Care Quality Commission

Ashton Care Homes Limited

Ashton House

Inspection report

Bolnore Road
Haywards Heath
West Sussex
RH16 4BX

Tel: 01444459586
Website: www.ashtonhousehaywardsheath.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13, 14 and 15 November 2017.

At a focussed inspection on 28 July 2015 looking at how safe and effective the home was we found concerns relating to actions taken following accidents and incidents. Improvements had been made. There were now actions clearly recorded and taken following any accident or incident. However, we did find new concerns with medicines management, the assessment of risks to people, inconsistencies in care plans and people with specific health needs not having clear guidance in place.

Ashton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
Ashton House accommodates up to 100 people across two separate units, each of which have separate adapted facilities. One of the units, Hazelwood, specialises in providing care to people living with dementia. The main house has a wider range of older people living in it. At the time of the inspection there were 74 people living at the home. It is a large, detached home with accommodation across three floors. Most people have a single bedroom. There are two double bedrooms.

At the last inspection the service was rated good.

The home currently has a senior registered manager supported by two unit registered managers. 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. One of the unit registered managers had recently left employment.

People were not always kept safe at the home. Improvements were required when some people had specific health and care needs. Risks had not always been assessed or identified to enable people to retain their independence and receive care in line with their needs. Medicines had not always been managed safely because there were occasions where more than one staff had worked from the same medicine trolley. One person who required medicines administered in food or drink did not have it done safely. People were protected from potential abuse because staff were able to recognise signs and knew how to report it.

People and their relatives were involved in writing their care plans. Some care plans contained inconsistent information and lacked guidance for staff to follow. Systems were not always in place to ensure people had a dignified death.

There was a programme of activities in place to provide a range of opportunities. People were encouraged to suggest activities and trips which would respect their hobbies and interests. People and their relatives knew how to complain and action was taken. However, lessons learnt from complaints had not always been recorded.

The provider and registered manager tried to promote high quality care. The registered managers and provider had systems to monitor the quality of the service and made some improvements in accordance with people's changing needs. The systems in place had not identified some concerns found during the inspection. There was a positive approach to improving the service once they had been highlighted. People were positive about the management of the service. Staff felt supported. The provider had not always completed statutory notifications in line with legislation to inform external agencies of significant events.

People were supported to have choice and control of their lives. When people lacked capacity the statutory principles of the Mental Capacity Act 2005 had not always been followed following feedback from an external audit. People and their relatives were positive about the food and meal times were treated as a social opportunity. Staff had the skills and knowledge required to effectively support people. People and their relatives told us their healthcare needs were met and staff supported them to see other health and social care professionals.

People and their relatives told us, and we observed staff were kind and patient. People's privacy and dignity was respected by staff and their cultural or religious needs were valued. When people had specific needs or differences they had been considered by staff. People, or their representatives, were involved in decisions about the care and support received. There were enough staff to meet people's care and health needs.

We found one breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always have their medicines managed safely.

People did not always have risks identified or mitigated in line with their care and health needs. When specific equipment or action was required the guidance was inconsistent or unclear.

People who had accidents and incidents had actions taken following them and lessons were learnt.

People had risks of potential abuse or harm minimised because staff understood the correct processes to be followed and who to report concerns to.

People were protected from the risks associated with poor staff recruitment because a safe recruitment procedure was followed for new staff. There were enough staff to meet people's care and health needs.

Is the service effective?

Good

The service was effective.

People's rights were respected because the principles of the Mental Capacity Act 2005 were mainly followed. People's choices were respected.

People benefitted from good medical and community healthcare support and links the staff and provider had developed.

People had access to a varied and healthy diet to meet their preferences and needs.

People were supported by staff who had the skills and knowledge to meet their needs.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who were kind and caring. Staff respected people's individuality and spoke to them with respect.

People were able have visitors at any time, and could meet them where they liked.

People's privacy and dignity were respected and supported.

People were able to make choices and these were respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs and wishes regarding their care were understood by staff. Improvements were required because their care plans contained information which was inconsistent or contradictory at times.

People benefitted because staff made efforts to engage with people throughout the day. Activities were in place in accordance with people's interests. These were sometimes adapted to meet people's preferences.

