Forest Care Limited

Cedar Lodge Nursing Home

Inspection report

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Date of inspection visit:
07 June 2018

Date of publication:
03 August 2018

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

Cedar Lodge Nursing Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cedar Lodge Nursing Home is registered to provide accommodation for up to 60 older people who require residential or nursing care. At the time of our inspection there were 52 people living at the home.

The inspection took place on 7 June 2018 and was unannounced.

The last inspection of Cedar Lodge Nursing Home was undertaken in November 2016 when the overall rating was Requires Improvement.

At the time of inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safe living at Cedar Lodge Nursing Home because all staff looked after them well. People told us that the staff were very good and kind and they supported them when they needed it. Staff were knowledgeable about keeping people safe and the reporting procedures to follow if they had suspected or witnessed abuse. People were kept as safe as possible because potential risks had been identified and assessed to help maintain their independence. There were sufficient numbers of skilled staff and appropriate checks were carried out to help ensure only suitable staff were employed to work at the service. Safe procedures were followed to ensure that people were protected against the spread of infection. Medicines were safely stored and administered to people at the times as prescribed by their GPs.

People's rights under the Mental Capacity Act 2005 were respected and staff followed the legal procedures when making decisions on behalf of people who lacked the mental capacity to do so for themselves. People's needs and choices were assessed and care, treatment and support was delivered in line with people's wishes. Staff had received training, supervision and appraisals that helped to ensure people received effective care from staff who had the skills, knowledge and understanding needed to carry out their roles. People's nutritional needs and preferences were recorded in their care plans and the chef had regular discussions with them to ensure that meals provided were to their liking. People received support to keep them healthy. People lived in an environment that that was adapted to meet their needs. The environment had undergone a recent refurbishment and was brightly decorated.

People were treated with kindness and compassion in their day-to-day care by staff who were caring and respected their privacy and dignity. People were involved in making decisions about their care, support and treatment and their independence was encouraged by staff.

People received care that was personalised to their needs. Comprehensive care plans had been written and regularly reviewed with the involvement of people and their relatives that were responsive to their individual needs. Staff had got to know people well and were aware of people's
needs. There was a varied programme of activities people could get involved in. Complaints and concerns were taken seriously and used as an opportunity to improve the service. End of life care was provided sensitively and in line with people's needs and preferences.

Accidents and incidents were recorded and an analysis of why accidents or incidents had occurred or what action could be taken to prevent further accidents had been developed. The provider and staff undertook quality assurance audits to monitor the standard of service provided to people. An
action plan had been produced and followed for any issues identified. People, their relatives and other associated professionals had been asked for their views about the home through surveys and resident and relatives' meetings. The provider and staff worked with other related agencies that ensured people received joined up care, treatment and support.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable about the process to be followed if they suspected or witnessed abuse.

There was sufficient staff deployed at the home to meet people's needs.

Risks to individual people had been identified and written guidance for staff about how to manage risks was being followed.

People were kept free from infection because staff understood the infection control processes to prevent cross infection.

Accidents and incidents were recorded and monitored to help minimise the risk of repeated events.

The provider had carried out full recruitment checks to ensure staff were safe to work at the service.

People's medicines were managed, stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and had opportunities to meet with their line manager regularly.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People's nutritional needs were assessed and individual dietary needs were met.

People had involvement from external healthcare professionals and staff supported them to remain healthy.

The environment had been adapted and was suitable for the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

People's care and support was delivered in line with their care plans.

People's privacy, dignity and independence was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

People were supported with their religious beliefs and were able to practice their faith.

Is the service responsive?

Good

The service was responsive.

People received person centred care. Where people's needs changed staff ensured they received the correct level of support.

Activities were appropriate to the needs of people.

Information about how to make a complaint was available.

People's end of life care was provided sensitively and in line with people's needs and preferences.

Is the service well-led?

Good

The service was well-led.

People and their relatives had opportunities to give their views about the service.

Staff felt well supported by the manager.

The provider had implemented effective systems of quality monitoring and auditing.

The provider and staff worked with other related agencies that were involved with people living at the home.

