St. Cloud Care Limited

Chestnut View Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 21 February 2017.

Chestnut View Care Home provides nursing care and accommodation for a maximum of 60 older people who may be living with dementia and or a physical disability. They also provide respite care. Respite care is a service giving carers a break by providing short term care for a person with care needs. Accommodation is provided over three floors. The top floor is primarily for people with nursing needs, the first floor is for people living with dementia and nursing needs and the ground floor is primarily for people living with dementia. At the time of this inspection there were 55 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.

Chestnut View Care Home was last inspected on 11 January 2016 when it was given an overall rating of 'Requires Improvement'. No breaches of regulations were identified, however the manager at that time had only been in post for six weeks and her application to register as manager of the home had not been concluded. We made four recommendations that related to the deployment of staff, information about people who were living with dementia, record keeping and the environment. At this inspection we found that the recommendations had been acted upon.

Prior to our inspection concerns had been raised about staffing levels that we shared with Surrey County Council. When they visited the home they recommended that the staffing levels within the dementia unit be increased. The registered manager acted upon this immediately. At this inspection people's views on staffing levels varied. However, we observed that there were sufficient staff on duty and that people received assistance and support when they needed it. Appropriate recruitment checks were undertaken before staff began work.

People said that they were treated with kindness and respect. The atmosphere in the home was calm, relaxed and friendly. People's privacy was respected. An abundance of information was displayed around the home in different formats to help people understand choices about their care. Relatives were welcomed at the home. A dementia support group organised by the registered manager offered support to relatives of people who lived at the home.

Staff were skilled and experienced to care and support people to have a good quality of life. A training programme was in place that helped to ensure staff knowledge was current. Staff were confident about their role in keeping people safe from avoidable harm and abuse. They demonstrated that they knew what to do if they thought someone was at risk of abuse.

Risks to people's safety were managed. Some people had been assessed as having high risk of developing pressure wounds and they had skin integrity assessments in place. We saw these people had specialist beds and pressure relieving equipment to prevent their skin becoming sore. Staff supported people to move safely from wheelchairs to armchairs using a hoist. Records were in place that confirmed that hoists and slings were checked on a regular basis along with a system to report if equipment was faulty. The registered manager had a good oversight over accidents and incidents within the home.

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. The medicine management in the home was safe. People said that they were happy with the choice of activities on offer. Trips out into the wider community were routinely planned for and enhanced people's wellbeing.

The registered manager had taken appropriate steps to manage restrictions on people's freedom. DoLS applications had been submitted to the authorising authority for people who lacked capacity and were unable to leave the home freely. Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise.

People said that the food at the home was good. People had choice over their meals and were effectively supported to maintain a healthy and balanced diet.

There was a positive culture at the home that was supported by a registered manager who took steps to ensure this was inclusive and empowering. She was passionate about providing a quality service to people. People said they felt confident that issues and concerns would be acted upon when raised. Quality assurance systems were in place that helped ensure quality standards were maintained and legislation complied with.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks were assessed and managed well, with care plans and risk assessments providing information and guidance to staff.

There were enough staff on duty to support people and to meet their needs.

Robust recruitment procedures were followed to help ensure that staff were suitable to care for people.

People told us they felt safe. Staff understood the importance of protecting people from harm and abuse.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were skilled and experienced to care and support people to have a good quality of life.

People consented to the care they received. Chestnut View Care Home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The home followed the requirements of the Mental Capacity Act 2005.

People were supported to eat balanced diets that promoted good health.

People told us that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively.

Effort had been made to ensure the design and decoration of the home was suitable for people who lived with dementia.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by dedicated and committed staff.

People were supported to express their views and to be involved in making decisions about their care and support.

People were treated with dignity and respect. Staff were able to explain how they promoted people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care and treatment was provided in response to their individual needs and preferences.

A varied activity programme was in place and people expressed satisfaction with the range of activities available. Regular opportunities to access the wider community were available to people.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns.

Is the service well-led?

Good

The service was well-led.

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

Quality monitoring systems were being used to identify and take action to reduce risks to people and drive improvements at the home.

People spoke highly of the registered manager and said that the home was well-led. Staff felt well supported and were clear about their roles and responsibilities.

