems was in place to measure and monitor the quality of care delivered. Where actions were identified, steps were taken to make improvements.

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

Overall the service was safe.

Risks to people had been identified and assessed appropriately. Guidance was in place for staff to enable them to support people safely.

Staffing levels were sufficient to meet people's needs and the manager was in the process of increasing staffing levels.

People and relatives felt Aldwick House was a safe place to live. Staff had been trained to recognise the signs of potential abuse and knew what action to take.

Safe recruitment practices were in place.

Medicines were managed safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff attended team meetings and the majority had received supervision this year. The manager was aware this was an area for improvement. Staff had completed a range of training to provide them with the skills needed to support people effectively.

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

People and relatives liked the meals on offer. However, the lunchtime experience for some people was difficult in relation to eating independently in their armchairs. Staff did not always interact with people to make the mealtime a pleasant experience.

People received support from healthcare professionals as needed.

The lounge/dining area was set out in a way that provided little

space for social interactions.

Is the service caring?

Good

The service was caring.

Positive, warm and friendly relationships had been developed between people and staff. Visitors and relatives made positive comments about staff.

People were supported to express their views and to be involved in decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Good

Overall the service was responsive.

A range of activities was available to people, provided by the activities co-ordinator and by an external entertainer.

Care plans provided detailed information and guidance to staff on people's care and support needs.

Complaints were managed appropriately.

Is the service well-led?

Good

The home was well led.

People and their relatives felt they were involved in developing the service. Relatives and residents' meetings took place.

Staff spoke highly of the manager and felt supported. The home benefited from good management and leadership.

A range of systems was in place to measure the quality of the care delivered. Plans were in place to drive continuous improvement.

Aldwick House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 2 and 5 May 2017 and was unannounced. An inspector and inspection manager undertook this inspection.

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

We observed care and spoke with people and staff. We spent time looking at records including six care records, two staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

On the day of our inspection, we met with four people living at the service and spoke with five relatives and three friends of people living at Aldwick House. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the manager, the area manager, the quality manager, the clinical lead, two care staff, the chef and the activities co-ordinator.

The service was last inspected on 25 and 26 February 2016 and was rated as 'Requires Improvement' overall.

Good

Is the service safe?

Our findings

At the inspection in February 2016, we found the provider was in breach of a Regulation associated with safe care and treatment. We asked the provider to take action because risk assessments for people were not always completed accurately. In addition, pressure relieving mattresses were not always used effectively to support people at risk of, or living with, pressure areas. Care plans were not always regularly updated to reflect people's current care needs. 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.

People's skin integrity and risk of developing pressure areas was managed in a satisfactory manner. For example, one person's skin condition was monitored regularly, photos taken of the affected areas and body maps completed. Advice was sought from the GP in relation to changes of the skin and a dermatology appointment was booked for May 2017 to continue the management of this condition.

We asked staff about the management of people's pressure areas. One person had a pressure area which had now healed, although nursing staff continued to dress the area as a precaution. Monthly wound audits were completed to monitor the progress of people's skin integrity needs. At the time of our inspection, no-one had graded pressure areas. Relatives explained how their family member's risk of developing pressure areas was managed as they remained in bed most of the time. They said, "She is on an airflow mattress. Staff reposition her all the time". Another relative told us that their family member needed to be repositioned in bed every four hours. They said, "Staff are in and out of the room all the time monitoring him". However, we checked the repositioning chart for one person and there were gaps in recording for 1 May. For example, on the night of 1 May into the early hours of 2 May, no information was recorded between 23.10hrs and 08.46hrs, indicating the person was not repositioned during this time. Most entries read that the person was found on their back and then repositioned onto their back again. Therefore, it read that the person was not moved from side to side throughout the day to avoid pressure on their lower back/sacrum and hips. We discussed this issue with the manager and with the quality practice manager, who agreed there were gaps in recording and that they would investigate this issue further.

People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The provider had completed these assessments using the Malnutrition Universal Screening Tool, a tool designed specifically for this purpose. There was a significant error in one person's weight recording which we discussed with the manager. From the records, it stated that the person had lost 29kg between February and March 2017. The manager recognised this was an error and likely to be due to the scale used being incorrect. The manager had already addressed this issue with staff to ensure they considered the accuracy of scale measurements; training had been arranged for the following day for staff. In reality, the person had actually gained 2kg between March and April, despite their poor appetite.