Cedar Lodge Nursing 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 7 June 2018 and was unannounced.

The inspection was carried out by three inspectors, a specialist advisor in nursing care and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed 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. This information was reviewed to see if we would need to focus on any particular areas at the service.

As part of our inspection we spoke with eight people living at the home and two relatives. We spoke with seven staff members and the registered manager. We also spoke with two visiting healthcare professionals. We looked at the care plans for ten people, medicines records, accidents and incidents, complaints and safeguarding. We looked at mental capacity assessments and applications to deprive people of their liberty. We reviewed audits, surveys and looked at evidence of activities taking place at the home.

We looked at three staff recruitment files and records of staff training and supervision, appraisals, a selection of policies and procedures and health and safety audits. We also looked at minutes of staff meetings and evidence of partnership working.

Good

Is the service safe?

Our findings

People were safe living at Cedar Lodge Nursing Home because staff looked after them well. People told us that the staff were very good to them. One person told us, "Yes I feel safe living here, there are good staff around to assist me when I need them." Another person told us, "Yes I feel very safe here." Relatives were complimentary about how staff kept their family members safe. One relative told us, "Yes definitely, [family member] is safe here, it is better than a lot of places we've experienced." Another relative told us, "[Family member] has never complained about feeling unsafe and we visit here on a regular basis."

People were protected from abuse because staff understood their roles in keeping people safe. Staff were knowledgeable about keeping people safe and the reporting procedures to follow if they had suspected or witnessed abuse. One member of staff told us, "I would report my concerns to the manager straight away and I know I can always call the local authority safeguarding team if I felt the need to." Staff told us that they had not needed to raise any concerns about the safety of people. The staff members we spoke with had undertaken adult safeguarding training within the last year and training records seen confirmed this.

People were made aware of risks associated with their care and support. One person told us, "Yes [staff made me aware of the risks], they [staff] assist me in getting up and help me to sit in my wheelchair. They ask me to ring for them so I can be moved safely." Another person told us, "They [staff] ask me to use the call bell because they use a hoist to move me and they always have to have two members of staff to do this."

People were kept as safe as possible because potential risks had been identified and assessed. Each person had risk assessments in place to help them maintain their independence. Risks were being routinely assessed and the actions in care plans were designed to manage risks. For example, one person was at risk of falls and this was on the front page of their care plan as a 'risk to be aware of.' The risk of falls was managed with a zimmer frame and one member of staff walking with the person for short distances. For longer distances the person used a wheelchair. Another person was at risk of pressure sores. There was a waterlow score (this is a tool used to give an estimated risk for the development of a pressure sore in a person) that was reviewed monthly that showed high risk. A skin integrity plan stated skin should be checked daily and cream applied. There was a repositioning chart completed and the person had an air flow mattress and this was on the correct setting as described in the person's care plan. All checks and charts were up to date on an electronic system used at the home. We noted all care plans had main risks displayed clearly for staff. Relatives told us that they were made aware of any risks to their family members. One relative told us, "My family member had a fall out of bed (about three months ago) and they talked us through the options of minimising the risk of it happening again."

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. People and their relatives told us that there always enough staff on duty. One person told us, "I have nothing to complain about, yes there is always someone available to help me when I need them." Another person told us, "There is always someone available." A relative told us, "It's hard to tell, as places like this could always do with more staff, but I have not noticed any issues with the care of my family member. They (staff) are always around."

The provider told us in their PIR that they used a dependency tool to decide the levels and skill mix of staff needed for each shift. They also stated that staff rotas are produced to ensure that there is a balance of experienced staff and less experienced staff on each shift and we found this to be the case. The duty rota viewed confirmed the staffing numbers as stated by the registered manager. There was a core team of 11 staff, that included senior staff, and three registered nurses (RNs) on duty each shift. There was also a cook, kitchen, domestic and staff teams. Staff told us that there was always enough staff to meet the needs of people. One member of staff told us, "Yes (there's enough staff). If someone rings in sick we have regular agency we use." Another member of staff told us, "There's always enough staff here." Staff were given recognition by a company director in celebration of 'Nurses Week.' They were thanked for all their hard work and dedication. The registered manager told us that staff often receive small treats after their shifts, for example, the provider had brought pizzas for staff.

