New Century Care (Bognor Regis) Limited

Aldwick House Care Home

Inspection report

Nyewood Lane
Bognor Regis
West Sussex
PO21 2SJ

Tel: 01243842244
Website: www.newcenturycare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 25 and 26 February 2016. At our previous inspection in February 2015 we found concerns with regard to the management of risks to people, the management of care and consent to care delivered to people, and the lack of dignity and respect afforded to people. At this inspection we found improvements had been made in these areas, but further improvements were still required.

Aldwick House Care Home is a 32 bedded nursing home that provides care and support to older people living with dementia. At the time of inspection there were 28 people living at the home. The registered manager told us that everyone who was living at the home had a diagnosis of dementia and that this was their primary need.

During our inspection the registered manager was present. There had been a change of manager since our last inspection. The current registered manager has been in post since October 2015 and had just recently registered with us. 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.

People said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything.

Risks to people had not always been managed safely. Care plans and assessments were not always updated to reflect changes in needs.

People told us that they were happy with care they received. One relative told us, "My family member is content, happy and settled here. I feel all their care needs are being met." However, we found that some people did not receive care and support which met their individual needs. This included pressure area care, meeting nutritional needs and dementia care.

Staff understood the principles of the Mental Capacity Act 2005 (MCA), the Deprivation of Liberty Safeguards (DoLS) and how they affected their work. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. They confirmed they had received training in these areas. However, the principles of the MCA had not always been put into practice.

The registered manager advised us no one accommodated had capacity to make decisions for themselves. People's relatives or representatives had not always been involved in decision making processes about their care when required. DoLS applications for three people had been appropriately made to ensure people's human rights were upheld. However, there was no recorded guidance for staff to follow to ensure care

provided was appropriate.

People said that the food at the home was good. There was evidence of people being offered choices in relation to food and drink.

We heard staff speaking kindly to people and they were able to explain how they developed positive caring relationships with people.

The registered manager had begun to make improvements required to the environment to help meet the needs of people living with dementia. They have also begun to improve care records to ensure care delivery is person centred and they have begun to improve the provision of activities for people. We have made a recommendation that further work is done in these areas in order to meet people's individual needs.

People, relatives and staff told us that there were enough staff on duty to support people at the times they wanted or needed. We also found that this was the case.

Staff told us they felt well supported in their work by the registered manager. Training was provided during induction and then on an on-going basis. A training programme was in place that included courses that were relevant to the needs of people who lived at Aldwick House Care Home.

The registered manager had arranged meetings with people and their relatives meetings to enable people to express their views and to be involved in making decisions about the service.

The registered manager also provided us with documentary evidence that demonstrated how the service had been monitored. They included routine health and safety checks and maintenance of the environment, the management of medicines and infection control.

A written complaints procedure was in place that showed that, where concerns or complaints had been raised, the manager would respond to them on an individual basis in writing. Since appointment, the registered manager had not yet received any complaints. There was evidence to demonstrate that the findings from individual complaints would be incorporated into the provider's auditing system in order to identify trends and to learn from them.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care records did not provide staff with sufficient up to date information to ensure care was delivered safely and met people's needs. The registered provider had not ensured, where people lacked capacity to make decisions for themselves, the principles of the Mental Capacity Act had been followed. You can see what action we have 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.

Identified risks to people had not always been managed safely to reduce the likelihood of recurrence.

Staff understood the importance of protecting people from harm and abuse.

There were enough staff on duty to deliver care to people at the times they wanted or needed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received appropriate training to enable them to provide care skilfully and effectively.

When people did not have the capacity to consent to care and treatment, suitable arrangements had not always been made to ensure decisions were made in their best interests. Deprivation of Liberty Safeguards (DoLS) applications to deprive people of their liberty had been made lawfully to ensure people's rights were protected.

People were supported to have sufficient to eat and drink.

People had access to community healthcare services.

Is the service caring?

Good

The service was caring.

We observed interactions between staff and people were kind and caring.

Staff received appropriate training so that they were able to provide care skilfully.

People's privacy and dignity had been respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no opportunity for people to take part in meaningful activity.

There was very little evidence to demonstrate care had been planned in a person centred manner.

