Barchester Healthcare Homes Limited

Tandridge Heights

Inspection report

Memorial Close
Off Barnetts shaw
Oxted
Surrey
RH8 0NH

Tel: 01883715595
Website: www.barchester.com

Date of inspection visit:
25 July 2018

Date of publication:
16 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 25 July and was unannounced.

Tandridge Heights is a purpose-built care home that provides nursing and personal care for up to 75 older people. 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.

At the home, people were cared for over three separate floors. One of the floors specialised in providing nursing care to people living with dementia. At the time of our inspection, there were 61 people living at the home. There were seven people living with dementia on the specialist unit.

The home is run by a registered manager who was present for the inspection. 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 in April 2016, we reported that the service was 'Good'. At this inspection, we found staff did not always respect the dignity for the people they cared for, or understand the impact of their actions on people. Care plans did not always reflect a personalised approach in the way they were written and people were not always involved in agreeing their care.

During the inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made one recommendation. The provider demonstrated they had begun to take action following the inspection.

People felt safe at the home and staff knew what actions to take to protect people from abuse.
Risks were being assessed, recorded and reviewed and staff knew what to do to safely meet individual needs. Care was provided to people by enough staff who had received training to carry out their role. The service followed safe recruitment practices.

People lived in a safe and clean environment and they were protected from the spread of infection.
People's medicines were managed and administered safely. Processes were in place in relation to the correct storage and auditing of people's medicines.

People's needs were assessed before they moved into the service to help ensure that their individual care needs could be met by staff. The staff supported people to maintain their health, making referrals to healthcare professionals when required.

People had sufficient to eat and drink and the mealtimes and food were enjoyed. Any risks to people with their nutrition or weight loss was monitored and plans were in place to ensure support was given.

People were supported by staff who worked together and who received support to understand their roles and responsibilities through supervision and an annual appraisal.

The building and premises was well maintained. On the ground floor we saw people and relatives were enjoying meeting each other in the open entrance hall.

The service was working within the principles of the Mental Capacity Act, and the conditions for an authorisation to deprive a person of their liberty were being met.

People felt emotionally supported by staff and told us they were kind. People's independence was promoted and they were encouraged to make decisions about their care. Relatives were welcomed at any time to visit.

The registered manager and staff responded to complaints that were raised with them. People and their relatives felt their concerns were listened to and dealt with.

The service worked with other healthcare services when people were at the end of their lives to ensure, as much as was possible, that they were pain and symptom free.

The registered manager promoted a positive culture with their staff and engaged with people and their relatives in an open and honest way. People were given opportunities to be involved in decision making and giving feedback about this service.

The provider had a robust quality assurance programme in place and where issues were identified through audits, an improvement plan was in place. There was an effective process for monitoring addressing care and environmental issues that would arise in a home of this size. CQC registration requirements were met with notifications of incidents sent when appropriate.

The service had good links with the local community and encouraged school and young children people to visit through intergenerational activities.

You can see what action we told the provider to take to address the concerns we found at the back of the full version of this report.

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 remained safe.

People were cared for by a sufficient number of staff.

Staff understood their responsibilities to safeguard people from harm.

People were protected from the spread of infection.

Medicines were managed well and safely.

The risks people experienced were assessed, recorded and managed.

Is the service effective?

Good

The service remained effective.

People's needs had been assessed.

People were cared for by staff who had received training and were supervised.

People's nutritional needs were met.

People were supported to maintain their health and well-being.

The premises were adapted and maintained to meet people's needs.

Staff worked within the principles and requirements of the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always act to ensure people's privacy and dignity was maintained.

People felt supported and cared for by kind staff.

Staff involved people in their care and promoted their independence.

People were supported to maintain relationships close to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans and notes were not always written in a person-centred way. It was not always clear how people and their relatives were involved in their care.

The service responded to complaints. People and relatives felt able to raise any concerns.

People were cared for well at the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a breach of regulation and action was needed to address the concerns we found.

A positive culture was promoted and staff enjoyed their work.

There was a clear governance framework in place.

The service acted on the findings of quality audits to improve the care and environment.

People could be involved in decisions about the service.

The service worked with other agencies and had a community connection.

Tandridge Heights

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 was carried out on 25 July 2018 and it was unannounced.
We had brought this inspection forward following some complaints and notifications that we had received.

