Cheriton Nursing Home Limited

# Cheriton 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

We undertook an unannounced inspection of Cheriton Care Home on 15th December 2017. Cheriton Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. On the day of our inspection 36 people were living at the service, some were living with dementia.
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.
At the last inspection, the service was rated Good.
At this inspection we found the service remained Good overall.
People and their relatives complimented the compassionate nature of staff and told us staff were caring. On the day of our inspection we saw examples of kind and compassionate interactions that demonstrated staff knew people well. People's dignity, privacy and confidentiality were respected.
People told us they were safe. Staff knew what to do if they had safeguarding concerns and were aware of the provider's whistle blowing policy. People were supported by sufficient staff to keep them safe and the provider ensured safe recruitment practices were followed. Staff training was ongoing and the records confirmed staff received supervisions.
People's care plans contained risk assessments that covered areas such as falls, mobility or nutrition. Where people were at risk, their records outlined management plans on how to keep them safe.
People's medicines were stored securely and administered safely.
The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
People were supported to maintain good health and access health professionals when required.
Staff ensured people were supported with their meals when required and people were referred to a dietician or Speech and Language Therapist if required.
People were assessed prior to coming to live at Cheriton Care Home and people told us staff knew them well.
People's care files gave details of the level of support required and people's wishes and choices. These also contained information about people's personal histories, medical information, their likes and dislikes.
Information on how to complain was available to people and the provider had a complaints policy in place. The registered manager ensured when a complaint had been raised it had been investigated and responded to in a timely manner.
The registered manager ensured various audits were being carried out, where improvements were identified we found evidence that these had been carried out.
We saw evidence that the management team was committed to making improvements and had already made positive changes. As a team staff were focused to deliver good care and to deliver it in person centred

ways. The registered manager informed us of notifiable incidents in accordance with our regulations

## 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 remains Good

### Is the service effective?

Good

The service remains Good

### Is the service caring?

Good

The service remained Good

### Is the service responsive?

Good

The service was responsive.

People received group activities and stimulation which met their needs.

People's records were current and reflected their needs, wishes and interests. The provider had implemented an electronic system which had benefits to staff and people using the service

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's wishes about End of Life care were documented

### Is the service well-led?

Good

The service was well led.

The provider's quality assurance systems were effective.

The registered manager had implemented significant changes and had a clear plan to develop the service further.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made people feel included and well supported.

# Cheriton 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 15th December 2017 and was unannounced. The inspection team consisted of two inspectors and one Expert by Experience in the care of older people. 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 reviewed the information we held about the service and the service provider. The registered 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. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.
We spoke with 14 people and four relatives. We looked at six people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the deputy manager, the senior nurse, two nurses, care staff and catering staff . We reviewed a range of records relating to the management of the home. These included three staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We reviewed feedback from people who had used the service and their relatives.

Good

# Is the service safe?

## Our findings

People continued to feel safe. Comments included, "I feel absolutely safe", "There are lots of staff about", and "I moved in November 24th last year, I feel very safe here, much better than living on my own, I've made lots of friends here." Relatives also felt people were safe, they told us, "We're visiting my sister, yes she is absolutely safe", "There's always plenty of staff and importantly they always take time", and "Dad is a lot safer here than the other place. They're so on it here, they listen to us and it's very homely. As a family, to find this place is such a relief".

Staff had the knowledge and confidence to identify safeguarding concerns and had attended training in safeguarding vulnerable people. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff explained what they would do if they had concerns, "Ask the person about it, record on the tablet, call a nurse. [The] Concern is how did it happen, what happened? If I was concerned nothing was done I would go to the manager, I would go above the manager and I could report to the CQC".

The registered manager had a clear understanding of their responsibilities in relation to safeguarding. Concerns were responded to in a timely manner and the registered manager had taken appropriate action to prevent further occurrences and submitted the correct notifications.