People and their relatives had opportunities to give their views about the service they received. They felt able to raise concerns or make complaints. They were confident the provider would respond appropriately.

Is the service well-led?

Good

The service was well-led.

The current registered manager promoted a positive culture which was open and inclusive.

Staff were well supported and were clear about their roles and responsibilities.

Quality monitoring systems were in place and action had been taken to address shortfalls in the quality of the service provided to people.

Aldwick House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 25 and 26 February 2016 and was unannounced. The inspection team was made up of an inspector and a specialist advisor in nursing and dementia care.

Before the visit we examined information we had about this service. This included previous inspection reports and statutory notifications the registered person had sent us. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information of concern that had been sent to us by members of the public and comments we had received from West Sussex County Council Adult Services. We used all of this information to help us decide which areas to focus on during the inspection.

We spoke with four people who used the service and a relative who was visiting Aldwick House. We also spoke with the registered manager, the deputy manager, two registered nurses, three care assistants and two other members of staff who were on duty. We spoke with a social worker who was visiting a client. We also spoke with two members of the local authority's Dementia Care Team who were visiting to support members of staff in improving their understanding and skills in delivering care to people living with dementia.

All of the people accommodated at Aldwick House were living with dementia to some degree. This meant that most people were unable to tell us about their experience of the service because they had difficulty with verbal communication. Some people were only able to provide short responses to us. We observed people's facial expressions and body language when they received care.

We observed care and support being delivered in the lounge and dining areas. We also spent time observing the lunchtime experience people had. We used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who were unable to

talk with us. We also observed the medicines round that took place at lunchtime.

We reviewed a range records relating to the management of the home and the delivery of care. They included care records for seven people, medicine administration records (MAR) for 14 people. Management records included the provider's quality assurance records, the supervision records of three members of staff, staff rotas for a period of four weeks, minutes of recent staff meetings and the training records of all the staff employed at Aldwick House.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection, in February 2015, we found the service was not safe in relation to the management of identified risks to people. The provider sent us an action plan that set out the actions that would be taken to make the improvements required. The action plan also stated this would be completed by June 2015. At this inspection we found evidence that demonstrated that some improvements had been made. However, we identified new concerns in relation to how identified risks to people had been managed.

There was a system in place to assess people's needs, to identify risks and protect people from harm. Care records we looked at provided information about their needs in relation to the provision of a safe environment, moving and handling needs, potential falls, skin condition, nutrition and hydration. Risk assessments in relation each person's needs were within each care record we reviewed. However, they were not always completed accurately. For example, there was a falls risk assessment for one person but it did not refer to other conditions that would affect the potential risks of falls. Care records indicated this person had recently had a chest infection. They also had limited vision and sight. Using the scoring tool that was in place, these factors should have increased the current score of 7 to a score of 11, and should have taken the risk level from low to medium. This meant that the assessment of risk was not accurate to enable staff to provide care which would reduce this risk.

People who had been assessed as needing to use pressure relieving mattresses did not have, within their care plans, details of the specific type of mattress required and the settings required to ensure they were effective. We were informed that it was the responsibility of the maintenance person to set up mattresses according to the individual's weight, when they were required. However, there was no system in place to check them to ensure they had been set correctly and that they were effective. We checked four pressure mattresses that were in use. There were several different types. Some were set according to the weight of the person, while others had a graduation of soft to firm as the settings. One person's mattress had been set at 80kg. The nurse on duty was unable to state if this was the correct setting for this person. This person was a small, frail person and, the nurse agreed, could not be this weight. Where pressure relieving mattresses had been used, which had graduated settings, there was no evidence that the manufacturer's instructions had been followed to ensure the setting was appropriate to the person's needs. In addition, there was no review or evaluation of the use of pressure relieving equipment. This meant that people were at risk of not having effective pressure relief, which may result in further tissue damage if the incorrect setting or equipment has been used.

In addition, most of the care plans we looked at had not been regularly updated to reflect current care needs. We found examples where care plans had been written in 2014, and that evaluations stated there were no changes to the person's needs. However, in one instance a person, who came to Aldwick House fully mobile, was now immobile even though their care plan had not been changed to reflect this. Another person's care plan identified they required assistance with oral health care. It stated, 'If gums are observed to be bleeding when (the person's name) is cleaning their teeth, (person's name) should be advised to concentrate on that area.' We learnt that, since this care plan had been drawn up, the person had been prescribed Warfarin to prevent blood clotting, but the care plan had not been updated. If staff followed the

guidance in their care plan around oral care, this person would be at risk of blood loss which may require medical intervention.

