Optivo

Chestnut Lodge

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 comprehensive inspection took place on 1 and 2 October 2018 and was unannounced. The service was previously registered with another provider and transferred to the current provider, Optivo, in October 2017. This was the first inspection of the service following the change of ownership.

Chestnut Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

Chestnut Lodge accommodates up to 64 older people across four separate units, each of which has separate adapted facilities. All four units provided care for people living with the experience of dementia and two units also provided care for people with additional nursing care needs.

The service had a registered manager. 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 using the service and their families told us managers, nurses and care workers in the service were extremely kind, caring and patient. Many people and their relatives commented very positively on the care and support people received. People and their relatives were involved in decision making and encouraged to express their views. Staff in the service respected people's privacy and dignity and encouraged their independence.

The provider had systems in place to protect people from abuse. All staff completed safeguarding training and the provider carried out checks to make sure staff they employed were suitable to work with people using the service.

The provider assessed possible risks to people using the service and acted to mitigate any risks they identified. There were enough nurses and care staff to support people when they needed it and we did not see people waiting for care and support.

People and their relatives told us that nurses and care staff understood their care and support needs and they met these in the service. The registered manager, head of nursing and senior staff assessed people's care and support needs in line with current legislation and evidence based guidance. People's care plans included an assessment of their health care needs and details of how staff would meet these in the service. People using the service also received the medicines they needed safely and as prescribed.

Staff working in the service had the training they needed to care for people effectively.

People and their relatives told us they enjoyed the food provided in the home and where people needed support with eating and drinking, the provider included this in their care plans.

The service was working within the principles of the Mental Capacity Act 2005 and the registered manager and the head of nursing fully understood their responsibilities under the Act.

The provider employed a full-time coordinator who arranged a programme of activities and worked alongside care staff to provide an activity each morning and afternoon.

The provider had a policy and procedures for responding to complaints they received. Records showed they had received two complaints. The registered manager had investigated these in line with their procedures and acted to make sure people were satisfied with the outcome.

People's relatives told us they thought the service was well led. Staff also told us they felt the service was well managed and said they were supported. The provider had appointed a qualified and experienced manager who had managed the service for another provider for nine years and reregistered with the Care Quality Commission (CQC) in October 2017 when the provider changed.

The provider had systems in place to monitor quality in the service and make improvements. The provider also involved people using the service, staff and the public in reviewing the care and support provided in the service.

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.

The provider had systems in place to protect people from abuse.

The provider assessed possible risks to people using the service and acted to mitigate any risks they identified.

There were enough nurses and care staff to support people when they needed it and we did not see people waiting for care and support.

The provider carried out checks to make sure staff they employed were suitable to work with people using the service.

People using the service received the medicines they needed safely and as prescribed.

Is the service effective?

Good

The service was effective.

The registered manager, head of nursing and senior staff assessed people's care and support needs in line with current legislation and evidence based guidance.

Staff working in the service had the training they needed to care for people effectively.

People and their relatives told us they enjoyed the food provided in the home and where people needed support with eating and drinking, the provider included this in their care plans.

People's care plans included an assessment of their health care needs and details of how staff would meet these in the service.

The service was working within the principles of the Mental Capacity Act 2005 and the registered manager and the head of nursing fully understood their responsibilities under the Act.

Is the service caring?

Good

The service was caring.

People using the service and their families told us managers, nurses and care workers in the service were kind, caring and patient. Many people and their relatives commented positively on the care and support people received.

People and their relatives were involved in decision making and encouraged to express their views.

Staff in the service respected people's privacy and dignity and encouraged their independence.

Is the service responsive?

Good

The service was responsive.

People and their relatives told us that nurses and care staff understood their care and support needs and they met these in the service.

The provider employed a full-time coordinator who arranged a programme of activities and worked alongside care staff to provide an activity each morning and afternoon.

The provider had a policy and procedures for responding to complaints they received. The registered manager investigated any complaints in line with their procedures and acted to make sure people were satisfied with the outcome.

People received the care and support they needed at the end of their life.

Is the service well-led?

Good

The service was well led.

People's relatives told us they thought the service was well led. Staff also told us they felt the service was well managed and said they were supported.

The provider had appointed a qualified and experienced manager.

