Care Quality Commission

Elderet Limited

Woodbine Manor Care Home

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection was unannounced and took place on 16 and 17 October 2014.

Woodbine Manor Care Home accommodates up to 29 older people who live with dementia. It is situated in a residential area of Bognor Regis, West Sussex. At the time of this inspection, there were 28 people living at the home. During our inspection the registered manager was present. 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.

Management of the home was fragmented and this translated into a culture of inconsistency in the way people who lived with dementia were cared for and treated. Quality assurance processes and audits completed by the manager had not identified the inconsistent service that people received. Therefore, they were not effective. The manager had not ensured her knowledge and management skills were current to ensure the home was well led.

Summary of findings

People told us that they felt safe in the home. However, staffing levels did not ensure that people who lived with dementia received all the support they required at the times they needed. We found that there were not enough staff on duty to ensure that people who lived with dementia received stimulation unless external entertainers visited the home. A variety of external entertainers visited the home two or three times a week to provide activity sessions specifically for people who lived with dementia. The home had recently introduced a new activity of 'Informative Talks'. This was an entertainment and reminiscence service that used digital technology with pictures, video and music to involve people and encourage mental stimulation.

The manager had not sought people's consent or acted on advice when she thought people's freedom was being restricted. The manager confirmed they had not followed best interest decision making pathways for people who did not have the capacity to consent to the use of equipment. The manager had not completed mental capacity assessments or made DoLS applications. This meant that people's rights were not protected.

Areas of the home and furniture were stained and had unpleasant odours and were not included in the deep cleaning routines that took place. The lack of deep cleaning did not help to prevent the risk of the spread of infections.

Some staff did not communicate effectively and show consideration to people who lived with dementia despite having received training in this area. This caused some people to become distressed. Some effort had been made to make the environment suitable for people who lived with dementia but this was inconsistent. For example, signage was not in place in all areas of the home that people used and some that were in place were not of a size or type that would make it easily identifiable to people with limited vision or dementia.

Staff understood the importance of protecting people from harm and abuse. However, the manager had not notified the Commission when safeguarding issues had arisen at the home and therefore we could not monitor that all appropriate action had been taken to safeguard people from harm.

Staff said that they felt supported by management to undertake their roles. However, they had not been receiving regular, formal, supervision and appraisal that would support their development and allow the manager to formally monitor staff practice. The manager had devised a plan to address this.

People's nutritional, health and personal care needs were assessed, planned for and met. When recommendations were made by external healthcare professionals these were acted upon to ensure people received the care and support they required. Staff knew the needs of people. The majority of staff treated people with kindness. However, some staff did not speak to people in a respectful way.

There were no formal processes for actively involving people in making decisions about their care and treatment but people told us that they exercised a degree of choice throughout the day. For example, what time they got up, went to bed, where they ate and what help they needed. Everyone said that management at the home were approachable and listened to people's views, opinions and concerns.

Medicines were managed safely. Care records were clear and gave descriptions of people's needs, including any potential risks and included instructions how these should be managed and met safely.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

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 safe.

People told us that they felt safe in the home. However, staffing levels did not ensure that people living with dementia received all the support they required at the times they needed.

Some areas of the home and furniture were stained and had unpleasant odours that made the building unpleasant for people and could increase the risk of infection.

Staff understood the importance of protecting people from harm and abuse. Medicines were managed safely along with risks to individual people.

Is the service effective?

Requires Improvement

The service was not effective.

Some staff did not communicate effectively with people. This caused people to become distressed.

Signage around the building was inconsistent and of poor quality which made it difficult for people living with dementia or poor vision to orient themselves to their surroundings.

The manager had not obtained people's consent for the use of equipment that could restrict their movements. When people did not have the capacity to consent the manager had not made suitable arrangements to ensure decisions were made in their best interests.

People told us that food at the home was good. People enjoyed their meals and each other's company. People's health care needs were met.

