Care UK Community Partnerships Ltd

Beech Hurst

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Beech Hurst on 23 January 2017. We previously carried out a comprehensive inspection at Beech Hurst on 16 and 17 June 2015. We found areas of practice that needed improvement. This was because we identified issues in respect to the provision of meaningful activities, and the culture and values of the provider not being embedded into daily practice. The service received and overall rating of 'requires improvement' from the comprehensive inspection on 16 and 17 June 2015.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had made the required improvements. We found improvements had been made in most of the required areas. However, further improvements were needed in relation to the provision of meaningful activities and the mealtime experience.

We have made a recommendation about the provision of meaningful activities.

The overall rating for Beech Hurst remains as requires improvement. We will review the overall rating of requires improvement at the next comprehensive inspection, where we will look at all aspects of the service and to ensure the improvements have been made and sustained.

Beech Hurst is located in Haywards Heath, West Sussex. It is registered to support a maximum of 60 people. The service provides personal care and support to people with nursing needs, some of whom were living with dementia, some of whom had mental health issues, or a learning disability and those who had complex health needs and required end of life care. The service is divided into three separate units and set over two floors. On the day of our inspection, there were 46 people living at the service.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager had left the service approximately four months previously, and day to day management of the service was carried out by an interim manager and deputy manager.

At the last inspection on 16 and 17 June 2015 we identified areas of practice that needed improvement. This was because we found the provision of meaningful activities for people were not consistently based on their assessed need and personalised to them. This was specifically significant for people living in the Seaford Unit of the service. Some improvements had been made. The service had arrangements for people to take part in activities. However further work was required to ensure that everybody at the service had access to meaningful activities.

People were encouraged and supported to eat and drink well, and their hydration and nutritional needs were met. However, improvement was required to the mealtime experience for people in some parts of the

service.

There was a varied daily choice of meals and people were complimentary about the food and drink. They were involved in making their own decisions about the food they ate. Special diets were catered for, such as pureed and fortified. Health care was accessible for people and appointments were made for regular check-ups as needed.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. One person told us,"I am always safe. They wheel me and my wife about in our special chairs with wheels". Another person added, "I would tell the carer if I wasn't safe". When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, which included wound care, catheter training and palliative care (end of life). Staff spoke highly of the opportunities for training. One member of staff told us, "I'm up for all training if it helps with my role". Staff had received both one to one and group supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. A relative said, "They are so caring, they really get what it means to care for the individual". Care plans described people's needs and preferences and they were encouraged to be as independent as possible. People were also encouraged to stay in touch with their families and to receive visitors.

People were encouraged to express their views and had completed surveys. Feedback received showed people were satisfied overall, and felt staff were friendly and helpful. People also said they felt listened to and any concerns or issues they raised were addressed. One person told us, "I have never had a reason to complain, but if I did, I would speak to the nurse".

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns. The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to maintain their hydration and nutritional needs. However, improvement was required to the mealtime experience in some parts of the service.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision. Their health was monitored and staff responded when health needs changed.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The service had arrangements for people to take part in activities. However, further work was required to ensure that everybody at the service had access to meaningful activities.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff spoke highly of the registered manager. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided.

Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

Beech Hurst

Detailed findings

Background to this inspection

We inspected Beech Hurst on 23 January 2017. We previously carried out a comprehensive inspection at Beech Hurst on 16 and 17 June 2015. We found areas of practice that needed improvement. This was because we identified issues in respect to the provision of meaningful activities, and the culture and values of the provider were not embedded into daily practice. The service received and overall rating of 'requires improvement' from the comprehensive inspection on 16 and 17 June 2015.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had made the required improvements. We found improvements had been made in most of the required areas. However, further improvements were needed in relation to the provision of meaningful activities and the mealtime experience.

Two inspectors and an expert by experience in older people's care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before our inspection we reviewed the information we held about the service, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to complete 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.

