Cheerhealth (Selsey) Limited

Tenchley Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 3 and 13 October and was unannounced.

The last inspection took place in February 2015. As a result of this inspection, we found the provider in breach of a regulation relating to safe care and treatment and asked them to submit an action plan on how they would address this breach. An action plan was submitted by the provider which identified the steps that would be taken. At this inspection, we found that the provider and registered manager had taken appropriate action and the regulation had been met.

Tenchley Manor Nursing Home is registered to provide accommodation and nursing care for up to 37 older people. At the time of our inspection, 29 people were living at the home. The home provides permanent placements and short-term breaks for older people with a variety of nursing and healthcare needs. Tenchley Manor Nursing Home is a large detached house situated on the coast at Selsey with views across the Solent towards the Isle of Wight. Communal areas include a large sitting room incorporating library and dining areas, a kitchen area where people and their relatives can help themselves to hot or cold drinks and a separate sun lounge. The majority of rooms have en-suite facilities. The home has extensive gardens to the rear of the property with access to the beach beyond.

A registered manager was 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.

People were provided with safe care and treatment. Risks to people were identified, assessed and managed appropriately. There were sufficient numbers of staff on duty to keep people safe and meet their needs. The registered manager was in the process of recruiting new staff to fill staff vacancies and employed safe recruitment practices. Staff had been trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place. Medicines were managed safely and administered by trained, registered nurses.

Staff were trained in a range of areas to care for people effectively. New staff followed the Care Certificate, a universally recognised qualification. Training was updated as needed and staff were encouraged to study for additional, external qualifications. Staff had regular supervision meetings with their line managers and attended team meetings. The requirements of legislation under the Mental Capacity Act 2005 were followed and staff had a good understanding of their responsibilities under this legislation and about Deprivation of Liberty Safeguards. People had sufficient to eat and drink and all spoke highly of the food on offer. Special diets were catered for and people were supported to maintain good health through access to a range of healthcare professionals and services. People's rooms were personalised and tastefully decorated and furnished.

Staff knew people well and cared for them in a kind, caring and compassionate way. People were complimentary about the staff who looked after them. They were supported to express their views and to be involved in making decisions about their care. People were treated with dignity and respect and had the privacy they needed. At the end of their lives, people were supported to have a comfortable, dignified and pain-free death.

Care plans included detailed, comprehensive information about people, their personal histories, likes and dislikes and how they wished to be cared for. A programme of activities had been organised for people and people were also able to access the community, either through organised outings, with staff or relatives or independently. Complaints were managed in line with the provider's policy.

People were involved in developing the service and relatives and residents' meetings were organised at which people could feed back their views. People were positive about the care they received and of the management of the home. Staff felt supported by management and said the registered manager was approachable and listened to any issues they raised. High quality care was evident and relatives too spoke highly of the care provided at Tenchley Manor Nursing Home. A range of audits measured and monitored the quality of care delivered. Some care plans and personal details about people had not been kept in a confidential way. We raised our concerns with the provider and registered manager and action was taken promptly to address the issues raised and ensure that records were stored securely.

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.

People's risks were identified, assessed and managed appropriately by staff. They were protected from the risk of abuse by staff who had been trained to recognise the signs of potential abuse.

Staffing levels were sufficient to meet people's needs and new staff were recruited safely.

Medicines were managed appropriately.

Is the service effective?

Good

The service was effective.

People were supported to have sufficient to eat and drink and they had access to a range of healthcare professionals and services.

Staff completed essential training relevant to support and care for people effectively. They had regular supervision and team meetings.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Is the service caring?

Good

The service was caring.

People were looked after by caring and kind staff and positive relationships had been developed.

People were encouraged to be involved in all aspects of their care and they were treated with dignity and respect by staff.

At the end of their lives, people's wishes were respected and they were supported to have a private, comfortable, dignified and pain-free death.

Is the service responsive?

Good

The service was responsive.

People's care needs were summarised within detailed and comprehensive care plans which provided advice and guidance to staff on how people wanted to be supported.

