Care UK Community Partnerships Ltd

Tiltwood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Tiltwood provides residential care for up to 50 older people, who may also be living with dementia. The service is arranged into five individual units, named: Pines, Elms, Chestnuts, Walnuts and Willows. Each unit has ten bedrooms, a communal dining/living space and toilet and bathing facilities. Titlwood also has an onsite day service which is accessed by some of the people who live at Tiltwood, in addition to being open to the wider community.

The inspection took place on 15 March 2017 and was unannounced. There were 42 people using the service at the time of our inspection.

The service had 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. The registered manager had been in post since November 2015.

We previously carried out an unannounced comprehensive inspection of this service on 4 November 2015. At that inspection we found one breach of legal requirements in respect of staffing levels and a requirement action was set. We also made recommendations that the provider take steps to improve the outside safety of the service, support staff to better manage people's anxieties and develop more meaningful activities. As a result the findings from that inspection, the service was rated Requires Improvement. The provider sent us an action plan which identified the steps they intended to take to make the required improvements and this inspection confirmed that the provider had done the things they told us they had.

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. This report also highlights that the registered manager was in the process of implementing a further number of changes to improve the quality of support provided. For example, the deployment of a senior team leader to more closely coach and monitor staff practices, specific training for staff in managing challenging behaviour and the personalisation of people's rooms and living spaces. We expect these changes to be fully embedded over the coming months and will monitor the service against them at our next inspection.

People experienced varied quality of support at Tiltwood. As such, we found differences in the care and support that people received both across different units and between different staff. In one unit, the quality of some people's care was compromised by the high needs of one person. This meant that other people did not always receive the same level of support and attention they required.

Whilst there were systems in place to train and support staff, these was not always consistently reflected in the behaviours and practices of staff. For example, some staff had an excellent understanding of people's

needs and engaged effectively with people. Other staff however, lacked either the necessary skills or empathy to effectively support older people living with dementia.

People's care records did not always provide easy access to current and detailed guidance about how to support people. Good communication between staff mitigated some of the risks associated with this, but some people did not receive the most personalised and consistent support.

Staff were working hard to improve the quality of activities across the service and many were seen to take opportunities to engage with people in a positive and creative ways. Whilst staffing levels were now safe, the quality of people's social experiences were affected by both the availability and skill of the staff deployed to work with them.

Risks to people were assessed and actions taken to manage avoidable harm. The processes in place to safeguard people were effective and the registered manager and staff had a good understand about their roles and responsibilities in protecting people from abuse.

New staff were subject to a series of recruitment checks and completed a recognised programme of induction before working alone with people. Staff told us that they were well supported by each other and the registered manager in the delivery of their work.

People were supported to access the healthcare support they required and medicines were managed safely. Senior staff had good knowledge about people's healthcare needs and the importance of managing people's pain or medical needs. People had some choice over their meals and were effectively supported to maintain a healthy and balanced diet.

The atmosphere across the service was relaxed and friendly and overall staff respected people's privacy and dignity. People were encouraged to make express their wishes and staff understood the importance of allowing people to make their own decisions. The registered manager had worked hard to ensure staff delivered care in the least restrictive way.

The registered manager was widely respected by people, relatives and staff alike. She was hands on in her approach and a positive role model for staff. The management style had a fostered a more open culture throughout Tiltwood where people were encouraged to share their views with confidence that they would be listened to and acted on. Systems for monitoring quality and auditing the service had improved and were being better used to develop the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were now sufficient to meet people's assessed needs safely. Appropriate recruitment checks were carried out to ensure suitable new staff were employed.

The processes in place to safeguard people were effective and staff understood their role in protecting people from the risk of abuse.

Risks to people were assessed and actions taken to manage the avoidable harm.

Medicines were managed safely and people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

There were systems to train and support staff, but these were not consistently reflected in their behaviours and practices.

People had some choice over their meals and were effectively supported to maintain a healthy and balanced diet.

Staff understood the importance of gaining consent from people and there were now processes in place to provide care in a less restrictive way.

People were supported to access the healthcare services they required.

Is the service caring?

Good

The service was caring.

The atmosphere in the service was relaxed and friendly. People were encouraged to express their views and be active in making decisions about their care.