The inspection was carried out by three inspectors, a specialist nurse 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 service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are changes, events and incidents that the service must inform us about. This enabled us to ensure we were addressing any potential areas of concern at the inspection.

The provider had completed a Provider Information Return (PIR) in December 2017. We used information the provider sent us in the Provider Information Return. 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 11 people and three relatives. We were unable to speak with some people at the home due to their health condition. To try to understand these people's experiences, we spent time observing interactions between people and the staff. We spoke with eight staff, including the a chef, two nurses, an activities co-ordinator and the registered manager.

We looked at the care plans for nine people, including their assessments, care plans and risk assessments. We checked what was detailed in these plans matched the support and care people received. We looked at

mental capacity assessments and any applications made to deprive people of their liberty.

We checked how medicines were managed and associated records . We looked at three staff recruitment files, staff training records and how the service is monitored through audits and reviews of accident and incidents in the home.

We received feedback about the service from the local authority quality monitoring team and two healthcare professionals.

Following the inspection, we asked the registered manager to send us some further information and evidence about people's care, which they did.

Good

Is the service safe?

Our findings

People told us they felt safe living at home. One person told us, "I feel safe with staff, they look after me well." Another said, "I'm looked after 24 hours a day. If something happened I would be alright. It's want you want a nursing home to be." Relatives had trust in the staff and managers. One relative said, "I just feel he is in safe hands."

People were cared for by a sufficient number of staff. Staffing levels on each floor were observed to be good on the day of our visit. We did not see people waiting to receive care. A relative told us, "There are people constantly on duty, there's always someone around." A person who spent most of the time in their room said, "There are always staff walking past, any problems you can call out."

Staff told us there were enough of them to meet the needs of people. One member of staff told us, "If someone is off sick, they can call in another one of us. We rarely need to use agency staff. We are lucky here as most staff will help out when needed." The registered manager used a dependency tool to determine when more care staff may be needed to ensure the safe running of the home. There was either a Registered Nurse or a Senior Carer on each floor supported by care staff according to people'sdependency. The use of agency staff was being monitored. The registered manager told us, "We use the same agency and try to have the same staff too, so that they are aware of the home and people's needs."

People were cared for by staff who had undergone appropriate checks before they began working at the service. Prospective staff were required to submit an application form with details of two referees. Staff recruitment files contained evidence that the provider obtained the references, proof of identity and a Disclosure and Barring Service (DBS) certificate before staff started work. DBS checks identify if prospective staff have a criminal record or were barred from working with people who use care and support services. The nurses were registered with their professional body; the Nursing and Midwifery Council.

People were protected from the spread of infection because they lived in a clean environment. The bathrooms and specially adapted equipment, such as hoists, were well maintained. One relative told us, "It's very clean here and tidy, there's not too much clutter." Staff had good access to personal protective equipment (aprons and gloves) when caring for people. There were hand sanitizers in all the toilets, the sluice room and nurse's office. One staff member said, "We have infection control training every year." Another said, "We always wear gloves and aprons when attending to people's personal care needs and we change them for each person." They also knew what to do with any soiled items, disposing them in the correctly coloured bags. People and relatives told us that staff always used aprons and gloves when giving personal care.

People's medicines were managed in a safe way. Medicines were administered with care by the nurse. One person said , "Yes I get it regular. I can tell the time by it." The storage and administration of medicines was managed by the use of an electronic system. This reduced the risk of errors as it clearly identified when medicines were required, and flagged if this had not been done. If medication was overdue then an alert was shown. There was space to write a note if, for any reason a medicine was not given, for example, the person

refused or a clinical decision. The system also allowed free text to state the reason for administering 'as required' medicines. Specialist medicines used for end of life care were checked by a second nurse.

The storage of medicines was also safe. For example, medicines were kept in a locked trolley which was kept in a locked room when not being used on a medicines round. Specialist medicines were kept in a locked cupboard within the locked room. There was a book in which stock levels were recorded. Medicines that required refrigeration were stored correctly and the temperature was checked and recorded daily.

