Carebase (Guildford) Limited

# Queen Elizabeth Park

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Outstanding |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This inspection took place on 20 December 2017 and was unannounced. Our last inspection was in November 2015 where we rated the service as 'Good'.

Queen Elizabeth Park is a nursing home providing support to a maximum of 77 older people. People living at the service had physical disabilities, long term medical conditions and many people were living with dementia. Care was provided across three floors in a purpose-built building.

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

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

Staff were committed to improving people's lives and they found innovative ways to do so. The provider found creative ways to encourage people to have fun and engage in activities they would enjoy. Care was planned and delivered in a person centred way and technology was utilised to achieve outcomes for people. Projects were undertaken in areas such as exercise and the provider built strong links with the local community which people benefitted from. These interventions had seen people develop confidence and skills. Staff understood the importance of promoting people's independence and care was planned in a way that helped them to achieve this. Where people received end of life care, this was delivered sensitively and in line with best practice.

People received food that they liked and their dietary needs were met. People's care plans were person-centred and reflected their needs and preferences. Risk assessments identified and managed risks people faced. Where clinical needs were identified, these were met by competent clinical staff. People's medicines were administered in line with best practice and people had regular support from healthcare professionals, who worked alongside care staff to ensure people's health was maintained. There were effective systems in place to manage the risk of the spread of infection and we found the home environment to be clean and staff were knowledgeable in this area.

Where accidents or incidents occurred, staff responded appropriately. Staff took actions to ensure that people were safe following incidents such as falls or illness. Staff understood how to respond if they suspected abuse had occurred and we saw evidence of them doing so. The provider analysed accidents and incidents as well as clinical needs and risks. Where patterns or trends were identified, appropriate actions to reduce risks were identified and implemented by staff.

People were supported by respectful staff that they got along well with. Staff had a good understanding of people's needs and we observed pleasant interactions taking place during our inspection. Staff routinely involved people in choices about their care and the provider had systems in place to ensure that people could give feedback and make decisions wherever appropriate. The provider carried out a regular survey and a clear complaints procedure was in place and was known to people.

There were appropriate numbers of trained staff to meet people's needs. Clinical staff got the support they needed to remain up to date with current practice. Staff received training to support them in their roles and had regular contact with their line managers. Regular meetings took place to involve staff in the running of the home and staff felt supported by the management.

Regular checks were carried out on the quality of the care that people received. The provider had a robust regime of audits in place that identified improvements which were then implemented by staff. People's records were up to date and regularly audited. The home environment had a number of checks in place to ensure its health and safety. Equipment and procedures were in place to keep people safe in the event of a fire or an emergency.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service remains Good.

Risks to people were routinely assessed and plans were identified to keep people safe. Staff responded appropriately to any accidents or incidents and understood their roles in safeguarding people from abuse.

People's medicines were managed and administered safely. The provider had robust systems in place to manage the risk of the spread of infections.

There were sufficient numbers of staff to meet people's needs. The provider carried out appropriate checks to ensure that staff were suitable for their roles.

People lived in a safe environment and the provider had plans in place to keep people safe in the event of an emergency.

### Is the service effective?

Good

The service remains Good.

People were supported by staff that were trained to carry out their roles. Clinical staff were given the support that they needed to maintain and develop their professional competencies.

Staff worked alongside healthcare professionals to meet people's needs. People received a thorough assessment that covered all clinical needs when they came to live at the service.

People liked the food that was on offer and the provider ensured that people's dietary needs were met.

Staff asked for consent from people and followed the correct legal process where people were unable to consent.

### Is the service caring?

Good

The service remains Good.

People were supported by kind and caring staff that knew them

well.

Staff routinely involved people in their care. People were supported to make choices and staff promoted people's independence when providing care.

People's privacy and dignity was respected by staff.

## Is the service responsive?

**Outstanding** ☆

The service was exceptionally responsive.