People and their relatives could be confident any concerns would be managed in line the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were supported in a home where the provider and registered manager had quality assurance systems. Improvements were needed because these were not always identifying concerns.

The provider was not fulfilling their legal responsibilities because notifications were not always being sent to the commission in line with current requirements.

People benefitted from living in a home where the provider and registered manager supported staff.

People were able to receive high quality care because the provider and registered managers were striving to make improvements.

Care Quality Commission

Ashton House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13, 14 and 15 November 2017 and was unannounced. It was carried out by three adult social care inspectors, a specialist advisor nurse and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service for people.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at other information we held about the home before the inspection visit.

We spoke with 24 people who lived at the home, seven relatives and two health professionals. We also had informal conversations with people at the home as we walked around and completed the inspection. We spoke with two providers, two registered managers and fifteen members of staff including activities staff, nurses and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at fourteen people's care records in depth and other people's care records in relation to medicine management. We observed care and support in communal areas. We looked at staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints and complements files, medication files, environmental files, activity records, statement of purpose, provider internal communication documents and a selection of the provider's policies.

Requires Improvement

Our findings

At the last focussed inspection, concerns were raised that appropriate actions had not been taken following accidents and incidents to ensure people's safety. During this inspection we found there had been improvements. There were clear action plans following accidents and incidents which highlighted ways to prevent reoccurrence. For example, after one incident relevant training was sourced for staff and there was a new protocol for contacting people's GPs prior to admission to get medical histories. However, new concerns were found with the management of medicines, risks not always being identified or assessed and some people were not receiving safe care or treatment to meet their needs.

Some people with behaviour which could be challenging to themselves or others had plans in place to minimise distress, but other people did not always have clear plans or guidelines for staff to follow. One person had a rummage box they could take to a quiet place when they became more anxious. Others had behaviour monitoring charts so patterns could be identified and strategies put in place to support their anxiety. Sometimes, advice from other health and social care professionals was sought.

However, some people who became distressed were at risk of being isolated in their bedrooms without the risks assessed and ensuring it was the least restrictive option. One person with dementia was found alone in their bedroom in a distressed state. Staff confirmed the person was given some time in their bedroom to help them calm and prevent others becoming distressed. They told us the person was monitored every hour. The person's care plan had contradictory information. In one place it said someone should sit with the person until they had "Calmed down". In another place it stated if the person was in bed they were to be checked every half an hour. There was also a note to warn staff the person could climb bed rails when they were distressed. This meant staff were not given clear guidance on how to keep this person safe from hurting themselves. The senior registered manager told us they would update the person's care plan to provide clear guidelines. One of the provider's explained they were about to swap to an electronic care plan system which would improve people's care plans.

A second person was in their bedroom, alone, calling out at various points during the inspection. One member of staff told us the person had recently declined in health and their mobility had reduced. They explained the person could become distressed and would shout until tired. The care plan did not reflect the approach of leaving the person alone in their bedroom. One member of staff said, "I check in care plan. Usually, care plan gives up to date information". This meant there was a risk staff would not support people in line with their health and care needs to keep them safe. One nurse told us the person's care plan needed to be reviewed and they would do this.

People with specific health needs were placed at risk of declining health and infection spreading. One person with a pressure ulcer had no information in their care plan about how often they should be repositioned nor did they currently have the wound recorded. The unit registered manager said, "She should be repositioned two hourly as she is at high risk". They confirmed the person was unable to turn over in bed independently. The repositioning records indicated 16 occasions over six days where they had not been repositioned every two hours. Part of the reason was because there were options to record whether the person had been 'Checked' or 'repositioned'. One member of staff said, "We only check them and their position is not changed" when a 'check' was marked. Neither registered manager nor the provider had identified this issue. The unit registered manager agreed the person's care plan needed updating to ensure they were being kept safe from pressure sores. The senior registered manager was going to change the repositioning records to remove 'checked' as an option.