Chestnut View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 February 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist dementia nurse advisor and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of 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. We reviewed the completed PIR and we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with 16 people who lived at the home and four sets of relatives. We also spoke with three nurses, four care staff, the administrator and a visiting hairdresser. Prior to the inspection we made contact with six external health and social care professionals, one of whom agreed for their views to be included in this report.

Some people at the home were living with dementia and we were unable to hold detailed conversations with them. Therefore, we spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included eight people's care and medicine records, staff training, support and employment records, quality assurance audits, minutes of meetings with people and staff, menus, policies and procedures and accident and

incident reports.

Good

Is the service safe?

Our findings

People's views on staffing levels varied. One person said, "I only have to call and the staff come." A second said, "Yes I think there are enough." A third said, "Not enough staff in the evenings." A fourth said, "More staff are needed in the mornings when they are getting us all up."
Despite the views of people being varied we observed that there were sufficient staff on duty and that people received assistance and support when they needed it. If a member of staff had to leave the lounge they alerted another member of staff to ensure people were observed at all times. When we arrived at the home we were informed that there were no activity staff on duty that day as both staff who undertook this role had taken people on a trip to the seaside the day before. However, the registered manager arranged for them to come and provide an activity later in the day.

At the start of our inspection there were three staff on duty compared to the rostered four allocated to the top floor of the home. The skills of a support worker who was allocated on shift in addition to the named four staff on the rota were utilised to provide the extra care for people. The support worker role included assistance at meal times. One of the nurses told us, "I was phoned this morning as you were here to come and help out with the medicines and GP visit."

The home used a dependency tool to decide staffing levels that considered people's individual needs, the layout of the building and also considered the skill mix of staff required. This was reviewed weekly or if there was a change in a person's needs. Staffing levels consisted of two nurses, 10 care staff and a support worker during the day and one nurse and four care staff during the night. In addition to this, separate cleaning, kitchen and activity staff were allocated to undertake specific duties. Staff said that staffing levels were sufficient to provide safe care. One member of staff said, "Some days can be busy and an extra pair of hands would help but other times we are ok." A second member of staff said, "Sometimes it can be busy, but it is very important that we take our time."

At the beginning of February 2017 Surrey County Council visited the home. They recommended that the staffing levels within the dementia unit be increased. The registered manager acted upon this immediately. The registered manager informed us that a meeting was due to take place with the provider where she intended to propose that another member of staff be allocated to the ground floor of the home to enhance the quality of service that people received further.

Appropriate recruitment checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home. Confirmation was also in place that nurses were registered to practice with the National Midwifery Council. Profiles were also in place for agency staff that confirmed they also had the required checks completed on their suitability to care for people.

People said that they felt safe and we observed that they appeared happy and at ease in the presence of

staff. One person said, "Yes I feel safe and comfortable here and I tell my son there is no need to worry about me." A second person told us that they liked to have their bedroom door slightly open at all times and said this was always so. They also said that their belongings were safe.

Staff were confident about their role in keeping people safe from avoidable harm and abuse. They demonstrated that they knew what to do if they thought someone was at risk of abuse. Staff told us that the registered manager operated an 'open door' policy and that they felt confident she would act immediately if they raised any concerns about people's safety. They also said that they would report abuse to outside agencies such the local authority safeguarding team, the police or CQC if necessary. For example, one member of staff said, "I would whistle blow if needed but I am confident the manager would act on concerns. I believe in good care and I wouldn't stay here if I didn't believe that's what people get." The registered manager demonstrated knowledge and understanding of safeguarding people and her responsibilities to report concerns to the relevant agencies. She had reported concerns when necessary to the local authority and to CQC.

Information about safeguarding was displayed within the home. This included guidance in an 'easy to read' format that would help people to understand their rights.

Risks to people's safety were managed appropriately. One person told us that they sometimes went for a walk outside of the home on their own. They said that they always signed in and out of a book when doing this so that staff would know their location in the event of a fire. A second person also liked to go for walks by themselves. They had a card on their person with the homes phone number on it so that they could be contacted in an emergency. People had risk assessments in their care plans for identified risks such as moving and handling and detailed guidance for staff included the use of hoists, what slings to use and the amount of staff needed. We saw staff were competent using this procedure. One member of staff told us, "I did my moving and handling training. I always do it safely and with two people if needed."