The provider found creative ways to engage people in meaningful activities that improved their lives. People took part in activities, parties and outings that they enjoyed and that achieved positive outcomes for them.

Care was planned in a person-centred way, in line with people's preferences and needs. Regular reviews took place to ensure care was meeting people's needs. People who were receiving care at the end of their lives benefitted from a holistic and sensitive care service, in line with best practice.

There was a clear complaints policy in place and complaints were investigated and responded to appropriately.

## Is the service well-led?

**Good**

The service remains Good.

People benefitted from the provider's links with the local community.

Regular checks and audits were carried out to assure the quality of the care that people received. The provider regularly sought feedback from people, relatives and stakeholders.

The provider kept accurate and up to date records. Notifications of important and significant events were submitted to CQC in a timely manner.

# Queen Elizabeth Park

**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 20 December 2017 and was unannounced.

The inspection was carried out by three inspectors, a specialist advisor in nursing care 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 gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with eight people, six relatives and a visiting GP. We spoke with the registered manager, the regional manager, three nurses, six care staff, a lifestyle co-ordinator, a housekeeper and the kitchen manager. We read care plans for seven people and looked at the medicines records for ten people. We reviewed the records of accidents and incidents, complaints and safeguarding. We looked at mental capacity assessments and applications to deprive people of their liberty. We reviewed audits, surveys and looked at evidence of activities taking place at the home.

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

Good

# Is the service safe?

## Our findings

People told us that they felt safe living at the home. One person said, "Oh yes, I feel safe because there's always someone around, always someone to help me." Another person said, "Yes, very safe. There's always someone to help you if there's a problem anywhere. It's the next best thing to home." A relative told us, "When [person] came in he was covered in pressure sores but they sorted all that out. I think [person]'s very safe and well looked after."

Risks to people were managed effectively. The provider routinely assessed risks that people may face and identified appropriate plans to keep people safe. Care records contained risk assessments in areas such as nutrition, falls and pressure care. Staff implemented plans which were reviewed each month to ensure that they were working. For example, one person was unable to weight bear and spent a lot of time sitting or in bed. Due to this, their risk assessment highlighted that they were at increased risk of pressure sores. To reduce the risk, the person had an airflow mattress and cushion to alleviate pressure on vulnerable areas. Staff checked the person's skin daily for any signs of skin breakdown and applied creams. There was a clear plan to support the person to move, using equipment to reduce friction on the skin. We also noted that there had been very few pressure sores at the home. People were enabled to develop skills and independence. A risk assessment was in place for one person to enable them to use the bus and go to the shop independently. People had clear risk assessments in place to manage risks relating to dementia or falls. During the day we observed staff supporting people to walk patiently, providing gentle encouragement where necessary. In communal areas, people were observed with any walking aids close to them so that they could easily mobilise safely and independently if they wished.

Staff responded appropriately to accidents or incidents. The provider kept a record of any accidents or incidents that occurred and documented the actions taken in response to them. The records showed that staff acted appropriately to minimise the risk of the same incident occurring again. The provider analysed accidents and incidents each month and produced a report that identified any trends such as if people were falling regularly in a particular part of the home or at a certain time of day. An analysis was also carried out on people's weights, skin integrity and infections each month. This helped to reduce a repeat of these falls. The provider noted that one person had fallen three times in one month and their risk assessment was reviewed after each fall. The registered manager met with staff and a plan was developed. Staff noted changes to the person's behaviour that increased the risk of them falling, so the person's community psychiatric nurse (CPN) was contacted. Staff increased their supervision of this person to reduce the risk of further falls and recording any changes in behaviour on a behaviour chart. This showed that the provider had systems in place to learn lessons from, and respond to, repeated risks.