Another person had epilepsy. There was no guidance for staff in place in their care plan for the actions they should take. This meant there was no indication about how to identify the person was having a seizure or the actions which should be taken. By not having this information there was a risk the person's health could deteriorate. There were some agency nurses who did not have epilepsy training working in the unit this person lived. The senior registered manager was going to make sure the person's care plan was updated and liaise with the agencies about specific training their staff have. Following the inspection, the senior registered manager sent us an updated epilepsy plan and seizure monitoring chart which was now in place for the person.

A third person was unable to swallow so had a tube to deliver food to their stomach. There were no guidelines in place for staff about how this tube should be managed to prevent it blocking or prevent the spread of infection. One nurse explained they did clean the tube daily with cleaning equipment but they were not recording it. We spoke with the registered managers who informed us they would immediately put systems in place to ensure this person's equipment was managed safely. Following the inspection, the senior registered manager sent an updated care plan and daily recording chart they had put in place to ensure the person received safe care.

The Provider Information Return (PIR) told us, "The nursing staff are competent and confident in their medication and medical training". We found medicines were not always managed safely. On two occasions two staff were working out of one medicine trolley which increased the likelihood of errors. The first time the staff told us they were nervous about the inspection so wanted to support each other. On the second occasion one nurse said they were only counter signing the administered medicines. However, they had not been watching every medicine being administered as they were talking with people. On one occasion the medicine had been administered in a different room. The nurse was about to sign to say they had witnessed it being administered. On both occasions we spoke with the registered managers who agreed the practice was not safe. They told us in the last year there had been three lots of medicine management training for staff because concerns had been identified by the provider.

People who had medicines administered covertly in their food or drink were at risk of poor administration and their medicines being damaged and less effective. None of these medicines had been checked with a pharmacist to ensure the efficiency of the medicine within specific food or drink. One person did not have their medicine administered safely when it was administered covertly in food. The nurse put the medicine in their food and the person said, "I don't want that messing up my dinner". It was left in the food by the nurse. After ten minutes, the person's unfinished meal was taken by a member of care staff. This had not been witnessed by the nurse; a member of the inspection team had to inform them. There was a risk the medicine had not been taken by the person. The nurse told us they would try to administer the medicine later. When we later checked, we were told they had not been administered the medicine later because they were not

sure how much the person had already taken so further administration presented an overdose risk. The senior registered manager told us they would follow this up with the member of staff.

This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt safe living at the home. One person said, "I enjoy it here and feel safe because they [meaning staff] are so good". Other people told us, "It's so cosy and warm here and the staff are so nice, that makes me feel safe." and, "It is safe living here because there's always someone to look out for you". One relative said, "My mother came in here when I could no longer look after her myself. It is because I know she is kept safe, that I'm happy she is here". Other relatives told us, "I'm very comfortable that mum is safe here" and, "Since coming here mum has blossomed and smiles again. She is safe here and that is so important".

People were supported by staff who knew how to keep them safe from potential abuse. One person said, "Yes, the people [meaning staff] here make me feel safe." All staff knew how to report potential abuse and thought action would be taken. The senior registered manager took a proactive response to safeguarding allegations and worked with the local authority to keep people safe.

People and their relatives were involved in decisions about how their medicine was administered. One person said, "If I had a headache or anything I could just ask and they'd give me paracetamol or something." One relative told us, "I used to look after mum myself and it was tricky for me to give her medication. They have had the same problems here and we discussed it and I gave permission that they could give mum her medication by whatever means they thought was best. They're the professionals and they know what they're doing, they do a fantastic job." Medicines were stored securely including those which required additional storage or refrigeration. Most stock was managed well so all medicine was accounted for and errors could be identified.

People were supported by enough staff to meet their health and care needs. People told us, "The staff are always looking in several times a day and when I need help they are there" and, "I think there are quite a lot of staff and generally there are enough". The senior registered manager told us they worked on identifying the skill mix of the staff to ensure they were able to keep people safe and meet their needs. Every three months, the provider completed dependency profiles. These highlighted people's current support needs and how many staff were required in each unit. One of the providers told us when they used agency staff they always tried to use the same ones for consistency. One agency staff confirmed they had been working at the home for eight years.