The provider had systems in place to monitor quality in the service and make improvements.

The provider involved people using the service, staff and the public in reviewing the care and support provided in the service.

Chestnut Lodge

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 1 and 2 October 2018 and was unannounced. The inspection team consisted of two inspectors and an 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 reviewed the information we held about the provider and the service. This included information the provider gave us when they registered the service and statutory notifications they sent us. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted 13 health and social care professionals who worked with people using the service. We received two responses.

We also used information the provider sent us in the Provider Information Return on 6 September 2018. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 15 people using the service and eight relatives and visitors. We also spoke with the registered manager, head of nursing and 10 other staff working in the service including nurses, care staff, housekeeping and catering staff. We reviewed the care records for six people including their care plans and risk assessments, the recruitment and training records for four members of staff, 10 people's medicines records and other records related to the running of the service. We also carried out a Short Observational Framework for Inspection (SOFI) observation exercise during lunch on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People using the service and their families told us people were cared for safely. People told us, "Yes, I feel safe, they look after me very well" and "It's very safe here, there's nothing to worry about." Relatives also told us, "My [family member] is very safe here; at home he kept getting out [of the house]," "Security is very good. You have to either use the buzzer or enter a code to get in and then there's the electronic sign in. I saw that the side door entrance is kept locked," "My [family member] has not had any falls since arriving at this service. They had many at the previous service."

The provider had systems in place to help protect people from abuse. They had a policy and procedures they reviewed regularly and staff completed training in safeguarding adults as part of the provider's mandatory training. Nurses and care staff we spoke with understood the provider's procedures for keeping people safe from abuse. They could tell us about the types of abuse they may witness and what they would do if they had concerns about a person's safety. Their comments included, "I would inform my manager," "If I thought it might be an abuse concern I would go straight to the manager. If I felt the manager didn't take it seriously I would go higher, inform the regional manager" and "If I suspected physical, neglect, financial, institutional, sexual or emotional abuse, I would go to the manager."

People's care records included risk assessments for moving and handling, falls, skin care and nutrition. Where the assessment identified a possible risk to a person using the service, the provider gave care staff clear guidance on mitigating the risk. For example, where a person was at risk of falls, their care plan reminded care staff to keep their room and other areas free from obstructions and to check they were wearing suitable footwear when they moved around the service. Other risk assessments for people at risk of falling reminded staff to make sure the person used the correct walking aids when they moved around the service. Where a risk assessment showed a person was at risk of weight loss we saw that staff had worked well with the speech and language therapy and dietician services to make sure they had the support they needed to eat a healthy and nutritious diet, with supplements as required. The person's care plan also included a monthly record of their weight and this showed they had gained weight since moving into the service.

During the inspection we saw there were enough nurses and care staff to support people when they needed it. We did not see people waiting for support and care staff worked well together to make sure they responded to requests for support promptly. Nurses and care staff told us there were usually enough staff to care for people. They said, "It can be very quiet and peaceful, sometimes it is hard. It can depend on the residents, we all have moods on some days but we have skilled staff, very trained staff" and "I think there are enough staff. We don't have any problem with that." A relative commented, "The staff that I see are all regulars."

The provider carried out checks to make sure staff they employed were suitable to work with people using the service. Staff recruitment records included an application form and employment history, references, proof of the person's identity, address and right to remain and work in the United Kingdom and a Disclosure and Barring Service (DBS) check.

People using the service received the medicines they needed safely and as prescribed. The provider stored medicines securely in an air-conditioned room and nurses recorded the temperature of the room and the medicines fridge each day to make sure storage conditions were suitable and safe. The service had a separate medicines trolley for each of the four units. We checked two of the trollies and saw that nurses had recorded the opening dates on ear or eye drops to make sure they did not use them beyond their use by dates. Nurses completed the Medicines Administration Record (MAR) sheets each time they gave a person their medicines and we saw no errors or omissions on the records we checked. Where people needed PRN ('as required') medicines, the provider had agreed a protocol with the service's GP and nurses maintained accurate records that included the reason for administering the medicines on each occasion.