Is the service caring?

Requires Improvement

The service was not caring.

People were not actively involved in making decisions about their care and treatment. However, people told us that they exercised choice in day to day activities throughout the day.

People told us that they were treated with kindness and that positive, caring relationships had been developed. We observed that staff knew the needs of people. However, the way that some staff, at times spoke to people who lived with dementia was not respectful or considerate.

Is the service responsive?

Requires Improvement

The service was not responsive.

Summary of findings

People said that staff did not have time to be actively involved in activities. This meant that at times, people did not receive stimulation that met their needs.

People's needs were assessed and care given that reflected changes in people's needs. When recommendations were made by external professionals these were acted upon to ensure people received the care and support they required.

People felt able to express concerns and these were acted upon.

Is the service well-led?

The service was not well-led.

Requires Improvement

A culture of inconsistency was imbedded at the home that was driven by a manager who had not ensured systems and communication empowered people.

Quality assurance processes were not effective because audits had not identified aspects of the service that required improvement. As a result, people received an inconsistent service.

Although the manager was kind and caring her leadership skills were at times lacking and this had impacted on the running of the home. People and their relatives felt able to approach the manager and there was open communication within the staff team.

Woodbine Manor 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 16 and 17 October 2014 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience who had experience of dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 11 people who lived at Woodbine Manor Care Home, six relatives, three care staff, one ancillary worker, the deputy manager and the registered manager. We observed care and support in the lounge during the morning and afternoon on the first day of our inspection. We also spent time observing the lunchtime experience people had and part of a medication round where people were supported to have their prescribed medicines.

We reviewed a range of records about people's care and how the home was managed. These included care records for four people, four medical administration record (MAR) sheets and other records relating to the management of the home. These included four staff training, support and employment records, quality assurance audits, cleaning records, menus and incident reports.

Woodbine Manor Care Home was last inspected on 20 September 2013 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

Staff confirmed that they had received safeguarding training and were able to describe the various types of abuse. They told us what they would do if they suspected abuse was taking place and that they would speak to the deputy manager, manager or social services. We saw that the manager had raised safeguarding alerts with the local authority when abuse was suspected. The service had taken steps to ensure people were safe. However, the manager had not notified the Commission when safeguarding issues had arisen at the home in line with her registration requirements and therefore we could not monitor that all appropriate action had been taken to safeguard people from harm. This is a breach of Regulation 18 Health and Social Care Act 2008 (Registration Regulations) 2010.

Five people told us that they thought that there should be more staff on duty, especially at weekends. One person said, "Sometimes I've had to wait about half an hour when I need the toilet. I try not to bother them during the night". Another person said, "Sometimes it's been about 11.30am before they get me up depending on what else they have to do". A relative said, "At weekends we have sat in the lounge and not seen a member of staff for over an hour". Rotas confirmed that at weekends, even though care staff levels were the same as in the week, there was no management or office staff presence, apart from Sundays from 8am until 2pm. This resulted in there being two staff less available to assist people to get up out of bed and with personal care on Saturdays and afternoons on Sundays. In addition, the care staff on duty had additional tasks that included answering the telephone and arranging cover if staff called in sick.