The PIR told us and we found people were kept safe because staff had been through a safe recruitment process. This included checks on staff suitability to work with vulnerable people and references from previous employers. Staff confirmed to us the records that they had been required to provide, as well as their job interview before they were offered employment. The provider told us the process they went through to speak with previous employers for references.

People were kept safe because there were strong health and safety monitoring systems in place. One of the provider's was proud of the systems they had in place to monitor these. All service and maintenance contracts were up to date. The water had been routinely checked for Legionella and all equipment such as hoists and the lift had been serviced in the last year. Fire systems were in place and people had personal evacuation plans to identify the support they required in the event of a fire. When a maintenance issue occurred the management were responsive in resolving it. For example, one of the keypads to a unit broke

during the inspection. One of the provider's had immediately contacted the relevant people to get it fixed.

Good

Our findings

People were asked for consent if they had capacity to make a decision. People told us, "They always ask before they do anything" and "They do ask me for consent before they do anything". One member of staff said, "I always ask before I do any care". Many people living at the home lacked capacity to make some or all important decisions because of their dementia. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and found people who lacked capacity did not always have their needs and wishes considered in line with current legislation. When decisions had been made in their best interest they were not always decision specific. For example, some people had bedrails in place, which was a restrictive care practice. Staff were able to explain why the rails were in place saying it was in the person's best interest. However, there had been no formal recorded decision specific assessment of the person's capacity when staff were unsure. There was often a blanket consent form in place for these people. On occasions, consent was being given by a relative who did not have the right authorisation to give it.

Two people who lacked capacity shared a double room. There was no agreement, consent or best interest decision to this double room arrangement. There were no records to demonstrate staff had considered the compatibility of the two people. One of the people told us they preferred privacy and their care plan confirmed this. The other person had difficulty sleeping and was regularly up during the night.

The provider and registered manager's told us a care consultancy firm who completed an audit for them advised a change to how they recorded people's capacity and consent. The provider had authorised this change. During the inspection the senior registered manager showed us an alternative way of reviewing people's capacity and recording best interest. This was in line with the statutory guidance. We were told this would start to be used immediately and had used it prior to external advice.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People who were being deprived of their human rights had DoLS in place or applications made. Appropriate applications had been made to the

local authority to lawfully deprive people of their liberty though in many cases they had not been acknowledged by the local authority. During the inspection the senior registered manager followed up all these applications for an update from the local authority. However, systems in place had not identified one person's DoLS had expired and not been renewed. During the inspection the senior registered manager made contact with the local authority and ensured a new DoLS application was submitted.

People's equality and diversity was respected by the staff who supported them. The senior registered manager told us all staff had received training about this and they were one of the staff who promoted dignity. On one occasion staff had facilitated a person to live an alternative lifestyle in the way they chose. Other people who were unable to leave their beds had sensory profiles completed so staff would be aware of smells and touch they enjoyed. One person with mobility issues said, "The staff are simply marvellous and so compassionate. I can't get around without their help but they do so and never make me feel like a nuisance. They seem to keep me jolly". One relative told us, "The staff spoil him [meaning their family member]. He can have very dark moods but they cajole him and know how to deal with them".

The PIR told us, and we found, people were supported by staff who had received training to meet their health and care needs. One person said, "They're all very good [meaning the staff] and always being given in-house training how to treat us. I only have one leg so have to be lifted. They use a very safe hoist and I have never once felt unsafe". Another person told us, "The nurses are well trained". Visitors were generally positive about the quality of the staff including the training they appeared to have. Staff said, "Plenty of training to do in the home", "We get all the training we need" and, "We get told what training to do and when it's due to be refreshed". Records showed staff received varied training which covered topics of how to support people and meet their needs.

The PIR told us and we saw staff were provided with support throughout the year. Supervision and appraisal records demonstrated these were carried out at regular intervals. All staff had yearly for appraisal. Supervisions were an opportunity to discuss good practice and areas which required improvements. Training needs could also be identified during these. Some staff did not have English as their first language. The provider had provided English lessons twice a week to promote improvements and support them. The provider and registered manager sourced additional training which was relevant for members of staff. The new administrator was completing a diploma in business administration whilst some care staff were completing specialist health and social care qualifications. This meant people were being supported by staff who had the skills and experience to meet their needs and communicate with them.