Controlled medicines were securely stored in a separate lockable cabinet in the main medicines storage room. The head of nursing showed us that two nurses signed the controlled drugs register. The head of nursing also carried out a monthly audit of medicines management on each unit and we saw that when they identified issues they needed to address they acted. For example, one audit identified that not all Medicines Administration Record (MAR) sheets included information about people's allergies. The head of nursing ensured that nursing staff recorded all allergies before they finished the audit. A second audit identified that staff had not been given instructions about how to administer one medicine. The head of nursing checked the correct procedure and made sure they recorded this on the MAR sheet. The registered manager also checked and signed off the audits each month.

Housekeeping staff told us they had access to the equipment and cleaning materials they needed to keep the service clean. During the inspection we saw that all parts of the home were clean and people using the service and their visitors also commented on this. We did identify one area where there was a malodour but the staff made sure they dealt with this promptly when we raised it with them. The provider had up to date COSHH (Control of Substances Hazardous to Health) assessments for cleaning materials and other chemicals used in the service. A relative told us, "I am very, very, very happy for the cleaning and for the way they look after people. I am very happy for it."

The registered manager kept a record of any accidents or incidents that affected people using the service. They reported these to the provider and acted to mitigate any further risks to people. For example, when a person was admitted from hospital with a pressure ulcer, the registered manager ensured they referred them to the tissue viability nursing service and obtained the equipment they needed to make sure the person was treated effectively and was comfortable. Also, following an unwitnessed fall in a person's bedroom, they sustained a cut to the head. Care staff made sure they asked a nurse to review the injury, who then called an ambulance and the person went to hospital for treatment.

The provider had systems in place to monitor safety in the service. They had an emergency plan to make sure the service continued to operate in the event of an emergency and the registered manager had reviewed this in January 2018. People using the service had a Personal Emergency Evacuation Plan (PEEP) that detailed the support they needed in the event of a fire and the need to evacuate the building and the registered manager had reviewed these during 2018.

The provider carried out a health and safety inspection of the property in January 2018 and did not identify any issues they needed to address. The service's maintenance person also carried out a monthly health and safety inspection of staff, communal and external parts of the service.

The provider arranged for regular service and maintenance visits for the passenger lifts, the last time in August 2018. They also arranged service visits for kitchen and laundry equipment, firefighting equipment, the collection and disposal of clinical waste, gas and electricity supplies to the service. Following a gas

safety visit in June 2018, the engineer classified the service's central heating boiler as 'unsafe'. The registered manager confirmed the provider had installed two new replacement boilers.

The service's maintenance person also carried out a monthly health and safety check of people's rooms and we saw this included checks of opening restrictors fitted to windows and hot and cold water temperatures.

Good

Is the service effective?

Our findings

The registered manager, head of nursing and senior staff assessed people's care and support needs in line with current legislation and evidence based guidance. The provider's policies and procedures included references to guidance from health and social care organisations, including the Royal Pharmaceutical Society and the National Institute for Health and Care Excellence (NICE). The head of nursing was also able to refer to relevant guidance regarding medicines management and the training and quality assurance manager had reviewed the process for recording monitoring visits to services to bring them in line with Care Quality Commission (CQC) fundamental standards.

Staff working in the service had the training they needed to care for people effectively. The provider's training matrix showed staff completed training the provider considered mandatory, including fire safety, patient handling, health and safety, food safety, infection control and safeguarding adults.

The Care Certificate is an identified set of 15 standards which health and social care staff should adhere to in their daily working life. The provider's Care Training and Quality Assurance Manager told us, "As Optivo [the provider] now pays the Apprenticeship Levy, all new Adult Care Workers are automatically enrolled on an Adult Care Apprenticeship with the Diploma element focussing on the Dementia Units once they have completed the Care Certificate. Chestnut Lodge has one apprentice with five awaiting start doing the Care Certificate."

Nurses and care staff working in the service told us they found the provider's training helpful. Their comments included, "I've worked in many care homes in the past, but this is the best, because of the training. If there are some new changes, we have training," "Colleagues will go on training and they will come and tell us, for example about diabetes and their support ideas," "The training is interesting. I learn more each time I have training," "My favourite was the virtual dementia training. You learn how the residents are feeling and thinking. You were in their shoes." After the training I stepped up my practice. I take things more slowly and have more time and be patient. The training was powerful, to know you're doing the right thing anyway but you know how they are feeling," and "I've done DoLS, safeguarding, duty of care, dignity and respect, food hygiene, virtual dementia training, moving and handling, everything we require for our jobs. If you want to request, you ask and then you have the training."