Risks to people were identified and risk management plans were in place to minimise and manage the risks and keep people safe. These protected people and supported them to maintain their freedom and independence. Some people had restricted mobility and information was provided to staff about how to support them when they moved around the home. Risk assessments included areas, such as falls, fire safety and moving and handling.
We saw evidence of positive risk taking, for example one person with mental health needs wished to lock her door at night. This was supported, with staff only entering her room if there was a concern or if the person rang their bell.
People had personal evacuation emergency plans in place (PEEPs). These contained detailed information on people's mobility needs and the support required in the event of a fire. They also contained information about people's mental health needs, and what additional support they should be given in an emergency. For example one person's PEEP stated "[person's mental health needs] will make her suspicious of people and therefore repeated explanation and reassurance will be required".

There was sufficient staff to meet people's needs. Cheriton Care Home used a new dependency tool to calculate required staffing levels, which used information from people's electronic care records. This new tool had provided evidence, which led to increased staff numbers. One staff member told us, "I think we do get the resources to enable staff to be caring. We have a new dependency tool which has resulted in more staff". This was corroborated on the day of our inspection. We saw people were attended to without unnecessary delay and staff took time engage with people.
Cheriton Care Home had staff vacancies and the registered manager told us they were recruiting for various positions, including activity coordinators and a clinical lead. The home used regular agency staff to cover

staff shortages and this allowed continuity of care.
The provider followed safe recruitment practices. Records showed that appropriate pre-employment checks had been made to make sure staff were suitable to work with vulnerable people. Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).
People received their medicine as prescribed. The provider had a medicine policy in place, which guided staff on how to administer and manage medicines safely. During our observations this was followed accurately. Medicine administration records (MAR) were completed to show when medication had been given or, if not taken, the reason why. People's medicines were kept in individual locked cupboards in their bedrooms. We observed a nurse administering medicines, they gave people time to understand what was happening, asked for their consent and enabled people to take their medicine safely.
The environment looked clean and equipment used to support people's care, for example, weight scales, wheelchairs were clean and had been serviced in line with national recommendations. We observed staff using mobility equipment correctly to keep people safe. People's bedrooms and communal areas were clean. Staff were aware of the provider's infection control polices and adhered to them. We observed staff using appropriate Personal Protective Equipment (PPE), and saw evidence in records and audits that tasks involved in the prevention of infections had been completed.
The provider had a business continuity plan and an emergency plan. These plans outlined the actions to be taken to ensure the safety of people using the service in an emergency situation.

Good

# Is the service effective?

## Our findings

People received effective care from staff who were knowledgeable, skilled, confident and well trained in their practice. People's relatives said, "[Relative] has [multiple mental health needs] the hospital couldn't deal with her so she shut down. She does get anxious and stressed but she seems so happy here. They deal with it well here, there's always people around" and "My sister is challenging and has challenging behaviour. They deal with her well, they explain to her [the support they give] is in her best interest and it works".
Records showed, and staff told us, they had the right competencies, qualifications and experience to enable them to provide support and meet people's needs effectively. One member of staff said "It's a good organisation and I feel supported here, they give us lots of training, I've asked and the manager organises it quickly, she always delivers".
Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. The induction training was linked to The Care Certificate standards. The Care Certificate is a set of nationally recognised standards to ensure all staff have the same induction and learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This included training for their role and shadowing an experienced member of staff for up to two weeks. Staff told us they received training before they started working at Cheriton Care Home.This training included, manual handling, safeguarding, personal care, fire safety and information governance, staff were also supported to attend refresher sessions regularly.
Nursing staff were supported to attend training specific to their roles which including catheterisation and venepuncture. One nurse told us "It [training] is better, the [registered manager] has been supportive of us doing our revalidation, they're in the process of arranging more training".
Staff told us they felt supported and had received supervisions (one to one meeting) with their line manager. Supervisions enabled them to discuss any training needs or concerns they had. Staff were also supported to develop and reflect on their practice through yearly appraisals. We saw evidence that supervisions and appraisals were scheduled throughout the year.
People's care records showed relevant health and social care professionals were involved with their care. People were supported to stay healthy and their care records described the support they needed.
People told us they enjoyed the food and were able to make choices about what they had to eat. Comments included, "The food is absolutely tremendous, they bring it to me, I eat in the dining room. They've always got a jug of water on the table, and orange juice too", "The ice cream is luxury, like homemade. It doesn't seem like a corporate place, it is like home", "The chef comes up and chats in the mornings to see what we like, she is lovely" and "I used to be a cook. It's good food".
People's dietary needs and preferences were documented and known by staff. Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. Staff assessed and monitored people's risk of malnutrition and dehydration and contacted GP's, dieticians, speech and language therapists (SALT) if they had concerns over people's nutritional needs. Where people were identified as being at risk of malnutrition, a malnutrition universal screening tool (MUST) was used to assess, monitor and manage this risk. Records showed people's weight was maintained.
One person told us, "My health needs are being met, absolutely". A relative told us, "We love that Mum is here, the staff and the Doctors are very good to her, they know her health needs".
People were supported to make choices about their meals. Drinks and snacks were available to people