New staff were given a thorough induction when they started working at the home. All new staff completed the provider's own version of the Care Certificate. The Care Certificate is a nationally recognised standard to make sure all staff working in care have basic skills to look after people. Some staff were in the process of completing each unit. New staff were encouraged to shadow more experienced staff so they could learn about their role. They had a review with the manager during their probation period to discuss any training needs and their performance. Nurses new to the home also had a comprehensive induction programme leading to the completion of a competency framework. This made sure their skills were up to date and they could meet people's care and health needs.

People were supported to eat and drink healthy meals in line with their dietary requirements. One person told us, "They feed us very well. There is a good choice of food. If I get served something I don't like I can always tell them and they'll offer me something else. I'm fairly easy to please." Other people said, "The food is amazing", "The food is very nice" and, "The food is lovely". During some observations one person called out, "Nurse it is delicious" about the pudding they were eating. One relative told us about their family member who required a specific diet and told us, "The staff are all totally aware of this and I am confident

she has never been offered the wrong food".

People were given choice about the food they were eating at each meal. One person had sandwiches cut in triangles rather than the options on the menu. Another person told us, "I'm not really a good eater. I'm very, very picky. They always want to please me but I love my cornflakes, I could just live on them." There was a box of cornflakes on the side.

One member of staff was offering gravy to people throughout the meal and waited for their choice. When people were identified to have a weight loss, action was taken to prevent their health declining. One person had a loss of over five kilograms. They had their dietary needs reviewed to ensure they were getting enough food to remain healthy. At meal times in the main house there were tables set with a linen tablecloths, fresh flowers, condiments, juice and a bottle of red and white wine. One of the providers told us they wanted it to be like going to a restaurant for people living at the home.

People who required specialist soft diets had their needs met to prevent choking or weight loss. One person was given a plate of food with each food pureed separately on the plate. The member of staff supporting them was providing encouragement. However, one person was lying in their bed with a paper bib on and had food left on the side under an open window. The person was unable to support themselves to eat and was chewing on a mouthful of food. One member of staff came after six minutes. They told us they had left the room to make a cup of tea for a different person's relative. The member of staff told us the food had arrived very hot so they needed to wait a few minutes for the food to cool.

The registered manager and provider were currently developing the environment around the home to support people with dementia. There were plans to name all the corridors by street names so it was easier for people with memory loss to navigate. All bedrooms had a picture on the door and the person's name. Each picture was chosen by the person and was something important to them.
People had access to other health and social care professionals when their health declined and whenever they required them. The provider organised the GP to come twice a week to hold reviews for anyone who required them. One person told us, "My GP looks in on a Friday. We can call on a dentist if needed, they will come here. Only got to say you have a pain and the doctor will come in. The usual routine though is that I am seen once a fortnight. If I need a chiropodist there's one who comes in and I can ask for him to visit me". There were regular visits from the psychiatrist to support people with their mental health needs and dementia. During the visit further communication with the psychiatrist led to plans to provide medication reviews for people when they first moved into the home.

When people's health deteriorated suddenly staff were proactive in getting them help from health professionals. One relative said, "The care in Ashton House is exceptional. My husband had sepsis which was identified here and he was blue lighted to hospital. I didn't think he would make it but their swift action saved his life." Other people whose health had declined were referred to the GP, hospital or another professional specialising in the care. For example, when people displayed high levels of anxiety and distress the psychiatrist was called to reassess.

People were supported by staff who worked with other health and social care professionals to meet their care needs. There were occasions when this led to people leading a more fulfilled and settled life. One relative told us, "My husband had pneumonia about a year ago. They nursed him back, which was amazing." Another person had moved to the home receiving end of life care and requiring specialist pain relief. Staff worked with the doctors and over their time at the home the person's health had improved and they no longer required the special pain relief.

Good

Our findings

The PIR told us, and we saw, people continued to be supported by kind and caring staff most of the time. One person told us, "Most of the staff are very jolly. They chat to us and I like them". They continued, "They have always been very gentle and kind but, most of all, calm and assuring" and continued "I'm really quite glad of the help I get." Other people said, "They're kind", "Very nice people [meaning staff] who are very chatty and I like living here" and, "They are very good. They look after me". One relative told us, "The care is very good, in particular, [name of staff member] is very conscientious and keen to do everything correctly. He is kind and attentive". Staff spent time with people and they appeared calm and comfortable in their presence.