People were supported by staff that understood their roles in safeguarding them from abuse. Staff had been trained in how to identify potential abuse and knew what to do if they had any concerns. Staff knew how to escalate concerns within the organisation and were also aware of relevant agencies they could contact. Staff told us they would contact the local authority safeguarding team, police or CQC if necessary. Records showed that staff had recently raised concerns regarding one person appropriately and this was being dealt with by the local authority and the provider was supporting with this. Safeguarding information was also

available to people in a clear and accessible format. A guide was provided for people with pictures and clear details of how to raise a complaint with the provider or how to contact the safeguarding team directly. After the inspection, the provider notified CQC of a safeguarding concern that had been raised by a relative. At the time of publication, the provider was taking appropriate action to respond to and investigate the concern, alongside the safeguarding team.

People were protected against the risk of the spread of infection. The home environment was clean with no malodours. The provider recruited cleaning staff and we observed them cleaning throughout the day. The house keeper told us that they monitored the cleaning schedules on a weekly basis to ensure all cleaning has been completed. Cleaning staff had clear routines each day that ensured every area of the home was cleaned frequently. Staff had been trained in good practice in infection control and we observed them adhering to this during the inspection. Staff were observed washing their hands before and after providing support to people. Staff told us that they had access to the personal protective equipment (PPE) that they needed, such as gloves and aprons. We observed staff using PPE appropriately throughout the day. For example, when sorting laundry, a staff member used disposable gloves and removed them when they had finished the task. Later in the day, staff were observed using aprons when supporting people to eat. The provider audited infection control every month and the audits were robust and provided an important check on cleanliness and staff practice.

People received their medicines safely. Medicines were administered by trained nurses whose competency had been assessed. Medicines training was provided to staff and refreshed every year. Staff told us that the medicines training was clear and gave them confidence when it came to administering medicines. We observed medicines being administered and best practice was followed. Staff checked medicines against the people's medicine administration records (MARs) to ensure they were administering the correct medicines. MARs had a clear photograph of people and staff checked these to ensure they were administering medicines to the correct person. After administering people's medicines, staff recorded that they had done so on the MAR. There had not been any recent medicines errors at the time of our inspection which showed that staff were competent in medicine administration.

People's records contained evidence of medicine reviews and regular contact with the GP. During the inspection, we observed staff discussing a person's medicines with their GP. The GP told us that staff gave them the right information to make clinical decisions about people's medicines. A nurse at the home was a trained prescriber and was able to prescribe some medicines to people. The provider gave us examples where this had meant people could access the treatment that they needed without requiring GP consultation or hospital admission. The provider had a good relationship with the pharmacist and we saw evidence of the pharmacist carrying out audits at the home as well as providing professional advice where necessary. A recent compliment letter from the pharmacist praised the staff at the home, it said, 'Whenever we've needed to query a medication or care plan for a service user staff, they make themselves available and are proficient in communicating any medicines management issues with us efficiently and promptly.'

MAR records were up to date with no gaps. Where people had not received medicines, for example where they had been in hospital, staff recorded this accurately. People who received 'as required' (PRN) medicines had clear protocols in place to guide staff on when to administer them. For example, one person was living with dementia and was prescribed PRN paracetamol. A protocol outlined that staff should look for signs of discomfort or distress, as the person could not verbally express if they were in pain. The provider regularly audited medicines records to ensure they were up to date.

There were sufficient numbers of staff present to safely meet people's needs. Staffing numbers were calculated based on the needs of people and rotas demonstrated that the provider maintained their

calculated staffing numbers. Staff were observed responding to people promptly and spending time with people in communal areas. A number of people required the support of two staff due to being cared for in bed. We observed that these people were attended to by two staff, as outlined in their risk assessments.

People were protected from being supported by unsuitable staff. The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff files contained evidence of references, work history, proof of right to work in the UK and a Disclosure & Barring Service (DBS) check. This is used to identify potential staff who would not be appropriate to work within social care.