People and their relatives told us they enjoyed the food provided in the home. Their comments included, "I'm vegetarian and there is always a vegetarian option on the menu," "I love the food" and "The food is very good, there's always more if you want it and you can have a snack between meals." Peoples' relative told us, "[The staff] are always walking around offering drinks to people; they offer me too," "They took the time and patience to get to know [my relative]; what they liked. Small plates of food, eating with their fingers and ketchup! There was a time when they were not eating or drinking. The staff did not want to send them to hospital and they worked with them, for example by hand feeding them grapes," "The food that I've seen looks good and when [my relative] was able to communicate she said she was very happy with it," "[My relative's] eaten everything since he's been here" and "They have offered me lunch so I could eat with my [relative]. She eats better that way, she likes the food."

Where people needed support with eating and drinking, the provider included this in their care plans. We saw they recorded people's preferences for food and drinks and where they liked to eat their meals. We saw that some people chose to eat in their rooms, while others ate in the communal dining room on each unit. Where necessary the staff worked with a person's GP and a dietician to monitor the amount people ate and drank. Where this was required, we saw care staff kept a detailed record of how much the person ate and drank.

The local authority carried out a food safety inspection in September 2018 and commented, "Overall good preparation and storage of food, good hygiene standards and good food safety management systems."

At lunchtime we carried out a SOFI in the dining room on one unit. We saw that people had a positive experience and received the help and support they needed. The provider's guidance on creating a positive atmosphere at meal times advised care staff to turn off TVs and music, unless people requested this and we saw staff on the unit did so. They offered people a choice of main courses and allowed them time to make a choice. Where people needed assistance with eating and drinking, a member of the care staff team sat with them to ensure they had enough to eat. Where people could eat more independently, equipment such as plate guards were provided to enable them to do so.

The visiting GP commented that the service's new care planning system had improved communication and the identification of people who they needed to see during their visits. They confirmed that staff referred people appropriately and always followed advice and treatment plans they and their colleagues gave for people using the service. People's care records included information about clinicians who were involved in their care. We saw records of their visits to the home and staff supported people to attend clinic appointments, if necessary.

People's care plans included an assessment of their health care needs and details of how staff would meet these in the service. Records showed that people saw their GP when they needed to as well as other clinicians, including the dentist, optician, chiropodist, dietician and tissue viability nurses. A relative told us, "I know that [my relative] is in really good hands. They are prone to infections and they spot them by subtle changes in [my relative's] mood."

The Mental Capacity Act 2005 (MCA) provides a 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and found the registered manager and the head of nursing fully understood their responsibilities under the Act. When we asked nurses and care staff what they could tell us about the MCA they said, "It means working in their best interests, with DoLS assessments and mental capacity assessments," "If assessed as lacking mental capacity we can deprive them of their liberty for their best interests," "The MCA lets us know if they have the ability to do things for themselves," "It's about the resident's ability to retain information, to process information and give you an answer related to that" and "It helps to protect them from any falls, everything needs to be done in their best interests."

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When necessary, the registered manager applied to the local authority for authorisation to ensure people's safety. For example, the registered manager told us

some people using the service could not go out safely without support. On occasion, a person might have to wait until enough care workers were available before they could go out. Also, the provider locked some doors in the service to keep people safe. We saw that the registered manager had consulted local authorities responsible for people's placements in the service about these restrictions and they had been approved. The registered manager was aware of their responsibility to notify the Care Quality Commission of the outcome of any application to deprive a person of their liberty and they did this.

Good

Is the service caring?

Our findings

People using the service and their families told us managers, nurses and care workers in the service were extremely kind, caring and patient. Many people and their relatives commented very positively on the care and support people received.

When we asked one person if the care staff looked after them well, they replied, "They do! They do! They do! They only look after you excellently. I can get up and go to bed when I want, I can have a shower anytime. I can't go out alone, that's one restriction they made but I understand why this is and accept it." Other people using the service commented, "I'm very happy" and "It's nice here you know. It's relaxed. It's nice living here. The staff are good. They don't hustle you too much. They are nice to the people they deal with. It's nice the staff are relaxed; you don't have to worry. It's a nice staff to deal with."