Despite some people feeling that there should be more staff on duty, people said that they felt the staff addressed needs as quickly as they could, with the resources that they had at the time. People were sympathetic to having to sometimes wait. One person said, "Sometimes they're so busy they don't even have a break". During both days of our inspection we observed that staff were available at all times on the ground floor of the home when people needed assistance with personal care but that this was not always the case on the first floor of the home. For people who choose to stay in their rooms we saw that they could call for assistance, as the home had a call bell system in place. We observed three rooms where people could not reach their call bells and one room where the call bell lead was not in place. The person in this room told us, "I'd just shout if I needed them". This person was on the first floor of the home where, throughout most of our inspection we did not see a staff presence. This meant that people on the first floor or with no access to a call bell may not be able to summon assistance quickly if they needed help. Individual dependency assessments were completed for people who lived at the home. However, the manager confirmed that an overall assessment was not completed when deciding safe staffing levels that considered other aspects such as the layout of the home and ancillary staff. This all meant a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we asked people and their relatives for their views on cleanliness at the home they said that the home was clean and homely but not immaculate. One person said, "Not pristine but homely". A relative said, "I often take mum out as I can't stand the smell of urine at times". The majority of staff undertook infection control training on a bi-annual basis. In addition, some staff had completed a more detailed, distance learning course. Staff used personal protective equipment (PPE), including disposable gloves and aprons when they carried out personal care such as assisting with continence to help reduce the risk of the spread of infection. Hand gels and alcoholic hand rubs were available at strategic points throughout the home, including the entrance hall that people could use to help reduce the risk of the spread of infection. The manager, as the person with overall responsibility for infection control had not ensured all areas of the home were clean. Some carpets in communal areas, hoists, wheelchairs, arms on lounge chairs and pressure relieving cushions were badly stained and/or covered in food debris and crumbs. Some rooms had a strong unpleasant urine odour. One person told us that they regularly noticed unpleasant odours when they visited the home. Cleaning records had been completed showing the daily cleaning that had taken place and monthly deep clean routines. However, the deep clean routines did not include carpets and equipment. Systems were not in place to reduce the risk of infections spreading. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that the majority of people who lived at Woodbine Manor Care Home lived with dementia. Some people were unable to communicate with

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Is the service safe?

us verbally, but others told us they felt safe. One person said, "Yes I do feel safe here" and another said, "It's comfy and I know I'm safe here". A relative said, "I go home and don't worry about mum, you see such terrible things in the news but I don't have any of those sorts of worries". We observed that people looked at ease with the staff that were caring for them.

We observed that people moved around the home freely, including access to the garden area and people told us this was the norm. One person told us, "It's good, I can go where I like, when I like". Hoists were used where needed to ensure that people were moved safely and these had been recently serviced. We observed two staff supporting one person to move safely from a wheelchair to an armchair in the lounge using a stand aid.

Risk assessments were in people's care records on areas such as moving and handling, skin integrity including pressure sore risk assessments, malnutrition and mobility. Monthly psychological assessments were in place that took into account people's dementia. These assessed people's orientation, mood, personality and risks associated with walking and aggression (if any) in order that action could be taken to minimise potential or actual risks to people. In addition people had individual dependency assessments completed which the manager informed us were used to help to decide staffing levels.

Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. People's individual care and support needs were reviewed when incidents occurred to help keep them safe. For example, when people experienced falls that resulted in injuries, the manager reviewed the individual accident records and made changes to the care that they received. This included putting pressure mats next to people's beds at night in order to alert staff if someone fell and could not call for assistance. However, people were not routinely involved in the compilation or review process. The manager and staff told us this was because people had dementia.

We looked at the management of medicines at Woodbine Manor Care Home and observed their administration to people during the lunchtime period. We saw that the member of staff who administered people's medication did this safely. We saw that medicines were stored safely in a locked trolley which was not left unattended when open. Everyone told us that they were given their medicines on time and that pain relief was offered and could also be asked for and records that we looked at confirmed this.

There were guidelines for the administration of medicines required as needed (PRN). Staff knew when PRN medicines should be given and why. Staff were able to explain the safe procedures that they followed for the receipt, storage, administration, recording and disposal of medicines that included controlled drugs.

The member of staff described how they completed the medication administration records (MAR) and we witnessed this during the medicines round. Competency assessments were completed for staff who administered medication. These included a member of the management team observing staff when they gave people their medication to ensure they did this safely and in line with the home's medication policies and procedures.

Appropriate checks were completed to ensure staff and equipment were safe to support people who lived at the home. Four staff files confirmed that the home recruited staff appropriately and checks had been undertaken with regard to criminal records, obtaining references and proof of ID. Checks had been undertaken on lift servicing, electrical portable appliance testing (PAT) and hoists.