People lived in a safe environment. Regular checks were undertaken on the health and safety of the home environment. The provider employed maintenance staff and records showed that they swiftly actioned any necessary repairs. The risk of fire had been assessed and fire safety equipment was in place for use in the event of an emergency. The provider carried out regular checks on the effectiveness of their fire equipment and procedures. There was a plan in place to ensure that people's care could continue in the event of an emergency.

Good

# Is the service effective?

## Our findings

People told us that they were supported by staff that were competent in their roles. One person said, "I think they [staff] are very professional; they are focused on the patients having a good quality of life." Another person said, "They are very well trained." A relative told us, "I think they're very kind and well trained, very patient with [person]."

Staff told us that they had received appropriate training to give them confidence in their roles. One staff member said, "Most of my training is up to date and I did a lot at induction." The provider had their own induction programme which all new staff attended. This was called a 'Day School' and involved new staff attending an induction at a hotel with new recruits from the provider's locations in the region. The induction covered important areas such as safeguarding, health and safety and fire safety. Staff also spent time at the home shadowing an experienced member of staff to prepare them for working with people independently. The provider kept a record of all training and ensured training in mandatory areas such as infection control and medicines was regularly refreshed. Staff also received training specific to the needs of the people that they supported. For example, staff supported people with Parkinson's and records showed they had attended training in this area. Staff were also trained in how to support people with needs relating to dementia and moving and handling. Staff completed e-learning online and they told us that if they did this at home, the provider reimbursed them for 1.5 hours work.

Clinical staff had the right support to maintain their professional competencies. Nursing staff were kept up to date with ongoing mandatory supervision. The provider ran workshops for clinical staff that kept them up to date with current practice in clinical procedures such as catheters and venepuncture (procedures for inserting a needle into a vein). The provider kept a record of nurses' registrations with the Nursing and Midwifery Council and ensured that supervisions and training were carried out in line with their requirements for revalidation.

Staff had regular support from their line managers. Staff had regular one to one supervisions and they told us that these were informative and supported them in their roles. Staff told us that they discussed people's needs as well as their work and any areas where they wished to access training. The provider had an appraisal process that was used to measure staff performance and set goals. Records showed that appraisal meetings were up to date and staff were having regular discussions in this area.

People's healthcare needs were met appropriately. People benefitted from access to trained nurses at the home and they told us that they could see a nurse whenever required. There were sufficient numbers of clinical staff on each rota to ensure that nurses could cover tasks such as administering medicines, applying dressings or checking people's catheters. Where people were at risk of pressure sores, specialist support was in place. One of the nurses was also a qualified tissue viability nurse (TVN). A TVN is a nurse with a specialism in identifying and preventing skin breakdown . We noted that there was a low number of pressure sores at the home, despite a large number of people being cared for in bed. Where people had been admitted with pressure sores, we saw that clear and effective plans were implemented that had led to improvements. The provider also took part in local initiatives with community health organisations. These included a hydration

project, where people were encouraged to increase fluids. Improving people's hydrations had contributed to a reduction in falls and infections at the home. The home was also signed up to a local 'red bag' scheme. This was a scheme in residents took a red bag with them on hospital admission. The red bag contained essential clothes and toiletries as well as records detailing people's needs and preferences to ensure they received the right care in hospital.

People received a thorough assessment before receiving a service. People's needs were captured as well as their choices and preferences. People's preferences were recorded clearly for staff and regularly reviewed. Assessments followed current best practice and picked up people's clinical needs. Records showed that staff were competent in using tools such as waterlow (to measure risk of pressure damage to skin) and the malnutrition universal screening tool (MUST). Where needs were picked up in these areas, clear plans were developed. Where staff had noted a low MUST score for one person, because they had lost weight, they had been seen by a dietician. People's mobility needs were assessed and the home environment was suitable for people who used a variety of mobility aids. The building was purpose built with wide corridors and doorways. People were observed accessing parts of the home in wheelchairs without difficulty. There was clear signage around the home to assist people who were living with dementia to orientate themselves.