The provider's action plan showed what steps had been taken to review people's care plans and risk assessments so that these reflected people's current needs. People's needs were reviewed monthly when they were 'Resident of the Day'. This system ensured people's needs were reviewed and their care plans

updated. In addition, their relatives were invited to review their family member's care plan to check for accuracy. We observed one relative reading a care plan at the time of our inspection and they told us they would be reviewing this with the manager later. Risks to people were managed so they were protected and their freedom was supported and respected. People's risks had been identified and were assessed appropriately. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments provided guidance to staff on how to support people safely. We looked at care plans which showed people's risks in a range of areas such as moving and handling, skin integrity, falls and evacuation plans should people need to be moved in the event of an emergency. Accidents and incidents were recorded appropriately, with details of the issue and the action taken. Documentation we checked showed good, clear and accurate recording.

People told us they felt safe living at Aldwick House and relatives we spoke with agreed. One person commented that staff always made an effort to welcome their visitors. They said, "They seem to get to know them and I feel safe here". Another person said, "I feel safe" and that staff respected them. They added they were able to make their own choices about their daily routine. One relative felt their family member was completely safe in the care of staff at the home. They said, "I wouldn't be able to leave if I felt mum was unsafe".

Staff knew what action to take if they suspected a person was at risk of abuse or harm. One staff member said, "I'd report it to the manager", explaining the manager would then report any concerns to the provider's head office and the local safeguarding authority. Another staff member confirmed they had completed their safeguarding training and said, "I would report any concern, even if I wasn't 100 per cent sure. We put people's interests above everything else". A third member of staff described the action they would take if they found a person with unexplained bruising. They said, "I would report it to the senior on shift who would take it to the manager. There would be an investigation as to how this injury took place". The majority of staff had completed safeguarding training. Staff we spoke with were able to name the different types of abuse they might encounter.

There were sufficient numbers of suitable staff on duty to keep people safe and meet their needs. We asked the manager about staffing levels and they told us they were in the process of looking at their current occupancy and dependency levels of people. As a result, it had been agreed to increase the level of afternoon staffing to six care staff. This meant that, throughout the day, six care staff would be on duty and a registered nurse. The manager said they were looking towards having two registered nurses on duty in the morning. They explained, "This really helps so that we keep on top of documentation and basic nursing care". At night, one registered nurse was on duty and three care staff. One staff member said, "Everyone would like more staff. I would definitely like one more staff in the morning and another carer to help with breakfast". Relatives had mixed views. One said, "Generally I would say the care is fine. There's not as much staff as one would like". Another relative commented, "It would be better if they could have more staff, but they cope extremely well". A third relative said, "There seems to be enough staff. You never hear the bell going constantly. There are always people [staff] around". Two visitors felt there were probably enough staff, "Oh yes, I think so". However, they felt staff appeared very busy and sometimes people's morning routines took a long time. One said, "Getting people up in the morning can go on until lunchtime". In addition to nursing and care staff, various ancillary staff ensured the smooth running of the service. This included a chef, kitchen porter, laundry assistant, cleaners, an administrator and a maintenance person. We checked the staffing rotas which showed staffing levels were consistent across the time examined.

We did, however, observe one incident during the afternoon when staff were changing shifts. One person expressed they needed the toilet. Staff kept promising they would attend to them, but no-one came. One

staff member leaving their shift told the person that staff would come to help after the handover meeting. The person continued to call out their distress about needing the toilet and no-one helping. After about 15-20 minutes, a member of the inspection team went to inform the manager, but it was still a further 5-10 minutes before staff came to assist. It did not appear that there were sufficient staff available to support people during the handover period.

We asked the manager about staff vacancies. They said when the previous manager left, about half of the permanent staff also decided to leave. This was a very challenging time for the home and meant a high reliance was placed on agency staff. The manager had done a great deal to recruit to vacant posts and to reduce the use of agency staff. The manager said, "The agency staff who come to us are consistent … some of the agency staff are absolutely brilliant".