Some people had been assessed as having high risk of developing pressure wounds and they had Waterlow skin integrity assessments in place. We saw that people had suitable beds in place and pressure relieving equipment to prevent their skin becoming sore. People also had body maps to log any skin discoloration and marks that also recorded how these were being cared for.

People who were prone to frequent falls had falls management plans which included a falls identification form, a falls prevention plan and post falls/accident observation.

Environmental risks had been considered and mitigated. Each person had a Personal Emergency Evacuation Plan (PEEP) that provided guidance to staff in the event of an emergency situation. These were accessible to staff and the necessary equipment to aid evacuation was readily available throughout the home. Staff supported people to move safely from wheelchairs to armchairs using a hoist. They explained the process to people, telling them what was happening and provided reassurance.

Records were in place that confirmed that hoists and slings were checked on a regular basis along with a system to report if equipment was faulty. The registered manager had a good oversight over accidents and incidents within the home. Records contained information about how incidents occurred, action taken and referrals made as a result where necessary. In addition, accidents and incidents were analysed to identify trends. For example, the registered manager had identified falls as an area of risk. In response, she had requested falls prevention training for staff and whilst this was being sourced had given staff written guidance about falls prevention.

The medicine management in the home was safe. Medicines were stored in a designated medicine room and in trollies which were allocated to each unit. There were locked and secured to the wall when not in use. Medicine Administration Record (MAR) charts were well maintained. Each chart included photographic identification, and any known allergies were noted and there were no gaps of signatures seen. People who took anti-coagulant medicine had their blood taken regularly by the nurse and their dosage adjusted according depending on the results.

People who were prescribed PRN (as required) medicine were given these according to the MAR charts. PRN protocols were in place and we saw the nurse who gave people their medicines ask if they required this medicine. For example, "Have you got any pain" and "Would you like something for that." There were clear instructions for staff to follow regarding PRN medicine. These included what triggers may prompt staff to give this, when to give this, how to give this and the maximum dose.

Staff followed safe medicine administration procedures. They wore a special apron to say they were not to be disturbed while undertaking a medicine round, they locked the medicine trolley while it was unattended, washed their hands between and people and only signed MAR charts when medicine had been administered. Nurses had received medicines training and their competency had been assessed as part of this process.

Good

Is the service effective?

Our findings

People said that they consented to the care they received. 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).

Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise. This was in line with the MCA Code of Practice which guides staff to ensure practice and decisions are made in people's best interests. We did note that best interest decision meetings were not always recorded. This had been identified by the registered manager as an area that needed improvement in the PIR she submitted to us and within the quality assurance systems in place at the home. Action was being taken to address this. Staff had received MCA training and understood the importance of gaining consent from people and were aware of the principles of the MCA.

The registered manager had taken appropriate steps to manage restrictions on people's freedom. DoLS applications had been submitted to the authorising authority for people who lacked capacity and were unable to leave the home freely. As part of this process mental capacity assessments had been completed which considered what decisions people had the capacity to make.

The registered manager had sought written confirmation from people who had Lasting Power of Attorney for health and welfare or financial matters issued by the Office of the Public guardian to ensure people had the legal right to act on behalf of individuals. Confirmation had been received for 19 people and prompt letters had been sent for those outstanding. Information about the MCA and DoLS was on display in the home and included an easy read format that helped people to understand their rights.

People said that the food at the home was good and that their dietary needs were met. Comments included, "The food is excellent here" "Lovely meals" "I look forward to my dinner" and "Pretty good as a rule."

People had choice over their meals and were effectively supported to maintain a healthy and balanced diet. There were separate dining rooms located on each of the floors of the home which helped promote an intimate dining experience for people. The atmosphere in the dining rooms was relaxed and there was plenty of chatter throughout the mealtime. We saw staff sat with people and offered them support to eat. People were offered plenty of fruit juices and water with their lunch.

A four week menu was in place that offered people a variety and choice of home cooked meals, desserts and snacks. A range of fresh fruit and drinks were available to people that they could access independently and

at times of their choosing. Tea and coffee were served throughout the day and staff were seen to offer encouragement to people when this was needed.