throughout the day. There were facilities available for people to make drinks and have breakfast meals, for example toast, at any time of day.
We observed one person who required one to one support from a member of staff to eat their meal, which was pureed. The carer supported them slowly and checked verbally that they were ready for each spoonful. This ensured that the carer was able to ensure the person ate safely and was relaxed and reassured during their meal.
Cheriton Care Home has accommodation over two floors. People's rooms were decorated with personal items such as photos of family members, and pictures of their interests for example, horses, vehicles or football. The environment was light, with large windows allowing views of the surrounding countryside for many rooms and communal areas. Each room had the person's name on the door, with some having a photo to aid people's understanding. Rooms were spacious, with room around both sides of the bed for people requiring physical support. There was one double room which allowed a married couple to live together.

We found that the service had close links with the local Mental Health service, which provided training in dementia as well as care plans. The service also had links with the Prospect Hospice who provided support with End of Life care and training, and the local Deprivation of Liberty (DoLS) team who provided training and advice.
The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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. The registered manager and staff followed the MCA code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. Where people were thought to lack the capacity to consent or make some decisions, capacity assessments had been carried out. .
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the home met the requirements of DoLS. .
One member of staff told us, "related to the capacity of each individual and their capacity to make choices, for example a person wanting to leave on their own, but needing to be assisted by staff". We found that people's care plans directed staff to what support they could provide in line with DoLS.
The provider's equal opportunities policy was displayed in the home. This stated the provider's commitment to equal opportunities and diversity. It included cultural and religious backgrounds as well as people's gender and sexual orientation. We found evidence that staff had received recent training in Equality and Diversity, although when interviewed not all staff were clear about what this meant.

Good

# Is the service caring?

## Our findings

People told us they received care and support from staff who were caring, compassionate and kind. They commented, "Oh yes, the staff are lovely", "All the staff are so kind and respectful, it's a nice place here." and "I love it here, I've been here for just over a year now, the manager is cheerful and she really listens". People's relatives also felt staff were caring, comments included, "[Staff always kind and friendly, takes great care of my mum, [the manager] always listens to us, she's brilliant" and "One carer did a little booklet of photos on Dad's birthday. She didn't have to do that".

Throughout our inspection, we observed many positive and caring interactions between staff and the people they were supporting, and we saw warmth and affection being shown to people. The atmosphere was calm and pleasant. There was chatting, laughter and use of light appropriate humour throughout the day. Staff were flexible and provided support when people needed it. For example a person came out of their room with their coat on. A member of the domestic team stopped hoovering and asked the person where she wanted to go and if they could go with her. The member of staff then supported the person to go shopping. On her return the staff member told us "I can come back and do the cleaning but to do that [support the person with shopping] means more than anything, I just help whenever; it's teamwork". The registered manager explained that all staff working within the home were expected to provide support to people if needed, and that training was provided to enable them to do so.

People received care and support from staff who knew them well. A relative of a person living with dementia told us, "They are very respectful, she recognises their names and some of them, which is so good, they know her well"

Staff told us they enjoyed working at the home. Comments included. "I love my job and I love it here, it's the best job I've ever had. I like interacting with the residents, I like improving things" and "I like it here. I think it's a very good team. The best bit about the job is the satisfaction you get from helping the service users and it's good to feel you're making a difference".