A range of organised activities was on offer to people.

Complaints were managed appropriately.

Is the service well-led?

Good

The service was well led.

People and their relatives spoke highly of the care delivered at the home and their feedback was acted upon.

Staff felt supported by the management team.

A range of audits measured and monitored the quality of care delivered and identified any areas for improvement.

Tenchley Manor Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 3 and 13 October 2016 and was unannounced. One inspector and a nurse specialist undertook this 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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including six care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection and we met with four people living at the service. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the provider, registered manager, training and administration manager, chef, two senior care assistants and a care assistant.

Good

Is the service safe?

Our findings

At the inspection in February 2015, we found the provider was in breach of a Regulation associated with safe care and treatment. We asked the provider to take action because there was no effective system in place to identify and mitigate risks to ensure the welfare and safety of people living at the home. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

Risks to people were managed so that people were protected and their freedom was supported and respected. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. We looked at risk assessments within people's care records. Assessments had been drawn up in relation to risks associated with mobility, the use of bed rails, skin integrity and each person had a Personal Emergency Evacuation Plan in place, should they need to leave the building in the event of an emergency. One person had a risk assessment in place for moving and handling and there was guidance for staff on which equipment was needed to move the person safely, for example, when transferring them from a wheelchair to their bed. Numbered slings used on hoists ensured that people were allocated the correct size of sling in relation to their height, weight and assessed need, so they could be moved safely. Equipment was serviced annually and we saw dates on labels affixed to equipment which showed when checks had been completed which confirmed this. We observed staff moving one person from a wheelchair to an armchair in the sitting room. Two staff members safely moved the person and provided reassurance to them during the process. Screens were placed round the person to ensure their privacy whilst being hoisted.

People's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for this purpose. Where people had been identified as being at risk, for example, because they received nursing care in bed, turning charts were completed which ensured that people were repositioned to alleviate pressure on different parts of the body. In addition, wound management care plans were in place and evidenced good practice. One person told us about their special bed which supported their weight and said, "I've got a bariatric bed plus airbed and it's really comfortable". Pressure relieving mattresses were in use where needed. A member of staff told us that if people's risk assessments changed, for example, after sustaining a fall, then they would be informed. They explained, "We're made aware if someone's situation has changed, for example, if someone has a fall". The registered manager had made a referral to the West Sussex Falls Team for one person who had sustained two falls in one month. We saw an assessment for one person in which their risk of developing a chest infection had been identified. The assessment was dated 13 September 2016 and stated, 'If [named person] is displaying the signs and symptoms of a chest infection, please inform the nurse in charge'. We discussed this assessment with the registered manager and suggested that more information be provided to care staff on what signs or symptoms they needed to look out for which might indicate a chest infection. The registered manager agreed to take immediate action to provide this further detail.

There were sufficient numbers of suitable staff to keep people safe and meet their needs, although people and staff felt that, at certain times of the day, staff were pressured and did not have time to sit and chat with people. The registered manager was in the process of recruiting new nursing and care staff to avoid the use of agency or bank staff where gaps in the staffing rota were identified. One person said, "I feel sorry for the staff because they're often short staffed. There is quite a lot of agency at the moment and they need to recruit" and added, "They manage, but they could do with more permanent staff". We asked people whether staff were quick to attend to their needs when they rang their call bell. One person said, "If they can't see you, they come back as soon as they can". Another person talked about agency staff and said, "Some I like and some I don't". Where possible, the same agency staff were used who knew people well and could provide consistency of care. A third person told us, "Staff are very friendly and they will all muck in together. Sometimes you have to wait a long time for staff to come". On the first day of our inspection, some people had to wait to have their lunch served because staff were busy. One registered nurse completed the administration of lunchtime medicines at 2pm, although the delay may have been due in part to a disruption caused by the inspection process.