People had good relationships with staff who made efforts to engage with them in a positive and meaningful way.

Staff respected people's privacy and took appropriate steps to ensure their dignity was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always have the time or guidance to deliver truly personalised support to people.

The development of meaningful activities was continuing to improve.

There were effective systems in place to ensure that when people raised issues that they were listened to and their concerns addressed.

Is the service well-led?

Good

The service was well-led.

The registered manager was a supportive and positive leader who was motivated by delivering high quality support to people.

The culture within the service was more open with the staff and management team working together to improve the quality of care people received.

Systems for monitoring quality and auditing the service had improved and were being better used to develop the service.

Tiltwood

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 was a re-inspection of this service to check whether the provider was now 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 15 March 2017 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. 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. This was because this was a follow-up inspection in which we were monitoring the service against the actions the provider told us they had taken to improve.

As part of our inspection we spoke with 23 people who lived at the home, three relatives, 11 staff, and the registered manager. We also spoke with two health and social care professionals who had been involved with the service. We also observed interactions between people and staff during the morning and afternoon on each unit. We joined people in the communal areas across the service at lunchtime to gain a view of the dining experience.

We reviewed a variety of documents which included the care plans for seven people, four staff files, the medicines records for 14 people and other documentation relevant to the management of the home.

Good

Is the service safe?

Our findings

People told us that they felt safe at Tiltwood. People consistently commented that staff made them feel safe and that they and no worries. For example, one person said, "Yes, I do feel safe and I don't worry about anything here." Similarly, another person informed us, "I am safe and so are my things. They do a good job looking after us." Relatives echoed the view that their loved ones were kept safe. One family member told us, "She is safe here and they look after her things." Likewise, another relative said, "She is fine here. I have no worries about that."

Our last inspection identified that staffing levels were insufficient to safely meet people's needs. As such we set a requirement action to ensure improvements were made. Following that inspection, the provider wrote to us to tell us that they had reviewed people's dependency levels and increased staffing levels across the service. At this inspection, we found that the provider had taken the action they told us they had and as such staffing levels were now sufficient to support people safely.

People told us that there were enough staff to make them feel safe. For example, one person commented, "There is enough staff and I know a lot of them during the day." Relatives also expressed that staffing levels were now generally sufficient to provide safe care. As such, one family member told us, "They seem to have enough when I visit during the day."

The number of care staff employed to support people had noticeably increased since out last inspection. The registered manager told us that there was now a minimum of nine care staff and two team leaders during the day. This meant that four of the five units now had two care staff permanently allocated to them. In the fifth unit (Elms) there were less people living there and two of those that did spent most of their time in other parts of the service. The two team leaders worked across all the units and were responsible for administering the medicines in the home and assisting where needed.

Staff said that they now had sufficient time to care for people safely. For example, one member of staff said, "Staff levels are much better than they were." Another told us that the increase to two staff on each unit had made "A big difference." Staff reflected that they had previously struggled to support people safely, but that the additional member of staff on each unit had changed this.

The rotas for the previous four weeks were viewed and mostly reflected the staffing levels described by the registered manager and as seen at the time of the inspection. Agency staff had been used to cover staff vacancies and it was evident that the provider was actively recruiting new staff. Three additional staff were working in the service on the inspection day as part of their induction and further staff were also in the process of undergoing recruitment checks. One staff member commented, "Staffing levels are getting better. We have three new staff on induction today and we had two last week so we are going to be using less agency."

In addition to care staff, domestic, catering and management staff were employed. A recent relatives' survey identified that some parts of the service were not always as clean as they could be. We found that whilst

overall standards of cleanliness were adequate, some floors were sticky underfoot and isolated areas of the service did not smell pleasant. The registered manager confirmed following the inspection that they were in the process of recruiting additional domestic staff to raise standards further.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history, professional and character references and interview responses in staff files to show that staff were suitable to work in the service. The provider also had systems in place to ensure that DBS and training checks were undertaken on all staff supplied by external agencies.