The evidence above indicated this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood how to identify and report abuse. Staff were aware of their responsibilities in relation to keeping people safe. They were able to tell us the different types of abuse that people might be at risk of and the signs that might indicate potential abuse. Staff also explained they were expected to report any concerns to their registered manager or to the nurse in charge. This was in line with the provider's and the local authority's procedures. Records showed that staff had received training to ensure they understood what was expected of them.

People who were able to speak with us confirmed they felt safe. We also saw that people showed no signs of fear or distress when staff approached them. A relative was very complimentary about the staff. They told us, "I have never seen anyone badly treated by the staff when I visit." Visiting professionals we spoke with also told us they had never witnessed any abusive behaviour towards people accommodated at Aldwick House.

There were sufficient numbers of staff to ensure people were safe. We observed care being provided to people during the course of our inspection. We saw no evidence of people having to wait before staff responded to provide assistance. A relative told us, "Going back a year or so, I would say that I did notice call bells ringing without being answered. But not now, there is always enough staff around."

Staff told us that there were enough staff to deliver the care people needed. A member of staff told us, "In my opinion, we should have one to one, but that will never happen! There is enough staff to make sure everyone is cared for."

The registered manager confirmed that, in October 2015 he had conducted a reassessment of people's care needs. As a result he determined that a minimum of four care assistants supported by a registered nurse were required between 8am and 8pm each day. At night, a minimum of three care assistants supported by a registered nurse, were required. This was not in line with the numbers of nursing and care staff that we found had been provided during our inspection in February 2015. At this inspection, and at the previous one, the registered manager was unable to demonstrate how this number was calculated. We looked at staffing rotas that covered a four week period from 8 February 2016 to 6 March 2016. They reflected the staffing levels that the registered manager had described had been provided during this period.

The registered manager informed us that they were currently recruiting to increase staffing levels so that five care assistants would be provided each day. He expected to increase care assistant levels by March 2016, taking into account the process of recruitment and induction. On the day of the inspection we saw at least three newly appointed care assistants who were undertaking induction training via a computer training package before they commenced work. The registered manager also sent us information after our inspection which demonstrated that four care assistants and a trained nurse had been appointed. He also sent us further staffing rotas which indicated that staffing levels had been increased to five care assistants from 8am to 8pm each day.

We were informed the registered manager was not a nurse and was supernumerary to the rota of trained nurses. The deputy manager was a trained nurse and provided advice and guidance in this area. He was also recruiting registered nurses to increase the numbers available. This would mean that, for some shifts, the deputy manager would also be supernumerary. In addition to nursing and care staff, domiciliary staff,

including house keepers and laundry staff, catering staff, including chefs and kitchen assistants, and maintenance staff were employed to maintain and keep the premises clean and to provide meals to people.

There were effective staff recruitment and selection processes in place. The manager confirmed that applicants were expected to complete and return an application form and to attend an interview. The application included information about their previous employment, education, evidence of appropriate training and their current health. We examined recruitment records of two staff members who had been recruited in the last four months. They confirmed the recruitment process that had been described by the registered manager. They also provided documentary evidence that the necessary checks, such as references, proof of identity, and proof of registration with regard to trained nurses had been undertaken before staff commenced work. Staff we spoke with confirmed the checks and documentation they were expected to provide.

Nursing staff supported people to take their medicines safely. They informed us they were expected to check that the medicines to be administered were in accordance with the prescribing directions recorded on the Medication Administration Records (MAR). They also informed us they would observe that the person had taken their medicine before recording this. If the person did not wish to take their medicine, this would be appropriately recorded in line with the provider's own written procedures.

We observed the nurse on duty administer medicines at lunch time. We observed that practices were in line with what we were told. The nurse demonstrated they knew people and their needs well. The nurse spoke with them professionally, but in a gentle and calming way.