Staffing rotas showed that six care staff were on duty during the morning and four care staff in the afternoon, plus at least one, usually two, registered nurses. During the night, two care staff were on duty and one registered nurse. One member of staff told us, "[Named registered manager] implements staffing levels. We've had a few [staff] leave and it's been hard on everyone. Some people take the job on and then decide they don't want to work nights or weekends". They went on to say, "Sometimes seven staff are on duty, sometimes six. I come on at 4pm. We do manage to do it". Another member of staff referred to staff who had left and said, "Quite a few left without much notice. They've started to use agency". A third member of staff referred to staffing levels and said, "They are a challenge and still days when you're short. We muck in and do the best we can on those days". Staffing levels were assessed based on people's levels of dependency and whether they had 'high, medium or low' needs. The registered manager felt that staffing levels were a challenge and said, "I'd love seven in the day and four in the evening". A registered nurse told us there was a registered nurse on each floor during the morning and one registered nurse on duty in the afternoon and at night. They said they were offered the opportunity to work additional hours and told us, "I only do 36 hours and they are not forcing us to do too much, only what most people do, which is 36 hours weekly".

Safe recruitment practices were in place. Before new staff commenced caring for people, suitable checks were undertaken, with two references, identity checks and applications made to the Disclosure and Barring Service (DBS). DBS checks help employers made safer recruitment decisions and help prevent unsuitable staff from working with people. Checks were made to ensure that nurses had completed and updated their registration with the Nursing and Midwifery Council (NMC).

People told us they felt safe living at Tenchley Manor Nursing Home. One person explained, "Yes I feel safe here". Staff knew what action to take if they suspected abuse was taking place and were aware of the local authority's multi-agency safeguarding policy. Staff confirmed they had received training in safeguarding adults at risk and were able to explain their responsibilities. One staff member told us, "If I suspected someone was being abused, I would go to my manager. I wouldn't ask any more questions to upset them" [referring to residents]. They gave examples of different types of abuse and named, "Sexual, physical and verbal". A registered nurse told us about an incident where she had contacted the police when a visitor to the home had been verbally abusive to a resident. People were encouraged to maintain their independence and three people went out independently. One person told us they went out to play cards and would inform the night staff so they could open the front door at around 10pm on their return.

Medicines were managed safely. Where needed, risk assessments had been drawn up in relation to the

administration of medicines. For example, one risk assessment stated, '[Named person] has some issues with medication as at times she will store medication in her cheek. Nursing staff to be vigilant and give [named person] time to swallow her tablets and go back and check'. We observed a registered nurse wait patiently with the person to ensure they had swallowed their medicines. Only registered nurses administered medicines to people and the registered manager told us, "Medication takes so much time", especially during the morning and early evening. However, we observed that people received their medicines as needed. Some staff were trained as phlebotomists and could take blood to test and monitor the effects of Warfarin, a drug which has an effect on blood clotting. This meant that people did not have to leave the home in order to have their blood taken.

A registered nurse said, "We order only what we need and keep few extras. The pharmacist comes to take away the ones we need to dispose of and we record that"; they told us that no-one received their medicines covertly, that is, without their knowledge. No-one living at Tenchley Manor Nursing Home administered their medicines independently, although some people did have their inhalers with them. Medicines that were taken as needed (PRN) were recorded in a separate log each time they were administered. Registered nurses were regularly assessed in their competency to administer medicines by the registered manager. We did observe that some bottles of prescribed syrups did not have the date of opening recorded on them. It is important to record when medicines are opened so that they are used up or disposed of within the recommended timeframe. We brought this to the attention of the registered manager who said they would remind nursing staff of this requirement. Medicines were ordered, stored, managed and disposed of safely. The medicines room was spacious, well arranged and adequately ventilated to ensure that medicines were stored at an appropriate temperature. There were two medicines trolleys, one for each floor. Medicines were dispensed from blister packs in a Monitored Dosage System (MDS). Medication Administration Records (MAR) were completed appropriately and staff signed these to confirm that people had received their medicines as prescribed. However, we saw there were some missing signatures in relation to saline not being signed for on three consecutive Saturdays. We drew this to the attention of the registered manager so they could identify which registered nurse was responsible. Audits for medicines management were completed in accordance with NMC guidelines.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. New staff could commence their training whilst they waited for their Disclosure and Barring Service checks to be completed. The training and administration manager said, "I try to meet with new staff every week to support them to complete their workbooks". We spoke with a member of care staff who had recently started work at the home. They explained the induction process and told us they shadowed experienced staff for a week, learning how to deliver care and getting to know people. They said, "During that first week, they [staff] would talk me through people's care needs and I read the care plans in my spare time". They added, "I went through all the basic training. I'm doing moving and handling tomorrow. I've done, fire, health and safety, just the basic ones so far". They had already completed a level 3 qualification in health and social care before coming to work at Tenchley Manor Nursing Home.