We observed care in the communal areas and over the two floors of the service. We spoke with people and staff, and observed how people were supported during their lunch. 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 spent time looking at records, including 12 people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, accident/incident recording and audit documentation.

During our inspection, we spoke with five people living at the service, two visiting relatives, three care staff, the manager, the deputy manager, the activities co-ordinator, the maintenance worker, a registered nurse, the administrator and the chef. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our

inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People told us they considered themselves to be safe living at Beech Hurst, the care was good and the environment was safe and suitable for their individual needs. One person told us, "They are good at keeping you safe. Today at 8:00am they had a fire drill. All the doors shut and it's a bit scary, but that is to contain the fire". Another person said, "I am always safe. They wheel me and my wife about in our special chairs with wheels". A further person added, "I would tell the carer if I wasn't safe".

People were supported to be safe without undue restrictions on their freedom and choices about how they spent their time. Throughout the inspection, we regularly saw people moving freely around the service. The manager and staff adopted a positive approach to risk taking. Positive risk taking involves looking at measuring and balancing the risk and the positive benefits from taking risks against the negative effects of attempting to avoid risk altogether. Risk assessments were in place which considered the identified risks and the measures required to minimise any harm whilst empowering the person to undertake the activity.

There were further systems to identify risks and protect people from harm. Risks to people's safety were assessed and reviewed. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We also saw safe care practices taking place, such as staff supporting people to mobilise around the service and transferring them from wheelchairs to armchairs.

Staff had a good understanding of what to do if they suspected people were at risk of abuse or harm, or if they had any concerns about the care or treatment that people received in the home. They had a clear understanding of who to contact to report any safety concerns and all staff had received up to date safeguarding training. They told us this helped them to understand the importance of reporting if people were at risk, and they understood their responsibility for reporting concerns if they needed to do so. One member of staff told us, "We all know the process and we would report any concerns". There was information displayed in the service so that people, visitors and staff would know who to contact to raise any concerns if they needed to. There were clear policies and procedures available for staff to refer to if needed. Staff were aware of the whistle blowing policy and when to take concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. We saw that policies, procedures and contact details were available for staff to do this.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. The manager told us, "We are using agency staff to cover when we need to and we increase the staffing levels if required. We have a resident who was unsettled, which triggered more unsettling behaviour in others, especially at night, so we put an extra carer on duty to assist. My line manager will support when getting extra staff". We were told that regular agency staff were routinely used and that existing staff would also be contacted to cover shifts in circumstances such as sickness and annual leave. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "The staff take good care of us. There are enough during the day and I don't bother about the night,

because I am asleep". Another person said, "They [staff] answer the bells quickly most times". A relative added, "There always seems to be enough staff. Some are agency staff, but they all seem good". A member of staff said, "There are enough of us. We use agency staff to cover, but they are regular agency staff who we know".

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The home had obtained employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. Files also contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had registration with the nursing midwifery council (NMC) which were up to date.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm tests took place along with regular fire drills to ensure that people and staff knew what action to take in the event of a fire. People's ability to evacuate the building in the event of an emergency had been considered and, where required, each person had an individual personal evacuation plan. 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. Water temperatures were tested regularly. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. Generic and individual health and safety risk assessments were in place to make sure staff worked in as safe a way as possible.

People received their medicines safely. We looked at the management of medicines. Registered nurses administered medicines. A registered nurse described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks for medicines stored in the fridge. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed.

We observed a registered nurse administering medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "I am given my medicine at the same time every day. One is pink, the other is white. I don't have any pains". Another person said, "They get my pills from Boots and they will give you painkillers if you need one". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "They make sure you have lots of drinks during the day. They bring tea and coffee and fill up the water". Another person said, "They seem well trained. They hoist me into my chair and they do it very well". A relative added, "I can't praise them highly enough. Wonderful, caring staff who know what they are doing. They meet my relative's needs, but also ours". However, despite the positive feedback, we saw areas of practice that need improvement.