Relatives commented positively on the care and support people received. They told us "To begin with [my relative] was aggressive around receiving personal care. They worked hard on that. They observed and used all the things they observed to understand what she likes and how they could best manage her needs and communicate non-verbally. They told me, 'We will dress your [relative] in the clothes she likes to wear.' " and "Instead of putting my [family member] into a wheelchair to move around the home, the staff take the extra time and effort required for two carers to support her to walk herself,".

Other comments included, "[My relative's] really happy. He smiles and laughs at all the carers. He seems to like them all. They tell me if there's anything wrong" and "[The care] is very good; it's how one perceives the behaviour of staff towards the residents, how they look after them. It's actually very good, I've no criticisms at all" and "I come at all different times of the day. What I've seen [of the care] at those times is very good. Staff say my [relative] normally does this or does that because they know her well. [The registered manager] is very good at writing emails asking for a decision to be made on behalf of my [relative] e.g. for a blood test. If there's a hospital appointment they will arrange for me or my sister to take her or they send someone from the home with her. I like it that there's a picture of her key worker on her wardrobe. Staff always call [my relative] by her first name."

People and their relatives were involved in decision making and encouraged to express their views. One person told us, "They're looking after me as well as they can and I get a choice, I do things my own way," Relatives commented, "They are very attentive. Once they get used to what the problems are they get ways to mitigate. My [family member] did not want to take tablets so covert administration in drink was instituted and I was part of that decision process" and "They let my [family member] have freedom and her own will as far as possible whilst managing risks."

Throughout the inspection we saw many positive interactions between staff and people using the service. We saw many examples of care staff doing things with people such as playing a game of 'snap' with large playing cards, looking at pictures in books, throwing a beach ball, sitting and chatting, sitting and holding hands or reading the newspaper with an individual. The atmosphere in the service during the inspection was calm and relaxed, staff greeted people and their visitors with a smile and a friendly greeting and made sure

that people has a place to meet privately, if they wished.

Staff in the service respected people's privacy and dignity and encouraged their independence. They told us, "Each room has ensuite facilities for personal care and we offer people the chance to use these rather than go to the assisted bathrooms," "If a person needs the toilet, ask them where they would like to go for this," "Ask their consent, follow their cultural beliefs, close curtains, ask them what clothes they want to wear not just tell them, show them by opening the wardrobe," "Giving people their choice rather than giving them our choice" and "Encourage them rather than doing for them.

One care worker described supporting a person and said that care workers, "Ask her to help lay the table, napkins, cutlery and fold clothes. They added some people "Help us with the washing up, to keep them busy and independent." A second care worker told us, "We knock on the door, say morning, ask if they're ready, shower and wash them, ask what they prefer. Go in happy and laughing, make them laugh, chat about things. Ask them what they want, when to wash their hair."

Another care worker said, "You can't do everything for people. Supervise making a cup of tea, choose their own music, the film to watch that day." They also reported encouraging people with, "Little bits, combing their hair, washing a little bit, asking them to do the little things." They gave another example of some people being able to brush their own teeth, whereas others if you give them their toothbrush and prompt they will then brush their own teeth. A fourth care worker described their team working with a person who, "At first was waiting for us to do it [personal care] for her." The care worker said that after working to encourage and respond to her, now the person "Is standing herself, going to the toilet herself, asking for help herself, changing her pad herself." They added, "I am so proud. It means we have done a good thing."

Good

Is the service responsive?

Our findings

People and their relatives told us that nurses and care staff understood their care and support needs and they met these in the service. They also told us they were involved in reviewing people's care plans regularly. One person said, "It's all written down, the help I need, it's all planned." A relative commented, "When they receive a new resident you have to go through about 40 sheets and sign them. You do this every year or whenever they are revised. They tell me what they have done."

During the inspection we saw evidence the registered manager and head of nursing had reviewed a total of 29 people's care plans with the person and their family members. The head of nursing told us the reviews would continue until each person's plan had been reviewed with them and any relatives involved in their care.