MAR sheets were up to date which evidenced that people received their medicines as prescribed. The majority had clear information recorded about individual preferences for the way that person wished to take their medicine. Where people had been prescribed warfarin there was clear evidence of regular blood clotting checks having been completed to ensure that the correct doses had been administered.

People were prescribed when required (PRN) medicines, mainly for pain management. The administration of when required medicines had been recorded. Nursing staff had also routinely recorded information with regard to the reason why medicines had been given and whether they had been effective. This information ensured agreed measures to manage pain were effective and to ensure that PRN medicines had been used appropriately.

Storage arrangements for medicines were secure, maintained at appropriate temperatures and were in accordance with appropriate guidelines.

Current practices were not in line with current guidance for the prevention and control of infection. We visited the laundry room and found that red sacks which contained clothes soiled with body fluids had been stacked on the floor. There were also soiled bed sheets which had not been put into red sacks. We spoke with staff about laundry practices. We were informed that linen and personal items of clothing that had been soiled were removed from the red sacks before they were put into the washing machine. We were informed this is because some items of clothing could not be washed at high temperatures without risk of shrinkage. We were also informed that the red sacks clogged up the washing machine. We brought this to the attention of the registered manager as the practices described increased the risk of cross infection. Before we left we observed that the registered manager had provided a washable container where soiled linen could be stored before it had been laundered. They also confirmed they would speak with staff to clarify how red sacks should be used to prevent the risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

At the last comprehensive inspection, in February 2015, we found the service was not effective in relation to the obtaining and acting in accordance with the consent or best interests of people, the effective management of people's care needs, person-centred care planning and the effective management of eating and drinking risks. The provider sent us an action plan that set out the actions that would be taken to make the improvements required. The action plan also stated this would be completed by June 2015.

At this inspection we found evidence that confirmed the improvements the provider had made in these areas demonstrated regulations had now been met. However, we have identified new concerns with regard to obtaining consent, acting in the best interests of people and the effective management of peoples' care needs. We have considered the evidence regarding person-centred care planning under the 'Responsive' domain.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager confirmed that Deprivation of Liberty Safeguards (DoLS) applications on behalf of everyone had been sent to the local authority. At present, DoLS for were in place for three people. Care records included appropriate documentation which gave the reason for the restriction and the length of time they would be place before a review was required. However, care plans did not provide staff with sufficient guidance to ensure they implemented restrictions safely. For example, one person's care records stated they could be resistant to personal care. There was no guidance for staff to follow to ensure they built a trusting relationship with the individual, provided care in a way that met their cognitive needs and used techniques, such as 'hand under hand' to help them feel in control.

The registered manager informed us that mental capacity assessments indicated that people accommodated had fluctuating capacity with regard to giving consent care. This meant that people were able to give consent with regard to day to day decisions, such as when they would like to get up, or what they would like to do during the day. But this could change from day to day. However, they were unable to make complex decisions which affected their health and welfare. The registered manager also informed us, where people lacked capacity to make decisions they, and the care staff, would be guided by the principles of the Mental Health Act (MCA) 2005 to ensure any decisions were made in their best interests. Documents we looked at confirmed that capacity assessments had taken place. They also confirmed, where this had

taken place, best interest decisions had been recorded and also documented who had been involved.

However, practices we observed indicated that the principles of the MCA may not have been followed in every case. For example, we found a sensor mat was being used for another person so that staff knew if they moved out of their room. Bedrails were also in use for a number of people. We found no evidence that best interest decisions had taken place before they were put in use and that other options had been considered to ensure this was the least restrictive way to ensure people's safety.
The evidence above indicated this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed interactions between people and staff on duty. We observed staff seeking consent before undertaking any activities. They gave the person time to respond and make their choice before care was delivered. Staff we spoke with demonstrated a good understanding of the MCA and how it affected their work. A care assistant told us, "Everyone has mental capacity in some way. It is up to us to help them to make their choices." Training records indicated that the registered manager, all of the nurses and all except one care assistant had received up to date training in this area. Training records indicated this member of staff was due to receive training shortly.

