Rosehill (UK) Limited

Rose Hill Nursing Home

Inspection report

9 Rose Hill
Dorking
Surrey
RH4 2EG

Tel: 01306882622
Website: www.rosehillnursinghome.co.uk

Date of inspection visit:
13 June 2018
18 June 2018

Date of publication:
02 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 13 and 18 June 2018 and was unannounced. There was a registered manager in post, however they were not present on the first day of our inspection. We returned on a second day to obtain some further information from them to complete our 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.

Rose Hill is a care home, registered to provide nursing care and accommodation for up to 35 people. One the day of our inspection there were 24 people at the service, including some people on short term or respite care.

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 Rose Hill, the accommodation is arranged over two floors. A passenger lift provides access to the first floor. Rooms are single occupancy and some have en-suite facilities. There is a large garden to the side and rear of the service.

At our last inspection, in November 2015, the service was then rated as "Good". However, at this inspection we found there were some aspects of the service that needed to be improved.

The premises needed to be made safer for people living with dementia. In particular, all windows were required to be risk assessed and made secure with restrictors that comply with Health and Safety regulations.

There were also parts of the building where cleanliness needed to be addressed, for example in the laundry and sluice rooms that staff used. The physical environment was not decorated to a consistent standard, and in some bedrooms the bedding and carpets looked stained.

Staffing levels were adequate and people's needs were met. However, we were told that staffing levels were based on the numbers of people living at the home. We have made a recommendation to the registered provider to also take into account the needs of people to ensure there are always sufficient staff.

Medicines practice was safe and well administered. We noted a gap in recording and protocols that affected a small number of people. These have been corrected since the inspection.

Whilst people were involved in decisions about their care, staff understanding of the legal basis for consent was limited. We could not find sufficient evidence that the service was acting in line with the legal requirements of the Mental Capacity Act 2005 (MCA). There were gaps in people's records on mental capacity assessments and where decisions were taken in a person's best interests.

People's needs had been assessed to provide effective health and social care. Information about people was stored on a relatively new care management system. People's personalities and needs were known by staff, but some individual care records needed to be updated.

We heard positive feedback about the way the service was managed from staff and relatives, but there were aspects of service governance that needed improvement. The quality assurance system was not effective in reviewing the quality of the service provided. Audits did not identify any actions to mitigate the risks or address the shortfalls we found. Learning from accidents and falls across the service was not developed.

People were looked after by staff who were kind and caring. We heard from relatives who praised the kindness and attention that was shown. However, some staff did not communicate as well as others and appeared task focused. We have made a recommendation to the registered provider that all staff are supported to communicate to a required standard of English.

Staff were trained (apart from in the Mental Capacity Act), supervised and supported to undertake their caring role. The provider had carried out appropriate checks on staff to ensure that they were suitable for their roles.

People were looked after by staff who knew about keeping people safe from abuse. There was evidence that risks to people were assessed. Staff knew people well enough to ensure they took actions based on risks and needs. Staff practiced infection control measures when caring for people. There was a plan in place to deal with emergencies.

People had enough to eat and drink throughout the day and their nutritional needs were being met. Meal time was positive with people enjoying their food. The cook was responsive to individual needs and knew about any dietary risks.

Healthcare professionals and specialists were involved in people's care to monitor and to meet their health needs.

People were supported to undertake daily activities of their choice. There was also a clear programme of events and good use was made of the attractive garden for the benefit of people living at the home.

People could find their way in the building and the premises met the needs of those who lived there. People were enabled to be as independent as possible and their privacy and dignity was maintained by staff.

A complaints process was in place and this was followed. Where concerns by relatives had been raised, these were responded to and changes had been made. The management was accessible and responsive to people.

There was an end of life care plan in place for everyone. The service had established a link with the hospice and had experience of caring for people at the end of their lives.

We received positive feedback about how the service was managed from relatives, staff and visiting

professionals. The staff and managers demonstrated they worked well together and were committed to the people in their care.

People and their relatives were encouraged to give feedback on the care and the service.

The service had some good partnerships with local services in order to support people's healthcare. The registered manager attended local provider forums and was exploring ways the service could improve.

During this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made five recommendations to the registered provider. You can see what action we told the provider to take 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?

Requires Improvement

The service was not always safe.

People were not adequately protected from the environmental risk of falling, or leaving the building unsupervised, by a window.

Staff were aware of infection control measures but cleanliness in some parts of the home needed to be improved.

Staffing levels were adequate. Staff were recruited and managed safely.

People felt safe and staff knew how to identify and report abuse.

People received their medicines safely.

Risk assessments for people were in place and staff were aware of risks.

Is the service effective?

Requires Improvement

The service was not always effective:

People's consent was sought by staff, but the service was not acting in line with the legal requirements of the Mental Capacity Act 2005 (MCA).

The premises met the needs of those who lived there, but some improvements were needed.

People's needs were assessed to provide effective health and social care.

Staff had access to training and were supported and supervised to carry out their role.