The provider used an electronic care planning and recording system. The system enabled nurses and care staff to enter information onto a person's record, amend their care plan and risk assessments and record any interactions the person had with staff, family members or visiting professionals. The care plans covered 15 health and social care areas including personal care, nutrition, mobility, safety, autonomy and choice, communications, skin care, mental health, end of life care, sexuality and gender care and medicines management.

Nurses and care staff told us they could update people's care plans and risk assessments more easily than using the previous paper-based system. They used desktop computers and handheld devices to record all information electronically. The registered manager and head of nursing also told us they could produce reports to monitor aspects of people's care, for example the date of the last care plan or risk assessment review or the number of people who were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation and when the registered manager needed to apply to the local authority for a renewal. Staff comments about the new care planning system included, "If I have the plan, I just log in and find things. Not like [paper] folders going in different places by different staff," "It's better than sitting down with paperwork. I thought it would be hard, but it's like using your own phone," "It's very easy. You find all the information that you want, it's there. Now we have time to talk to residents" and "You get more information about the person, their choices, likes, juice preferred, clothes preferred, religious needs."

Care records showed staff responded when people's care plans or risk assessments identified an issue they needed to address. For example, one person's care records showed they had lost weight. The records showed staff referred the person to a dietician and the speech and language therapy (SALT) service, they followed advice to provide a fortified diet, recorded what the person ate and drank each day and weighed the person regularly. As a result, the record showed the person had regained weight they had lost, their body mass index (BMI) was healthy and the dietician and SALT had discharged them. The personal safety plan for a second person included their belief that someone was entering their room and taking their possessions. Staff investigated the person's concerns, reassured them and gave them a key so they could lock their door when they left the room. A third person's care plan included a mobility plan provided by the physiotherapist for care staff to implement. The person was advised to complete three exercise sessions a day and the care

records staff completed showed they supported the person to do this each day.

The provider employed a full-time coordinator who arranged a programme of activities and worked alongside care staff to provide an activity each morning and afternoon. Activities included a music therapy session every Friday, outings for a pub lunch and outings to Gunnersbury Park, Kew Gardens and the local memory café. Care staff also worked with individual people to do art work, play card games, read the newspaper, look at photo albums and talk. We saw that people enjoyed the activities in which they took part.

The provider had a policy and procedures for responding to complaints they received. Records showed they had received two complaints. The registered manager had investigated these in line with their procedures and acted to make sure people were satisfied with the outcome.

People using the service and their relatives told us they knew how to make a complaint, if necessary. They commented, "I've never had any great complaints" and "Nothing to complain about. If there was I'd speak with [the registered manager]." A relative commented, "I know about the complaints procedure but we have never needed to use it."

The head of nursing told us the service could provide care and support for people at the end of their lives but this care was not needed at the time we inspected. We saw evidence the head of nursing worked with the service's GP, local hospice and specialist nursing services to make sure people had the care and support they needed at the end of their life.

Good

Is the service well-led?

Our findings

People's relatives told us they thought the service was well led. They said, "[The manager] is wonderful. He cares about every single individual. He's a great leader. He's big on 'respect' – everything comes back to that. He respects the staff and the staff respect the residents," "Relatives' meetings are an open discussion with the manager and the head of nursing. If I don't attend I get the minutes sent to me," "[The manager] and the two [staff] in the office are fantastic. They keep in touch [with me]" and "I just wanted to say how good this home is, we were so lucky to find it. [The registered manager] and [Head of Nursing] are fantastic people, they care so much about every person here and they lead by example so all the staff are good. I honestly don't think care homes get any better than this."

Staff also told us they felt the service was well managed and they were supported. Their comments included, "The Head of Nursing is very friendly. It is not 'management' and 'staff' [indicating a divide]. It is like a family, we are very open," "If you have any problems, we talk with them. They are really nice. This is good. I feel safe here," "It's very good here. Very good managers," "The managers are very good, very helpful and supportive. Managers will come and support us and work as a team," "They are very open, very good manager. If you have anything to say, [the registered manager] always listens. He's very good, very professional, he listens" and "That's why we have stayed here so long, the management is so nice. Management is very important."