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting.

Medicines were managed safely. However, sometimes the administration of people's morning medicines took longer, especially if they chose not to have their medicines before breakfast. The clinical lead said, "My biggest goal is to get a second nurse to help with medication", adding that when two nursing staff were on duty in the morning, the administration of medicines could be completed by 10am. One person said, "There's a nurse who comes around every day with my tablets". Nursing staff had completed foundation or advanced medication training. Medicines were dispensed from two medicines trolleys, one for each floor. We looked at the management and storage of medicines. Medication administration records were completed appropriately and confirmed that people had received their medicines as prescribed. We checked the stock levels of some medicines. We found an excess of stock of one medicine, which was prescribed to be taken as needed (PRN), and that the person had 400 tablets in stock. Another person, who had a similar medicine to be taken PRN, had 200 tablets in stock. We discussed this with the quality manager who told us they were aware of this issue and steps were being taken to rectify this. A pharmacist audit had been completed in February 2017 and no significant issues were identified. The provider had also completed an audit in March 2017 when the excess stocks of medicines had been identified.

The home was clean and odour free. However, we observed wet chairs in the reception area which were the result of one person sitting in them who had continence issues. We discussed this with the manager who told us the person did wear pads and was regularly offered support to go to the toilet. They said, "That's not usual. She does get offered the toilet on a very regular basis".

Requires Improvement

Is the service effective?

Our findings

At the inspection in February 2016, we found the provider was in breach of a Regulation associated with the need for consent. We asked the provider to take action because consent was not always gained in line with people's best interests to ensure effective management of their care needs. 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Clear mental capacity assessments had been completed for people and best interest decisions recorded, for example, in relation to two hourly checks and the use of bed rails. We saw a best interest decision had been taken on behalf of one person. A record of this decision stated, '[Named person] unable to use call bell due to her poor comprehension. Risk of strangulation. Call bell not in situ therefore'. Instead, staff regularly monitored this person. DoLS authorisations had been applied for, as needed.

We asked staff whether they had completed training on the MCA and checked their understanding in this area. One staff member said, "It's the mental capacity of that person, whether they're capable of doing anything for themselves and how much you have to assist. It's putting their needs first. There are legal implications, whether the home has to have full rights of what might be best for the person". Another staff member said, "It's about people's best interests. You've got to put these first for their safety and they have to be involved in all their care. Some people don't have capacity, so you have to put their best interests first". A third member of staff explained their understanding of DoLS and said, "It's the timeline between depriving someone and ensuring they're safe and letting people have choices". We discussed the fact that some people were not free to leave the home unattended. The same staff member said, "People are free to go into the garden if they're mobile". We observed people strolling round the garden and enjoying the sunshine.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. A new member of staff told us about their induction. They said, "I've done so much. All my on-line training was completed in the first two weeks. Everyone's been so fantastic and helpful. I need to learn the basics first, then get my teeth into the role". Another member of care staff told us

about their induction and that they had completed three days of work shadowing an experienced member of staff. They had also completed the provider's version of the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff told us they were encouraged to study for additional qualifications, such as diplomas in health and social care.

Staff completed essential training in a range of areas: moving and handling, fire safety, health and safety and infection control. Other training included: dementia awareness, first aid, basic life support, mental capacity, dignity and choice, nutrition and hydration and safeguarding. The provider told us that, according to their statistics, 86.2% of staff had completed this training. A staff training plan indicated when staff training was due or needed to be refreshed. Except for moving and handling and fire safety training, all training was completed by staff through e-learning. Staff had mixed views about learning electronically. One staff member said, "I think face to face training is better. We did the fire training and then we did a test". Another staff member said, "There's a lot to take in and you have to achieve 70 per cent to pass". A third staff member, referring to the provider, said, "They're quite good at seeing you get all your training". They added, "I like it [training] better in a group because you can talk about it more".