Staff received training which was delivered internally on topics such as infection control, safeguarding, fire awareness, moving and handling, management of substances that might be harmful to health, food safety and health and safety. First aid training was also available to care staff, whilst nurses completed resuscitation training. The training and administration manager told us, "Every year staff have a competency assessment for each topic" and we saw workbooks that had been designed to test staff's understanding on various subjects. The training matrix confirmed that staff had completed all relevant training. Staff were also encouraged to study for external qualifications such as National Vocational Qualifications in Health and Social Care. Nursing staff received additional training in specialist areas such as venepuncture and catheter care. The training and administration manager told us that they were looking into introducing e-learning courses for night staff as sometimes it was difficult for them to attend training during the day.

We asked staff whether they met with their line managers to receive supervision and staff confirmed they met every four to six weeks. A new member of staff told us, "[Named registered manager] is very approachable. I'm having my first supervision with her today". We looked at staff supervision records which documented the issues that had been discussed, any ongoing concerns and an action plan. The supervision record was signed by the supervisor and supervisee. Mostly supervision records were detailed and clearly described the issues that had been discussed. However, a small number of records only provided scant information. For example, in one supervision record we read, 'Staffing levels discussed'. It was not clear what points were discussed, whether this was an area of concern and any action points arising. We discussed this with the registered manager who agreed that more detail would provide clarity on the issues discussed and expected outcomes. Team meetings were also held for nursing staff, night staff, housekeeping staff and care staff and records confirmed this.

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. We asked staff whether they had received training, and checked their understanding of, the MCA. One staff member said they, "Always assume someone's got capacity". Another member of care staff said, "Yes, people here do have capacity. We have copies in people's care plans on whether they agree with their care or not. People have choices. If people don't want to wash or get up, they do what they want to do". Capacity assessments had been completed for people living at the home and nursing staff confirmed they completed assessments on capacity and these were regularly reviewed. Nursing staff also told us that they tried to involve family members when decisions about people's care and welfare needed to be made.

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, everyone living at the home had been assessed as having capacity and no-one was subject to DoLS. Where bed rails were in use as a form of restraint, people's consent had been gained and they understood the need for having bed rails, to prevent them from falling out of bed.

People were supported to have sufficient to eat and drink and were encouraged to maintain a healthy diet. People spoke positively about the food on offer. One person said, "Oh it's lovely. Yes, unfortunately I put on weight when I came here. [Named chef] comes round and asks you what you want for breakfast, lunch and supper". Another person described the food as, "Excellent" and added, "If you don't like something, you can send it back and they'll change it for you". They told us that they had been out recently and said, "Chef made me a lovely picnic and saved me something warm for when I got back". We observed people having their lunch in the dining area and from overlap tables in the sitting room area; some people preferred to eat their meals in their room. On the first day of our inspection, the lunchtime choice was either sausages and potato cake or ham and tomato quiche, both served with fresh vegetables. To follow, there was a choice of bread and butter pudding or a cold option.

We spoke with the chef on duty who told us, "There's a chef in the kitchen 12 hours a day. I try and put a few different things on the menu like sweet and sour chicken". If people did not like either of the two hot options at lunchtime, then the chef said they could have a salad, omelette, jacket potato or other light meal. The supper menu comprised a hot option, sandwiches and/or soup. Menus were rotated over a four weekly cycle, with a roast lunch on Sundays and a fish option on Fridays. The chef told us, "Sometimes I mix them up. It depends on the weather. People can have a full cooked breakfast or kippers, but the majority like porridge or cereal, toast and marmalade and fruit juice. People are very traditional in their choices". Menus were also discussed at residents' meetings.