People we spoke with confirmed they were satisfied with the care provided. A relative told us, "My family member is happy and settled here. I feel all their care needs are being met." We observed

At our last inspection we found concerns about the effective management of eating and drinking risks. We observed staff providing support over the lunchtime meal. Where people required help with eating their meal, a member of staff sat with them and ensured the food was offered at a tempo and pace that had been set by the individual person. This also ensured people, who had been identified as being at risk of choking, could receive the time and support they needed. There were enough staff on duty so that other people, who were capable of eating and drinking independently, did not have to wait to have their meal served to them. People clearly enjoyed the lunchtime experience and the meal they had eaten. A relative said, "I have seen the food provided. I am quite satisfied with this." There were several bowls of fresh fruit on display in different areas of the building along with jugs of fruit squash and water with glasses in the dining area. We also observed fluids available to people in their own rooms.

Staff on duty confirmed the training they had received. This included moving and handling, food hygiene, fire safety, health and safety and infection control. In addition, staff told us they received training with regard to nutrition and hydration, how to reduce the risk of pressure sores and the how to provide care to people living with dementia. They also confirmed that the training enabled them to provide the care and support people required. Training records confirmed staff had received this training. In addition, they indicated that, of the 16 care assistants employed, ten had been awarded the Diploma in Health and Social Care at Level 2 or Level 3.

When we asked about their role one member of staff told us, "We have to be for our clients everything that is missing. For example, we have to be their hands or their eyes." Another member of staff said, "We have to remember everyone is different. They need to be treated individually. We need to know what they like." Staff were also knowledgeable about the needs of individual people and their care needs.

Staff confirmed they received individual supervision from the registered manager a more senior member of staff. They found this provided them with the support and guidance they needed to carry out the work that was required of them. Records we looked at confirmed the registered manager had already provided

supervision sessions for at least half of the staff team and plans we place to provide this to the remainder.

People were supported to maintain good health by having regular access to health care services. The staff would contact the GP on their behalf if they needed an appointment when they were unwell. Arrangements would be made for GPs to visit the person at Aldwick House, or, if the person wished, appointments would be made to visit the GP at their surgery. The manager confirmed arrangements would be made to accompany the person if this was required. The manager also confirmed, where necessary, access to specialist services for people living with dementia would be arranged via the GP. We saw that visits made by the GP to people had been recorded together with any treatment prescribed.

Good

Is the service caring?

Our findings

At the last comprehensive inspection, in February 2015, we found the service was not effective in relation to respecting and involving people who use services. The provider sent us an action plan that set out the actions that would be taken to make the improvements required. The action plan also stated this would be completed by June 2015. At this inspection we found evidence that confirmed the improvements the provider had made in these areas demonstrated regulations had now been met.

People were very complimentary about care staff. One person said, "They (the staff) are all very good". A relative told us said, "My family member is well cared for. I am quite satisfied. The staff are very friendly and caring."

Care records we looked at indicated that the person or their relative had been involved in drawing up care plans. There was also evidence that, within this process, each person's personal preferences had been taken into consideration. However, the registered manager was aware that this work was not yet completed and had identified this was a priority for himself and the staff. We saw evidence within meetings the registered manager had held with people and relatives that there had been discussions between them with regard to how he intended to involve them more in this process.

We observed interactions between staff and the people living at Aldwick House were kind and caring. They had clearly developed caring relationships with people and spent time with people talking and listening to them. We observed the care and support provided over lunch. Some people were brought into the dining room at approximately 12 noon, before the meal was served. We were advised that this meant people were given the opportunity to socialise with others. People were asked where and with whom they wished to sit. Other people had chosen to remain in the lounge where they were served their meal where they sat. Others had stayed in their rooms and we saw staff take meals on trays to them.

As staff served the meal they engaged with each individual in a positive manner. They were asked if they needed help with cutting up their food, if they needed help with using sauces and condiments that were on the table. They were also asked if the required a protective cover to make sure their clothes were not soiled by any food that might fall from their cutlery or from their mouth. Staff also explained what the food was before they left. There was also laughter and jokes shared between people and staff, which everyone enjoyed.

The staff attended to one person who became very agitated because they believed another person had been rude to them. Whilst this was not the case, the person became very angry. A member of staff immediately went and sat down beside to ensure they had eye contact. They spoke very calmly and gently to the person until they also calmed down. The conversation after this, gave the person options to leave the room, to talk about their feelings or to get involved in another activity. The person took up the option of doing something else and became quite calm and settled again. This demonstrated an understanding of how someone with dementia needed to be supported sensitively, calmly and compassionately.