People were complimentary about the food that was prepared for them. One person said, "The food is very good and there's always a choice, I eat in my room." Another relative told us, "[Person] enjoys the food." There was a menu available to people with two choices for each meal. People made a choice ahead of mealtime but we observed that staff gave people an opportunity to choose again when food was served and they could see and smell the food being served. This was particularly important for people living with dementia who may have difficulty remembering their memory choices. Where people did not want either menu choice, the kitchen was able to prepare a variety of alternative dishes. The kitchen had a record of all people's preferences and dietary needs.

People's dietary needs were met. Where people had specific dietary requirements, these were recorded in their care plans and shared with the kitchen. For example, one person had been seen by a speech and language therapist (SALT) because staff had noted they were having difficulty swallowing their food. The SALT recommended that the person ate a diet of pureed foods to reduce the risk of choking. This information was added to the person's care plan and they were served food in line with this guidance. The provider had recently undertaken work to improve the presentation of pureed foods. We observed that pureed food had been piped onto the plate, making it attractive and very well presented. This demonstrated an attention to detail when encouraging people to eat by ensuring food was appetising.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff followed the correct legal process as outlined in the MCA. People's records contained MCA assessments that were decision specific. Staff carried out MCA assessments appropriately, in line with guidance. For example, one person was living with dementia and was assessed as unable to consent to receiving care. An MCA assessment had established this and staff had then

documented a best interest decision that involved the person's relatives as well as staff, GP and a social worker. A decision was made that it was in the person's best interest to stay at the home and have their personal care needs met. The provider then submitted an application to the local authority DoLS team to seek authorisation for this restriction on the person.

Good

# Is the service caring?

## Our findings

People were complimentary about the caring nature of staff. One person told us, "They [staff] are extremely pleasant and caring, they take a real interest in us and they're very courteous." Another person said, "They are lovely, always willing to give me a hug if I need it." A relative told us, "The staff are exceptionally caring, kind, funny and treat people with dignity. They have the best quality of life, it's everything I thought a home wasn't, and everyone is smiling."

We observed numerous pleasant interactions between people and staff during our visit. In the morning, we observed staff sitting with one person who was living with dementia. Staff were holding hands with the person and singing as the person smiled and nodded along to the tune. Later, staff noticed a person walking without their shoes on. The staff member gently encouraged the person to put some slippers on and when they refused, the staff member respected their decision and checked their socks were a good fit to avoid a slip or fall. The staff member then accompanied the person safely to their room. The caring nature of staff was further evidence by numerous compliments received from relatives and professionals. Staff were committed to their roles and this was reflected in their feedback to us. One nurse said, "The best thing about working here is caring for everyone like they're our own family. I think every one of us treats [people] the way we'd want to be treated ourselves."

Staff knew the people that they were supporting. People's care records contained information about people's background and preferences, and staff were knowledgeable about these. For example, one person was a Manchester United fan and three staff were aware of this fact about the person. Staff were able to give us details on people throughout the day, without needing to refer to care plans. Where people had specific needs, we observed staff meeting them proactively which showed that they knew them well. For example, one person appeared anxious whilst walking in a communal are. They told staff that they were tired. The member of staff said sympathetically, "I know, you didn't sleep very well last night did you?" and helped the person to choose a seat to have a nap in. This showed a good staff knowledge of the person's needs and their recent health and wellbeing.

People were involved in their care. Throughout our visit, staff were observed offering choices to people. People were offered choices of hot and cold drinks from staff throughout the day. At lunch time, people were shown the food on offer and encouraged to make a choice. In the afternoon we heard staff informing people of activities taking place in another part of the home and offering people the chance to attend. People's preferences were recorded and staff were knowledgeable about these when we spoke with them. For example, one person liked to dress smartly when their relatives visited and staff knew this about them.