Most staff were responsive to people's needs. One person called out, "What day is it today?" They immediately received a response from a member of staff saying, "It's Tuesday". Another person was falling asleep with a half full cup of drink in their hand. A member of staff spotted this and the cup tipping. Straightaway, the staff member caught the cup and helped the person to wipe the spill from their trousers.

Compliments received by the home reflected the positive comments received during the inspection. One said, "Since [name of person] has been to Ashton House he is much happier and staff are wonderful". Whilst others included comments like, "Great kindness and commitment", "Staff helpful and kind" and "Staff always go above and beyond to assist my family and husband". One comment explained how they had helped the family to not worry as much. It read, "Caring and professional, exceptional care which puts our mind at rest".

The management tried to lead by example. They greeted people as they walked past and stopped to have conversations when it was appropriate. One of the providers was proud of the observations they completed around the home to ensure people were receiving kind care. During these they would identify staff kneeling down to speak to people at their level. They focussed on how the people's experience was at specific times of the day such as meal times. When they saw positive interactions they informed staff. They also provided suggestions on how to make improvements at the handover following an observation.

People were able to have visitors and could meet them in communal areas or their bedrooms. One person told us, "My son can come in any time he likes; he usually visits twice a week." Relatives said, "There are no restrictions, I can pop in whenever I want to. I am always made to feel welcome", "I come in every day to see mum. The staff know me well and always make me welcome and offer me a drink." And, "The family can pop in whenever we want to. The wonderful staff make us feel part of the family and offer tea". When

people's families were unable to visit the home, staff supported them to remain in contact. One person told us staff always brought them the telephone so they could speak with their sister.

People were offered choices and their decisions were respected by staff. One person said, "I am able to get up when I want or go to bed as I want. I have a slot for a shower once a week but could do so more often if I wanted. The choice is mine. I was asked if I wanted to register for a female only carer for personal care but I told them as long as whoever helps can do the job I don't care". Other people told us, "Of course I make my own choices".

People's privacy and dignity was respected most of the time. Staff knew to knock on people's doors before entering their bedrooms. People were supported with intimate care in private by the staff. However, on one occasion a person was walking along the corridor who had clearly had an accident. A member of the inspection team had to speak with staff so the person was taken to their bedroom. We spoke with the staff who explained due to being in handover there were less staff monitoring people.

Requires Improvement

Our findings

People and their relatives told us they were involved in their care plans. One person said, "I have a care plan and they come round regularly and refresh it. I have a copy in my room." Relatives told us, "Mum has a care plan and it was reviewed recently", "My mother has a social worker and my brother deals with them and the care plan" and "I was involved in the initial care plan and the review". However, people's care plans had not always been updated when their care and health needs changed. When there had been changes some contained contradictions. For example, two people had changes in their mobility. Their care plans had separate entries which gave different information to staff. For example, one person recently had a medical procedure which affected their mobility. Another part of their plan stated there were no mobility issues. There was use of agency staff who could refer to these plans. By having contradictory information there was a risk people would not receive care and support in line with their needs and wishes.

People's daily routines were sometimes outlined in the care plans to help staff know their preferences. This was important because some people had verbal communication and memory difficulties. One person's included their preferred time to get up and go to bed. It had information about their sleeping patterns and support with their continence needs. However, there were care plans which lacked information or guidance for staff to follow. One person required support with their continence needs. Their care plan did not provide enough information about the support required by staff so they did not become anxious and potentially hurt themselves or the staff members. A second person's care plan stated in the diet and weight section the person was still able to eat independently. In another part of the care plan it said, "Needs a lot of encouragement to eat and drink". By having inconsistent information it could cause the person to receive care not in line with their needs and wishes. One of the providers and the senior registered manager told us a new electronic care plan system was going to be introduced following the inspection. All people's care plans would be reviewed and updated in line with this change.