There were systems in place to safeguard people from the risk of harm. People told us that staff were kind to them and that they felt safe in their company. All staff received training in safeguarding and demonstrated that they knew the different types of abuse. Staff understood their responsibilities to raise concerns if they thought people were at risk or being abused. For example, one member of staff said, "I would go to my manager and if she wasn't about I would go to the regional manager, police or CQC." During the inspection, we observed an incident which we brought to the attention of the registered manager. This was responded to immediately and effectively and demonstrated that the safeguarding systems in place were robust.

Individual risks to people were appropriately identified and managed. Care records documented the risks that had been assessed in respect of areas such as skin care, falls and weight loss. Where a risk had been identified there was a clear plan in place to manage it. Staff on duty knew the risks associated with the people they supported and followed the guidelines in place to manage the risks. For example, staff knew which people needed support with eating and drinking and their specialist needs associated with this. Similarly, we saw that people's weights were regularly monitored and that staff had appropriatly sought medical advice when people had lost significant weight.

The registered manager had a good oversight over accidents and incidents within the service. She checked accident and incident records as they occurred and also completed monthly and three monthly audits of these. The actions taken had reduced the number of falls across the service. For example, staff were able to describe the preventative measures for those people known to be at high risk of falls. Likewise, following a recent accident where a person had fallen from their bed, the registered manager had taken a number of steps to prevent re-occurrence not only for this person, but for all people living at the service.

People told us they received appropriate support with their medicines. People said that staff brought their medicines to them and made sure they took them when they needed them. For example, one person informed us, "They bring them after breakfast and after dinner. They remind me it's time to take them. They talk with me and my son about them and I know what they are for." Similarly, another person commented, "I have [my medicines] on time and I know what they are for and we talk with my wife about things like that. They keep us up to date."

Staff were knowledgeable about the safe management of medicines. Staff responsible for administering medicines were trained and competency assessments were in place that included observations of their practice. They understood that trollies used to store medicines needed to be locked when not in use, what medicines needed to be stored in a fridge, the importance of accurate records and potential side effects of certain medicines. One member of staff explained, "The trolley must be locked at all times. We store eye drops and antibiotics in the fridge. Every morning we check the temperature of the fridge and the medicines room and record this. When giving medicines we have to check it's the right person, the date, dose, time,

balance and reason and sign only after we have seen them take it."

We saw that staff locked the medicine trollies when leaving them unattended and did not sign Medicine Administration Record (MAR) charts until medicines had been taken by the person. People had a profile that included a photograph at the front of the MAR so staff could be sure they were giving the medicine to the right person. Profiles included details of people's diagnoses, allergies and possible side effects of the medicines they were taking.
Audits of medicines were completed by the pharmacy that supplied medicines. In addition to this the registered manager completed weekly checks of certain medicines. For pain relief medicines applied directly to the skin a patch application record was in place that was used to monitor which part of the body the patches were applied. A member of staff explained, "This is a brilliant way of seeing and monitoring that patches are not applied to the same part of the body on a regular basis." This was in line with National Pharmaceutical Society guidelines.
There were procedures in place for the use of homely remedies and as and when required medicines (PRN). These had been authorised by a GP and information was in place about each medicine, the reason for administration, the maximum dose allowed and the minimum time between doses. Detailed records were maintained when these were given in addition to staff having signed MAR charts.

There were good systems to ensure people's pain was managed safely. All but one person at the home lived with dementia which had the potential to impact on them being able to communicate if they were in pain. A pain management tool was used to assess non-verbal signs of pain that staff understood and applied. If a person took PRN pain relief medicine for three days in succession they were then seen by a GP and if necessary prescribed regular pain relief medicine. No one at the home was prescribed PRN medicines for the management of behaviour. A member of staff explained, "If pain is managed then behaviours that can be challenging associated to dementia are better."

One person was prescribed Warfarin, a medicine to stop blood clotting. Staff were knowledgeable about the actions they had to take to ensure this was given safely and side effects. A member of staff said, "If someone is on Warfarin and they have any bleeding of any sort, if they fall and have a head wound we have to immediately ring 999 and they have to be taken to hospital." A system was in place for monitoring the person had regular blood tests to measure how long it took for their blood to clot with the results then resulting in their medicine dose being altered. Information about Warfarin was on display for staff to refer to if needed.

Requires Improvement

Is the service effective?