Regular meetings took place at the home and people told us that these were used to make suggestions and make choices. One person said, "We talk about the food, activities, outings and changes in the home." Where people had specific religious needs, these were catered for. People's care plans recorded if they practiced a particular faith so that plans could be implemented to support them in this area. For example, one person was of Buddhist faith and had particular requirements around personal care. These were documented and staff were aware of them. The activities timetable contained a regular visit from a local

church that a number of people attended.

People's independence was encouraged by staff. One person told us, "I like to wash myself and staff let me do this." People's care plans recorded their strengths and what they were able to do so that staff could support them in a way that encouraged them to retain independence. One person was able to wash their face and attend to their oral care independently and this was recorded in their care plan. Another person liked to do their own make up each day after being supported with personal care and this was recorded in their care plan.

People's privacy and dignity was respected by staff. One person told us, "They [staff] do knock on the door, they don't just walk in." People told us that staff provided care in a manner that was respectful and dignified. People said staff ensured doors were shut and curtains were closed when they provided personal care. We observed staff knocking on people's doors and waiting for permission before they entered. A number of staff took on the role of 'Dignity Champions' within the home. These staff took the lead on informing good practice amongst their colleagues to promote people's dignity. Staff had received training in this area and dignity was discussed at supervisions and encouraged in line with the provider's values.

Outstanding ☆

# Is the service responsive?

## Our findings

People were happy with the activities on offer at the home. One person said, "Oh definitely there's plenty to do." Another person told us, "Yes, there's enough going on for me." Another person said, "There's always bits going on that you can join in with if you want to. You don't need to sit alone in your room."

People had access to a wide range of activities and these were achieving positive outcomes for people. Staff worked with people to identify activities that they enjoyed and reflected their interests. There was a timetable of activities on offer at the home. The provider employed a lifestyle co-ordinator and they involved people in choosing activities or finding things that they would like to do. For example, the provider had built links with a local disability centre. Through this, people had been on a tester session for 'rebound therapy'. This is a trampoline-based activity designed for people with disabilities or frailty. The activity enables movement and exercise by stimulating different parts of the body. We saw photographs of the session and two people responded particularly well to the activity so it was being arranged again. People also attended the disability centre regularly for exercise groups and swimming. Involving people in these activities was part of a project that had recently been undertaken at the home to engage people in exercise. A range of professionals and coaches were involved to identify ways of encouraging different forms of exercise to people with limited mobility and those who were cared for in bed. A 'moving and grooving' dance therapy activity had recently been set up for people. After a trial people had responded positively so this had been added to the activities timetable. Staff reported how people who attended these activities had become more steady and confident on their feet, reducing their risk of falls. One person had a history of falls and the exercise programme had reduced their falls significantly and improved their mobility.

People took part in activities that were meaningful and stimulating. The provider routinely involved people in activities based on their interests, backgrounds and memories. For example, the home had recently held a VE day celebration. This involved people sharing their stories from the war as well as assisting in decorating the home and creating a display with photographs of people and their written stories and memories. The provider had also arranged for county councillors to visit the home to discuss local history, as people had responded well to this type of activity. The registered manager told us that they valued all involvement from relatives and therefore relatives were invited on all outings and to parties. People were also encouraged to dine with their spouses at least once a week at the home and this was written into their care plans. A volunteer scheme had been set up and relatives volunteered at the home. Relatives regularly supported with quizzes, parties and coffee mornings which provided more opportunities to support people to engage in these activities. There was a comfortable cinema room at the home that showed films of people's choosing each day. There was a brightly decorated bar area and tea room and photographs showed that this was well used for parties and special events. People had access to a well maintained garden area. For people who found it difficult to go outside, a 'garden room' had been created with astro turf grass flooring, plants and bright decorations. We observed people spending time relaxing in this room. Some people at the home enjoyed bird watching but were not able to go outside regularly to look at the provider's bird houses. The provider set a camera up and streamed footage from a bird house in the garden to people's televisions to enable them to watch the birds.