We observed lunch in the dining area of all three units in the service. People were considerately supported to move to the dining areas, or could choose to eat in their room. Tables were set with place mats, napkins and glasses. The food was presented in an appetising manner, cutlery and crockery were of a good standard, and condiments were available. In both the Seaford and Hickstead units, we saw that the atmosphere was enjoyable and relaxing for people. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or additional choices. However, our observation of the lunch service in the Ashdown unit was not as positive. People were seated in the dining area for their meal. Food was being served at 13:10, however some people were still waiting to be served up to 20 minutes later whilst others were eating. Some people required assistance with feeding and interactions between people and the staff supporting them were not always positive. Some staff started assisting one person with their meal, but before the person had finished, they started assisting another person. With the exception of one member of staff, other staff did not interact with people in a sociable and encouraging manner throughout the meal. Staff were seen to be quiet, and the process of assisting people to eat was done in silence without eye contact and any sociable engagement that would have been pleasurable during the mealtime experience. One person had a pureed meal. The plate was attractive and each component of the meal had ben pureed separately. However, the member of staff assisting the person only kept stating to them that it was "chicken pie", despite other pureed foods, such as vegetables being on the fork. This may have confused the individual in terms of the tastes of the food they were eating. People were not put at risk and they were supported to have their nutrition and hydration needs met, however in relation to the mealtime experience, we have identified the above as an area of practice that needs improvement.

People were complimentary about the food and drink, and were involved in making their own decisions about the food they ate. Special diets were catered for, such as pureed and fortified. For breakfast, lunch and supper, people were provided with options of what they would like to eat. The chef confirmed that people could have an alternative meal if the person did not want what was on offer. They also confirmed that there were no restrictions on the amount or type of food people could order. Staff understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration or weight loss. Where people had been identified at risk of weight loss, food and fluid charts were in place which enabled staff to monitor people's nutritional intake. People's weights were recorded monthly, with permission by the individual. Where people had lost weight, we saw that advice was sought from the GP.

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. Staff had knowledge of the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. Staff told us they explained the person's care to them and gained consent before carrying out care. One member of staff told us, "Some people can't fully make their own decisions. I follow procedures and have had training on the MCA". Throughout the inspection, we saw staff speaking clearly and gently and waiting for responses. Members of staff recognised that people had the right to refuse consent. The manager and staff understood the principles of DoLS and how to keep people safe from being restricted unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty, and we saw appropriate paperwork that supported this.

Staff told us the training they received was thorough and they felt they had the skills they needed to carry out their roles effectively. Training schedules confirmed staff received essential training on areas such as, moving and handling, health and safety and infection control. Staff had also received training that was specific to the needs of the people living at the service, this included wound care, catheter training and palliative care (end of life). Staff spoke highly of the opportunities for training. One member of staff told us, "I'm up for all training if it helps with my role". The provider operated an effective induction programme which allowed new members of staff to be introduced to the running of Beech Hurst and the people living at the service. Staff told us they had received a good induction which equipped them to work with people. One member of staff told us, "They run a very strict induction. I feel like I've worked here my whole life". The manager added, "We offer a 12 week induction plan with mentoring and shadowing. New staff who have not worked in care before are put on the Care Certificate". The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. There was an on-going programme of supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Members of staff commented they found the forum of supervision useful and felt able to approach the registered manager with any concerns or queries.

People commented that their healthcare needs were effectively managed and met. They felt confident in the skills of the staff meeting their healthcare needs. One person told us, "They are quite good at sending for the doctor if you are not well. I have a very good lady doctor who comes in". Another person said, "I have had an eye test and seen a dentist recently. They come here, which is good". Where required, people were supported to access routine medical support, for example, from an optician to check their eyesight. In addition, people had input into their care from healthcare professionals such as doctors and chiropodists whenever necessary. Staff were committed to providing high quality, effective care. The manager added, "We have a GP round every Wednesday and Thursday, but staff would definitely recognise if somebody was ill and discuss it".

Good

Is the service caring?