People were protected from unsuitable staff because safe recruitment practices were followed before new staff were employed. The provider told us in their PIR that they have a safe recruitment processes in place and we found this to be the case. The provider had obtained appropriate records as required to check prospective staff were of good character. These included a full employment history with explanations for any gaps in employment, two written references, proof of the person's identification, and a check with the Disclosure and Barring Service (DBS).

Medicines were administered, recorded and stored safely. People told us that they received their medicines as and when they required them. One person told us, "Yes I get them on time, they are brought round three times a day." A relative told us, "[Family member] takes lots of medicines, I couldn't tell you (what medicine is for) but they always get them on time."

The home used an electronic system to encourage safe practice and reduce the risk of medication errors for people. Each person has their medications stored in a labelled box in a locked mobile trolley. The medications were clearly labelled with individual barcodes per medicine and then a resident bar code on the box. We observed the lunch time medicines administration. The RN wore a red apron which had 'Do not disturb' written across the front and the back. They used the electronic handset that indicated when a person was due their medicines. The administration, recording and storing of all medicines was safe and in line with Royal Pharmaceutical guidance.

People were protected against the spread of infection within the service. People and their relatives told us that the home was always very clean and tidy. One person told us, "Staff wear gloves and aprons and I have seen them washing their hands regularly." A relative told us, "The home is always clean, staff make sure of that."

Staff maintained appropriate standards of hygiene which protected people from the risk of infection. Staff told us that they wore personal protective clothing such as gloves and aprons and they were changed after helping each person with their personal care needs. Staff followed good practice in infection control and hen providing personal care. The provider had infection control procedures for staff to follow and carried out regular audits to check appropriate standards of infection control were being maintained. All bathrooms and toilets had liquid soap and paper towels that help to reduce the risk of cross infection. Daily cleaning schedules are followed and audited by the house keeper. Monthly audits were undertaken to monitor any type of infection at the home by the registered manager and actions taken had been recorded.

There was evidence of learning when adverse events occurred. People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. There had been 13 accidents in April, six in May and only one in June at the time of our visit. The name of each person was included in the

summary so the registered manager could see if people were having multiple incidents in a month. At the end of each month a one-page summary of actions taken to resolve the incidents had been summarised. For example, a report dated 1 June 2018 noted that there had been a reduction in falls in May. This was due to closer monitoring of people at risk being put into place. The 'Forest Care' physiotherapist visited every Monday and people who had falls were reviewed and advice was sought to improve individuals' mobility and reduce the risk of further falls.

Good

Is the service effective?

Our findings

People's rights under the Mental Capacity Act were respected. The Mental Capacity Act 2005 (MCA) provides legal framework for making 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 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).

At our previous inspection in November 2016, we found a breach of Regulation 11 regarding the Mental Capacity Act 2005 (MCA). Consent to care had not always been obtained in line with the MCA. Furthermore, mental capacity assessments were not decision specific and staff did not have a clear understanding of the MCA. During this inspection we found that the required improvements had been made. Assessments had been undertaken for each decision. For example, use of bed rails, medicines, safety (keypad locks) and personal care. Best interests decisions were clearly documented dated and signed. The best interests meetings had involved a multi-disciplinary team and DoLS applications had been approved.

Staff were knowledgeable about issues of consent and had a good understanding of the MCA. Staff told us they had undertaken training in this area and the training records provided to us confirmed this. Staff were aware of the implications of Act and DoLS for the people they were supporting. Staff told us that they always asked for people's permission before they did anything for them. One member of staff told us, "I always assume that people have the capacity to make decisions unless it has been proved otherwise."

People told us that staff wouldn't do anything without asking them first. One person told us, "They [staff] will ask me if I am ready to get up or help me dress." Another person told us, "Yes they do ask for my consent. Staff ask me if they can take me to the dining room for my meals when I am ready."