People were cared for by staff who understood their responsibilities should they suspect abuse was taking place. Reporting procedures were in place and staff awareness of these was high. Staff attended mandatory training about safeguarding people. One of the care staff said, "If I saw anyone hurting a resident, whoever it was, I would report it." Another told us about the role of the local authority and that of the police. A third staff member said, "I would follow the whistle blowing policy and report straight to a manager. There has not been any abuse that I've seen here." Lessons had been learned by staff following a recent safeguarding incident when unexplained bruising was found on a person. The deputy manager had investigated and had found there was an increased risk that the person with deteriorating health could bruise easily when staff were helping to move them. A new detailed moving and handling plan was put in place and all staff had received clear instructions to reduce the risk.

Action was taken to minimise the risk of harm in relation to people's care. Care plans included individual risk assessments on manual handling, nutrition and hydration, use of call bell, danger of entrapment in wheelchairs, falls, pressure sores, and choking. When supporting people to mobilise staff followed the guidelines detailed in the moving and handling risk assessment for that person. A relative told us, "Yes it's safe, because I observe the care they give to people who need physical attention and I see them doing that safely." Where people were nursed in bed there were risk assessments for skin integrity. Care staff used a certain type of cream twice a day to keep a person's skin healthy and moist. Pressure relieving mattress settings were checked daily. As it was a very hot day, we asked staff about the risk of dehydration. One staff member described the physical signs they would look out for and another said those at high risk and needed support to eat and drink were being monitored. Staff gave people drinks and fluid charts were in place for those at high risk.

There was a 'wellbeing checklist' in place for people that needed hourly visits by a member of staff. This monitored that the visits were done, and any actions such as repositioning the person, personal care, the mattress setting and whether their call bell was in reach.. The registered manager or nurse reviewed these during the day.

The registered manager reviewed accidents and incidents to try to minimise the risk of them happening again. These were discussed at monthly clinical meetings. Incident forms showed what actions were taken by staff to prevent a reoccurrence. For example, one person said they had dropped some hot tea on themselves and was found to have some skin damage. The wound was dressed and a note was made to ensure staff were made aware of the risk and cooler tea was to be given to the person. Another person had recently had a fall on getting up from a chair. There was a note to say, "Increase staff support for transfers as [name] has variable mobility." A staff member said, "I consider how unsteady the person is on their feet, and the time of day, when giving personal care and shower. I'd ensure the seat is in place for them."

Good

Is the service effective?

Our findings

People's needs and individual requirements were assessed before they moved into the service. This ensured that their people's care and equipment needs could be met by the staff. The assessments included the person's diagnosis, communication, personal hygiene, continence, mobility, nutrition, breathing, pain, mental cognition, any special needs (under the Equalities Act) and their preferences for social activities. This information was used to develop the person's care plan. People's care needs were assessed using recognised national tools, for example when measuring the risk of pressure sores.

People's nutritional needs had been assessed to ensure they received a balanced diet. Care plans gave staff information on people's individual support requirements such as how they would support people who had difficulty swallowing, or were at risk of malnutrition. Where people had poor appetites, supplementary drinks had been prescribed. A fluid and food chart was put in place to monitor people at high risk of weight loss or dehydration. Staff were aware of people's needs. One staff member told us, "Each person has a nutrition plan which states their needs, for example, if they are diabetic, or need soft food diet. We always communicate with the kitchen about any changes and send a form with people's weight. Today, a person is arriving who is diabetic, so I made sure the kitchen was aware yesterday." The chef had a system for recording people's individual allergens and dietary needs. One person who had moved to the home with complex needs was at high risk of weight loss. Staff were aware of the risks and the current plan for the person, which had been agreed with the input of an advocate, dietician, the hospital and GP.

People had a varied choice of food which was displayed on a menu. One person said, "Yes it's lovely couldn't wish for better." Another person called it, "Top nosh." The chef asked for people's wishes and suggestions at the residents' meetings and responded to ideas. For example, some people asked for "Plainer food" and the chef took this on board. One staff member, who was employed as 'host', told us their role was to ensure people were served drinks and snacks mid-morning and mid-afternoon and to help at meal times so everyone had their food in a timely way. One person said about the food and snacks, "If I needed anything, I only have to ask and I get it."

At lunch time, people were seen to be enjoying the meal in a peaceful environment. Staff were on hand to assist those who needed it, for example by cutting up food. Staff noticed a person struggling with their plate moving about and provided a plate guard which meant they could eat independently. The meal was not rushed and people were given choices. One person living with dementia did not want a hot meal and was provided with some sandwiches. Some people enjoyed a glass of wine with lunch and this was offered to people based on staff knowledge of their needs and preferences.