We observed people being supported in a caring and patient way. Staff offered choices and involved people in the decisions about their care. For example, we observed the nurse on duty administering medicines. She sought and waited for consent before administration, and asked each person where they would like to receive their medicines. The nurse then gave people as much time, guidance and support as they needed. She also asked people if they would prefer to delay taking their medicines until they were ready. We saw that people responded positively to this person centred approach and were relaxed and happy. The nurse told us, "I like that medicines are kept in their rooms, it gives me more time to spend with each person and interact with them".

People told us staff treated them respectfully and maintained their privacy and dignity. Comments included, "All the staff are so kind and respectful, it's a nice place here", and "They always knock on the door before entering the room, every time". This was confirmed by our observations. We saw staff knocking on people's doors and asking if they could go in. Staff told us how they protected people's dignity when giving personal care and explained what they were about to do. One member of staff told us "[They] always close curtains and doors, cover them when delivering care". One person said, "I know what's going on, the staff always tell me and give me information."

Staff knew people's individual communication skills, abilities and preferences. Care plans contained information and guidance on how best to communicate with people who had limitations to their

communication. For example, we saw a member of staff working with someone with advanced dementia who could only say one word. However the staff member recognised that the person was distressed, so reassured her gently. They waited until the person's vocalising became calmer and more relaxed, before supporting her to sit up and drink. A member of staff also told us "[person] is non-verbal but we use a picture chart so she can make her wishes known".

Staff spoke with us about promoting people's independence. They said, "Some people want to do things by themselves, you always allow them" Support plans detailed the care needed to maintain people's current skills and preserve their independence.

Staff were provided with guidance in relation to confidentiality and were aware of the provider's policy on confidentiality. Staff used tablets to access care plans and record delivery of care. These tablets required individual pin codes to access then, which ensured the information on them was secure.

Good

# Is the service responsive?

## Our findings

People had their needs assessed before they came to live at Cheriton Care Home. A member of the nursing team visited the person, and involved them and their relatives in planning care. The registered manager explained that as well as assessing if the service could meet the person's needs, they also ensured the person's choices were considered and assessed the impact of their admission on the rest of the service before proceeding. We found evidence that these assessments had been carried out in people's care files.
People's care records contained detailed information about their health and social care needs. Care plans reflected each person as an individual and their wishes in regard of their care and support. For example, people's preferences about what time they preferred to get up, how they communicated and how to communicate with them, or what food they liked to eat. People and relatives confirmed they were involved in planning their care.
Each care plan contained a life history detailing people's career, interests and significant events. These included "I joined the army during the war, married and lived mostly in Wiltshire" and, "My home and family are most important to me, as well as my faith". We observed how staff used this information to support people. For example, one person was supported to attend a lunch with friends they knew from their previous employment.
The service used an electronic care monitoring system.This enabled staff to have easy access to key information about the people they were supporting, through the use of digital tablets that every member of staff carried with them while on duty. Delivery of care was also recorded after each intervention. For example, on the day of our inspection we could see that people had been supported in various activities, such as drinking and washing, which were recorded as they happened. This enabled care to be monitored and action taken promptly if there were difficulties, for example a person not eating and drinking sufficiently.
Handovers between staff ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff shared information about any changes to care needs, activities attended, planned appointments and generally how people had spent their day. This meant staff received up to date information before providing care, maintaining consistency. Records showed that handovers took place daily, and were attended by all staff, including domestic staff.
The provider used a key worker system. A keyworker is a staff member responsible for overseeing the care a person received and liaised with families and professionals involved in that person's care. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency.
The provider did not have an activities coordinator in post, but was in the process of recruiting for the role. People's files contained an "Interest Checklist" which detailed activities they enjoyed and would like to do in the future. People told us "At the moment we haven't got a permanent activity person, [member of domestic staff] is very good, she does activities, she gets it all going", "They take me to the park not far from here and I can do drawing, even the cleaners will take me", and "I went upstairs yesterday, the do activities like bingo". We observed examples of activities being carried out. One member of staff engaged people with playing percussion instruments and singing while they waited for their meals. People joined in with singing and appeared happy and engaged. We also saw a group of people being supported to make biscuits. Staff supported them when they needed help, but also encouraged people to complete as much as they could by