People's needs and choices were assessed and care, treatment and support was delivered in line with the pre-admission assessment. People and their relatives told us that they had an assessment undertaken before they came to the home. They told us that their care and treatment was delivered as per their care plan. One person told us, "I believe I had an assessment done." Another person told us, "Yes, I had a full assessment before I came here and they asked me lots of questions."

We saw evidence of initial assessments being carried out. For example, one person had an assessment that captured falls risk and memory needs as well as preferences such as what time they liked to get up. It also recorded they liked porridge or scrambled eggs each morning and that they were allergic to peppers. This information was all then added to the person's care plan.

People received effective care from staff who had the skills, knowledge and understanding needed to carry

out their roles. The provider told us in their PIR that staff are 'supported in completing NVQ levels 2 and 3 with currently 15 in progress. Mandatory training is completed annually and further specific training such as dementia awareness, nutrition, dignity and respect is completed and regularly refreshed. Comprehensive staff induction takes place within the first two weeks of employment and nurses are supported through revalidation'. We found this to be the case. Records confirmed that all staff had received the training they need that helped them to provide effective care to people. Staff had also undertaken training in the use of syringe driver (medicine used to control pain), end of life care and the Care Certificate training. The Care Certificate is a set of agreed standards that health and social care staff should demonstrate in their daily working lives. One member of staff told us, "The training here is very good, we have in-house training once a month." They told us that they had recently attended training on swallowing and this had made them more aware of choking risks. They told us what they had learned from this training, "We learnt what to look out for and to ensure people sit up. I support one person who needed thickened fluids and the training made me understand the reasons for this more."

People were supported by staff who had regular supervisions (one-to-ones) with their line manager. Staff told us that thy received supervision every two months. Staff told us that they discussed their roles, the people they worked with and identified their training needs. A member of staff told us, "We do supervision regularly. I talk about any concerns or training and how I want to progress." RNs had regular competency tests undertaken that monitored their roles and provided support to them as and when required.

People's nutritional needs and preferences were recorded in their care plans. People were supported to ensure they had enough to eat and drink to keep them healthy. People and their relatives were complimentary about the food provided. The menu offered a choice of varied meals that included fresh meat, fish and vegetables. One person told us, "Everything is provided here, there are good choices of food and drinks like tea, coffee and juice are brought around." Another person told us, "The food is excellent, there are choices and always a good atmosphere in the dining room."

We observed the lunch time experience. Tables had table cloths and cloth serviettes. There were sufficient numbers of staff attending to people as and when required in the dining room. Staff were interacting with people and asking if they would like support, certain condiments and drinks.

The chef sought regular feedback from people about their meals. For example, the chef responded to a request that had been made to the registered manager for a person regarding supper meals. As a result, they had served them with their requested meal. The person gave positive feedback about this.

A visiting healthcare professional told, "Staff adapt well to changes in people's needs with food and fluids." They said staff understood how dementia changed people's nutrition and hydration needs and the registered manager had introduced fluid trollies that helped to reduce the number of urinary tract infections (UTIs) and falls.

People benefited from staff who worked across organisations to deliver effective care, support and treatment. People received support to keep them healthy. People and their relatives told us that the GP and other health professionals visited regularly. One person told us, "I saw the doctor this morning because I was feeling dizzy." Another person told us, "Yes, I see the GP and the optician, I have new spectacles as the optician came and tested my eyes." Records also showed when other healthcare professionals had visited such as the tissue viability nurse, community nurses, dentist, dietitians and occupational therapists.

People lived in an environment that that was adapted to meet their needs. The environment had undergone a recent refurbishment and was brightly decorated. The flooring was plain coloured carpets,

which reduced the risk of people with visual impairments relating to dementia from becoming disorientated. There was signage around the home to help people living with dementia navigate around the environment. People had walking aids and wheelchairs to help them with their mobility needs. Hoists were used for those who required this and people had their own individual slings. All equipment used was serviced in line with the manufacturers' guidance to ensure it remained in a good state of repair and was safe for people to use. The corridors were bright and clutter free that helped to reduce the risk of people tripping or falling. There was building work taking place during our visit. The effect on people at the home was minimal as there was no dust or dirt created within the environment.