Some people's care plans had information about their life history. This was important because many of them had memory loss because of their dementia. One person's care plan stated where they were born and included information about previous employment and their hobbies. Another person's care plan had a full life history including their previous employment as a secretary. During the inspection one member of staff knew a person used to be a nurse. They spoke to the person about them liking to help others. The senior registered manager informed us it was sometimes difficult to obtain this personalised information when the person was unable to tell them and there were no family members to consult but they made effort where possible.

Some people had their end of life wishes considered so they could be supported to have a comfortable, dignified and pain-free death. One relative told us, "[Name of senior registered manager] has discussed end of life care for my husband with me and explained everything very well". There was guidance around whether the person wanted to be resuscitated and information about people wanting to remain at the home. However, two people had recently been considered as requiring palliative or end of life care by their GP. The two registered managers were unaware of this recent change. The unit registered manager explained this was because agency nurses had spoken with GPs and had not communicated this to the management. One had been communicated in the nurse communication book and the other had their care plan updated. Both people were on pain relief at the time of the inspection. By not having the correct information clearly communicated or followed there was a risk people would not receive a dignified death in line with their wishes and preferences. Following the inspection the provider informed us there had not been time to tell the management. Nurses had liaised with the two people's family and records had now been updated to reflect these changes.

People and their relatives told us there was a range of activities they could participate in. One person said, "There is plenty enough going on. They have people coming in who sing, play instruments, they do arts and crafts and all sorts of things. I tend to sit and chat, watch television and I have colouring books which I bought myself, or I've been given as presents, and I enjoy doing them. We also get taken out in the mini bus, I particularly like going to the garden centre and going to the cafe for tea and cakes." Relatives told us, "My husband is able to go out in the wheelchair and he loves being taken out in the mini bus to the Memory Cafe in Haywards Heath. [Name of activity coordinator] is brilliant with him" and, "I know that my mother is taken out because she tells me. I'm not sure what activities she joins in with but what I can say without a doubt is that her personality has improved dramatically since being here. It has been like a breath of fresh air. She is so much happier and that makes us feel so much better too".

During the inspection there was a range of activities taking place. Some people were playing card games in groups; others were having one to one sessions in their bedrooms. One person had been assessed as able to access the community independently and we saw them come and go when they liked. If people had specific needs such as smoking then these were facilitated by the activity and care staff. Throughout the home there were pictures of activities which had happened. There had been birthday parties held for people and pets as therapy dogs had come in. In the Hazelwood unit there was a reminiscent area for people to sit in. There was progress sheets recorded for each person about the activities they had participated in. Staff also recorded people's hobbies and interests so activities could be identified in relation to them.

The PIR told us, and we found, people and their relatives knew how to raise concerns and told us the management were responsive about resolving them. One person became distressed whilst we spoke about a specific staff member supporting them. The unit registered manager came straight away. They explained the specific member of staff was no longer providing support for the person to respect their wishes. Another person said, "If I had a complaint I would get taken to reception and speak to whoever was on duty". One relative told us about an occasion they had raised a complaint about the care their family member had received. They said, "The incident was investigated and the person involved no longer works here. I am satisfied with the outcome". Complaints were generally handled within a reasonable time frame and within 28 days .However, there was not always information recorded from the complainant that the complaint was resolved to their satisfaction. There was also no record of any debrief to staff or any learning from complaints.

Requires Improvement

Our findings

The provider and registered managers had systems to audit the care and support people were receiving. There were monthly checks by the unit registered managers. The senior registered manager and one of the provider's completed quarterly checks. A specialist health and social care firm was asked to complete annual audits of the systems in the home. This was to ensure there had been external, independent audits. When shortfalls were identified action had been taken. For example, the employment of a staff member had been reviewed in relation to multiple concerns about their performance. On another occasion the provider had identified people's DoLS conditions should be reflected in their care plans which was then actioned.

However, none of these systems had identified some concerns found during the inspection. For example, repositioning charts were not clear. Care plans contained contradictory information and lacked guidance to meet people's care and health needs. Risks had not always been identified or managed for some people. There were no clear systems in place to identify people receiving end of life care. This meant people might not receive support in line with their care and health needs.