People had enough to eat and drink throughout the day and their nutritional needs were being met.

People had their healthcare needs met and referred to a specialist if needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were treated with kindness.

Some staff were limited in their interactions with people and focused on tasks rather than the people.

People's independence was promoted, and their privacy maintained

People, and their relatives, were supported to be involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received care and support that was responsive to their wishes and needs.

People were supported to undertake activities daily.

People's communication needs were identified and understood.

People and their relatives knew how to complain and raise any concerns.

End of life care plans were in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality audits were done but were not sufficiently robust to pick up shortfalls.

The records were not always accurate or up to date.

Learning from accidents, incidents and falls was not always evident.

The management was accessible and relatives and people were encouraged to give feedback.

The service had established links with the local services and networks.

Rose Hill Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 18 June 2018 and was unannounced. The inspection was carried out by 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 service. This included the previous inspection report and notifications since the last inspection. Notifications are changes, events and incidents that the service must inform us about. The provider had completed a Provider Information Return (PIR) in December 2017. This is a form that asks the provider to give some key information about the service, what they do well and any improvements they plan to make. We reviewed the information in the PIR as part of this inspection.

During the inspection we spoke with nine people, four relatives and one visiting friend. Some people could not fully communicate with us due to their condition. During the inspection, we spent time observing interactions between people and the staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We interviewed four of the care staff, the chef, and a nurse. We also spent time with the registered provider, the registered manager and the deputy manager to better understand how the service operated and was managed.

We looked at the care plans for eight people, including personal risk assessments. We checked that what was detailed in these plans matched the support and care that people received. We looked for mental capacity assessments and any applications made to deprive people of their liberty.

We checked whether mandatory policies and procedures were up to date and in place. We reviewed the use of accident and incident forms in the home, checked three staff recruitment files, and the evidence of staff training.

We looked at evidence that regular tests and monitoring of equipment, premises and fire safety in the home was done. We also reviewed any recent internal audits and responses to complaints and feedback, to understand how well the service was being governed and managed.

We later received some feedback from two professionals who regularly visit the home.

Requires Improvement

Is the service safe?

Our findings

There was a potential risk to people's safety due to the lack of assessing and updating of the premises by the registered provider. A high number of people were living with dementia. Window restrictors were being used to ensure that windows could not be fully opened and to prevent a person from falling. We found that three bedrooms did not have these in place at all, and two bedrooms had broken restrictors. With these two rooms there was access to the roof or a fire escape. This meant that a person who was confused could get out and leave the home, or injure themselves. The home was also using old metal chain restrictors in some rooms, which do not meet health and safety standards. In the other rooms, the method used to prevent the window from being opened fully may not be fit for purpose. In September last year, a person living with dementia had left the home via a downstairs window and went missing for a short period. The registered manager told us the person used force to break the old chain. Afterwards it was replaced with an additional metal chain of the same kind. Although the person was brought back safely, and increased staff supervision was put in place, the provider had not risk assessed or upgraded the restrictors on any of their windows.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Safety and Suitability of Premises.

Staff practiced infection control measures when caring for people. We had read in the Provider Information Return (PIR) that this was something the registered manager monitored including the use of personal protective equipment (PPE) and safe disposal of any infected items. One person told us, "They always wear gloves and aprons." A staff member confirmed that they had access to PPE and received training on hygiene and cleanliness. They said, "It is something we are told all the time, not to leave the person's room before we have disposed of any waste in the bag, and removed gloves and apron." We could also see that people's rooms were kept clean. The provider had completed the necessary annual check to ensure the premises were free from Legionnaires Disease.

However, there were some things we saw that required improvement. The sluice rooms were untidy and disorganised and had little space for staff to clean and store items in line with best practice. They also had unlocked doors, which meant that unsafe or unauthorised access may occur. We found that a sink in the downstairs sluice room was marked and dirty and a used glove lay on the floor all day. The sluice upstairs had a clinical bin with a lid that didn't open properly, meaning staff would have to open the lid by hand. We also noticed that unused incontinence pads or sheets were out of their packets in two people's bathrooms. This is not good hygiene practice. In a communal bathroom, there was a bin with no lid and we noticed used gloves in this bin. In addition, the laundry room was not in a clean state that day.

We recommend the registered provider improves and maintains a safe, clean and appropriate environment that facilitates the prevention and control of infections.

Staffing levels were adequate on the day of our visit. However, feedback from people and their relatives was mixed about whether there were sufficient staff working at the home. One relative said, "I have seen them respond immediately" when the call bell was used. A person told us, "There are always carers around….

They are not always quick to come to me, as there are other people who need more help than me." But a visiting friend told us, "The staff are good and work hard. They are sometimes very busy, there may not always be enough. One person also said, "You have to wait an awful long time for them to answer the call bell sometimes."