Special diets were catered for, such as for people living with diabetes and pureed diets for people who had difficulty with swallowing, chewing or who were at risk of choking. People were assessed by a speech and language therapist or dietician where special diets were required. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The provider had completed these assessments using the Malnutrition Universal Screening Tool, a tool designed specifically for this purpose. People were weighed monthly. The chef told us that people who required a high calorie diet were catered for and explained they might use cream or butter to increase people's calorific intake where needed. Food and fluid charts were completed for people who had been assessed as at risk of malnourishment. Drinks were freely available, smoothies were also on offer and people could have something to eat at any time of the day or night. We were told that one person liked to have cheese on toast just before bedtime.

People were supported to maintain good health and had access to healthcare professionals and services. We observed a GP had come to visit people on the first day of our inspection and one person went to their room with the GP to discuss some recent healthcare concerns. Another person said, "They're good here, they get a doctor straight away if you need one". Healthcare appointments were recorded in people's care plans, the outcome of the appointment and any further action that was needed. People were asked for their consent to receive a 'flu jab and had access to dentists, chiropodists and opticians as needed.

People showed us their rooms which were nicely decorated and furnished with personal belongings and items of importance to them. The main communal area was large and overlooked landscaped gardens and the sea. We observed that some people were enjoying sitting in the garden, even though it was a little chilly and windy, but they were tucked up in blankets to keep them warm. The provider told us, "The environment is very important to us".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. One person said, "They have some good staff. Staff are very approachable and we have a laugh". They added, "The jolliness and the camaraderie exists between staff and us. They share with us their joys and happinesses, like a new grandchild". Another person referred to staff and said, "They work so hard, every one of them. I don't think there's one staff member I could say I don't like". We observed that people were cared for by kind and caring staff. For example, at lunchtime, we heard one person being offered a cushion by staff to make the chair more comfy as they sat at the dining table. Staff were mindful of people and knew their likes and dislikes, the way they wished to be supported and details about their personal lives and family members. People's life histories and personal profiles were recorded in their care plans. We looked at one person's food preferences and the care record showed they liked fruit, vegetables and fish, but disliked mashed potato. The chef told us about people's food preferences and was well aware of what people liked or disliked to eat. Staff thought highly of people living at the home. One staff member said, "It's a nice atmosphere and most people get on with each other. We get on well with the residents, they do take the mickey out of us!" Another staff member told us, "Residents are all lovely, they're chatty and will tell you things".

People were supported to express their views and to be involved in making decisions about their care, treatment and support. We asked people whether they were involved in reviewing their care plans. People seemed unsure what a care plan was, but all agreed they were asked for their consent relating to their care and were involved in decision-making.

People were treated with dignity and respect and had the privacy they needed. Some people preferred to stay in their rooms rather than join in with any organised activities. Whilst people were encouraged to participate in activities, if they chose not to do so, their wishes were respected. We asked staff how they treated people with dignity and respect. One staff member gave an example, "If you were going to wash a patient, I would ask them and consent would have to be given. The curtains would be drawn and doors shut. I cover people over with a towel and speak to them to explain what I'm doing". They went on to say that people often liked to choose what they would wear when they got up and that they would assist people with dressing. Another member of staff explained the need to maintain people's dignity and said, "People are covered up whilst having a wash. I try to encourage people to wash themselves".