Our findings

People's feedback about the effectiveness of staff was mixed. For example, some people spoke positively about the competency of staff and comments included, "They are good at what they do" and "They seem to be well trained." This was not consistent for everyone we spoke as we were also told, "You get the odd one that doesn't want to be here" and "It's hit and miss and depends who is on that day."

We found that whilst all staff had completed relevant training including how to support people living with dementia, this learning was not always consistently demonstrated in the behaviours and practice of all staff. Some staff consistently supported people in a competent and effective manner, but others did not and as such the effectiveness of staff was varied. At lunchtime we observed that some staff engaged well with people and routinely offered choices, whilst others provided support in a more task-based way.

In one unit (Pines), a member of staff was seen assisting a person to come into the room with the aid of a walking frame. The person became unsteady on their feet. The member of staff called for assistance from another member of staff but did not offer any words of encouragement or support to the person. However, when a second member of staff came to assist, they immediately knelt down on their knees to gain eye contact with the person and offered words of assurance. The person responded positively to this, smiling to the member of staff and they were then able to continue their walk. On another unit (Elms) we witnessed an incident which indicated that the staff member was unable to effectively deal with a situation in which a person living with dementia resisted personal care.

Staff said that they had not received specific behaviour management training but that this was covered in the dementia training they had completed. The registered manager had recognised this as an area for improvement. She had sourced additional training in this area and plans were in place to roll this out to all staff.

The registered manager informed us that staff competencies were assessed in various ways. She said that these included audits completed by herself and an area manager, and via night visits she conducted. She explained that if issues with practice were identified, one to one meetings were brought forward to discuss and review these. Staff records confirmed that discussions took place about their practices and areas for development.

The registered manager and senior staff recognised the need to complete more coaching. One staff member told us, "We are working hard to promote a more person centred approach to care. We are not there yet, but we are working to encourage less focus on tasks and more on people." The registered manager told us that the role of a senior team leader had very recently been created to provide more mentoring and observation of staff practices.

It is recommended that more formal observations and competency assessments are completed to monitor and improve staff practices and ensure that training has been effective.

New staff undertook a 12-week induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. In addition to formal learning, new staff also shadowed more experienced staff. Three new staff were on induction at the time of our inspection. They confirmed that they were undertaking a formal induction programme which included a combination of training and shadowing staff.

All staff told us that they felt well supported in their roles. For example, one staff member said, "There's always support and we help each other." Staff talked about working well as a team and this was reiterated by new staff who said that that the whole staff team had been, "Very helpful and supportive."

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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People told us that staff involved them in making decisions about their care and support. For example, one person informed us, "They write everything down and ask me questions. They ask me if I would need help and I say yes or no." Throughout the day we saw staff engaging with people and respecting their wishes.

There were appropriate systems in place to manage restrictions on people's freedom. The registered manager had submitted DoLS applications for people who lived at the home who lacked capacity to consent or use the coded key pads in place and who were under constant supervision. One had been approved at the time of inspection. As part of this process MCA assessments had been completed that considered people's ability to understand and retain information. Best interest decision records were also in place that evidenced the views of relatives had been obtained when the MCA assessments were completed. This was in line with the MCA Code of Conduct guidelines.

Staff received MCA training and understood how people had a right to consent to their own care. One member of staff said, "MCA gives people rights when they don't have the ability to make decisions for themselves. If someone lacks capacity and is being restricted a deprivation of liberty application has to be made. We have to help people to make decisions. Care plans tell us how they like things." A second member of staff said, "They have a right to say no, so everything has to be done with their consent. Some can give consent non-verbally. We have locks on doors that people can't consent to so have DoLS in place. It's important to document everything."

The registered manager had sought written confirmation from people who had Lasting Power of Attorney for health and welfare or financial matters issued by the Office of the Public Guardian to ensure people had the legal right to act on behalf of individuals.

People had some choice over their meals and were effectively supported to maintain a healthy and balanced diet. On the whole, people expressed satisfaction about the meals they received. For example, one person told us, "It can be really good, but you don't get as much choice as I'd like." Another person commented, "It is okay, Could be more choice though." A relative said that in their view the food, "Seems nice and quite appetising."