We asked the manager whether staff received supervision on a regular basis. They told us that staff were expected to have supervision with their line managers every two to three months as a minimum, with a target of six per year, some of which would be group supervisions. We looked at the records relating to staff supervisions and found that not all staff had received supervisions on a regular basis. The manager was aware of this and was striving to make improvements since coming into post. The majority of staff had completed at least one supervision so far this year. Records showed that, in addition to individual supervisions, a group supervision had taken place in May 2017 and at least seven staff had attended. Topics discussed included monitoring and repositioning charts based on people's needs, fluid charts, bowel charts, personal hygiene of people and daily reporting.

Staff meetings took place. One meeting was held on the day before our inspection and a previous one in March 2017. Meetings for nursing staff had taken place in January, February and May 2017 and records confirmed this.

People were supported to have sufficient to eat and drink and were encouraged in a balanced diet. We asked people and their relatives about the meals on offer at Aldwick House. One person said, "Food is very nice and you get a choice". Another person told is, "The food's not bad. I think the chef is really quite good". They felt there was not always much choice however, but had never asked for an alternative, adding that if they wanted something different, the chef would accommodate this. A relative told us their family member needed their food pureed and told us that the chef had made a special pureed/softened cake, "Especially for Dad", so he could enjoy the cake everyone else was having. They added, "Out of all the clients, he thought of my Dad". Another relative, referring to their family member, said, "She's very funny with her food" and that the person had lost their appetite. They said that staff gave their family member, "Reassurance all the time" on her food and offered alternatives. The relative said, "The kitchen are very helpful and accommodating" and that staff encouraged their family member to eat and drink sufficiently all the time.

We asked the chef about menu planning and whether specialist diets were catered for. The chef explained that there was a four weekly rolling menu and talked about people's food preferences and choices. They told us that some people living with diabetes needed a different diet and that others had their food liquidised. Some people were vegetarians and some had food allergies. The chef said that alternatives were always available to people such as jacket potatoes, omelettes or sandwiches. They told us, "We can be

flexible. We ask people one hour before the meal what they would like". People were encouraged to drink in sufficient quantities. In addition to jugs of water being available in people's rooms, there were 'hydration stations' in the dining area, so that drinks were accessible to people.

Before lunch, a staff member went around with a clipboard and asked people to make their lunch choices. The staff member spoke about the two choices available. Some people struggled to process this information and it was difficult for them to make a choice. The home could benefit from including visual prompts or showing people plates of food on offer so they could make a choice more easily.

We observed people having their lunchtime meal. Some positive interactions took place between staff and people. We saw one staff member offering a person the choice to come to the dining table or to stay in their armchair. They respected the person's choice to remain in their armchair. However, for the majority of the time, there was very little staff interaction with people, aside from tasks. For example, in relation to place settings, putting aprons on people and leaving drinks. It was very quiet and lifeless in the room. People were mostly sleeping in their chairs or appeared withdrawn or disengaged. We observed several examples where staff members put aprons on people before eating, but did not explain why they were doing this. This was not very person-centred. However, we did observe some staff explaining why they were offering aprons to people.

During lunch, several people ate their lunch in their armchairs they had been sitting in all morning. People were served their food on overlap tables which were not adjusted to an appropriate height or distance from the person. Some people were slumped awkwardly in their chairs. The poor posture and table position caused a lot of people to spill food down their fronts and made it more difficult for people to eat independently and in sufficient quantity. This did not make for a pleasant dining experience for some people.

We gave feedback about the meal and dining experience and supporting people to eat. The area manager said, "We have got quite a lot more plans to improve the dining experience", which could include changing the main meal of the day to the evening. We discussed the issues relating to people being supported to choose their meals and struggling to understand verbal choices given to them. The manager said they were hoping to introduce an approach where they would plate up food options on offer to show people the choices.

People were supported to maintain good health and had access to a range of healthcare professionals and support. One person felt that staff were responsive to their health needs. They gave an example of a time that they had a suspected infection. Staff acted quickly to contact the GP and test for infection; they had been started on antibiotics straight away. Visitors of one person living at the home had expressed concerns to us about the person's reduced mobility following a stay in hospital. We saw that GP advice had been sought in relation to getting physiotherapy/occupational therapy advice to see if the person's mobility could be improved. The manager told us that an appointment had been made the following day for healthcare professionals to assess the person. Care plans recorded the involvement of healthcare professionals for people, including GPs and other healthcare professionals, for example relating to one person's end of life care.