People were supported at the end of their lives to have a private, comfortable, dignified and pain-free death. Many people had made advanced care plans and their wishes were recorded in their care records. Where appropriate, 'Do Not Attempt Cardio-Pulmonary Resuscitation' forms had also been completed by healthcare professionals and people were involved in decisions about whether resuscitation should be attempted in the event of them have a cardiac arrest or dying suddenly. Some care staff had completed end of life training and one staff member explained what they would do for a person reaching the end of their life. They explained, "I'd find out what they need and want, what their families want. We will sit with them so they don't die alone". Nursing staff had completed training or received advice from a local hospice. Some had completed the Six Steps Programme, a programme designed to develop awareness and knowledge of end of life care.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans contained detailed information about people's care and support needs and guidance for staff. Before people were admitted to the home, a pre-assessment was completed to ensure their care needs could be met at the home and the appropriate support be given. We looked at a range of care plans and at the front of each plan, staff were alerted to any recent amendments or changes to people's care needs. Care plans provided information about people's personal care including washing and dressing, nutrition and food preferences, any specific issues on diet or swallowing, skin and tissue viability, mobility and dexterity, breathing and circulation, psychological wellbeing, capacity and consent, communication, social care and spiritual needs. Information was provided to staff on people's day and night-time routines and on their prescribed medicines. Some people also had additional plans of care for specific areas, for example, how to manage a chest infection, pain or urinary tract infection. Care plans were reviewed monthly and were signed by nursing staff to reflect any amendments or changes that needed to be made. The provider told us, "We do go through the care plans and they're very person-centred. We discuss each resident every month". A member of staff said, "I look at care plans and sometimes something needs to be updated and I will tell the nurse". The registered nurse would then update the care plans, thus ensuring that people's most up-to-date care needs had been identified and could be met. People were also allocated a keyworker, who co-ordinated all aspects of their care. One member of staff told us they checked on whether people had sufficient toiletries and explained about one person who enjoyed an occasional drink of sherry or brandy. They said that when these drinks were running low, they would ask the family to buy more. Another member of staff explained her understanding on the role of keyworker and said, "I go and spend a little time with them and I document it".

A range of activities were organised for people living at Tenchley Manor Nursing Home and external entertainers regularly visited. A printed programme, which was given to people, showed the activities planned for October 2016. These included exercises, singalongs, reminiscence, Tai Chi, church services and a creative talk, 'How we used to live in video and music'. On the day of our inspection, a married couple set up various musical instruments and entertained people with songs from the shows, folk music and songs that people remembered and could sing along to. We asked people whether they were happy with the activities on offer. One person said they would like to play Bingo more often and that this had been discussed at a recent residents' meeting. People could go out with their relatives and friends or occasionally outings were organised. Money was raised towards various outings throughout the year. Care staff told us about various activities and said, "We've had movie days and people have gone to the Butterfly Farm. [Named manager] has implemented more than we ever had. Some people don't like joining in a group activity. I go in to people, look at pictures, do their nails and do their hair. They absolutely love that". A hairdresser visited the home twice a week or people could have their hair done by their own hairdresser. Another person said, "I read and watch TV, sleep and eat. A lady comes in and does reminiscence therapy and I like to go to that". They told us they preferred their own company rather than to be involved in all the activities on offer. People had free access to the gardens surrounding the home and some people went outside to smoke a cigarette. Fetes and BBQs were organised in the gardens during the summer months.

Complaints were investigated and managed in line with the provider's policy. People knew how to make a complaint or raise a concern and most said they would talk to a registered nurse or the registered manager. One person told about a recent concern they had raised and told us that it had been managed to their satisfaction. Another person complained about their room being too cold and maintenance staff were immediately called and took prompt action to fix the problem.

Good

Is the service well-led?

Our findings

People were actively involved in developing the service. The provider told us that residents' meetings took place and said, "Everybody likes to have their say on entertainment, for example, we put an arts and crafts table in". A large table had been arranged in one part of the communal area and had various activities and reading material available for people to access. People confirmed to us that residents and relatives' meetings took place and one person said, "It's like a Trade Union meeting!" Another person said, "There are monthly residents' meetings where we can bring forward points. They're typed up and fed to [named registered manager]. We talk about things we're not happy about, for example, jugs of water left in places where we can't reach them". They added that the registered manager was, "Very approachable, she's very, very good". We looked at the minutes of the meeting which took place on 9 September 2016. These showed that items discussed were new staff members, menus, the summer fete and forthcoming events. Relatives also had their comments recorded. One comment was, 'I would like to say that I think Tenchley Manor is a really good home. I find the staff helpful and they have been very kind to Mum. A good attitude makes such a difference to the residents'. The registered manager told us, "I want the residents to be happy and feel listened to".