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Is the service effective?

Our findings

The manager and deputy had received specific training on the Mental Capacity Act 2005. The majority of staff had received training on the Deprivation of Liberty Safeguards (DoLS) as part of the safeguarding adults training that they had completed. 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. We looked at four people's care records and saw that mental capacity was not routinely assessed or considered and action taken when they lacked capacity to consent. As a result people's legal rights were not upheld.

The registered manager had some knowledge on DoLS and on mental capacity but not enough to ensure people's rights were upheld. They told us that no one who lived at the home was subject to a DoLS authorisation. We saw that there was a lock on the front door and that some people used bedrails. The manager and staff confirmed that many people who lived at the home were unable to consent to the use of bedrails and a locked front door due to them living with dementia. Individual assessments were in place for the use of the bedrails; however these did not include consideration of people's ability to consent to this equipment or of actions that should be taken if people did not have capacity to consent. There was evidence that less restrictive measures had been considered that still safeguarded people. For example, the use of pressure mats that alerted staff if people got out of bed at night. The manager confirmed they had not followed best interest decision making pathways for people who did not have the capacity to consent to the use of equipment. The manager had not completed mental capacity assessments or made DoLS applications. Later, after we had discussed the situation with the manager and explained that these were required the manager started to complete DoLS applications for people who lived at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had received training on dementia; however our observations showed staff competency was variable. For example, when one person asked about their mother staff explained to the person that their mother was dead. This had caused the person to become distressed on more than one occasion. Staff demonstrated a lack of understanding and empathy rather than exploring the feelings behind what the person who lived with dementia was experiencing. A relative said, "I think they need more training to understand people with dementia. Some staff are very good but others can be brisk".

We observed that some staff were very capable in communicating effectively with people who lived with dementia whilst others appeared out of their depth and ill equipped to respond effectively. One member of staff was cleaning the table near a person who lived with dementia and the person kept asking what they were supposed to do and could somebody help them. The member of staff was dismissive and carried on cleaning the tables. The person clearly needed some reassurance and for the member of staff to stop what they were doing to offer this. Later we observed a different member of staff do just that. The person said, "I don't know what to do with myself" and on this occasion the staff member sat beside the person, gave good eye contact, held their hand and asked what they wanted to do. They then had a lovely conversation about a family member that comes to visit. The person visibly relaxed and sat back in their chair looking reassured and happy.

On another occasion a member of staff kept trying to encourage another person, who clearly wanted to walk and to be doing something, to sit down. Eventually another member of staff gently took the person's hand and followed their lead in where they wanted to go. We observed two members of staff at lunchtime assisting people to eat their meal. When doing this they stood over them, leaving people before they had finished eating to assist others before coming back and doing the same again. This meant that people did not get the individual support they required to eat their meal when they needed as they had to wait for the staff to come back to them.

We recommend that the provider researches and implements best practice guidance on how to communicate effectively with people with dementia.

People's opinions of staff were mixed. New staff received an induction that was based on the Skills for Care Common Induction Standards Framework. This is a nationally recognised induction programme that helps equip staff with information and knowledge relevant to the care sector they are working in. A training programme was in place that provided a range of courses that staff were expected to complete. These included moving and handling, fire safety,

Is the service effective?

food hygiene and first aid. In addition, staff were also able to undertake additional qualifications such as Qualifications and Credits Framework (QCF) Levels 2 and 3 in Health and Social Care. Staff were able to describe the contents of courses they had attended and said that training helped them gain knowledge needed to perform their duties and care for people safely. Despite our observations most people told us that the staff were good at what they did and trained to do the job effectively. One person said, "They know what they're doing …good as gold they are".

There were no formal support systems in place such as supervision and appraisal. The manager had devised a plan to address this. Staff confirmed that formal support systems were not in place but said that they felt supported by the manager and deputy.