We asked relatives and visitors about the environment at Aldwick House. One visitor commented, "It needs smartening up". Referring to the layout of the lounge/dining area, they said, "There isn't enough space in the place". They added, "The quiet room … you can't get in there half the time because staff are using it. Some of the lighting in the home is dismal". However, they said, "[Named person] bedroom is gorgeous and I can't fault it. They keep her room very clean" adding that the rest of the home was always clean and tidy.

One person told us they preferred to spend time in their room watching television or reading. The main communal area of the home was the lounge/dining area which was furnished with tables, dining chairs and armchairs. The area was crowded with furniture and busy with staff supporting people, for example, when hoisting them from wheelchairs to armchairs. A staff member said, "I would change the lounge. Everyone is lumped in together". The area manager told us they had plans for refurbishment and told us, "We try and do things following feedback from residents and relatives. We're toying with the idea of creating a 'snug'. We thought about having a bar, but relatives were not in agreement". They added that the snug could be used as a separate activity area and that there were plans to develop a sensory garden outside. The area manager added, "We are all really keen to do something with the environment. We want to involve people and relatives about what they would want from their environment".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed one person greeting a staff member and said, "How is your husband?" as the staff member's husband had been unwell. This was a nice interaction and demonstrated a personal connection between the person and that staff member. We observed staff kneeling down to people's eye level to chat to them or offer support. We saw a staff member holding hands with a person and walking at their pace as they went towards the toilet. Another staff member was applying make-up for another person and they were both enjoying the experience, having a laugh together. One person felt staff were, "Very nice. We all get on and we get into a routine". Another person commented, "Most of them are very nice. I don't have any complaints about the staff". Visitors and relatives also had positive things to say about the staff. Comments included, "The staff do their very best and I think they are caring", "The girls [care staff] are so nice" and "We never feel that we have come at a bad time".

Staff described how they got to know people. A new member of staff said, "Personally it's all about getting to know people, but I'm getting there". Another staff member said, "People say you shouldn't get close to the residents, but you do get attached to them and you want to protect them within professional boundaries. People have a life and history". Staff told us that reading care plans was important in developing relationships with people. From our conversations with staff and our observations at inspection, it was clear that staff knew people well. However, care plans did not always include details of people's backgrounds or personal histories which would have enabled staff to have a greater understanding about people before they came to live at the home. The manager was aware of this and had identified this as an area which they were working on.

People were supported to express their views and, as much as they were able, were involved in making decisions about their care, treatment and support. A visitor of a person living at the home explained that staff made an effort to communicate with the person, despite their difficulty in hearing. A relative said that staff have, "Absolutely respected" their mother's choices, including her choice not to participate in group activities. We spoke with a relative who explained their involvement in decision making and was reading the care plan in preparation for a meeting with the manager that day.

People were treated with dignity and respect. One person told us that staff were kind and respectful to them and said, "Yes, they're all right". A member of staff told us, "If you can talk to people and keep it low key, you get better co-operation. If you try and rush people, it worries them". Another staff member said, "You always have to show people respect. You respect their religion. One person does Holy Communion with some residents and a priest comes in. Another person wants to visit the church". A third member of staff said, "I'd knock on the door before I went in. I'd ask the person whether they want to get up, washed and dressed and explain everything. Cover them up and draw the curtains. We try our best". However, we observed one person, who was being fully hoisted, had their lower back exposed as their trousers had slipped down. Staff were unaware that this was happening. We discussed this issue with staff later and they said that some people's clothes did not always fit very well and so could slide down easily.

People were supported at the end of their lives to have a private, comfortable, dignified and pain-free death. Some staff had completed end of live and/or palliative care training. One staff member told us, "Relatives can have a bed in someone's room or a recliner to stay with their family member at the end of life. You end up looking after the families too".

Good

Is the service responsive?