We spoke with the member of staff afterwards. They told us, "This person needs lots of reassurance from us. They are very religious and, if they hear someone, swearing, it upsets them. We have to explain that not everyone is perfect and (the person) has to forgive others. We also offer to take (the person) to their room so they can have their own space." Staff on duty also told us how they maintain people's dignity and respect. Another staff member said, "We have to keep the door to their room closed and the curtains closed when we are washing and dressing them. We also ask what clothes they would like to wear." Our observations indicated people were treated with dignity and respect. Doors were closed when personal care was provided and people were spoken to in a respectful manner.

The registered manager advised us that all the staff employed at Aldwick House were expected to develop a positive, caring relationship with people. They would be expected communicate with people in a kind, polite manner and make sure there was time to listen to people. They also informed us that this was discussed during induction and supervision, where support would be provided if problems were identified.

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection, in February 2015, we found evidence that the planning and delivery of care was not person centred. We also made a recommendation that the provider should research and implement relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'. The provider sent us an action plan that set out the actions that would be taken to make the improvements required. The action plan also stated this would be completed by June 2015.

At this inspection most of the care plans reviewed still fell short of being person-centred. There was no evidence to demonstrate, when they had been written, that the person or their representative had been involved. They were written in a generic, task focussed way, which did not take into account individual preferences or wishes. There was very little evidence of recorded life stories or biographies of each person to reflect their individuality and personal preferences. There were brief references in care plan to people resisting personal care or expressing distressed behaviour as a result of living with dementia. However, there was very little guidance for staff to follow to support people safely and effectively. We have identified where the safety of people may be compromised due to the lack of detail in care records under the 'Safe' domain.

At this inspection we found evidence that the registered manager had begun the process of getting care plans rewritten in a more personalised and person centred way. The registered manager had held a meeting with families and representatives of each person in January 2016, where he had invited them to assist with drawing up care plans by providing him with background information which would help staff to provide care in a more person-centred manner.

We found no evidence of meaningful activities being provided to people in communal areas or in their own rooms. Minutes of meetings also outlined further discussions which involved plans to improve the provision of activities for people. Those in attendance were advised that a new activities coordinator was being recruited. In- house activities discussed included animal therapy and reminiscence. In response to a request made by a relative the registered manager confirmed sensory equipment would also be purchased for people to use. There were also plans to redecorate and refurbish the home to ensure it was appropriate for people living with dementia. We saw that the dining area had been freshly painted in order to make it more welcoming and user friendly. A fish tank had been bought and was in the communal lounge. Photographs of staff were on display to help people recognise them.

The registered manager agreed that the work to make necessary improvements had begun, but it was nowhere near completion at the moment. Therefore we recommend that further work is done to ensure people's care plans and activities are person-centred in order to meet people's individual needs.

The registered manager informed us that arrangements had been made for the local Dementia Care Team to visit weekly for the next 16 weeks. During this time they will provide support and guidance members of staff so they may gain more understanding, knowledge and skills in how to provide effective care to people living with dementia. We were provided with a copy of a document that outlined the support that would be provided over this period. It included dementia awareness, communication and person centred care

workshops. We met two members of the Dementia Care Team who informed us this was their second week of the programme. We were informed they had observed good, positive interactions between people and staff. They also advised us that the staff were keen to learn and had engaged positively with the programme. We also met a social worker who was visiting to attend a review meeting for someone who lived at Aldwick House. They confirmed that they found the registered manager and the staff team wanted to work alongside visiting professionals in a positive manner to ensure delivery of good quality care to people living with a dementia.

A relative told us that they would know who to speak with if they had concerns or if they wished to make a complaint. They also said, "If I had any complaints, I feel I could speak to anybody. I am confident I would be taken seriously and they would listen to me." The registered manager confirmed that a written complaint procedure was made available to all people and they relatives. This was also on display in a communal area of Aldwick House. We were also advised that people and their representatives would be provided with opportunities to discuss any concerns they may have. An example we were given was of the visit by a social worker who we met during the inspection. The person had wanted to speak with them about their wishes to live in sheltered housing. We saw a record of complaints that had been kept, which indicated no complaints had been made since our last inspection.