People were cared for by staff who had the training they needed to provide effective support. Staff told us about the induction and mandatory training they had. One member of staff told us, "I had training on health and safety, infection control, safeguarding, food hygiene and first aid."
There was a system in place to monitor staff attendance at annual refresher training which was up to date. There was also scope for staff to continue in their professional development. A member of senior care staff had completed their medicines training and further training in dementia care. One of the nurses had applied

to undertake a palliative care course.

Staff had regular one-to-one supervision sessions with their line manager, which gave them the opportunity to discuss any support they needed. One staff member said about supervision, "I only had one four weeks ago. I have them at least once every two months." There was a plan in place that recorded these meetings and this demonstrated supervision took place every other month and appraisals planned every year.

Staff worked together for the benefit of people. We were told by staff, "We have a handover every day to make sure we know what people need. There is a diary system too, so we know if there are any appointments that day." There was evidence of good team work in place. We noticed staff asking each other to go to check on a person, or to help them undertake a task. A person was taken unwell whilst we were there, and the care staff consulted the nurse appropriately. The nurse made an assessment that an ambulance was required and the person could not be left alone. During this time staff remained calm and other staff helped.

People were supported by staff to maintain their health and well-being and access healthcare professionals when they were needed. Staff consulted the local health team regularly, including community matrons and tissue viability nurses for clinical support. One person had recently been reviewed by the speech and language therapist as they were finding it more difficult to swallow. The guidance to staff about thickened fluids and helping the person to stay in an upright position was well documented. One relative told us that their mother had just been to see a dentist, who had commented on how well the staff were keeping the person's teeth clean. They also said, "The staff will always mention if something might be helpful. When she hurt her knee they suggested physio, they talked through the options with me." Another relative told us, "I feel confident, they will look into anything and work with the hospital if needed." One healthcare professional said, "Staff provide a good assessment of the person's issues and follow up on any instructions."

The building and premises were well maintained and suitable to meet people's needs. On the ground floor people and relatives enjoyed meeting each other in the open entrance hall. Each floor had its own communal areas where people could meet or gather for an activity. It was a large home with long corridors. Where people required support to mobilise around the home, this was done by using wheelchairs, and with support from staff, where needed, to use the lift.

Bedrooms were spacious and people had room to move around and receive their personal care in private. One floor was designed for people living with dementia and effort had been made to make this different with pieces of old furniture and pictures that would mean something to the people living there. There were further adaptations that could be made on this floor to assist people living with dementia with their orientation. The registered manager said that they were are in the process of working on a corporate development plan to improve the quality of the environment for people living with dementia.

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 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).

The service was working within the principles of the MCA and that the conditions for an authorisation to

deprive a person of their liberty were being met. Capacity assessments had been done to support DoLS applications and where people required an additional restriction, such as a bed rail. We saw a bed rail assessment where some information was missing and the decision made in the person's best interests was not clearly stated. The manager was aware of need to check that staff recording. A recent management audit had found, "Not all MCA's have been completed in full and discussions documented." They were working with the staff to correct the paperwork, and which was completed and sent to us immediately after the inspection.

Staff we spoke with were knowledgeable about the need to gain consent from people and their role. One of the care staff said, "I always ask for their permission before I do anything like helping them to get washed." Another staff member said, "We help them make their decisions and these can be unwise. If we do things in a person's best interests it must be in the least restrictive way."

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring to them. One person said, "They are very considerate, very genuine and kind." A relative said, "She is treated like a grandmother, I have seen nothing but kindness." Another told us that staff were "Respectful." On the day of inspection, we found that that people in the communal areas looked happy and content. We also observed positive interactions and heard staff who spoke with people in a friendly and considerate manner. One new carer told us, they were expected to, "Respect and promote people's dignity."

Staff we spoke with said they always attended to personal care needs in the privacy of people's bedrooms with the doors closed. One member of staff also said, "We ask people if they would like a male or female staff to help them and we respect their choice.