Food at the home was good and the cook provided a good range of home-made meals. Comments from people and their relatives included, "The food is good and the chef really makes an effort", "The food is fabulous" and "You get a choice and if you don't like anything you only have to say". People told us that they always had drinks close by that were within reach and we observed this to be the case when we spent time with individuals.

We observed the lunchtime experience in the dining room. The atmosphere was calm. There were clusters of tables that seated up to four people which helped people who lived with dementia experience a more intimate dining experience. The tables had neat tablecloths, placemats, condiments, different cutlery, drinking vessels and plates according to people's individual needs. Juice was offered throughout the meal and people could have bread and butter with their meal if they wanted to. The mood throughout lunch was relaxed and friendly and people were enjoying the food and each other's company.

Care records provided information to staff about people's food and nutrition that also included people's food preferences. Specialist diets were catered for and the cook was able to explain which people required these and why.

People's health care needs were met. This included calling the doctor promptly as required and also having access to chiropody, opticians, dentists and district nurses. One person said, "I've never needed a doctor, I'm very healthy but I feel confident they would get one if I needed one". A relative said, "They get conjunctivitis on a regular basis and the doctor is called straight away". Another said, "Recently mum had tummy pains and they sorted it really quickly and some low level antibiotics were prescribed".

Staff looked at people's body language and facial expressions to help decide if people who could not tell us due to their dementia were in pain. There was no formal, nationally recognised pain assessment system in place. We discussed this with the manager on the first day of our inspection. Later, the manager had obtained this and said that it would be introduced as part of the care planning system in place at the home.

People's current health needs were recorded on their care records. Care records were reviewed monthly and updated to reflect any changes and people's most up-to-date care needs were met. One person's needs had increased as a result of a fall that resulted in a fracture. This had been reflected in their care plans along with the additional support they required.

Woodbine Manor Care Home had two lounges located on each floor of the building that people could access. During our inspection, the majority of people used the ground floor lounge. The chairs in the ground floor lounge were positioned all around the edge of the room. The manager informed us that the first floor corridors and lounge had recently been repainted with colour contrasting walls and doors to help aid orientation for people who lived with dementia. We were also informed that toilet seats were going to be replaced so that a colour contrast was apparent after advice from the local specialist dementia team from the local health service. The furniture in the first floor lounge had been replaced. One person told us, "This room was an old fashioned lounge with oldie worldly furniture that residents related to but whilst it's now all gleaming and fresh, it's modern with low seating which isn't helpful for the residents who live here. We wonder who was in mind when it was done as the staff seem to use it more than anyone else".

Pictorial signs were displayed on toilets, bathrooms and bedrooms to help people orientate independently. However, we saw that the signage was inconsistent and of poor quality. The majority of doors did not have signage and those that were in place were quite small and would not help people with poor vision or dementia. We also noticed a large mirror in the lift which could create difficulties for people who lived with dementia although

Requires Improvement

Is the service effective?

the wooden wall panelling softened the interior. One person approached us in a corridor and appeared slightly upset. They said, “Can you help me?” and linked arms with us. They then asked if we would like to look at their room to which we agreed. We started to walk down the corridor and the person read out loud the numbers that were on some of the rooms. When the numbers stopped and no other signage was in place in the corridor the person was no longer able to find their room independently and we had to seek assistance from a member of staff.

People’s bedrooms were personalised with possessions such as pictures, bedding and furniture. However we saw no evidence of anyone’s individual or personal interests integrated into the home outside of their rooms.

We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more ‘dementia friendly’.

Requires Improvement

Is the service caring?