Whilst we saw staff giving support to people in the lounge that day, a relative told us this was not always the case, and there were records of two falls that were witnessed by a resident in the lounge, rather than by staff. A relative said, "In the afternoon it's fine there's plenty of staff around all of the time, but it's in the mornings they could do with more staff." The nurse told us that staffing levels were based on the numbers of people living at the home. This had just been increased to five care staff and one registered nurse for 24 people. One staff member said, "It's enough now." Another told us, "We work in pairs. Quite a lot of people require two staff with personal care and transfers. It is very busy in the mornings."

We also saw, from staff allocation sheets, that night care staff were asked to, "Wash and dress" some people before they left their shift. A staff member confirmed that night staff had duties to support the day staff. The registered manager said that the night staff finish at 8am, so they have time to help with some early morning care. They only help people to get up early if they wanted this, for example one person starts to get agitated and wants to get out of bed. They also change people who have been incontinent, but who may not wish to get up then. A staff member we spoke to confirmed that the personal care given early morning was based on people's needs and wishes.

We talked to the registered manager about the staffing ratio tool they used. There was no evidence that the needs of people or dependency levels were considered when planning staffing. They said, the tool they used was basic guidance but they, "Would also adjust staffing based on people's needs, or for peak periods. We would be flexible and increase. If staff are struggling they would tell me and I would respond."

We recommend to the registered provider the use and implementation of a staff planning tool that is based on people's needs, risks and dependency levels.

People were being cared for by staff who had been safely recruited. We looked at the practice and process for recruitment and found evidence of appropriate references, identification and the right to work in the UK. Disclosure and Barring System (DBS) checks had been completed. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Several staff had worked there for longer than four years. The owner said that they have had recent difficulties finding the right staff. They have now recruited some staff through an agency on a long-term basis, so they can have consistency in their staff group. A senior carer told us that if staff are unwell, shifts are covered by staff they know and some will come in on their day off.

People felt safe from abuse because of the staff who cared for them. Staff understood their role and responsibilities to report any potential abuse or unsafe practice. One staff member told us, "I would challenge anyone if I saw them doing something wrong, then I would report to the nurse." Another said, "I would report to the manager and record what I've seen." People and their relatives told us they could rely on staff to keep them safe. One person said, "I feel quite safe and content, they're good." A relative said, "Safe? Oh yes. They do most things for him. He seems much happier." We saw that all staff had received mandatory training in safeguarding vulnerable adults and they were expected to keep this updated. People knew there were systems in place to keep them safe. One person said, "They set the alarms and there are codes on the doors. I've got these metal things (bedrails) on the bed because I have fallen." A relative told us, "We have to sign in and out, they are very careful."

People received their medicines safely and from staff who were trained to administer them. The nurses and registered manager had all updated their knowledge in the last 18 months. We observed that the nurse followed good practice when dispensing the medicines. They waited until people had taken their medicines and did not sign the sheet until afterwards. The Medicine Administration Record (MAR) for each person was kept up to date, with known allergies stated, and the person's photograph was on the front. Any changes to prescription information had been signed by two staff members in the record. The medicines were stored safely in a clinical room and a dedicated fridge was provided. The temperature of the room and fridge were being checked and recorded. We saw that the date liquid medicines were opened was written on the bottles, so it was easy to see if they went out of date. Medicines were also being disposed of safely and this was monitored.

In the medicine records, two people did not have an up to date body map, that showed where a prescribed cream or pain patch should be applied. Four people who had 'as required' (PRN) medicine prescribed, for example paracetamol or ventolin, did not have a written plan in place that detailed when they could be given this medicine and any maximum dosage. We brought this to the attention of the deputy manager. We later saw evidence that the body maps were corrected and the PRN protocols were put in place.

People's risks were identified and risk assessments were in use. There were specific assessments completed on each person for their risk of falls, diet and nutrition, skin breakdown and level of dependency in their care plan. We observed that staff were following care plans to meet people's need. For example, in a person's care plan it said, "High risk of falls; ensure person is in an area where they can be observed." We could see that one staff member was in the communal lounge always to support people. A person who was cared for in bed and unable to use their call bell, had hourly checks in place. Their care plan also noted, "Needs to have bedrails with bumpers on" and we saw these were in place. Another person had a hoist in place in their room. Their care plan recorded they were, "Unable to weight bear…. two staff are needed to use hoist, use the large sling."

Staff could tell us of the risks to people, and how they kept people safe. One of the care staff said, "If people are in bed I can make sure the rails and bumpers are in place. If they are at risk of falls, that the mat is in place on floor. I ensure drinks are always available." Another told us, "I would raise the bed when feeding people or they could choke." To avoid accidental trips they said, "I would remove a zimmer frame when not used." We observed staff feeding people who were in bed and saw that they were careful to ensure the person was positioned correctly. A staff member was also able to tell us how they gave a person living with advanced dementia a drink. They said they had received training to deal with the risks of choking. When people went into the garden, staff made sure they were protected from the sun, or had a blanket if needed.