People had nutritional care plans and a MUST assessment in place. Their weight was monitored and recorded in their care plan monthly. Those records we sampled evidenced that people maintained a healthy weight. We did note that some people at risk of dehydration had not always had their computerised fluid charts completed in full. We raised this with the registered manager who said she would provide additional training for staff to address this.

Since our last inspection the registered manager had arranged for the home to participate in a hydration project run by Kent Surrey Sussex Academic Health Science Network. As a result, three staff at the home had been trained and were hydration champions who shared their knowledge with other staff. People had been assessed in relation to risks of hydration, swallowing difficulties and independence.

Staff were skilled and experienced to care and support people to have a good quality of life. New staff undertook a 12-week induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. In addition to formal learning, new staff also shadowed more experienced staff. Newly recruited staff confirmed that that they had shadowed other staff when they first started to work at the service which allowed them the opportunity to get to know people and what was expected of them.

A training programme was in place that helped to ensure staff knowledge was current. Training was provided in areas that included first aid, fire safety, moving and handling, health and safety and infection control. In addition, training was provided relevant to the needs of people who lived at the home. This included dementia care, equality and diversity, malnutrition, person centred care and end of life care. Nurses had undertaken clinical skills refresher training in areas that included catheterisation and diabetes management.

Staff said that they were fully supported to undertake their roles and responsibilities. They received one to one supervision as well as group supervision and an annual appraisal. Nurses also received clinical supervision for nurses to ensure their practice was current. One member of staff said, "This is a good place to work. All the staff help each other. We get lots of training and support."

Since our last inspection the registered manager had implemented monthly workshops and reflection forms to enhance staff knowledge and practice further. Records confirmed that workshops had been used to discuss areas that included DoLS, person centred care, swallowing difficulties, skin care and positive meal time experiences. Staff reflection forms were linked to continuous professional development and explored aspects of staff practice, what they had learnt and how they would change practice in the future. The workshops and reflections of practice demonstrated a commitment by the registered manager to ensure staff continually provided effective care.

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. People were supported to maintain good health and access external healthcare support as necessary. People told us that staff arranged for them to see professionals such as the doctor, dentist or optician as necessary. A GP visited the home on a weekly basis in addition to people being able to request to see a GP at times of their choosing. We observed the GP visit on the day of our inspection and staff showed they knew the needs of people well when talking to the GP. The registered manager also involved physiotherapists, a dietician and hospital consultants where necessary.

The advice and guidance given by these professionals was followed.

Good

Is the service caring?

Our findings

People said that they were treated with kindness and respect. One person said, "I love it here, it's like home. The care is good." A second person said, "The staff here are very helpful, polite and caring and yes they treat me with respect. I like them they are very nice." A third person said of the staff, "Lovely, very caring and polite."

The atmosphere in the home was calm, relaxed and friendly. It was apparent that positive, caring relationships had been developed with people. For example, one person was seen sitting in a communal area doing their knitting. As a member of staff walked through the area they went and knelt down by the person and had a lovely conversation about the knitting the person was doing. When the member of staff left the area the person told us, "This is not a miserable place. The staff are lovely." Staff had a smile on their face every time they approached or spoke with someone. As at our last inspection staff understood the providers aims and objectives and reflected these in the care they provided.

Staff understood the importance of promoting dignity, respect and involvement. One member of staff said, "We have training and little workshops that have included dignity and dementia. I like to talk to the residents and find out their background. Reminiscing and listening to them is important. For example, X can't speak much. I asked him about his role in the war. He took me to a photo in his room of when he was in the army. That then opened a conversation that we both benefited from. Another person who lives here taught me to crochet so it's a two way thing between us all."

People had been supported to look smart and to dress in co-ordinating clothes. Some women wore items of jewellery that complimented their outfits. People's hair was clean and men were freshly shaven.

People's privacy was respected. People told us that staff respected their privacy. We observed that staff respected people's private space and as such they routinely knocked on people's bedroom doors and sought permission before entering. Support was provided in a discreet and caring way. Staff addressed people by their preferred name, which was usually their first name.