Good management and leadership was visible at all levels. The provider visited the home regularly and staff, relatives and residents could meet with him. The registered manager, apart from day-to-day management of the home, also worked on the floor, working with nursing and care staff to deliver care to people. Staff spoke highly of the registered manager. One member of staff said, "I've been here a long time. The previous manager was okay, but the manager we have now is a hundred times better. She's approachable and caring with the residents. She is very kind and caring and very approachable. If we have a problem, she will deal with it straight away". They added, "We'll see the owner from time to time. He always tries to do his best for the residents. Money is not an issue when it comes to getting things sorted or with food". We asked another member of care staff whether they felt the home was well managed and they responded, "Yes I do. I would recommend it to anyone. It's got a good reputation for care in the village. I would put my parents in here". A third member of staff simply said, "It's brilliant, everyone pulls their weight".

High quality care was evident in our observations at the home and through comments to us from staff, people and their relatives. One person told us, "It's just such lovely and caring care. Your clothes are clean, you can have your hair and nails done. I like pampering". A relative had written, 'You have always treated me as one of the family and this has brightened my life whenever I have visited you'. Another relative commented, 'We can't thank you enough for making him comfortable, especially in his last days. He could not have had better care anywhere else and he often told us how much he loved it there'. A third relative stated, 'I'd like to thank you for the care and dignity you showed him'. The provider told us, "We are interested in what residents individually want and try to tailor to their needs on the environment and with their care. We do questionnaires and these encourage feedback". The registered manager said, "I believe the care's good and the staff are trained and competent. The documentation is much better and I feel there is a smoother consistency of care". A member of staff commented, "I do love working here, because the people we look after are just kind and thoughtful. Everyone is looked after so well". Nursing staff spoke

highly of the manager. One registered nurse said, "The manager is energetic, solution-focused, dynamic and prompt when there is need to action any issue".

We observed that care plans, which were stored in a cupboard in the front hall area, were not kept securely. The lock had broken on the cupboard door, so records were not kept in a confidential way. In addition, a list of residents' names, their date of birth and whether they were diabetic, had been put on a wall next to a desk which staff used to look at care plans. This was visible to anyone visiting the home and meant that people's personal details had not been kept confidentially. Also, an allocation sheet used by care staff providing a summary of people's care needs had been left on the desk for anyone to see. We picked this sheet up and handed it to the registered manager. We discussed the issues relating to the unlocked cupboard and storage of personal information relating to residents. The broken lock on the cupboard was fixed on the first day of our inspection and the sheet containing people's dates of birth was removed from the wall. The registered manager concurred with our findings and stated she would remind all staff of the need to keep information confidentially and records secure.

A range of systems had been put in place to measure and monitor the quality of care delivered. The provider told us, "Usually once a month we do an audit. We talk about the home, the residents and staff. We chat during the week anyway, we get things done and see to things straight away. The audit is to formalise things and it's evidence for yourselves to see what we've done". They added, "We like to do everything well to be honest. We care about the residents and their opinions. We want them to come forward and suggest things". At the end of each month, the registered manager co-ordinated the various audits and completed a monthly report for the provider. Where improvements were identified, actions were taken to address these. We looked at the report prepared in October 2016. The report contained information about the residents, whether any people had pressure ulcers, nutrition, weight gains and losses, GP visits, analysis of accidents and incidents, referrals to Accident and Emergency and people's resuscitation status. Care plans were reviewed monthly, including associated risk assessments, Medication Administration Records checked, activities and entertainments that had been offered during the month, referrals to safeguarding, maintenance issues and information about staff training, qualifications and staffing levels. Questionnaires were sent out to people and relatives randomly throughout the year, although none had been sent in October.