Despite these positive examples, we found that not all staff acted in a way that showed respect for the people they cared for. A person told us they heard staff shouting in the corridors at night and this made them feel anxious. At lunchtime, a person living with dementia asked for help with their clothing, which was in disrepair and making in difficult for them to walk to the dining area. They were told to sit down and not offered any assistance by staff. A person was not given their privacy when they used the commode in their bedroom and their door was left open. This happened twice on the day we inspected. When we asked staff to address this they said the person wanted their bedroom door open. No alternative solution was suggested to maintain the person's privacy as well as respecting other people who might see something they would rather not.

Following the inspection, the registered manager told us they had spoken to night staff and that they would organise further training on communication and impact. They also said the use of a 'dignity screen' would be discussed with the staff and the person who wanted their door open.

We recommend that all staff are helped to recognise people's right for privacy and dignity and understand the impact of their actions on people.

People felt supported by staff with their emotional as well as physical needs. One person said, "I have weepy days I can't stop crying and they are very kind, they come to me and try and talk me out of it." Staff spoke kindly to people living with dementia and were giving appropriate physical contact that people enjoyed. One person displayed signs of anxiety and a staff member sat with them holding their hand and constantly reassuring them. A new person arriving at the home for respite care looked lost and disorientated once their relative had left them. Staff quickly came and talked with them, explained why they were there and offered them some tea. They also encouraged other people to talk with and welcome the person.

People told us their independence was promoted. One person said, "I don't like being bossed about. I was in another home where they stopped me from walking, but they are not like that here." They told us how they had been supported to go outside. "I like doing that and feeling independent." Another person said, "Lovely care home, they give you a lot of freedom here."

One staff member said, "People might forget things but we ask them what they want and give them a choice." One person declined to take some (as required) pain relief when offered. The nurse treated their decision with respect and reminded them that they could ask at another time if they required some.

People were supported to maintain relationships close to them. One said, "It's a good place, it's personal. It's safe to bring the grandchildren to visit too." They also said that the home had provided a large room for all the extended family and friends to hold the person's 91st birthday party. This meant a great deal to the person concerned. Another relative told us, "They listen to him. And I make sure they also hear what I'm saying, so we work together." Another told us, they were, "Always made to feel welcome" whenever they visited.

Requires Improvement

Is the service responsive?

Our findings

People's care plans contained information about their clinical and care needs but they did not have a person-centred approach. The language used was focused on tasks needed to be done to the person without reference to them or their personal strengths or aspirations. There was limited information about people's lives' and backgrounds. There was an "About Me" profile at the front of the plan, that summarised a person's physical and emotional needs and the activities they enjoyed. However, this was written in the third person, by staff, not with the person themselves and did not include much about the person's life. The daily care notes were also basic with little reference to the person themselves, for example repeating the phrase, "Eating and drinking well, assisted with full personal care." These examples of writing about the person did not support staff to give a personalised approach in their care.

Whilst some staff told us they used the care plans the examples they gave were about a person's care, rather than knowing the person's choices and goals. We heard from relatives who expressed that individual care was sometimes lacking. One said, "They keep as precise as they can, but big places have less control and intimacy." We also found that where information was in place, for example regarding a person's communication needs, not all staff were familiar with this. One person, we were told, liked to be called by a different name, but this was not reflected in their care plan.

There was a monthly review process for each person's care plan in place. The home used the "Resident of the Day'" method to ensure this was done with the person. However, the monthly review record was not prominent in the care plan so it was difficult to see if any changes had taken place that may impact on the person and their care. There was some evidence that people and their relatives were involved in the reviews. One relative said, "If there is something they need to change they will always run it by me first." However, the recording of the person's own views and any changes being made, on the examples we saw, was very limited. Care plans and reviews were not always signed as agreed by the person or their relative.

A senior manager told us the provider is looking at other methods that can support a more personalised approach to care plans to support staff in giving responsive care. Following the inspection, the registered manager sent us some examples of changes they would start to make for example, each person's profile to be written in the first person and to include details about the person's life.

The failure of the provider to always involve people in their care, and lack of information about people's lives and wishes, to enable staff to give personalised care, was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's preferences for social activities were known. Staff assisted people to take part in an activity of their choice. Those who were able, were encouraged to socialise during the day or attend events held on the ground floor. One person said, "Oh yes, we have a leaflet to tell you what's going on so you can decide."" There was an activities co-ordinator who was employed Monday to Friday and a driver who helped with occasional outings. Once a week there was a visitor or entertainer and another day there was pet therapy. A beauty therapist also visited weekly to do manicures and pedicures. On the day of our visit about 10 people

took part in a chair-based exercise group. This happened twice a month. In the afternoon seven people doing a word search together with soothing music. The doors were open into the gardens and some people were able to go outside in the sunshine. A person told us, "I enjoy what they do here." A relative said, "They had a BBQ last week and everyone was in the garden, the carers spent time with them. They have a new bus driver who takes them on outings, that has been a big change and improvement this year."