Our findings

Some staff did not show consideration and respect when they spoke to people. At one point there were several people in a corridor together and the staff member was quite brisk and said, "You stand there" and "don't go, wait there". On another occasion we heard a person say, "I want my Dad" and the staff response was curtly, "Come and sit down". This directive style was in contrast to the other warmth and affection we had observed and as a result people were not consistently treated with respect and dignity. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Formal processes for actively involving people in making decisions about their care and treatment were either not in place or used consistently. The manager told us that they spent a lot of time "on the floor" with people in order to monitor that staff treated people with kindness and respect. People were allocated staff as keyworkers whose role included acting on their behalf and helping them to make decisions. No one we spoke with was aware of this support system. One relative said, "I asked about a keyworker system as I thought it would be best for mum but was told that they don't do it here in case people are off or if the person doesn't like their keyworker it wouldn't work". Two people's records included evidence that they had been allocated a keyworker but that they had not been meeting with people on a regular basis. Another person's records did not include any evidence of a keyworker. This meant that systems to support people to make decisions about their care and treatment were not consistently applied. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they were treated with kindness and that positive, caring relationships had been developed. One person said, "They have a happy demeanour and sing a lot" and another said, "Carers are down to earth I'm quite happy here". A relative said, "They do have a good rapport with the residents here". Another relative said, "They are very caring and mum likes them because she chats about them fondly" and "If mum needs some affection it's reciprocated".

There was a stable staff group employed at the home and this helped build positive relationships with people. Staff were able to explain the individual needs of people and people's personal preferences. They told us that they got to know people by spending time and talking with them more than reading care records. One person was particularly fond of collecting soft toys and was very touched that a member of staff had thought about them when they were not on duty and bought one to the home when they were next on shift. We saw that hugs were comfortably offered if someone asked for one and reassurance given by holding hands or putting an arm around the shoulders too. One person said to a member of staff, "I love you" and immediately the staff member responded and said, "I love you too, we all do".

People felt that staff knew them well and that they exercised a degree of choice throughout the day regarding the time they got up, went to bed, whether they stayed in their rooms, where they ate and what they ate. People felt they could ask any staff for help if they needed it.

People told us that staff treated them with respect and dignity when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Attention to detail had been given with people's appearance with many ladies wearing items of jewellery that complemented their co-ordinated outfits and gentlemen were freshly shaved.

We saw that a member of staff who administered people's medication did this with sensitivity to their individual needs. For example, the member of staff was seen to get down on their knees in order to have eye contact with a person before giving them each of their tablets. Throughout the process the member of staff explained what they were doing and showed the person the tablets that were placed on a spoon before the person put the spoon in their mouth. The person was also offered sips of a drink between each tablet so that they were easier to swallow.

Requires Improvement

Is the service responsive?

Our findings

Staff did not have time to be actively involved in activities and as a result people did not consistently receive stimulation that met their needs. Several relatives felt that their loved ones and others who lived at the home were capable of chatting and engaging in so much more than what was offered. They said that aside from more meaningful and regular activity there wasn't the capacity for staff to have one to one chats with people on a regular enough basis. One person said, "If there's one thing we'd change it would be that there was more stimulation instead of so much sitting around". Another said, "At weekends it's even worse. There's just nothing at all". Someone else said, "They need more reminiscence conversations" and "Although there's not much time for one to one they will make time if someone's upset or needs them". Although care staff levels were the same of a weekend, three of the four day shifts did not include a management presence. At these times care staff would have additional duties such as answering the telephone and making arrangements to cover shifts if staff rang in sick. This left staff less able to engage with people individually. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Daily newspapers were available, however, there was not much physical stimulation such as interactive tactile activities or textured surfaces around the home for people who lived with dementia that would have provided people with something to do during the day when organised activities were not happening. The home did have a number of pets that offered stimulation and meaningful engagement for people. However, people told us that staff did not have the time to support them to interact with these. One person said, "The ideas are great but if no one takes the time to involve residents then it's all bit meaningless". Another started smiling and said, "Oh he's lovely. I love all animals" when they saw a dog that was in the manager's office. Most people were encouraged to spend their days in the lounge areas, where they were attended to by staff. There were no restrictions when relatives or friends could visit the home. Relatives felt welcomed by staff when they came to visit.