A visiting healthcare professional told us, "They are making use of things." They told us that the environment had got more dementia friendly with their input. For example, the provider had added more seating areas and had considered people's dementia in the improvements being made to the home.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives told us that all staff were very caring and they were kind and considerate. One person told us, "Staff are caring, friendly you only have to ask once and things are done for you." Another person told us, "Staff are nice, quite good and yes, they are caring." A relative told us, "Staff are really good-very caring with my [family member]." Another relative told us, "Staff care for [family member]. They can't do anything for themselves now, but they [staff] are there and know when they need help. Staff are lovely, fantastic. We have got to know them and they know us. They are all so friendly."

Throughout our visit we observed staff interacting with people in a courteous and caring manner. Staff would make eye contact with people and ask them how they were, did they need help with anything and had conversations with them. At lunch time we observed staff being polite, for example, after serving their lunch staff would say, "I hope you enjoyed your meal, let us know if you require anything else." We noted staff would wait for people to respond to any questions asked. People were spoken to respectfully and staff were aware of people's needs.

People were given the opportunity to make decisions about their care, support and treatment. People told us that they were involved in making decisions. One person told us, "I think they would ask me about what I want but I have not had to make any decisions about my care so far." Another person told us, "My family will get involved and discuss with me if there is something I am unsure of." A third person told us, "I make up my mind what I want to do. They will ask if I'm ready to get up, or ask if I want to go into the day room by myself." Staff told us that they involved people in their everyday care. They told us that they talked to people about their needs and if there was anything they would like to change.

People's privacy and dignity was respected by staff and their independence was promoted. People told us that staff encouraged them to do things for themselves. One person told us, "I can manage most things myself and staff would help me if I needed it."

Staff told us that they encouraged people to be independent. One member of staff told us, "There is one person who tries to feed themselves. They cannot grip so we got them some thick handled cutlery and encourage them to continue to feed independently. When they are not able to we offer to help them to eat." Care plans reflected strengths and what people could do. For example, one person's oral health plan recorded that if staff put toothpaste on the brush they could brush their teeth independently.

Staff were aware of the need to respect people's privacy and dignity. People told us that staff were respectful of their need for privacy. One person told us, "They [staff] will knock before coming into my room and they always close the curtains and doors when washing me." Another person told us, "Oh yes, they are very good, they all knock on my door and don't let me wear clothes that need washing." A relative told us, "I think they are quite respectful, they always knock on the door and my [family member] is always clean and tidy."

One member of staff told us that they always knocked on bedroom doors and waited to be invited into

people's bedrooms. They told us, "All personal care needs are done in the privacy of people's bedrooms with the doors and curtains closed. We learned in our induction the importance of keeping exposed parts of the body covered to maintained people's dignity." Relatives confirmed that staff respected people as individuals. They told us, "Yes, my family member was a proud woman and they do everything for her in a respectful way."

The registered manager told us that no person living at the home was from the lesbian, gay, bisexual or transgender (LGBT) communities. They told us that this was discussed during the pre-admission assessment process. The registered manager and staff told us that they treated all people as individuals and respected their individuality.

People's religious needs were respected. People could practice their religion and church leaders were welcomed at the home.

Good

Is the service responsive?

Our findings

People received care that was personalised to their needs. People we spoke to could not remember very much about their care plans. They confirmed that they had been involved with their care plans but stated that their family members would be more involved, although people could remember being asked about things they would like to change. One person told us, "My son would be the person to ask. I recall a recent conversation regarding my care plan but I'm not really worried about it." Another person told us, "It [care plan] was reviewed recently with me and my son." A third person told us," It is not something I worry about I am well looked after."

The provider told us in their PIR that the home had personalised and comprehensive care plans that were responsive to individual needs and we found this to be the case. Care plans were held electronically and were person centred and very detailed. They included information about people's personal care, communication, continence, daily lifestyle, maintaining a safe environment, medicines, mobility, nutrition and hydration, oral health, skin integrity and sleeping. Each part of the care plan provided enough detail to inform staff how each person wanted to have their needs attended to. They also included daily notes which were exceptionally detailed. Staff told us that the new electronic care planning system was very easy to use and enabled staff to quickly document care tasks, activities, food, fluids and people's wellbeing. The system also prompted staff when time had passed without an interaction with people.