themselves. People were obviously happy and enjoyed the activity and their interactions with staff and each other.
We found that relatives and friends were welcomed into the service and people were supported to maintain contact. People's comments included, "My son visits Thursday evenings, he is very welcome", "My friends from work came and took me out to the pub, it was lovely having a catch up. The home here gave us a little drink before we left" and "My daughters visit a lot". Relatives also told us how they were welcomed in to the home, their comments included, "We can visit any time, there's no need for a call first", and "This home is so welcoming and the manager is very approachable, she's all about the care".
We found there was a complaints policy and that the complaints procedure was displayed in the home. We saw that these were followed. For example, two people had complained about breakfast, staff had met with them and developed a plan to address their concerns. This was implemented in the person's care plan and we saw evidence in daily records that it was followed.
The registered manager had just developed a newsletter for people and their relatives. The first edition included photos of Christmas decorations, dates of upcoming events and a questionnaire to gain people's wishes on how to receive future newsletters.
People's preferences relating to end of life were recorded. Each person had a Treatment Escalation Plan (TEP), TEP is a document that records a person's wishes in with regard of to treatment as they approach end of life. We found that these had been completed with the person and their family. The decisions they documented included, admission to an acute hospital, use of IV fluids, use of artificial feeding and whether or not to resuscitate. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life, and the need to allocate experienced staff to work with them.

Good

# Is the service well-led?

## Our findings

The service continued to be well led. Cheriton Care Home was led by a registered manager who was supported by a deputy manager, clinical lead and a regional manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

We saw positive changes had been made since the registered manager's appointment, and that there were further plans to continue to develop the service. These included enhancements to the electronic care monitoring system including medicine administration records and staff access to policies and procedures. They were also plans to increase the activities provided when the new coordinator was in place, and to develop greater community links. The registered manage told us, "I'm very passionate about what I do, I want the best for people. Everyone is committed. We have a senior team who are striving for excellence and staff who are equally committed to providing great care".

Staff were appreciative of the registered manager and the positive changes they had implemented. One member of staff told us, "The manager has changed the atmosphere here so much. She put me on a management training course, I didn't think I could do it but she encouraged me". Another told us, "The manager is brilliant, I can't fault her, she's made me want to stay here".

There was a clear management structure in place, with staff being aware of their roles and responsibilities. Staff felt that they could approach the registered manager or other senior staff with any concerns and told us that the management team were supportive and made themselves available. Staff told us, "This manager has been here over a year, she is very fair, I could go to her with a complaint, or the directors; they always say if there's a problem come to us, but I'd go and see the manager".

Staff told us the registered manager and deputy manager had an open door policy and were always visible around the home. "The manager, she has an open door policy. I like the manager, she's firm but fair. If I ask for something she'll do her best" and "[registered manager] is very pleasant, approachable and helpful".

The provider valued staff contribution at all levels and facilitated an employee award system for good practice. Staff told us, "We have an employee of the quarter, we get a star and a prize and we're put into a draw for employee of the year" and "Yes, I feel our ideas are valued and encouraged".

We found evidence that the service engaged with people to involve them in changes to the service. For example, a survey was used to gather people's views on the food provided by the service. This used words and symbols to support people's understanding and needs around communication. The surveys were then collated to provide an analysis of people's views. The manager told us they plan to implement changes to the menu based on this feedback.

The service had systems in place to review, monitor and improve the quality of the service delivery. This included a programme of audits for reviewing the use and effectiveness of antipsychotic medicines, medicines compliance, catering, infection control and wound management. We saw that when improvements were required, these were actioned promptly. For example, as a result of one audit they had implemented a monitoring system for behavioural changes.

The provider had a whistle blowing policy in place that was available to staff across the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.