Whilst people could access the garden, their access to local towns was limited unless visitors took them out or they arranged their own transport. One relative said, "They don't have trips out as such but there are social events like the Summer BBQ and that sort of thing. It's lovely because all the families come along too and the atmosphere is great." Several other people spoke similarly of these events which were clearly enjoyed.

An activity programme was in place that consisted of external entertainers who visited the home two or three times a week as a minimum and provided sessions that included a gardening club, reminiscence and exercise to music. The home had recently introduced a new activity of 'Informative Talks'. This was an entertainment and reminiscence service that used digital technology with pictures, video and music to involve people and encourage mental stimulation. However, this did not effectively compensate for the lack of activities initiated by staff.

People needs were assessed prior to admission to the home and relatives confirmed this. Records showed that assessment included input from other professionals. The manager told us they would talk with potential residents and their families so that they had a comprehensive picture of the person, their health and care needs, personal preferences and cultural needs. They said that people's preferences with regard to gender preference of staff who assisted them with personal care was respected. The manager told us about three people who did not have assistance with personal care by a male member of staff in line with their wishes. One person said, "Well when (one care staff) came lots of them were up in arms about him doing personal care. I didn't mind and they've all got used to him now and ask for him he's very good". Whilst this person hadn't any objections they told us that they were not actually asked and said, "Well you have male doctors so you have to put up with it and get used to it when you get to our stage of life. It's just a job they have to do".

Care records were easy to access, clear and gave descriptions of people's needs and the support staff should give to meet these. Staff completed daily records of the care and support that had been given to people. These detailed task based activities such as assistance with personal care, moving and handling and eating. None included information about the person's frame of mind or stimulation that had been provided in relation to support with dementia. Relatives told us that they had been

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Is the service responsive?

involved in the formulation of some care records relevant to people's needs such as advanced care plans but none of the people who lived at the home were able to recall being involved in any such activity.

People had pressure relieving mattresses on their beds to reduce risks associated with immobility and skin integrity. There was no information included in people's records or available in the home in relation to the correct settings for pressure relieving mattresses. The manager told us that the company that provided this equipment set them based on people's individual height and weight and that they would revisit the home if the settings needed to be changed due to a change in a person's weight to ensure equipment was used appropriately when people's circumstances changed.

Where people were at risk of dehydration fluid input charts had been completed. However, these had not been checked by anyone and the amounts totalled to ensure people received further support to maintain good fluid levels when needed.

Referrals had been made to external health care professionals when changes occurred to people's mental wellbeing and memory. The findings from these assessments were then incorporated into people's care packages and changes made to the delivery of care so that people received the care and support they needed. One person's medication had been reviewed and changed as a result of the manager identifying this appeared to be affecting their personality and quality of life.

Everyone said they felt able to express concerns or would complain without hesitation if they were worried about anything. A relative said, "We had a situation with mums mattress and we spoke to the manager and it was sorted straight away". One person said that although very approachable and nice, "You often have to repeat it a few times before it gets acted upon". The home produced a yearly newsletter that included a section that advised people how to raise concerns. This information was also included in the Service User Guide, a copy of which was given to each resident. The manager told us that issues were usually dealt with informally and this resulted in the home having few formal complaints made. Records were in place that showed that where concerns or complaints had been raised, the manager held a meeting either by telephone or in person to address and resolve the issues. We were told that residents meetings were going to be re-introduced as another forum for people to raise issues.

At the entrance of the home, we saw that there was information displayed regarding the fees, service user guides and how to make comments, complaints or suggestions. Contact details for the Commission were also displayed so that people could make contact if they wished to share information about the service they received.

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Our findings

Management, communication, systems and structures at the home were fragmented and this translated into a culture of inconsistency in the way people who lived with dementia were cared for and treated. Although we did not see any evidence of deliberate intent the lack of questioning by staff demonstrated that the culture of inconsistency was imbedded at the home.