People were kept safe from the risk of fire. There was a plan in place to deal with emergencies. Staff were aware of the action to take in the event of a fire. Fire drills were completed six monthly, with the last one done a month ago. Fire safety equipment was checked regularly. There was evidence of weekly fire alarm tests and monthly fire door and fire extinguisher tests. Most people had a personal evacuation plan (PEEP) in place. This detailed the person's medical condition and any physical constraints and what to do in case of evacuation from the building. However, there were four people who did not have a plan. The registered manager had been on leave and said that these were for people who had recently moved in, or on respite care. One of them had gone home already. They said that plans would be put in place for the others right away.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who 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 capacity to make decisions, any made on their behalf must be done so in their best interests and in the least restrictive way possible.

People were involved, as far as possible, in decisions about their care on a day to day basis. We saw and heard staff asked for people's consent before they did something, for example when helping them with meals, or when supporting them to mobilise. One staff member said after lunch, "(Name), are you ready to go back to the lounge now?" Another told us how, "We always ask them, even if they may not always understand." Another said, "We talk to them, to reassure and explain what will happen."

However, staff understanding of the legal basis for consent was limited and the service was not acting in line with the legal requirements of the MCA. Some decisions had been made on behalf of a person without a documented mental capacity assessment or a best interests decision. This meant we could not be sure decisions were made lawfully, or were the least restrictive for that person. For example, two people's care plans stated they needed a lap belt when in a chair or wheelchair to ensure their safety. There was no evidence of consent being given, or that a mental capacity assessment was done and why this decision was taken in their best interests. A third person, who was on respite care, had a comment that said, "Unable to make own decisions, severe cognitive impairment." However, there was no evidence that any capacity assessment had been completed to allow and inform staff in making decisions on their behalf.

A person 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). Some people were deprived of their liberty without an assessment that this was needed. Several people at the home had restrictions in place, for their safety. For example, bed rails are a form of restriction, and we saw that some people had given their consent for these in their care plans. However, there were DoLS applications made for six people who were restricted with bed rails, or were under continuous supervision and not free to leave the home. For none of these could we find the necessary evidence that they lacked mental capacity and that the restrictions were in their best interests. One person did have the DoLS granted through the courts, and in this case, we could see that all the decision-making evidence was in place. This, however, had been completed by another agency.

We asked some staff about their understanding of the MCA and those we spoke were not aware of the principles or the legal framework. The training records showed that only two staff had completed a module on this, both in 2018. We asked the registered manager on their return from leave about what we had found. They acknowledged that there was a gap in the training. They also said the service had transferred over to the electronic records in 2017 and best interest's decisions made before would be in paper files. However, they could not show us any further evidence on paper. The electronic care plans and records have a section to record mental capacity decisions but these had not yet been used.

Failure to act in accordance with the Mental Capacity Act 2005 and code of practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The building and premises met the needs of those who lived there. There was a spacious and well-kept garden which was accessible and many people wanted to be outside that day. The corridors displayed colourful pictures and photographs of the people enjoying activities. This meant that people could recognise where they were more easily in the building. People, who were more independent, appeared to find their way around easily. People had call bells in their rooms to get help when needed. There were two lifts which enabled people to access the communal areas on the ground floor. On the day we visited, the main lift was not working and needed repair. The service had tried to reduce any negative impact on people's lives, for example by moving one or two people to a different room. After the inspection we heard that the lift was back in working order. In the last PIR, the registered provider had said one of their aims was to, "Continue to maintain the home in a good state of repair and decoration." They also told us at the inspection that one of the bedrooms had been decorated recently.

However, the physical environment was not decorated to a consistent standard. Although the standard of decoration and repair did not pose a risk to people, we saw aspects of the home and people's living conditions that needed improvement. In six of the bedrooms, we noticed stains on the sheets and bedding and dirty carpets. Some bedrooms looked plain and impersonal. In one communal bathroom the light cord was dirty with no end on it and there was rust around the bath seat. Also, on the ground floor, we saw a person being moved in a wheeled armchair, the arms of which were worn, with the stuffing exposed.

We recommend to the registered provider that improvements are made to the environment and equipment at the home which will have a positive impact on the well-being of people.

People's needs had been assessed to provide effective health and social care. Information about people was stored on a relatively new care management system. This detailed people's needs under 14 different care plans including, their level of cognition, nutritional needs, their medical conditions, their mobility and personal care and their social and emotional needs. The information was reviewed monthly, and the staff had access to the information via electronic tablets.

People were cared for by staff who had good access to training, apart from regarding MCA training above. A relative said about the staff, "By and large, they're pretty good" and another said, "They seem to be very competent." The training record was up to date and showed that mandatory skills training had been completed by the current staff group in the past two years. For example, on safeguarding, moving and handling, infection control, first aid, food hygiene, and fire safety. In addition, most staff had completed dementia awareness training which was very relevant.