Our findings

People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "They are very caring. I need help, because I get breathless". A relative said, "They are so caring, they really get what it means to care for the individual".

Positive relationships had developed with people. Staff showed kindness when speaking with them. Staff took their time to talk with people and showed them that they were important. Staff always approached people face on and at eye level, they demonstrated empathy and compassion for the people they supported. Friendly conversations were taking place. Staff demonstrated a strong commitment to providing compassionate care. From talking to staff, they each had a firm understanding of how best to provide support. The manager told us that staff ensured that they read people's care plans in order to know more about them. We spoke with staff who confirmed this was the case and gave us examples of people's individual personalities and character traits. Throughout the inspection, people were observed freely moving around the service and spending time in the communal areas. People's rooms were personalised with their belongings and memorabilia. People were supported to maintain their personal and physical appearance, and were dressed in the clothes they preferred and in the way they wanted.

The manager and staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. One person told us, "I have been here two years and I can propel myself in this wheelchair. I think they want me to get one of those fancy electric ones, but I can manage with this one". They told us they that they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed, how and where to spend their day, what they wanted to wear and how their care was delivered. One person told us, "We are able to make our own decisions". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "It's all about the residents, they get to make the choices. If they want to stay in bed, they can". Another member of staff said, "People get plenty of choice. When they get dressed and they can get up when they want. We listen to the residents". The manager added, "We speak to people and discuss their choices. We get feedback from them on their preferences and what they think of staff".

There were arrangements in place to protect and uphold people's confidentiality, privacy and dignity. Members of staff had a firm understanding of the principles of privacy and dignity. As part of staff induction, privacy and dignity was covered and the registered manager undertook competency checks to ensure staff were adhering to the principles of privacy and dignity. They were able to describe how they worked in a way that protected people's privacy and dignity. One member of staff told us, "I always knock and close the door and curtains, its automatic". People confirmed staff upheld their privacy and dignity, and we saw doors were closed and staff knocking before entering anybody's room. One person told us, "I'm always treated with dignity and respect, especially with personal care". Another person said, "Carers never rush me. They are polite and knock on the door and explain everything". Care records were stored securely. Confidential

information was kept secure and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training pertaining to this.

Staff supported people and encouraged them, where they were able, to be as independent as possible. One member of staff told us, "We want people to help themselves. Some residents may want to wash themselves and we just help to dress them, or do the things they can't. We encourage people to walk as well, we don't want people giving up". We saw examples of people using adapted cups, to enable them to drink independently, and care staff informed us that they always encouraged people to carry out personal care tasks for themselves, such as brushing their teeth and hair. The manager said, "Staff encourage independence. We have residents who help out around the home, serving food, making tea and folding napkins".

People were able to maintain relationships with those who mattered to them. Visiting was not restricted and guests were welcome at any time. People could see their visitors in the communal areas or in their own room. One person told us, "Relatives are invited to join residents for lunch and are made very welcome at all times. On Christmas Day they joined all the tables together and made a lovely spread". A visiting relative added, "We can visit any time of day or night, we are always welcome".

Requires Improvement

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "They have asked me for my views and I say I have no complaints". A relative said, "They know my relative so well and have involved us every step of the way. They listen to what we want and respond straight away". A further relative said, "I have no hesitation in telling them about [my relatives] special needs. He always looks clean and his clothes are clean. It's very well done". However, despite the positive feedback, we found areas of practice that needed improvement.

At the last inspection on 16 and 17 June 2015 we identified areas of practice that needed improvement. This was because we found the provision of meaningful activities for people were not consistently based on their assessed need and personalised to them. This was specifically significant for people living in the Seaford Unit of the service. Some improvements had been made, however further areas requiring improvement of the provision of meaningful activities were identified.