Regular parties took place that provided people with social interaction and a sense of fun. We saw photographs of a number of different themed parties that involved dressing up and playing games. Photographs showed people looking happy whilst wearing costumes or participating in activities. For example, a recent party had a 'tea with the Queen' theme to celebrate the Queen's birthday. As the Queen was not able to attend on that day, people and staff posed for photographs with a cardboard cut-out of the Queen. We saw these photographs on the day and they showed a fun spirit at the home. The registered manager told us about plans for a Christmas party the day after our visit. This involved Christmas carols, mince pies and sherry. The provider had arranged for a surprise visit from the Harlequins rugby team who trained nearby. This was arranged because there were people at the home that used to play rugby and this would be a special activity for them.

People were supported to identify and achieve goals. Care plans recorded people's aspirations and the support that people needed to achieve them. For example, one person used to play the organ at a church before they came to live at the home. Staff worked with the person and devised a care plan to ensure that they were supported to attend the church regularly to practice their faith and spend time with their relatives. Another person was not able to attend an awards ceremony of a close relative due to their mobility. The provider provided the person with a computer and Skype, and supported them to attend the ceremony through a video link. The home actively encouraged people to make use of technology to improve their lives. People were provided with tablets, computers and Wi-Fi throughout the home. The provider gave us examples of staff supporting people to access social media where they had not done so before.

People received personalised care. Each person had a care plan that reflected their needs, interests and preferences. For example, one person had a condition that meant they regularly experienced pain. Their care plan stated that staff should offer them medicine to reduce pain before personal care. It said that staff should support the person to move slowly and carefully avoiding any fast movements that could cause them pain. A staff member told us that they supported this person in line with this guidance. Where another person had requested they be supported by female staff only, daily notes showed that this was being fulfilled each day. People had memory boxes outside their rooms, these displayed photos and articles that reflected their backgrounds and interests. These created points of reference for people as well as conversation points for staff to engage with people. Staff were able to tell us about one person's history in the armed forces when showing us their memory box.

Effective care planning was achieving positive outcomes for people. One person came to live at the service following concerns for their health at home. The person had a long term health condition that affected their mobility and they had started to lose weight. A care plan was drawn up where the person had daily support with personal care, support to eat and close monitoring of the person's weight. Regular reviews took place involving the person, relatives and healthcare professionals. Review records showed that the person had gained weight and had developed confidence and improved wellbeing. Care plans had been reviewed regularly and where changes were identified, staff took appropriate actions. For example, staff had noted changes in one person's behaviour that increased their risk of falls. A review took place and the person's care plan and risk assessment had been updated to include additional monitoring and supervision. The person had also been referred to the community mental health team in response to this change.

End of life care was provided sensitively and in line with people's needs and preferences. A relative told us, "I can't think of anywhere better for [person] to see out her days, they seem to keep on top of everything. It's beautiful surroundings, lovely staff." People's care plans contained plans for the end of their lives and these took into account people's wishes. A number of people at the home were receiving palliative care and we saw evidence of regular involvement of the GP, hospices and relatives at these times. People and relatives were provided with information packs and the home had links with therapists and religious ministers to

provide appropriate support at these times. People also had access to aromatherapy, hand massages and music therapy as part of planned end of life care. Where people had specific end of life needs relating to their religion, these were documented and met by staff. The home was signed up to the Gold Standards Framework for end of life care. This is a set of standards and good practice for ensuring people received appropriate holistic support at the end of their lives.

Complaints were responded to appropriately. The provider had a clear complaints policy that was displayed within the home. People and relatives told us they felt confident they could raise any concerns that they may have. Records showed that complaints had been investigated and addressed to the satisfaction of the complainants. There had been two complaints in the last twelve months.

Good

# Is the service well-led?

## Our findings

People told us that they felt the service was well-led. One person told us, "The manager is excellent; very approachable. She's very on top of things." Another person said, "You could not wish for a better home manager. You can see her anytime, she always makes time for you." Another relative told us, "It's very well run and the level of care is very good." The registered manager had been registered with CQC since 2011. People, relatives and staff spoke highly of the management and we observed people staff and relatives interacting with the registered manager throughout the day.