Staff told us that they arranged social stimulation for the people living with dementia who may not join a group, for example listening to music. One relative said "I have seen how good they are with those with dementia."

Efforts were made to meet people's spiritual and cultural needs. For example, people and relatives told us that Christian ministers visited the home and a church service was arranged weekly for those who wished to attend. At the time of our visit, there were no people practising other faiths at the home.

People's individual communication needs were met. Staff told us how they made up picture cards for a person whose first language was not English so they could communicate better with them. One person with complex needs was unable to communicate verbally. Staff told us how they looked for non-verbal signs. One member of staff said, "I can tell if they are okay, when I hold out my hand and [name] touches it this means they are content. If they want to go out they stand up." There was a communication plan in place for this person to help staff interpret signs if the person was distressed or in pain." Another person was helped by a staff member carer to manoeuvre their wheelchair when it had got stuck in the corridor. This person was unable to speak clearly but the staff member could understand that they required help and they communicated with each other using hand signing.

People and relatives told us they felt they could raise any concerns. One relative said, "If there's an issue, I know where to take it. Either to the staff or to [registered manager]. Things are always acted on promptly." One of the staff told us that mostly there were verbal complaints that were, "Resolved through discussion." This was confirmed by another relative who said they "Would prefer to raise small incidents with a nurse, I have never made a complaint." There was a formal complaints process in place, which was also displayed. In the office, there was a record of the most recent formal complaints of which there were four this year. For example, one relative complained about staff not supporting the person to use the toilet and were putting them to bed too early. We spoke with this relative who said that they were now happy and these issues had been addressed.

People were supported at the end of life with a responsive approach. The care of a person who was at the end of their life was being managed in a proactive way. Their assessments and comprehensive plans were in place so that they could have as pain-free and dignified death as possible. We saw, where it was appropriate, that people had advance care plans in place to not prolong any suffering at the end of their life. The registered manager and nurses talked of their commitment to keeping people at the home if it was their preferred place of death. They worked with local healthcare and hospice to ensure people received the help they needed. A staff member also told us that it was important to, "Support family members during these difficult times." Staff were also given an opportunity to review their practice following a death and to get support. A trained nurse practitioner held monthly meetings where staff could share their experiences and feelings about the death of a person to both learn and address any emotional impact on them in their role.

Requires Improvement

Is the service well-led?

Our findings

At the inspection, we identified there was a breach of regulation in respect of people's involvement in care planning and judged that individual care was sometimes lacking. People were not always treated with dignity and respect. The registered manager had started to make some changes to care plans and records to support a more personalised approach. We will check that improvements are made and sustained at our next inspection.

People and relatives knew who the registered manager was and told us the home was well-led. One person said, "I find that the people running [home] take the job seriously. I find them extremely nice and they are keen to help people." Another said, "Top rate, very good she is." A relative told us, "I think she's extremely competent, approachable and fair. She knows what she's doing and her door is always open, plus she knows the residents and knows their families." The registered manager interacted well with people in an open and honest way and allowed time for any interruptions. They promoted a positive culture with the staff and said that they wanted to enable people, their families and staff to be happy at all times. They told us, "I want it to be like a family here."

Staff told us they were happy working at the service and were positive about their role. One carer said, "I look forward to coming to work here, the management and staff are friendly." Another staff member told us they were expected to, "Give the best quality of care that I can."
A relative told us, "The staff are appreciated by the manager and they get good feedback to help them improve." Each month a member of staff can be nominated for the "Employee of the month" award by their colleagues and relatives. The registered manager said this was for "Going over and above" what was expected of them in their care or thoughtfulness.

Staff were involved in the service through regular meetings held every other month. Staff also told us they felt able to contribute their ideas. At the meetings staff were asked for their suggestions about activities and events and resolving any issues, such as lost laundry items and taking holiday. Relevant information, such as recent changes to data protection law, were also discussed. The registered manager said they could share any new practice guidance with staff at these meetings.