People were supported to express their views and to be involved in making decisions about their care and support. An abundance of information was displayed around the home in different formats to help people understand choices about their care. This included information about standards of care people were entitled to, advice about fees and support organisations people could refer to if they wanted advice about specific conditions such as Alzheimer's disease.

Regular newsletters were published in order to inform people of events and occurrences at the home. For example, the February newsletter celebrated people's birthdays and informed people about new activities such as the new mobile library. These included the use of photographs to aid communication with people who lived with dementia. The newsletters were also sent to relatives so that they too were kept informed.

Relatives were welcomed at the home. One relative said, "The staff are very caring to both of us, it really is

like a family here". Even the cleaners and the maintenance man are great." This relative went on to tell us how a few months ago arrangements had been made for their family member to be taken to their daughter's wedding. This act of kindness had meant the world to them.

A dementia support group organised by the registered manager offered support to relatives of people who lived at the home. During 2016 four meetings had been held and the registered manager had arranged for external professionals to attend these such as a CPN to give advice to relatives. A schedule was in place for 2017 where five meetings were going to be held. Planned areas of discussion included managing stress and end of life care for people who live with dementia.

People's bedrooms had been personalised to reflect their own interests and hobbies. People told us they had appreciated being able to bring items of their own furniture and make their rooms their own. The home was dementia orientated and supported communication in clear bold signs, and reminiscence corners so people could potter and relax.

Good

Is the service responsive?

Our findings

Staff took appropriate action in response to changes in people's needs. When one person who was frail started to cough their temperature was checked and found to be slightly high. They were given pain relief medicine and the GP was called who prescribed further medicine to help manage their symptoms.

Another person's dietary needs had altered and they required a soft diet and supervision when eating. At lunchtime we observed that the person was provided with the appropriate diet and was supported by staff to eat as described in their plan of care.

People's needs were assessed and care and treatment was planned and delivered to reflect their individual care plan. People had pre admission assessments which were used as the basis of the persons full care plan. Everyone had care plans in place for identified needs. These included personal care, communication, elimination, sleeping, nutrition, medicine and moving and handling. People with specific needs had care plans to manage periods of change in their health such as a chest infection. The level of the information in peoples care plans varied from one line statements to quite extensive descriptions of care needs. For example, one person who suffered with Huntingdon's disease had a care plan in place but it did not detail individual symptoms of the disease and it was very generalised. It did not give staff much guidance to understand the intricacies of this illness. Despite the lack of detail staff were able to explain how this condition affected the person. The computerised care management system had been identified by the registered manager in the PIR she submitted to CQC as an area that needed further development. Plans were in place to address this over the next 12 months.

Two people who used wheelchairs said that access to the garden was limited as to use this they relied on staff and had to go through the key coded dementia unit. The registered manager informed us that a planning application had been approved by the local council to carry out building works that would include improved access to the garden for people.

People said that they were happy with the choice of activities on offer. One person told us how they particularly liked the knitting group and going to Church with their friends. Some people told us that they did not participate in many of the activities but that was their choice. For example, one person said, "I do the quizzes but nothing else, but that is my choice."

During the afternoon we observed seven people participate in a music and exercise session. Some of the people were living with dementia and did not join in with the singing and dancing. However, it was apparent they enjoyed the activity from the smiles on their faces and how they became alert and aware of their surroundings.

Information about forthcoming activities was displayed throughout the home so that people knew in advance events that were going to take place. Activities on offer included arts and crafts, bingo, armchair exercises, pet therapy, movie afternoons, coffee mornings, pampering sessions, knitting club and theme days. People were particularly complimentary about the themed days that had taken place. These had

included a 'Dignity Action Day' where parts of the home had been decorated in spring colours and discussions had taken place about what dignity meant to individuals along with tea and cakes.

People were supported to access their local community and to maintain links with people who were important to them. The home has its own mini bus that people could use to access the wider community. The day before our inspection seven people went on a daytrip to the seaside. People had also been assisted to visit places of interest on a one to one basis. For example, one person went to a museum and staff recorded, 'X spent a wonderful afternoon filled with memories about world war two and his service in the air force.' Photographs were taken of people enjoying the activities they had participated in. These were used to help people reminisce when their memory failed. Trips out into the wider community were routinely planned for and enhanced people's wellbeing. During January, 13 trips were arranged. These included visits to a garden centre, local shops and museums.