Staff training was mostly completed through an e-learning platform. The deputy manager said they could complete modules in the office or given time to do this at home. One staff member told us, "We can do one hour each week online. There is always a test and we have to pass." Staff appeared to like the e-learning system as they could complete additional modules when they had time. One of the care staff said they had recently completed the training on skin care. From our observations of staff with people we could see there was an awareness of the needs of people living with dementia. For example, we saw staff explaining to people what was happening before undertaking a task and allowing the person plenty of time. There was a good system in place to record the training that staff had completed and to identify when training needed to be repeated. There was a notice to staff about mandatory training that had to be scheduled and done in the next two to three months.

Staff were appropriately supported and supervised to carry out their role. One said, "There is good communication. The nurse will meet with us daily and update us on any changes with a person." Any new staff were given a period of induction which included learning on the job. A senior team member said, "They have to get to know the people, but they would always shadow a senior carer first, until they know what to do themselves, the new staff do not work alone." Another staff member they had supervision with their manager every three months, "To check how we are getting on and that our training is up to date." The Deputy Manager confirmed that this was happening and we later saw evidence that staff supervision meetings were taking place.

Staff worked together well and as a team. In the lounge, we observed staff meeting people's needs and checking with one another on who was needing assistance. One staff member explained how in the morning they work in pairs, as several people needed two carers to get up. Although they had their work allocated by rooms, they would also help each other depending on the needs of people. Another staff member told us, "There is always one of us in the lounge. We work together." They also said, "The night staff report to the nurse anything they have noticed, for example if a person was in pain, so we can pick this up in the day as well." There were daily handovers with the nurses and staff were updated about any changes with people's condition or behaviour.

People had enough to eat and drink throughout the day and their nutritional needs were being met. The nutritional and fluid intake for people living with dementia was monitored and recorded. People and relatives told us they liked the food. One relative said, "The food is very good. He is eating better, and he looks healthier since he arrived here." Another said, "The food is excellent, it really is." A person told us they were given a choice of what to eat, "Supper's always beautiful…. They come around in the evening to see what we want for the next day." We could see people being given drinks and snacks throughout the day. At lunch time, the tables were attractively set out with table cloths, paper serviettes and cutlery. People were offered a choice of two drinks and two different meals. There was enough staff to assist people in the dining room. Staff encouraged people to do as much for themselves as they were able. They encouraged some people to eat slowly and there was a relaxed atmosphere. A couple of people chose to eat by themselves in their own room and three people needed assistance to eat in bed with a pureed meal. We observed staff feeding people in bed. They were patient and persevered to ensure the person took in sufficient food and drink.

The chef was very aware of people's dietary requirements and the needs of people living with dementia. They told us, as some people could not express themselves, they look at any food that is refused and adjust for another option. They said, "I query what is happening with that person and find out what works. Sometimes it is variable." They also said that apart from the two choices of meal on offer, they also provided a vegetarian or fish option, and would make other meals to ensure people did eat something. The pureed meals were the same food as the menu as far as possible and choices were also available. The chef was aware of the needs of the four people with diabetes, and whether it was diet controlled or not. However, the notice in the kitchen only mentioned one person. They agreed to update this.

We had seen that one person, who was diabetic, was eating the strawberry gateaux at lunch. Another had chocolate cake given to them by one of the care staff, although it was taken away by another. Not all staff were aware of the restricted diets. From talking with the nurse, we were satisfied that there was effective and routine monitoring of people's blood sugar levels and that individual risks were recorded in their care plans. Two of the people were insulin dependent and their levels were checked twice a day. One person, whose condition was diet controlled had a daily check. The chef said this person had the capacity to choose if they wanted a small piece of gateaux. One of the care staff told us they knew how to recognise if a person with diabetes became unwell. "We only give (name) plain biscuits and they have the diabetic ice cream. If I

noticed any change in them, their breathing or colour of their face, or sweating, I would get the nurse."

We recommend to the registered provider that all staff are made aware of any person with diabetes, and information is clearly available about their dietary needs.

People had their health care needs met. Different healthcare professionals and specialists had been involved when needed to address needs. People had access to a physiotherapist who visited each week. We noted that a person had been referred to the doctor with concerns about a urinary tract infection. One person who had, "severe cognitive impairment" and hallucinations had been referred and seen by a specialist psychiatric nurse. One relative told us, "As far as we can see he's getting much more care here." Another relative had fed back that the service was, "Extremely swift in getting assistance when needed attention and hospital." A healthcare specialist who visited the home said the staff were, "Organised and efficient," ensuring people who needed their service received it.

Requires Improvement

Is the service caring?

Our findings

People were often spoken to in a respectful manner. We heard one staff member saying, "Can I take it sir? Thank you, sir," to a person as they took their plates away after lunch. One person told us, "Staff are never rude, always respectful." Another person said, "They look after me very well. They all know your name – that's another thing." Throughout the day, we observed staff asking people what they wanted, and checking with them before they took any action.

However, some staff were less able to communicate and respond to people's needs than others. A relative told us, "They are caring staff, but it would be nice to see some carers interact more." One person also said, "They don't noticeably stop and talk." Some don't speak a lot of basic English. Most carers are 'in tune' but others are not so and I don't think that they understand half of what I say."