Good

Is the service well-led?

Our findings

At the last comprehensive inspection, in February 2015, we found evidence of breaches with regard to three regulations. The details have been described earlier in this report. The provider sent us an action plan that set out the actions that would be taken to make the improvements required. The action plan also stated this would be completed by June 2015.

The previous registered manager deregistered in August 2015, whilst the current registered manager was appointed in October 2015. As required the provider us advised of the arrangements to manage the service whilst the post of manager was vacant. The change of manager has meant that any improvements made since our last inspection may not have been afforded the opportunity to become embedded in practice. The evidence gathered during this inspection has indicated that the further improvements were needed to meet requirements of the regulations and to ensure the care delivered has met peoples' needs.

At this inspection, people and relatives gave positive comments about the registered manager who, we saw, interacted in a warm, friendly but professional manner with people, relatives and staff. A relative said, "(The registered manager) is fine. He is always around and is readily available if I need to speak with him."

Visiting professionals also told us they had positive interactions with the registered manager. He had also demonstrated to them his intentions to focus on the needs of people accommodated. One professional said, "He is good communicator. He is not doing everything at once, he has made a plan. At the moment he is concentrating on making the staff feel more empowered. He is picking up on their strengths in their work. He is a great manager to work with." Another healthcare professional informed us, "There is a feeling of working together here!"

The registered manager informed us, "It is my intention to make the culture open, inclusive and empowering." We were advised that, to this end, regular meetings were being held with people and their relatives and different staff within the home such as nurses and housekeeping staff. The registered manager said, "This is to enable people, relatives and staff to express their views and concerns about the service and the organisations' values. Minutes of meetings we looked at provided evidence that meetings had taken place and confirmed they had provided people with an opportunity to express their views and to make suggestions to improve the service. Areas that have been discussed included activities, improvements to care records, and improvements to the premises."

Staff confirmed they felt well supported in their work. One member of staff said, "I am really pleased to be working here. It is very rare to find something like this. I feel we are doing the right thing for the people here. There is a good team spirit here." Another member of staff told us, "We do what is best for the residents. That is what the manager has told us. I like being here; it is a good place to work."

We were shown evidence that the registered manager had begun a programme of ensuring all members of staff have received planned supervision at regular intervals by either himself, or a more senior manager of

staff. This provided staff with an opportunity to sit down to discuss their work, the care practices, the aims of the organisation and their training needs.

The registered manager advised us how he intended provide good management and leadership to staff. He explained, "The staff need the manager to give them a clear and concise message. When incidents happen we need to learn from them. It is about driving the development of the team in a managed way. Previously, the staff were low in morale. They did not feel respected or valued. Probably the residents were feeling exactly the same." The registered manager had identified that, in order to make improvements he had identified, he would need to ensure good communication, provide adequate training and ensure staff were afforded the guidance they need to provide good quality care.

The registered manager also provided us with documentary evidence that demonstrated how the service had been monitored. They included routine health and safety checks and maintenance of the environment, the management of medicines and infection control. There were also regular audits of complaints, accidents and incidents in order to determine if there were patterns or factors that could be learnt from. In addition care records and staff recruitment records had been routinely checked to ensure they had been kept accurately. Each audit included an action plan which identified when the work needed to be done by, and by whom to ensure compliance.

The provider had also commissioned an inspection of the service in January 2016 by an external consultant. According to the report we were shown, the purpose of this was, '…to highlight, in a purely advisory capacity, any non-clinical areas which should or could be addressed by the organisation in order to improve the provision and recording of care.' The report used the headings of safe, effective, caring, responsive and well led to map out its findings, recommendations and priority levels for action. The registered manager confirmed that the report would be used as basis for creating an action plan to address and improve the areas identified as requiring improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: Where people were unable to give consent because they lacked capacity the registered person had not acted in accordance with the MCA. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that care and treatment was provided in a safe way. This was because risks to the health and safety of service users had not always been appropriately assessed or mitigated; equipment used by the service provider had not been used in a safe way; medicines had not been managed safely. Regulation 12(1)(2)(a)(b)(e)(g).