Our findings

At the last inspection in February 2016, meaningful activities were not being provided to people in communal areas or in their rooms. Following that inspection, an activities co-ordinator had been recruited and they worked five days a week. We spoke with the activities co-ordinator who was busy organising a Bingo day for people and their families that Saturday. They also spent time individually with people, for example, painting people's nails or providing hand massages. The activities co-ordinator said, "I like activities because you get to know people well. You have to talk to people differently. At the beginning of the week, we do a planner. Today at 11.30am there's singing and musical instruments and people really enjoy that". They added, "We see what people like to do. One lady loves Dad's Army, so we sat and watched it. We had cake and tea and she was really excited. Some people don't like activities. I can go to people's rooms and have a chat if they're not interested in activities". The activities co-ordinator told us about one lady who needed a new pair of slippers when her original pair no longer fitted well. They said, "It was a way of spending more time with her whilst she tried on different slippers". The activities co-ordinator had taken the trouble to learn how to do crochet and said, "One person wanted to crochet, so I learned how to do that. You do have to find things people like to do".

In addition to the activities organised by the activities co-ordinator, people benefited from entertainment provided by a person who visited the home daily. Afternoon activities took place at 4pm on weekdays. A relative explained this person engaged with people and would organise crosswords and quizzes for example. The relative said, "He goes to each person and shakes their hand. He knows everyone by name". However, another friend who was visiting at the time of our inspection said, "I interact with people more than staff do". They added, "The people using the garden are quite often the relatives who take people out. It would be nice if people could go out on a warm day, but it takes time to hoist people. The winter has been a long time for people. [Named person] is a smoker, so she gets taken out into the garden". This visitor told us that at least half of the people living at Aldwick House stayed in their rooms, but conceded that the external entertainer did visit people in their rooms. Overall, relatives were happy with the activities on offer.

People had mixed views when asked about the activities available to them. One person said, "It's monotonous. I get lonely", but added that they felt they had enough to do during the day to occupy themselves as they liked to read the paper, listen to the radio and write poetry. They added that they enjoyed the activities available from, "The fella who comes at 4.00 every day and gives us quizzes". We observed several people throughout our inspection who were present in the communal area. Two people were sat in the same armchairs the entire day, from the time we arrived until the time we left. They stayed in their armchairs for all their meals and daily activities. We observed one person was very anxious and needed constant reassurance. At about 5pm, this person kept asking, "Who is going to help me?" repetitively to a staff member. The staff member was calm and kept repeating, "I told you, [named two staff members]". But this was not very effective in reassuring the person. We saw there was a person-centred care plan in place for this person which documented their anxiety and that they needed a lot of reassurance to feel safe.

The area manager gave us a copy of a strategy they had developed in relation to caring for people living with

dementia. As part of the provider's commitment, the strategy stated, 'We will focus on quality of life for people with dementia, as well as quality of care. By knowing the person, their life history and their personal culture, our staff will deliver a personalised package of care and support'. The area manager told us that the manager and all staff were working hard to improve the quality of care, to ensure it was person-centred. Staff were signing up as 'dementia friends' and staff would be put forward to become dementia champions. The manager said that everyone living at Aldwick House had a diagnosis of dementia and added, "Although the important thing is about meeting people's needs".

Care plans provided detailed information about people's care needs and guidance for staff on how to support them. Care plans included information about a safe environment, nutrition and hydration, activities/social needs, sleeping/night needs, personal hygiene, mental health and capacity, future decisions and care. Other areas covered included equality and diversity, mobility, elimination, medication, breathing, tissue viability, communication and medical conditions. Each area included assessments. For example, under 'safe environment', assessments detailed the use of the call bell, bed rails, safety of people's possessions, evacuation plans and smoking (if needed). People's skin integrity and tissue viability was also documented. Care plans, including risk assessments, were reviewed monthly. Advice had been sought from the West Sussex Dementia Care Home In-Reach Team and this had been utilised in the planning of people's care to make it more person-centred. Staff had ready access to people's care plans. In addition, 'twist and turn' charts were completed in people's rooms. These charts displayed a picture on one side and on the reverse, provided staff with a quick and accessible summary of people's needs, likes, dislikes and preferences.

We asked people and their relatives whether they felt they would be listened to if they had cause to complain. One person said they did not have any complaints, but would feel comfortable to talk with staff if they had any concerns. Three complaints had been recorded in the past six months. All were responded to quickly and robustly and the complainant was informed of the process. All complaints were investigated thoroughly and remedial action taken to address any shortfalls.