At the last inspection, we found the provision of meaningful activities for people were not consistently based on their assessed need and personalised to them, specifically for people living in the Seaford Unit. We saw at this inspection, that improvements had been made. However, further work was required to ensure that everybody at the service had access to meaningful activities. We saw that in the Seaford Unit comprehensive individual activity plans had been written for people. It was clear that input had been received from people and their families in relation to the type of activities that would be interested in. However, despite this comprehensive information being available, staff did not follow these plans. For example, one person's activity plan stated, 'Can't take part in activities due to mental and physical health. Staff to ensure that one member of staff spend at least 20 minutes a day with her one to one, reading stories, singing songs, talking about family and past life. Show her pictures and ask her questions, as this improves her behaviour'. We asked a member of staff if this activity plan was being followed. They told us, "We sit with her, but not in one 20 minute block. Probably at different times, for about 20 minutes in total throughout the day". Another person's activity plan stated, 'Never been interested in activities, due to a short attention span. We will try sensory activities and maybe take her to the park or the town centre'. However, after speaking with staff, it was confirmed that these suggested activities had not happened. It is to be acknowledged that it was difficult to engage some people in activities in the Seaford unit, due to the nature of their condition. A member of staff told us, "It is difficult within this unit. People are set in their ways and are not interested in leaving the unit. The hairdresser comes in to see them and we encourage them to join in with activities, but some just want to stay in their rooms just watching TV and sleeping. We have day to day chit chat and we've tried to encourage watching films together, rather than just TV. Everyone is so different here, it is difficult".

We saw evidence of people taking part in activities in the wider service, which included arts and crafts, films and themed events, such as a party for Chinese New Year and reminiscence sessions. People were given the choice to join in activities, or to alternatively not take part should they not want to. One person told us, "I enjoy bingo and quizzes". Another person said, "They make an effort to bring in outsiders. One came who had them all exercising and dancing. It was excellent fun, but she hasn't been since". A member of staff told us, "I really enjoy working with the residents around activities, they've all got individual things they like".

Feedback from people who attended the activities was gathered, in order to guide staff to plan activities that were meaningful and relevant to people. For people who remained in their rooms and may be at risk of social isolation staff spent time with them on a one to one basis. One person told us, "The activity lady brings me magazines and chats to me". Another person said, "I'm quite happy, I never get bored. I have the TV and radio and CD's". However, we could not see that one to one time for all people who stayed in their rooms was scheduled. The service employed a specific activity co-ordinator. However, we were told that two activity co-ordinators were required to implement a meaningful activities provision for people. The manager told us that they were in the process of recruiting a further activity co-ordinator, and that specific training had been put in place for activities staff to assist them in their role. The manager told us, "We still have some way to go in the Seaford unit with one to one activities, there are still more things we can explore throughout the home". We have identified the above in relation to the provision of meaningful activities, as an area or practice that needs improvement.

We recommend the provider should take into account Common Core Principles to support good mental health and wellbeing in adult social care by Skills for Care.

We saw that people's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Paperwork confirmed people or their relatives were involved in the formation of the initial care plans and were subsequently asked if they would like to be involved in any care plan reviews. Care plans contained personal information, which recorded details about people and their lives. For example, one person told us they liked their room and of great importance to them were their soft toys and dog. The person showed us they had a large cushion with a picture of their dog on it, and made it clear how important this was to them. Their care plan confirmed this and informed staff that they had kept dogs in the past. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care.

Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required meeting those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. For example, one care plan stated that a person enjoyed listening to classical music, being of smart appearance and wearing a specific waistcoat. Another care plan stated that a person wished to get up at around 4:00pm – 5:00pm in the day. We saw that this was the case for both these people and their chosen plan of care had been followed. The manager told us that staff ensured that they read peoples care plans in order to know more about them. We spoke with staff who confirmed this and gave us examples of people's individual personalities and character traits that were reflected in peoples care plans. One member of staff told us, "One resident had very strong OCD (obsessive compulsive disorder) and needs tasks done in a very specific way that we have to follow". Another said, "The care plans are reviewed and we have to read them. We get to know people and what they want".