We also observed that some staff were limited in their interactions with people and focused on a task rather than the person. For example, one staff member brought a dessert at lunch to a person in their room. They put it down, without saying anything to the person other than the person's name, and went away. We observed a person who was nursed in bed and unable to speak, being helped to eat. The staff member asked them, "Can you open your mouth." And then repeated, "Open your mouth." The person did not seem to want to eat. Another staff member came in to assist, and gently helped the person to sit up a little more, talking with them and asked if they were comfortable. We saw that the person was more willing to take the food being offered. This indicated that the communication skills of staff had a direct impact on the care of people and their experiences.

We recommend that the registered provider sets a required standard of spoken English and communication for staff and ensures they can respond to people individually when meeting their needs.

People were treated with kindness by caring staff. In the lounge we observed that staff were attentive to people. One person was brought into the room in a wheelchair and helped into an armchair. The staff member asked them, "Are you feeling cold" and "Do you need anything". The person did not respond. The staff member went to get a small blanket and asked again, showing the person the blanket, which the person reached out for. Another one of the care staff came to take a person to the hairdresser. They knelt to the person's eye level to tell them what was happening, and asked them what they needed to take with them. "Do you want your bag…I can bring you your drink." We also observed one of the nurses showing compassion when giving medicines to a person cared for in bed. The nurse explained to the person what was going to happen, for example before lifting the bed riser to a sitting position. Before giving the person a drink and their medicines, asked if they were in pain. At lunch, we saw staff helping people with a calm and caring approach when they started to choke and were eating too fast.

One person told us how the care staff had supported them. "I had a vivid dream last night which really upset me, and the night staff were really good. They spent time with me and calmed me down and settled me back in bed." Another person told us of their experience. "I hated the idea of going into a home but what I do admire is that I'm quite rude at times, but they have been brilliant, very supportive through a lot of

hurdles."

A relative said, "They are really caring, a lovely bunch of staff." Another relative also told us, "They are very well cared for." We read further positive feedback from relatives on many thank you cards displayed in the hallway. Staff were thanked for their "Kindness and patience" and "For your compassionate care." One relative had given feedback that said, "Staff are always courteous and giving of their time." A professional, who visited the home regularly, also told us that people were treated with compassion and always spoken to kindly by staff.

People's independence was promoted. A person's care plan said, "(Name) uses the lift independently, gets himself ready and will use the call bell if needs assistance." We saw this person, moving around the home independently and returning to his room when they wished.
One person told us, "I want to be independent. I can manage personal care with a little help. Some carers want to do things for me, but they let me do my own thing which I like." At lunch time, we observed that staff were encouraging people to do as much for themselves as they were able. People were never rushed and able to eat and leave the table at their own pace.

People told us that their privacy was maintained by staff. One person said, "The door is always closed, and I'm given privacy." A member of staff said, they maintained people's dignity, "By closing curtains and doors and always explaining to people what you need to do and why." We were also informed that there was always one male and one female carer available to accommodate for people's wishes when receiving personal care.

People, and their relatives, were supported to be involved in decisions about their care. One relative, said that the service was, "Very helpful to us. If there's a problem they phone or email me." A person who was living with dementia was wanting to exercise their decision to get up and walk about by themselves. They were unsteady and needed supervision. We observed staff throughout the day enabling the person to walk about and providing reassurances without curtailing their freedom. One of the staff explained, that the person also did not want to wear an incontinence pad at night. They said, "We respect his decision and do what he wants, even though it could be difficult."

On the wall of one of the corridors was a reminder to staff of the Dignity Code and ten points of the Dignity Challenge which characterised a high-quality service. The Challenge reminded staff to "Enable people to maintain the maximum level of independence, choice and control." And to "Engage with family members." One family member we spoke to said, "They are really good at communicating when (name) has a problem. If it's really important they call or email me but if it can wait then they tell me when I come in." The registered manager said that they will welcome family and friends at any time of day.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their wishes and needs. The deputy manager said when a person first moved in they ask them, or their family, about their likes and dislikes, their communication needs, and how to best care for them. The care plans covered all aspects of a person's life, including their background and personality. Although we did see some inconsistencies in the care plan recording, these did not adversely affect the responsive care people received as the staff knew people well enough to meet their needs. One relative confirmed, "I am very involved in (name) care plan and it was reviewed with us the other day." People told us their wishes were responded to. For example, we met two people who wished to eat their meals in their room and they were supported to do so.

People were supported to undertake an activity each day, if they wished. The activities co-ordinator said that they, "Try to do whatever each person likes. There is a programme for some group activity in the afternoon and in the morning, it is one to one interaction which can be personalised." We observed how two people were helped to go for a walk. This was a regular activity. A staff member said, "Are you ready for your walk now." One person told us, "Fresh air is my medicine, but I normally walk up and down the corridor for my exercise. They could walk outside with assistance and walking aids. With other people, the one to one time was for reading/looking at newspapers. The co-ordinator found time to manicure and prepare one person's nails ready for varnish the next day. There was a visiting hairdresser that day and a few people were escorted to have their hair done. In the lounge later, some people played a word game, some exercised with a balloon and listened to music. One relative said, "They have a variety of activities…crosswords, music, slow yoga, visiting dogs." A person told us, "With the activities I do what I can, and join in with most things."