People were seen being offered a choice of drinks and snacks throughout the day. The lunchtime meal looked and smelled appetising and people ate and appeared to enjoy their food. On one unit (Pines) we noticed that four people were supported to sit at the dining tables, over half an hour before their meal arrived. One person fell asleep during this period, by resting their head and arms on the table. It was not clear why people had been assisted to prepare for their meal so far ahead of its serving.

With the exception of breakfast, meals were supplied by an outside catering company. Catering staff were well informed about people's needs and had information about people's preferences, allergies and specialist dietary needs. A member of catering staff told us that they had completed training on nutrition and was able to describe what sort of things they could do to help people's calorie intake, for example by fortifying people's meals.

Where people were identified as being at risk of becoming dehydrated or malnourished, food and fluid input and output charts were in place to help monitor their needs in these areas. These included a daily target for intake to maintain good health and daily review to ensure they were sufficient and a referral process for medical advice if not.

People were supported to maintain good health and access external healthcare support as necessary. People told us that staff arranged for them to see professionals such as the doctor, dentist or optician as necessary. For example, one person said, "They ask me if I would like to see a doctor if I say I feel ill." Similarly, another person commented, "I see the optician regularly."

A system was in place to monitor people's healthcare needs. A GP visited the home on a weekly basis to review people's medicines, conduct routine blood tests and to make referrals to other healthcare professionals such as physiotherapists. A member of staff explained, "The GP visits every Tuesday. The day before I fax a list of people who wish to be seen and any concerns to that the GP is prepared. We have a very good relationship with the practice."

Care records showed that people had been appropriately referred to other health services including; the doctor, speech and language therapist and the community mental health team. We saw that where specialist advice had been given about how to support people, this had been included in their care plan and staff were aware of the advice.

Good

Is the service caring?

Our findings

People referred to staff as being "Nice" and "Kind." People gave us examples of the things staff did that they felt was caring. For example, one person told us, "They let me do the things I like. I like to watch sport and they reminded me there is horse racing on today." Similarly, another person commented, "They listen to me."

The atmosphere across the service was relaxed and friendly and people were seen to be responding positively to staff supporting them. We observed many examples of genuine warmth and kindness towards people. For example, staff stopping to talk with people when they passed them and were seen holding their hands when speaking with people. We saw one member of care staff sitting for a long time with a person, chatting and stroking their hair whilst encouraging them to drink.

Staff worked hard to reduce people's anxieties. For example, one person was nervously awaiting news regarding a relative who was in hospital and due to their short term memory loss, couldn't remember what was happening. The registered manager had written the latest update on a piece of paper which the person could hold and we saw staff consistently reinforcing the message and comforting them.

As a service supporting people living with dementia, the concept of 'Butterfly Moments' had recently been introduced. As such, staff were seen wearing brightly coloured and unusual headbands to encourage eye contact and positive interaction with people. We saw many occasions when this approach triggered smiles and laughter from people which in turn lifted their mood.

Staff had a better knowledge of people's life histories and how this affected their care. For example, one person spent a lot of time walking up and down the corridors checking things. A member of staff told us that this was reflective of the person's previous occupation and provided comfort to them. We noticed that staff responded to this person with this understanding which clearly enhanced their well-being.

People's privacy was respected. People told us that staff respected their privacy. One person said that staff, "Knock if you are in the bathroom or if your door is closed." Similarly another person commented, "They are all good when you are using the bathroom as they will step outside or turn away if I am undressed and don't need them."

People were seen to be treated with dignity and staff were able to explain how they promoted people's dignity and respect. One member of staff said, "I always offer two choices at mealtimes. Always shut doors with assisting with personal care. It's all about respecting as a person. Don't force people to do things they don't want to do." A second member of staff said, "We have to set an example to each other. We have to respect them and their wishes."

People's spiritual needs were met. People told us that they had opportunities to follow their religious preferences. One person told us, "They respect and celebrate everything." Another person said, "I attend Communion every week and this is really important to me. A relative echoed the same view and informed

us, "They respect [my family member's] belief in God and invite her to their church services, they sing hymns and pray in the service."

People were encouraged to be involved in decisions about their care and be involved in changing the service. The registered manager had a plan for further improving the service, especially in respect off how people's rooms and communal areas were decorated and furnished. We saw in residents' meeting minutes that people had been consulted about these changes and their views reflected in the changes that were being made. For example, one unit (Chestnuts) was occupied by only by females and as such they had chosen a very feminine theme to their living space.