Good

Is the service well-led?

Our findings

People and their relatives were encouraged to be involved in developing the service. A relative told us, "There are meetings all the time" to discuss their family members care needs and that they felt very involved. They said regular relatives' meetings and regular care meetings took place. Another relative confirmed that relatives' meetings took place. They said, "Yes, they are held regularly, but I've not been able to attend recently. We get follow-up and minutes of the meetings are sent to me". We looked at records of meetings held in April and May 2017. Items discussed included: chiropody, care plans, activities, residents' meeting, staff, cleaning standards and Deprivation of Liberty Safeguards. The manager said, "Hopefully families are getting to know me and we have quite positive experiences with relatives' meetings". They added, "We had a residents' meeting recently and it was great fun. They tell us what they want". The manager said they were also looking towards including information about Aldwick House on social media which would make information for people and their relatives more accessible. A third relative was complimentary about the manager and said, "She's great. She's always talked to me when I wasn't sure about anything. She totally reassured me".

The area manager told us a food survey had been recently completed which would be used to plan the new summer menus. Questionnaires were completed by people and relatives and these were collated and analysed at the end of March 2017. Most respondents found the management and staff to be responsive and approachable and there were positive responses to the food and menu choices. The majority of people were satisfied or very satisfied with the activities provided. The most negative areas in the responses related to the standard and quality of the furnishings and décor, the responsiveness to complaints and concerns and involvement and consultation with care plans.

Good management and leadership were evident at the home. The area manager told us they were working on introducing a staff satisfaction survey to obtain staff feedback. Staff were complimentary about the improvements made since the new manager had come into the home, including the challenges of recruiting new staff. One staff member said, "I don't like change. I do like it here. We've had good and bad staff, but currently we have a good team since [named manager] came". They went on to say, "[Named manager] is a good manager and I feel listened to. She's approachable, but she's not daft and she won't take any nonsense. She's a good 'people person' with everyone and everything". A second member of staff commented, "I love the residents. The manager is very supportive and she always makes sure you're okay. She's one of the best managers we've ever had". The manager said, "It has been a challenge, but I feel we're turning the corner now. The staff team was all over the place. Things were difficult for people, but the staff meeting was very positive yesterday".

Whilst staff told us that the manager was very approachable, the manager's office was located two floors up, within the roof area of the home. This meant it was not quickly accessible by staff, however, there were plans to change this so that the manager could be readily available to people, relatives and staff, when they were not working on the floor.

Relatives were complimentary about the care delivered at Aldwick House. One relative said they had, "very

high standards" and that their expectations had been exceeded since their family member moved into the home. Another relative said, "I do feel they care which is important. The care is the number one important and they should always strive to improve". A range of systems was in place to monitor and measure the quality of care. There was a regular schedule of routine audits and checks carried out by the manager, including care plans, medication, infection control, health and safety, environment, kitchen, night checks, human resources, wounds, nutrition/meals, maintenance, activities and an analysis of accidents and incidents. There was a clear schedule for the frequency of these audits; some were monthly, others less frequent. The area manager showed us the new 'home manager audit' template which had been introduced and was completed three monthly as a comprehensive overview of quality and safety indicators at the home.

Any actions from these audits and checks were fed into a 'home improvement plan' which was held on the provider's shared drive, so it could be electronically updated regularly and monitored by the area manager and quality manager. The area manager told us they monitored the improvement plan regularly to ensure action deadlines were met and updated as agreed. The quality manager also checked actions plans at least monthly. We saw a copy of the action plan which reflected that all the actions were up to date and none were overdue. This was an active document that was continuously being added to and updated.

The area manager said that the provider's compliance team undertook unannounced 'mock inspections' which were meant to simulate CQC inspections and reviewed the five domains and key lines of enquiry. The compliance team awarded a rating for the home under each key line of enquiry and made recommendations for actions that may need to be made. Their most recent mock inspection was completed in April 2017, although we did not see a copy of this report.

The manager said, "I think now we're all settling down and getting to know each other. We've got a really good team. There's a passion to get things right and we've got a deputy manager now. That's my wish, to get a stable, competent care team".