Systems to assess the quality of the service provided in the home were not effective. An action identified by the manager to include people in the reviewing of care plans had not been acted upon despite the home having a monthly care plan review system in place. The manager completed audits of the service but these had not identified areas of the home and equipment that were not clean, inconsistences in the way that staff communicated with people, staffing levels that impacted on activities and the delivery of care and the lack of signage around the home to help orientate people who lived with dementia. As a result, people received an inconsistent service. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Everyone expressed the view that the manager and deputy were approachable and friendly. One person said, "The manager's not a control freak and she has a clear view about the strengths and weaknesses about the place and has brought staff in that she knows from previously". Another said, "She has a go with the flow approach". The manager treated people in a warm, supportive and friendly manner. The manager had analysed quality assurance questionnaires that had been completed by 15 residents and 14 relatives in 2013. The majority of people said that they were happy with the quality of service provided. When people had made suggestions for improvements, plans were in place to address these.

People told us that the home was well led. There was a stable staff group at the home, with many of the staff having worked there for a number of years. People who lived at the home, their relatives and staff all told us that they felt this helped people receive a consistent and good service. The manager held a National Vocational Qualification (NVQ) level 4 management. Since being registered in 2010 the manager had undertaken a number of courses, which included a 12 week distance learning course 'Principles of Dementia Care' in 2013. The course contents did not include management of staff practice which would support the manager with this area of her responsibility. All of the training that the manager had undertaken was relevant to a caring position. The manager had not undertaken further training to ensure her management skills and knowledge were current and that would ensure the home was consistently well led.

The manager demonstrated some understanding of promoting a positive culture that was person centred, open, inclusive and empowering. An annual newsletter that detailed the year's events was produced that included the use of colour photographs. This made the newsletter more visually appealing to people with poor vision or dementia and helped them to keep informed. The manager said she promoted a positive culture by "Leading by example. I cover shifts; do the cooking and cleaning if necessary. By being available for residents, relatives and staff. By being supportive and building trust. Also by following the rules yourself and showing this to staff. Praise and not always criticize but set boundaries". Records confirmed that the manager had covered care shifts when needed. However, the time spent by the manager covering care shifts impacted on the management of the home. For example, the manager had not formally supervised or appraised staff. Neither had she evaluated the effectiveness of training and staff practices to see if people benefited from a better service. Although the manager was kind and caring her leadership skills were at times lacking and this had impacted on the running of the home.

The manager told us that she operated an 'open door' policy and anyone could have access to her, the deputy or other staff members. We observed that people freely entered the manager's office and were welcomed when they did this which promoted an inclusive atmosphere for people. The manager completed regular reports that were shared with the registered provider in order that they were kept informed about the service. The manager told us that the provider "Is a very good owner" and that they visited the home on a regular basis.

Staff appeared motivated and told us that the training provided helped them to do their jobs. One member of staff had been awarded a certificate of excellence in 2014 for being a runner up in the 'Sussex Learner of the Year' awards. They received this award for undertaking a high number of courses and supporting other staff as well. Staff were aware of the whistleblowing policy and the action

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that they would take if they had any concerns. The manager told us that staff were encouraged to raise their concerns and complaints without fear of recrimination. The manager had reinforced this during a recent staff meeting that was held in October 2014.

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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured effective systems were in place to regularly assess and monitor the quality of services provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 (1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured appropriate standards of cleanliness and hygiene were maintained in relation to the premises and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 (1)(b)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured that service users were enabled to make, or participate in making decisions that related to their care or treatment. The registered person had not ensured that service users were treated with consideration and respect.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 (1)(a)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured there were always sufficient numbers of suitably qualified, skilled or experienced persons employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 (1)(2)(e) of the Health and Social Care Act 2008 (Registration Regulations) 2010. The registered person had not notified the Commission when allegations of abuse were made in relation to a service user.