People benefitted from the provider having strong links with the local community. The provider was proactive in fostering links with community groups and organisations and these were impacting positively on people's lives. For example, the provider had links with Kingston University and had signed up to a 'Hackathon'. This is a project based on 'life hacks' in which students troubleshoot aspects of people's lives to find innovative solutions. The current project involved identifying ways technology could assist people with visual impairments and people who became disorientated, using satellite navigation technology within the home. People also benefitted from links with the local disability centre used for fitness sessions and people could access coaches and professionals through this project. We also saw evidence of involvement of local schools, toddler groups and a regular dementia event that the provider held. This provided information and advice to people in the community, their relatives, staff and healthcare professionals.

The registered manager played an active role in the running of the home. During our inspection we observed the registered manager interacted with people and staff throughout the home. Staff told us that they felt supported by management and were encouraged to make suggestions if they wished. Regular staff meetings took place as well as daily handover meetings to enable good communication between management and staff. One staff member said, "We can raise things with [registered manager], I see her every day." The registered manager had recently been nominated for a 'Registered manager of the year' award with the Surrey Care Association and people and staff spoke highly of them.

Regular checks were carried out on the quality of the care delivered at the service. Records showed that the provider carried out a range of audits in areas such as medicines, health and safety and infection control. The provider carried out a monthly holistic audit in which they looked at a range of areas such as documentation and staff practice. There was an ongoing plan to identify and develop improvements at the service and these involved people wherever possible. For example as part of a plan to improve the quality and service of catering, the registered manager had planned a tasting event for January 2018. This provided people with an opportunity to give feedback on samples of a new pureed and soft food menu. The provider had also arranged a 'mystery shopper' experience. This is where an external company arranged for an unannounced visit from somebody posing as a relative, to provide feedback on their experience and interactions with staff. Record of the visit stated, 'I was very impressed with the team members who worked in the home. Everyone I met had a smile on their face, said hello or good morning and asked me if they could help.' This matched out observations on the day, staff were keen to assist us and co-operated with our requests for documentation and information.

People were regularly asked for feedback on the running of the home. The registered manager told us, "We hold meetings for people every third Friday of the month." Records showed regular meetings took place where people were asked for their feedback on their care, the food and activities. An annual survey was sent out by the provider and the most recent results were all positive.

Staff were rewarded and encouraged to provide high quality care. The provider had a recognition scheme in place. Each year, staff were nominated for a 'Heart of Gold' award and the winners attended an exclusive event, the winners on the year of our inspection attended an event at a zoo. Each year's winner became an 'ambassador' for the home and elected future winners and attended future events. The provider also put on events such as 'Carers Week' where staff were given treats and pampering to reward them for hard work. The provider had good staff retention, with many staff having worked at the home for over five years. Staff feedback was taken seriously. The provider had an, 'I Have An Idea' scheme in place and staff were encouraged to identify improvements at the home. One staff member had recently suggested using pictorial exchange system (PECs) for people who could not communicate verbally and this had been implemented by the provider. Staff had access to training to develop their roles and their careers. The provider had a programme of leadership training that was available to staff, and we noted the registered manager and members of the senior team had started work with the provider as care staff.

The provider maintained accurate and up to date records. Care plans that we looked at had been recently reviewed and daily notes were kept up to date. Clinical charts were completed as directed and regularly reviewed and analysed by management. Audits of documentation were carried out in line with the provider's policy to further ensure records were kept up to date.

The provider understood the responsibilities of their registration. Registered bodies are required to notify us of specific incidents relating to the home. We found that where relevant, notifications had been sent to us appropriately. For example, in relation to any serious incidents concerning people which had resulted in an injury or any safeguarding concerns.