People and relatives were aware of how to make a complaint and all felt they would have no problem raising any issues. One person told us, "I have never had a reason to complain, but if I did, I would speak to the nurse". A relative said, "I have only mentioned minor problems and they are always resolved". The complaints procedure and policy were accessible and displayed around the service. Complaints made were recorded and addressed in line with the policy with a detailed response. Most people we spoke with told us they had not needed to complain and that any minor issues were dealt with informally.

Good

Is the service well-led?

Our findings

At the last inspection on 16 and 17 June 2015 we identified areas of practice that needed improvement. This was because the culture and values of the provider were not embedded into daily practice and staff spoke negatively about the service and management. We saw that the required improvements had been made.

People, visitors and staff all told us that they were satisfied with the service provided and the way it was managed. Staff commented they felt supported and could approach the management with any concerns or questions. One person told us, "The deputy manager is excellent, she always listens and really cares. She is very easy to talk to". A relative said, "The new manager has made so many improvements, things are on the up and up". A member of staff added, "[The manager] has made a big difference here. I think the staff are happier now".

We discussed the culture and ethos of the service with the manager and staff. The manager told us, "I think the care delivery is good. We want to promote independence and create a culture of openness with staff, residents and relatives". A visitor said, "This is a well led, family orientated home". A member of staff added, "We support people and spend time with them, they get good care". In respect to culture and staff, the manager added, "We have had staff meetings to discuss culture and morale. I want to offer support, I'm not just here nine until five. I feel as though morale has improved". Staff said they felt well supported within their roles and described an 'open door' management approach. One member of staff said, "The manager is cheerful and talks to us, and if we want to talk to her, she listens". Another said, "I can approach the manager, I have no concerns there". The manager added, "I'm approachable, fair and transparent. My door is only closed if I'm in a meeting and then just put a note under it and I'll come and find you".

People were actively involved in developing the service. We were told that people gave feedback about staff and the service, and that residents' meetings also took place. We saw that people had been involved in recruiting a new chef for the service and had taken part in food judging panels to determine the best candidates. There were systems and processes in place to consult with people, relatives, staff and healthcare professionals. One person told us, "They have meetings sometimes, they talk about food and fish". Satisfaction surveys were carried out, providing the manager with a mechanism for monitoring people's satisfaction with the service provided. One person told us, "I have filled in a questionnaire, but I haven't been to a meeting". Feedback from the surveys was on the whole positive, and changes were made in light of peoples' suggestions. Staff were encouraged to ask questions, make suggestions about how the service is run and address problems or concerns with management. The manager told us, "I want open communication with staff. Staff know their responsibilities to report and act".

Management was visible within the service and the manager worked alongside staff which gave them insight into their role and the challenges they faced. A member of staff told us, "She [the manager] gets stuck in and helps as well. That makes a huge difference". The manager added, "I have a good understanding of the day to day. I know what's happening on the floor. I'm a nurse of 30 years, I've been at the coalface and I'll help the staff if I can do things to make their life easier". The service had a strong emphasis on team work and communication sharing. There were open and transparent methods of communication within the home.

Staff attended daily handovers. This kept them informed of any developments or changes to people's needs. One member of staff told us, "We have regular meetings. We discuss what has happened with each resident". Staff commented that they all worked together and approached concerns as a team. One member of staff said, "We get on well and support each other and communicate. We are a good team, it's all rather exciting". The manager added, "I am a firm believer in good communication in a service, getting feedback and generating improvement. We have regular meetings to discuss assessments and issues".

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included medication, care planning and infection control. The results of which were analysed in order to determine trends and introduce preventative measures. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. Accidents and incidents were reported, monitored and patterns were analysed, so appropriate measures could be put in place when needed.

Mechanisms were in place for the manager to keep up to date with changes in policy, legislation and best practice. The manager was supported by the provider and up to date sector specific information was also made available for staff, including guidance around pressure care and the care of people approaching the end of their life. We saw that the service also liaised with the Local Authority and Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery, and learning was cascaded down to staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.