Requires Improvement

Is the service responsive?

Our findings

People told us that they felt most staff knew their needs and provided their care as they liked. For example, one person said, "I think they know me very well and the stuff I need help with." Another person commented about staff, "Some of them do [know me] because they make time for a chat and read your plan." Similarly, a third person said staff, "Know me quite well, I make sure they do."

Whilst those people who were able to talk to us about their care felt most staff understood their needs, we observed some practices in which care was not personalised or in line with their assessed needs. For example, one person was observed spending most of the day walking around the service in loose fitting slippers. The care plan for this person identified that walking was usual for this person and the current falls risk assessment recorded that staff should ensure that the person wore appropriate footwear. We asked staff what they considered was appropriate footwear and they replied, "He would normally be wearing shoes and should be." Staff across the service had interacted with this person and yet no one had identified that his footwear was not in line with his care plan.

Care records did not always provide current guidance about how to support people with difficult or challenging needs. For example, during the inspection there was an incident with one person whilst they were being supported with personal care. We looked at the care records for this person, but they were not clear as to how the person should be supported with this need or how current continence needs were being managed. The registered manager demonstrated a clear understanding about the support needs for this person, but this was not fully reflected in the care plan and staff were not consistent in the way they supported the person.

Similarly, the care records for another person did not include information about behaviour they regularly displayed. This meant staff were not provided with information to deliver personalised care in a responsive way. Behavioural charts were in place that staff used to record incidents and these showed ongoing incidents of aggression. There was however, no risk assessment or care plan for the management of this known behaviour.

The care records for a further person in relation to their anxiety stated, 'Staff to ensure X is wearing her glasses, make sure they are clean as X cannot see clearly without them.' Staff were not aware of this and told us that the person would refuse their glasses. The person was not wearing and staff did not offer them their glasses at any point during the inspection.

It was not always possible to identify whether people's individual needs had been met. One person had poor oral hygiene. When we asked staff about this they told us that the person did not always let staff support them with this. The care plan stated that this was an area in which the person required help, but there was no record as to whether staff had been successful in providing it or not. Staff on duty were unable to tell us when the person had last brushed their teeth.

On one unit (Willows) the high needs of one person negatively impacted on the quality of care other people

received. The registered manager was aware of the situation and was appropriately liaising with other relevant agencies in respect of this person. Whilst steps were being taken to support the increased risk and needs for this individual, other people living in the unit did not have their needs fully met as a result of staff being more occupied with them. For example, one person had been assessed at being at very high risk of developing pressure sores. The care plan documented that, 'Staff are expected to assist X to stand every hour or so the blood can circulate around the body'. This did not happen. Staff on duty told us that they tried to do this wherever possible, but due to the needs of the other person living on the unit, it was not possible.

The deployment of staff across the service did not always facilitate personalised and responsive care. Whilst staffing levels were now safe, the dependency tool used to calculate the number of staff required, did not consider the layout of the service. For example, because there were five units, this meant that if the two allocated staff were supporting one person, everyone else was left unattended or experienced delays in receiving support. We observed the impact of this throughout the inspection and people provided their own examples. As such, one person told us, "They are better if you are not in your room otherwise you do a lot of waiting around." Likewise, another person commented, "You wait varying times. Longer in the mornings but they come eventually."

On one unit, (Willows) we observed that both allocated staff were supporting one person for 25 minutes. During this time the other people were left without any staff presence. On other units we identified that whilst staff were safely supporting people, the only care workers who were spending time with people in a non-tasked based way, were the new staff on induction.

The impact of the above gaps in providing person centred care that is responsive to people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff team were working hard to improve the quality of activities across the service and whilst this was still an area in progress, there were overall more opportunities for people to be engaged with. People provided positive feedback about the things they did. For example, one person told us, "I like to do puzzles in my room and read. They do get me new books and take me to the book area so I can choose." Another person commented, "I like to sit in the garden and have tea and I like the dog coming."