When we raised concerns with the management they took them seriously and responded promptly. They had strong relationships with other professionals which meant they could resolve the issues in a timely manner. For example, some concerns were raised about the use of medicines with some people. Immediately, the senior registered manager and one of the providers was able to speak with health professionals to resolve the issue. In addition, they created an action plan to improve people's medicine management further by putting in additional reviews. Following the inspection further updates were received about actions the senior manager had taken to update people's care plans.

Notifications had not always been sent in line with current legislation. The provider had notified Care Quality Commission (CQC) about safeguardings and changes to the home. However, there had been occasions when notifications to the CQC had not followed statutory guidance. Some safeguardings had not been sent as soon as the provider was aware of them. This meant external parties were less able to monitor the care and safety of people. We spoke with the two registered managers and provider and they had not always been clear at what stage CQC should have been notified. They assured us all future notifications would be sent in line with the legislation.

Most people and their relatives knew who members of the management were and spoke positively about them. One person said, "There are two managers, I don't know who does what, they are very good and got their finger on the ball". Other people said, "[Name of unit registered manager] is very good indeed. Relatives

told us, "I think the home is well run. They speak to me and keep me informed" and, "All my dealings in terms of the management have been good. My mother has a nominated nurse but for the life of me I can't remember her name. I know her by sight of course". Staff were positive about working at the home.

There was a 'thank you' board at the entrance to the home. This celebrated many languages of how to say thank you. Alongside this were feedback forms where people and their relatives could complement staff and provide suggestions. At the end of each month the complement slips were put up and the staff member with the most was named 'employee of the month'. The registered manager told us it had a positive impact on moral for the staff. In turn, this motivated them to deliver high quality care and support to people.

The provider had introduced a range of ways to promote high quality care. They engaged and involved people and their relatives in providing feedback about the service. People told us, "We do have residents' meetings. I've been to two or three. We all get a copy of what was discussed" and "I've not been to a residents' meeting but was given a questionnaire quite recently". One relative said, "I did go to a residents' meeting" and continued, "I can see what's going on as I'm here so often, I would speak up if I had to rather than wait for any meeting". Another relative said, "I have been to a residents' meeting and found it useful". They had an extensive range of questionnaires and a suggestions box for people and their relatives to provide feedback. One of the providers told us they worked hard to then action this feedback and make improvements where they were required.

One of the providers told us they completed regular observations of staff interactions with people. They felt this was a vital part of ensuring people received high quality care. As part of the process they provided feedback at staff handover. The provider told us this had promoted staff to respect people more and have positive interactions throughout the day. They had been promoting a 'dining room' atmosphere at all meals. This included staff serving people their meals and telling them what they were having. During the inspection some staff had positive interactions with people whilst they were eating.

The senior registered manager told us they were now completing detailed supervisions with all heads of department. This involved speaking with other staff who worked with them and looking at their quality of work. Detailed feedback was provided to the staff member on what was going well and what could be improved. The senior registered manager said, "We are striving to improve" The home had been accredited with the investors in people award to reflect the support they provided staff with.

The senior registered manager told us the provider had been actively involved in local and national schemes. They were a member of the National Skills Academy which is an organisation with a leading role in developing the infrastructure needed to deliver specialist skills. Locally, they were a member of a local dementia group promoting best practice and part of the safeguarding steering group. The provider was signed up to the Registered Nursing Home Association and National Activity Provider's Association. This meant they were trying to keep up with best practice and any changes which occurred. It also provided them with opportunities to drive improvements for people receiving care and share good practice with other organisations.

The senior registered manager was constantly striving to improve their own knowledge. They had completed various courses so they could provide support to other managers and staff. This included completing a mentorship course at Exeter University and they were an assessor for health and social care diplomas. This meant they could provide guidance for other staff to improve their support for people. They had completed their own diploma in psychology health education and had completed the leadership and management award. Currently, they were making enquiries about joining the Queen's Nursing Institute (QNI). The QNI is a charity which aims to improve the quality of nursing people received in their own home.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that all risks had been identified and mitigated, medicines had not been managed safely and specialist equipment was not managed safely to prevent the spread of infections. This is a breach of Regulation 12 (1) (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.