People said they felt confident that issues and concerns would be acted upon when raised. One person told us, "I would tell the staff if I wasn't happy with something, I would certainly make a complaint." A second person told us, "I believe in going direct to the top" but that that they had never needed to. Other people told us that if they had concerns they would either speak to a member of staff or to the registered manager. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place. A suggestions box was located at the entrance of the home that people could use to raise concerns if they did not wish to use the formal complaints process. A relative confirmed they had been given a copy of the home's complaints procedure when their family member moved into the home.

The complaints procedure was displayed throughout the home and included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. In addition to this, posters were displayed using symbols and colour to help people with visual impairments or who were living with dementia to understand their rights. Also on display was the provider's Duty of Candour policy. This helped inform people of their rights to receive a written apology and truthful information when things go wrong with their care and treatment. The registered manager demonstrated understanding of the policy and reflected an open and transparent demeanour throughout our inspection.

A record was in place of complaints received, investigations undertaken and the outcome of these. The records also referenced if an apology had been sent to the person who raised the complaint. This demonstrated that the providers Duty of Candour policy was being put into practice.

Good

Is the service well-led?

Our findings

People said that the home was well-led by the registered manager. One person said, "We have an excellent manager." A second person said of the registered manager, "She is good and helps you when she can." A relative said that the registered manager was "Very approachable." The home had also received lots of positive praise by people who registered their satisfaction on a national website.

There was a positive culture at the home that was supported by a registered manager who took steps to ensure this was inclusive and empowering. As at our previous inspection everyone that we spoke with said that the registered manager was a good role model. Staff were motivated and told us that they felt fully supported and that they received regular support and advice. One member of staff said, "By far she is the best manager we have had here. She is calm and supportive and approachable. She instils a sense of calm and if she says she is going to do something she does it and this results in staff who trust her." The registered manager was aware of the attitudes, values and behaviours of staff. She monitored these when completing audits and during staff supervisions and staff meetings. Since our last inspection a 'Worker of the Month' scheme has been introduced as further recognition for staff and the work they have done.

The registered manager placed a strong emphasis on continually striving to improve. She was passionate about providing a quality service to people. Reflective practice was being used to encourage staff to think about their actions and how their practices could further improve care. The home was signed up to 'Oomph!' an award-winning social enterprise dedicated to enhancing the mental, physical and emotional wellbeing of older adults. As a result staff had received training to provide stimulation and activities that have meaning to people. The home was also registered with National Activity Providers Association (NAPA).

The registered manager took responsibility for ensuring her own knowledge was up to date. She had attended workshops arranged by Surrey Skills for Care and was in the process of completing the level 5 Diploma in Health and Social Care qualification to supplement her other qualifications.
The registered manager demonstrated a good understanding of her responsibilities and had ensured legislation was complied with. She was aware of the legal requirement to report significant events. As such, notifications were submitted to the Commission in a timely and transparent way. Information was stored securely and in accordance with data protection. The registered manager had completed and returned the PIR when requested. The information in the PIR was accurate and identified areas for future development. This demonstrated a commitment by the registered manager to be open and transparent about what aspects of the service she would like to improve.

Whistleblowing procedures were in place and known by staff. One member of staff said, "I know my residents, and I would have no problem whistleblowing if I saw something wrong. Their care comes first."

Quality assurance systems were in place that helped ensure quality standards were maintained and legislation complied with. These included audits of medicines, accidents and incidents, health and safety, care records and staffing. A Continuous Improvement Plan (CIP) was in place that was linked to the Fundamental Standards. The registered manager used this to monitor that action was taken in a timely way

to drive improvements. We did note that some actions referenced in the PIR and identified during our inspection were not included in the CIP. The registered manager agreed this should be reviewed in order that the tool for monitoring improvements was used to its full potential. People's views were sought and used to drive improvements in the form of surveys. These were sent to 10% of people on a monthly basis. Throughout our inspection we observed examples of person centred care that was responsive to people's individual needs. However, peoples individual care records did not always reflect what we observed. The registered manager had identified within the CIP that improvements to the level of detail recorded in peoples records was needed and steps were in place to address this.