Tiltwood has an onsite day centre which is accessed by some of the people who lived at the service in addition to being open to the wider community. At the time of our inspection, six people living at Tiltwood were attending the day service. We observed that the atmosphere was vibrant and chatty and people were fully engaged with what was going on. One person told us, "I like everything they do in the day centre. It gets me out of being in one room." Another person informed us, "I sometimes like the day centre to do a quiz or listen to a bit of music."

Staff told us that they thought activities across the service had improved and there was a greater emphasis on getting to know people's interests. Some staff demonstrated a good knowledge of people's life histories and used this information to engage people in activities of interests. For example, two people were interested in the countries of Europe and as such the staff member told us how they did quizzes with them.

The morning of the inspection was unusually warm and as such staff responded appropriately, by encouraging people to either take a walk or sit outside. We observed a number of people engaged in a ball game outside. Later in the morning, a therapy dog and his owner visited people, who were seen to be enjoying the tricks and the therapeutic nature of this activity.

People were given information about how to make a complaint and there was evidence that when they did, their concerns were listened to and investigated. The complaints procedure was prominently displayed and people and their representatives told us that they felt comfortable to raise any issues with the registered manager. For example, one person informed us, "The manager and the staff all listen. The manager wrote down my complaint and sorted it out quickly." A relative also echoed, "The manager is always around and is really approachable."

Complaints records were well documented and showed that issues had been responded to appropriated. For example, where concerns had been raised, the person had been provided with a full explanation, apology and details of the actions taken to address their concerns. There were no significant complaints about the quality of the care.

Good

Is the service well-led?

Our findings

People were positive about the management of the service and in particular the visibility and approachability of the registered manager. Everyone we spoke with was immediately able to identify the registered manager, both by sight and name. One person told us, "She is very nice and sorts everyone out." One relative described the registered manager as being, "Great and really proactive." Another commented, "The manager is fantastic."

Staff also praised the registered manager and her leadership of the service. One said, "The changes that X (registered manager) has made are phenomenal and everyone has joined in." They went on to describe, "People are doing more and there is a lovely atmosphere." A second member of staff said, "The manager is so supportive. She is really accommodating. She says things in a nice way. Last year the home was sad, now it's alive with lots of colour, noise and life. It's a nice place to work."

Staff reported that they had regular staff meetings and that communication was generally good across the service. There was a clear management and staffing structure across the service. Staff reported that effective handovers took place on every shift changeover which allowed information and issues to be shared and taken forward.

People and relatives told us that they felt better engaged with and that their views were now being listened to. Regular residents and relatives meetings were now held and had been successful in building a sense of partnership in the way the service was delivered. People told us that they were regularly asked for their feedback. One person said, "They listen to what you have to say if you suggest something at the meetings." As a result of these meetings and the engagement with people and their advocates, who had been able to directly influence areas such as activities, outings and the ongoing re-decoration of the service.

People's views were obtained and used to drive improvements. Relative's surveys were conducted between July 2016 and November 2016 and 12 relatives had responded. Relatives particularly praised how regularly their family members were offered drinks, access to the registered manager and being kept informed of changes. A resident's family meeting had been held during January 2017 where the registered manager discussed the survey findings and informed people of actions being taken to address issues raised. For example, the registered manager had requested more cleaning staff to improve the cleanliness of the home. People were also informed that plans were underway to make the home feel more homely. This included personalising bedrooms and redecorating them all as they become vacant.

There was a system of auditing in place that focussed on different subjects each month. The audits were completed by the registered manager and also by the provider's external team. There was evidence that identified actions were transferred into an overall improvement plan for the service. The registered manager was responsive in the way she responded to feedback. For example, following the inspection, she wrote to us to say that in response to our feedback about new and temporary staff having immediate access to the key information about people, they were introducing summary information sheets about each person's needs.

The registered manager was aware of the legal requirement to report significant events. As such timely notifications were submitted to us. During the inspection, we observed the registered manager deal with number issues which saw her liaise swiftly and professionally with other agencies. She was a good role model for staff and an effectively advocated on behalf of people using the service.

The provider had implemented a Duty of Candour policy. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to service users in relation to the incident. The registered manager reflected an open and transparent demeanour throughout our inspection which demonstrated that the principles from this legal requirement were being upheld.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always provided in a person centred way that fully met people's individual needs.