One person's mobility plan documented that they often moved quicker when male staff supported them to move. This was because it 'reminds me of soldiers back in the 50s'. The person had worked with the military and a staff member we spoke with was knowledgeable about this. The care plan informed that the person liked to get up at 8am, and daily notes reflected this. It was also recorded that they liked to wear trousers and a shirt and we noted they were wearing these clothes in line with this when we saw them.

People received responsive care and support from staff who had got to know them well. Staff were aware of people's needs. For example, one member of staff told us that they got to know people through spending time getting to know them and reading their care plans. The staff member could inform us about a person whom they worked with that included their past life. For example, they were aware that the person liked dancing and they had previous worked with the military. The member of staff told us, "We get given one hour each morning to read at least one care plan and sign to say we have read it."

People had access to a range of activities they could get involved in. The provider told us in their PIR that they ensured residents were as active and engaged as they wish to be and they had an extensive and varied activity programme across seven days per week. It said, 'We help residents express and follow individual interests and organise and manage leisure and social activities both internal and external'. We found this to be the case. There was an activities programme that provided up to four activities each day. These included chair aerobics, arts and crafts, dominoes, quiz, 'play your cards right,' reminiscence and external entertainers. Frequent trips were organised to take people out to local places of interest. People told us that activities took place and they could choose to join in with them. We observed people taking part in activities throughout the day.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The provider had a complaints procedure that was available to people and visitors to the home. It provided the timescales for responding to and resolving complaints. The provider received and addressed complaints they had been resolved within the timescales set in the policy. People told us that they knew how to make a complaint. One person told us, "I have not had any reason to complain." Another person told us, "I did complain about person's television which was very loud and it was resolved." The provider had also received many letters complimenting how good and caring staff were at the home.

End of life care was provided sensitively and in line with people's needs and preferences. The provider told us in their PIR that they had an end-of-life champion and residents' preferences and choices for their end of life care were clearly recorded, reviewed, shared and communicated. We found this to be the case. Staff told us that they had a syringe driver and they were all trained in use of this. They told us that they had attended training at a local hospice in Farnham and that they were supported with training by the community matron. A visiting healthcare professional told us that staff were competent in using the syringe driver and knowing when to administer anticipatory medications for people who were reaching their end of life. People who were deemed to be 'palliative patients' had anticipatory medications prescribed. They were all prescribed appropriately and within the required ranges with indications for use clearly documented.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed.

Good

Is the service well-led?

Our findings

Quality assurance systems were in place to monitor the quality and running of service being delivered. At our previous inspection in November 2016, we found a breach of Regulation 17. The systems in place to assess, monitor and improve the service were not effective. During this inspection we found that required improvements had been made.

The provider told us in their PIR that clinical governance was further enhanced through quarterly external quality audits. The resultant report listed required actions and best practice recommendations and an action plan was produced accordingly. We found this to be the case. The provider had quarterly quality audits completed by a consultant. The audits were based around the CQC's five key questions, and a rating was given for each domain. The last audit rated the service as good in all but the Safe domain.

An issue identieid during one audit was that the morning medicines round which started at 08:30 was not completed until 11:15. However, the provider had an electronic medicines system installed that would not allow staff to give further medicines until the correct times between dosage had passed (so there was no risk of an overdose) but it did impact on the timing of medicines over the rest of the day.

The audit also included an action plan that reviewed actions from the previous audits and if these had been completed. For example, an action from the January 2018 audit was to contact the DoLS team to review referrals that had not yet been authorised. These were seen and were in place and up to date. Another action had been to review medication stocks and complete a stock control audit, to remove any overstocked medicine and dispose of or return as appropriate. On the day of our inspection there was no overstock of medicines.

The action plan from the April 2018 audit included to 'consider how to ensure morning medicines round is completed in a more efficient manner.' The registered manager told us that this had now been addressed. They looked at which people were up and about and did the medicines in that order, rather than following a list of names and waiting for each person to wake up. The medicine round on the day of our inspection had finished by the target time of 10:30 which demonstrated this change had been effective.