We also heard about how the service arranged events and regular outings, which are supported by other care staff. People's birthdays were celebrated with a cake and tea party if this was what the person liked. Whenever possible they hold events in the garden and are fortunate to have a very well-kept beautiful garden, of different areas. We observed how interactive the activity co-ordinator was with people, giving individual care and time to each person. A relative said, "They only have one activity person…. she's like `gold dust', she's incredible." However, they also said there, "Was not much happening," when that member of staff was on leave or not available. People's religious and spiritual needs were being met with visiting clergy and leaders from local places of worship. One person said, "The priest comes fortnightly, and I always like to attend."

Each person's room had a photograph of them on the door as well as their name. Beneath this there was brief information about them, for example what they enjoyed and who their family were. This meant that all staff had some important individualised information about the person if they were new to them. Some rooms were homely and personalised with pictures, photographs and things of personal interest. One relative told us, "The handyman made the room really personalised and homely. He put pictures up on the walls where (name) wanted them."

People's communication needs were identified and understood. For example, one person was not able to communicate verbally so we were told that staff needed to observe them and read their expression and

other non-verbal signs to assess their wishes and whether they were happy and comfortable. There were pictures of meals used for the days menu as well as words, to support people living with dementia. The days date was also on display in the lounge. One person who was visually impaired was helped at lunch time. A staff member spent time chatting with the person, describing the dining room, who was there, and the dinner that they were eating. Another person who was deaf required a, "Special hearing aid." We noticed that they had been supported to use this during the day.

Relatives and people, we spoke to felt able to complain and raise any concerns. One relative told us they could, "Speak with the manager" about any concerns. One relative told us, "Yes, she's a good manager and she always makes time for me and does listen to me." Another said, "I've met the manager and the owners. They are helpful, available and pleasant." A person living at the home said, "We see the manager all the time." This demonstrated that management was accessible and responsive to people.

There was a complaints process in place. Three formal complaints had been dealt with since the last inspection. One of these was in relation to the cleanliness of a person's room and the staff's failure to have their relative ready for a trip out. The registered manager had completed a full response and addressed the issues. Another complaint was relating to a financial matter. This had not yet been resolved but there was a good record in the log of progress in relation to the complaint detailing what had been tried and who else was involved. We also learnt of an informal complaint about the food from a visiting friend. They said that, "This has all improved now."

The service had experience of caring for people at the end of their life, but there had not had been a recent death. One staff member told us how they had cared for a person towards the end of their life. "I looked after their oral care and made the person comfortable at all times. The family came every day and we talked to them about this person's wishes. The GP was here when needed too." There was an end of life care plan in place for everyone, although some of the information in these was limited. For example, one person's plan said that their, "Family will make decisions". Another said "(Name) and family have no plans." One person with the mental capacity to decide, had provided information about their wish to be resuscitated and have full health treatment to the end. In this case, their wishes about what would happen to them were well documented. The provider told us that they encouraged relatives to spend as much quality time with their loved one, as they wish, in the last weeks and days at end of life. They always attended funerals to show respect and supported families in their bereavement.

Requires Improvement

Is the service well-led?

Our findings

People gave us positive feedback about how the service was managed. One person said, "It's very well run and there are no problems." Another said, "We see the manager all the time." Staff also told us that they respected and liked the registered manager. One said, "We are treated well and it's friendly here. I respect her." Staff thought they were well managed and they had guidance and support. One staff member said, "We are reminded what we need to do." Another said, "We have a supportive manager, they are very good, and they will tell us if something is wrong."

In the absence of the registered manager on the first day of our inspection, senior staff were helpful, able to respond to our requests and dealt calmly with the demands of an inspection. This demonstrated good team working and knowledge of the care delivered. The registered manager praised, saying, "Team work is very good. We are open to new ideas and there is a committed staff group." The registered provider told us that the philosophy of the service is all about the, "The good welfare of the people who live here."

Despite this positive culture and comments, we found that aspects of the service needed improvement and legal requirements were not met. These shortfalls have been described in the Safe and Effective domains. There was a system in place to quality monitor and review the delivery of care. For example, there were audits carried out in May and January 2018 which covered clinical issues such as pressure sores and medicines, care plans, nutrition, continence, infection control, and restraint. However, we noted that these audits were not effective in identifying the shortfalls and there was no evidence of any actions taken as a result. Under infection control, the audit found the service was clean and in a good state of repair, which we did not see in all areas on our visit. In addition, the last audit stated there were no restraints in use apart from a lap belt for one person, but there were two people recorded as needing lap belts, as well as several people needing bed rails. It also said that all windows at first floor level and above had window restrictors, but we did not find this to be the case on our visit. The 'monthly' window restrictor check had not been done since September 2017.