People were involved in decision making and giving feedback through monthly resident meetings. One meeting documented some changes to the food and menus in response to people's feedback. Some people had also asked to be able to use the garden more during the warmer weather, and we observed this happened on the day of the inspection. There had been feedback about staff being loud in the corridors at times. This had been raised with staff by the registered manager.

The registered manager said they encouraged relatives to come to see her whenever they visit. One relative, said that they were told "If you have any problem do come and tell us." Another relative also said, "They actively seek and encourage people to give them feedback on aspects of anything." However, there was no formal recording of how the service had responded to feedback from relatives. A Barchester Healthcare survey was also undertaken to measure satisfaction and quality from the perspective of people and their

relatives. There was no information provided on how this feedback was used to improve the service.

The provider had a governance framework in place to check the service quality, staffing and maintenance issues. There was a twice-yearly Quality Improvement Review, where a monitoring visit was done by Barchester Healthcare team. This was broken into domains covering the home environment, medicines, food, health and safety, documentation, lifestyle and finances. The issues that had been identified at the last audit had been actioned. For example, in April 2018, the medicines room had been found unlocked, mattress settings for people on specialist beds were not being checked and the list of people's dietary needs in the kitchen was out of date. The action plan was produced and was signed off with the date that action had been completed. At our inspection, we did not find any concerns in these areas.

There were monthly internal audit visits which checked progress against the action plan, and could identify new issues. In June 2018, the monthly audit found actions including, the ground floor sluice room was dirty, fluid charts were "not consistent", that the kitchenettes required cleaning and dining room chairs needed a deep clean. The checking of progress by managers external to the service ensured that issues identified were not likely to drift but be addressed. There was one relevant action, that was still in progress, which identified that equality and diversity training for staff was not up to date and only a quarter of staff had completed this. The standard for the home was that the staff's understanding was strengthened with at least 90 per cent had completed the online training. The registered manager was aware of the need to ensure staff met this requirement.

In response to a complaint, Barchester Healthcare also undertook an unannounced site visit in June, including during the night. This identified a need to review call bell response times and availability, as two people were found unable to reach their call bell. This was discussed with staff and was to be reviewed on the next night visit. Staff members had also left a floor unattended and it was documented that disciplinary action was taking place. The registered manager said they were now undertaking regular spot checks, including the evenings and night time, every four to six weeks. They said, "It is good for the night staff to see me here, they are part of the team, and for me to check that their practice is what we expect."

There were also quarterly health and safety meetings where the standards relating to the physical environment or with equipment were raised and discussed. At the last meeting changes to the window locks were recorded as well as improvements to level the patio outside to ensure safe access.

Significant events, accidents and safeguarding incidents were reported and one of the managers had submitted notifications to CQC in line with their requirements of registration. The timeliness of reporting had been identified as an area to improve in the provider's last Quality Improvement Plan.

The service had formed positive relationships with external agencies both locally and nationally to improve the care people received. The registered manager is involved with, and attends, the local care home forums supported by the Clinical Commissioning Group. The engagement by the service was mentioned by healthcare professional in their feedback to us. At a recent meeting, they discussed sepsis and received training from the hospital infection control lead. Tandridge Heights is used as a 'hub' for the sepsis training and involved in a scheme to train their nurses to carry out triage for GPs. They have also arranged information days with nurses from the organisations such as Diabetes UK and the Stroke Association. These were open to all local care homes and the community providing an educational talk and information stands to raise awareness and share updated information and practice.

Recently, there had also been a visit from Barchester's Dementia Care Specialist. This was both observation and support to prepare the home for their own internal scheme to improve the experience of people living

with dementia. The registered manager told us they will make improvements with the decoration and environment and put in place life history books for individuals at the home.

People's experience was also enhanced through the service's links with the local community. There was an emphasis on intergenerational activities, for example, the local school children visited. There was a play group held once a week in one of large lounges on the first floor. A relative told us, "My mum always goes to it, she loves it."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not always have a person-centred approach. The language used was focused on tasks needed to be done to the person without reference to their personal strengths or aspirations. Profiles were written in the third person, by staff, not with the person themselves. It was not evident that people were always involved in their care or in reviewing their care.