At our previous inspection in November 2016, we found a breach of Regulation 18 in that the provider had failed to submit notifications to CQC when appropriate. During this inspection we found that notifications were submitted in a timely manner. For example, when a person had suffered a serious injury.

People and staff benefitted from a registered manager who was committed to working with people and improving the service. People and their relatives told us that the home was well managed. One person told us, "Yes they are very good, they keep us informed and staff get on well together." Another person told us, "Seems to be [well managed]." A relative told us, "There is a good atmosphere at this home. The manager is lovely and always speaks to us. I think it is well managed, I wouldn't have [family member] anywhere else.".

Staff were complimentary about the registered manager and the support they received from her. One

member of staff told us, "The manager is really good and very caring. She makes things better for staff and residents." Staff told us that were regular staff meetings. One member of staff told us "We talk about things and we can make suggestions." They gave us an example that information on medicines was moved on to the care plans, to make it clearer. This was to ensure staff could see where people required half hourly medicines as staff had raised it as an issue at a meeting.

A healthcare professional told us that they found the registered manager very responsive and always available. They said she was always keen to learn and "Communication is always very good."

People and those important to them had opportunities to feedback their views about the home. One person told us, "The manager asks us for our feedback." Another person told us that the registered manager acted on what they say. They told us, "Yes they do listen to what we say and act. I had asked for apricots and cream to be made available and they have provided this." There were quarterly relative's meeting and a separate residents meeting. One resident meeting held in May 2018 included discussions about celebrations and trips out. The Royal wedding, Alzheimer's charity event, Ark Millers Farm trip, Bird World and Basingstoke boat canal trip were discussed in the June meeting. Minutes of the last meeting were reviewed for updates. For example, a suggestion had been made for a cheese board to be offered to people. They talked about how this had been introduced, but it had had very little take up by people, and had not been popular, so it was 'on hold', but could be tried again if people asked.

The relatives meeting in May 2018 reviewed the information from the previous meeting and gave updates on the home refurbishment. Discussions took place about care plan reviews and how staff would like to have family involvement so they could deliver the best care. Staff also talked about welcoming positive and negative comments, as they would be taken on board as a tool for making improvements. They also talked about the activities that people would like to do. A summary had been completed by the registered manager to check that meetings had taken place on schedule and that minutes had been produced and sent out.

A survey of healthcare professionals had been undertaken with five responses. It scored 95% 'Excellent' with the remaining 5% as 'Quite Good'. There was one suggestion to improve activities. The registered manager had recorded that this was underway as part of the improvements to the home and changes to activities schedules. External outings had already been added to the activities schedule.

Residents survey had five returned forms. These showed that 56% of those who responded were, very satisfied' and 43% were 'satisfied'. There was a suggestion for a downstairs shower room which the registered manager told us had been done.

The provider had a set of values that enable people to receive safe, effective, responsive and well led care. The provider told us in their PIR that their vision was to deliver the best quality care and to treat everyone in the home equally and with dignity and respect always and we found this to be the case. Staff were aware of the values and visions of the provider and we saw staff incorporating these values in their work.

The provider and staff worked with other related agencies that ensured people received joined up care, treatment and support. Records maintained at the home showed that people had access to all healthcare professionals as and when required. There were also links with other organisations that would help staff and the provider. We saw there was involvement with Surrey Social Services quality assurance (QA) team. A recent report from the QA team visit was positive.

A healthcare professional told us that the manager worked well with them. They told us, "The manager comes to the care home forum and has shared learning and best practice." For example, they told us that the registered manager had introduced fluid trollies as a result of shared best practice at the forum. We saw these during our inspection.

Healthwatch Surrey did an 'enter and view' visit in February 2018. The only issue raised was for 'the manager to review current meal time procedures and consider how choice can be better facilitated at mealtimes.' They were positive about 'never a shortage of tea, coffee and biscuits' and that there was a 'good rapport and friendly communication between staff and residents.' A written response to address the minor issue raised was completed by the registered manager. We did not identify any issues with meal choices during our inspection.