Whilst accidents and falls in the home were recorded, there was no formal review of these, or any analysis which may prevent similar incidents. In the accident log, we saw that two-people had several unwitnessed falls in the last three months, though no injury, or a very minor injury, was sustained. Two other people had been found on the floor in their room, although also unhurt. Another fall had occurred in the lounge when staff were present but they had not seen how this happen. There were people at the home who were at risk of falls, due to physical frailty or their cognitive impairment. The pattern of falls across the home was not assessed to see whether there were things that could have been done to prevent further falls. We asked the registered manager about this and they said the risks were addressed individually, and in people's care plans.

Some people's care plans were inconsistent or inaccurate and this also had not been addressed following monthly reviews or audits. For example, one person had bedrails in place, yet their care plan said, "Doesn't need bed rails up when in bed." Another care plan we looked at, was inaccurate and said the person was, "non-mobile", when we could see this person was walking about the home with staff supervision. The

person's falls risk assessment also came out as, "Low risk", whilst the care plan said, "At risk of falls due to physical weakness." We had asked the deputy manager about this, and they agreed that records were not consistent and the risk assessment would be updated. The staff were aware of the risks for this person, and we could see that they took action, but there were inconsistencies in maintaining records.

Some information on plans was more robust than others. For example, one person's behaviour care plan said, "Can be physically and verbally aggressive at times. Get support from his sister if staff not able to encourage him to shower." It also noted that the person wanted assistance from a male staff member only. It was not clear what the role of the sister was, and when they would get involved. The deputy manager was aware there was more work to do on the care plans but said that staff were always updated daily at handover on managing people's needs and wishes.

The service had policies in place, for example, for safeguarding, fire safety and evacuation, health and safety, but most of these were dated 2015 and needed review. We did not see a policy that covered the Mental Capacity Act and any implementation of the associated code of practice.

Failure to assess, monitor and improve the quality and safety of the service, not identifying and mitigating risks and failing to maintain accurate, contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We reminded the registered manager that as their main lift had stopped working the week before, this was a notifiable event affecting their service. They sent the notification in to us the next day. We did have evidence that other notifications had been sent to us as required.

The provider had ensured a fire safety assessment was done in the last year. In July 2016 the fire brigade had made an assessment and some recommendations. We saw evidence that these had been acted on, for example improvements to fire doors and the laundry area where there was a risk due to smoke inhalation. The provider had in place maintenance contracts for equipment such as baths and hoists and slings. These were checked and serviced every six months and there was evidence that it had been done in April 2018. There was a new service contract in place to maintain and repair all the profiling beds and ensure alarms for the pressure relieving mattresses were working. All electrical equipment in the home, including kitchen equipment, had been checked within the last two months by a professional electrician.

People and relatives were encouraged to give their views on the service. The registered manager described their approach as an, "Open door policy," in that people and relatives could come and discuss anything with them at any time. The PIR said that the service welcomed feedback and wanted to develop their, "Ongoing monitoring of feedback from families and residents…identifying with them ways and means of further improving." An annual questionnaire was sent to relatives. The most recent one was underway when we inspected, but we could see the results and outcomes from 2017. There had been positive comments about the care and the staff team. There had been a concern about the laundry and items of clothing going missing and damage to some clothes. This had been addressed by ensuring staff were aware and using the right cycles for washing clothes. A two-month programme of activities was also organised and more meal choices offered following feedback from relatives.

Staff meetings were also held every quarter with the registered provider and the registered manager. At the last meeting, in April 2018, we saw that staff were reminded of infection control procedures, to complete this training, and to ensure people's wheelchairs were kept clean. They were also told that everyone needed to

speak English in front of people and relatives. The involvement of staff in the meeting seemed limited, although staff we spoke to valued the meetings. One staff member said, "The meetings are useful for going over things we all need to remember and help new people to be welcomed." They could tell us what was discussed and what was expected of them.

The staff were proud of their established links with the local services, including an optician and foot care specialist, the local hospice and palliative care team. One professional told us that the management was always helpful and the staff had developed good relationships with people and visitors. The registered manager had plans to support staff to become Dementia Champions, gaining a better understanding of the individual and to promote person centred care. The service was a member of the Surrey Care Association and the registered manager attended relevant network meetings. They were keen to work with them on innovations that improved the care and the experience of people living with dementia, and reduced any unnecessary admissions to hospital.

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 11 HSCA RA Regulations 2014 Need for consent No evidence of mental capacity assessments before making decisions in person's best interest's or prior to DoLS application. Training for staff lacking.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Window restrictors not meeting H&SE standards. Three rooms no restrictors, 2 with old/not fit for purpose and 2 broken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management quality audits not conducted robustly to pick up shortfalls. Issues in SAFE domain not noted. Record keeping in care plans inconsistent.