When we asked staff if they received regular supervision and an annual appraisal, they told us, "I can go to the office whenever I need to and supervisions are two monthly. We talk about how to improve quality of care and our approach with relatives, how to deliver information to relatives," "Supervision is usually every month. We talk about mainly my work, how I'm getting on. She'll ask if I need any training, ask if I need help with anything. It's helpful, we can talk about anything we need to talk about," "We have six [supervision sessions] in a year. We discuss any area I want to improve on, if I want any training, any help, any improvements on my unit" and "I have supervisions with a senior carer. We talk about my role, what I want to do in the future, mostly we talk about providing good care to the residents here." Staff also told us they had an annual appraisal and the records we saw confirmed this.

The provider had appointed a manager who had managed the service for another provider for nine years and re-registered with the Care Quality Commission (CQC) in October 2017 when the provider changed. Before this they managed other care homes for five years and had also been a care worker, senior care worker and deputy manager. The registered manager had completed their National Vocational Qualification Level 4 in management. They told us they kept up to date with developments in social care by attending provider forums arranged by the local authority and training they provided. They also told us they referred to websites run by the Care Quality Commission, the Royal College of Nursing and Skills for Care.

The registered manager was supported by a head of nursing and a team of nurses, care staff, administrative, housekeeping and maintenance staff. They told us the provider was reviewing management arrangements in the service and they would create a deputy manager post to replace the head of nursing.

The provider had systems in place to monitor quality in the service and make improvements. The Care Training and Quality Assurance Manager told us, "We changed the way we started doing provider visits as of April this year due to the new inspection regime. One advantage of Nourish [the provider's electronic care planning system] is audits and elements of provider visits on care and care plans can be done remotely allowing me to be more effective when visiting the home. The new approach included a much slimmed down Action Plan that focusses on Regulations and potential impact of a breach and are limited if possible to two pages. [The service] has taken ownership of the actions and targets. I conduct a full visit where I look at all of CQC's key lines of enquiry. I find using Skills for Care's 'Good and Outstanding Care Guide' a useful tool for this. We follow it up with focussed visits with the managers addressing issues identified rather than repeating the full visit especially those that are quick wins."

Records showed the provider's representatives carried out regular monitoring visits to the service and used these to develop an action plan of issues for the registered manager to address. We saw the monitoring visits were mapped against the five questions CQC asks of all services and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to identify any breaches of regulations. The provider's monitoring visit dated August 2018 highlighted one housekeeping issue for managers in the home to address and the provider added this to the service's action plan.

The latest action plan showed the registered manager and head of nursing had made progress in several areas, including the revalidation of all nurses with the Nursing and Midwifery Council (NMC), ensuring all staff recruitment checks were completed and ensuring standards were met for medicines management and health and safety.

The provider involved people using the service, staff and the public in reviewing the care and support provided in the service. The registered manager arranged regular meetings with people using the service, their relatives and staff to get their views on the care and support people received. The record of the residents' meeting in September 2018 showed people discussed activities and day trips, the food provided in the service and flu vaccinations. At the staff meeting in September 2018, staff discussed care practices, recording and activities. We saw staff could ask questions and suggest changes to the registered manager, for example about the care of people at the end of their life and arrangements for storing equipment in the service. Records showed there was a separate meeting for nurses and senior care staff in August 2018 when they discussed activities, the Mental Capacity Act 2005, medicines management and care planning.

The registered manager arranged three meetings for people's relatives each year and we saw the last meeting was in May 2018. The registered manager used the meeting to tell relatives about changes to care planning and recording, the arrangements for inviting relatives to care plan review meetings and planned activities.

The provider also carried out an annual survey of the relatives and friends of people using the service. We saw the results of the survey the provider conducted in July 2018 and this showed people were positive about the care and support people received. Their comments included, "I had viewed many homes before [family member] came to Chestnut Lodge, not one came close to the cleanliness, friendliness, professionalism, transparency and care encountered here. The staff are all incredible," "Staff are very nice and know about my [family member] if I call. Managers are very nice" and "Caring, friendly team."

The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and they ensured they informed the CQC when the local authority authorised the legal deprivation of a person's liberty. They were also aware of their responsibilities under the HSCA (Regulated Activities) Regulations 2014 and made sure they informed CQC of any significant

incidents that affected people using the service. The registered manager also kept a record of any safeguarding concerns that involved people using the service and we saw they worked with the local authority and Clinical Commissioning Group to investigate and resolve any concerns.