The Royal Masonic Benevolent Institution Care Company

Tithebarn

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

Tithebarn is registered to provide personal care and accommodation for up to 42 adults. The home is run by The Royal Masonic Benevolent Institution Care Company. The home is fully accessible to people with restricted mobility. Accommodation is provided over two floors, with bedrooms located on the ground and first floor. There is a separate unit specialising for people living with dementia.

This inspection was carried out over two days on 20 and 21 September 2017 and was unannounced. This was the first inspection since the service was registered in 2016.

We found consistently good standards were maintained in the home with many areas of good practice evidenced. This was particularly evidenced with the support for people living with dementia who experienced exceptionally high levels of individualised care which reflected best practice in this area.

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.

We found medicines were being safely managed. The administration records for some medicines such as external applications [creams] and medicines to be given 'when needed' [PRN] could be further improved by including more detail.

We looked at how staff were recruited and the processes to ensure staff were suitable to work at The home. We saw required checks had been made to help ensure staff employed were 'fit' to work with vulnerable people.

We found there was sufficient staff on duty to meet people's care needs.
Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training in-house. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety checks were completed on a regular basis so hazards could be identified.

The home was clean and we there were systems in place to manage the control of infection.

Staff said they were supported through induction, appraisal and the home's training programme.

People we spoke with and their relatives felt staff had the skills and approach needed to ensure people were receiving the right care. Staff leading in support for people with dementia had been trained to a high level.

There were examples of good practice such as the attention to positive principals of care for people living with dementia. This meant people living with dementia experienced an exceptionally high level of wellbeing and quality of life.

We found the home supported people very well to provide effective outcomes for their health and wellbeing. We saw there was regular and effective referral and liaison with health care professionals when needed to support people. Feedback from visiting health care professionals we spoke with was positive.

People we spoke with said they were happy living at Tithebarn. Staff interacted well with people living at the home and they showed a caring nature with appropriate interventions to support people. We found a caring ethos throughout the home.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

When necessary, referrals had been made to support people on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the managers of the home.

We saw people's dietary needs were managed with reference to individual preferences and choice. Lunch time was seen to be a relaxed and sociable occasion.

People felt involved in their care and there was evidence in the care files to show how people had been included in key decisions.

There was strong emphasis on social activities and these were organised in the home and continued to be developed. People told us they could take part in social events which were held. We found social activities were linked to peoples preferred choices and cultural background.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain.

The manager and deputy manager were able to evidence a range of quality assurance processes and audits carried out at the home.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

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.

Medicines were administered safely. Some administration records could include more detail and this was being considered.

Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found there were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

There were enough staff on duty at all times to help ensure people's care needs were consistently met.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards were routinely monitored.

Is the service effective?

Good

The service was effective.

Staff told us they were supported through induction, appraisal and the home's training programme.

We found the service supported people to provide effective outcomes for their health and wellbeing.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

Staff displayed reassuring and effective communication when interacting with people.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care and could have some input into the running of the home.

Is the service responsive?

Good

The service was responsive.

The home had an high level of person centred activity and care. This was strongly evidenced for people living with dementia.

Care plans were being reviewed and monitoring of people's care evidenced an individual approach to care.

There was a strong emphasis on social activities planned and agreed for people living in the home which contributed to people experiencing a high level of wellbeing.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain.

Is the service well-led?

Good

The service was well led.

There was registered manager who provided an effective lead for the home and who had developed a positive culture of care in the home.

There were a range of quality assurance processes and audits carried out at the home to both monitor standards and help ensure continuous improvement.

Tithebarn

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 checked whether the provider was 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 was an unannounced inspection which took place over two days on 20 and 21 September 2017. The inspection team consisted of an adult social care inspector 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.

Prior to the inspection we collated information we had about the service and contacted the social service contracting team to get their opinions. We also reviewed other information we held about the home.

We were able to access and review the Provider Information Return (PIR). The PIR 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.

During the visit we were able to meet and speak with 11 of the people who were staying at the home. We spoke with two visiting family members. We spoke with seven of the staff working at the home including the registered manager, deputy and care/support staff. We also spoke with three visiting health care professionals. we also spoke with two visiting relatives by phone following the inspection.

We also observed care by carrying out a SOFI observation. SOFI stands for Short Observational Framework for Inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We used this on the unit for people living with dementia.

We looked at the care records for three of the people staying at the home as well as medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and

the dining/lounge areas.

Good

Is the service safe?

Our findings

People said they felt safe living at Tithebarn and comments included; "Just the people who work here, I've got confidence in them", "The [staff] are very helpful if you need any help", "The fact that people are vetted as they come in and nothing has disappeared from my room [is good]" and "There's usually somebody around if help is needed, [person] is rarely left on his own.

Key areas of the running of the home were managed safely. We found medicines were managed safely. There was an electronic administration of medicines system in operation. All staff administering medicines had received training on this system. The system had many positive advantages in ensuring correct and safe administration. Prompts and warning messages indicated any precautions to be taken or could alert staff about medicines being missed.

There were additional paper records for the administration of external medicines such as creams and prescribed substances such as 'thickeners' for drinks; the latter used to thicken the consistency of drinks for people who had difficulty swallowing. The charts recorded these medicines as given but there were gaps in the recording on two charts we saw indicating application had been missed. On questioning it became apparent that the creams were only to be administered 'when necessary' [PRN medicines]. We discussed the need to include this information on cream charts to avoid confusion.

Regular medication audits were being carried out by the manager and also by visiting senior managers. We saw audits of medicines in stock carried out weekly as well as monthly routine checks of all medicines when they were being 'signed' in when received. A weekly check of controlled drugs (CDs) was also made. Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded and records indicated that the fridge temperature had remained within safe limits. Medicines were administered from medicine trolleys on each floor. These were securely locked when not in use. We spoke with staff regarding the process of administration and the staff member understood the homes policy and good practice regarding this.

People told us they got their medicines on time. One person commented, "They never fall down on that; I get all my medicines on time."

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two files of staff employed and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been made.

We had mixed comments when we asked if people thought there were enough staff on duty at all times to support everyone appropriately. People living at the home said they felt there could be more staff whilst relatives visiting told us there was always a good staff presence. People we spoke with could not identify how shortages of staff affected care and all spoken with agreed that they had support when they needed it. The staffing levels to support 39 people resident in the home were normally two senior care staff and six other care staff. The registered manager and deputy were supernumerary to these numbers. We found there was also good ancillary support such as administration staff, kitchen staff and domestic and laundry staff.

When we spoke with care staff we were told that they enjoyed working in the home and felt there was a good atmosphere and good team work. Staff we spoke with confirmed that staffing in the home was stable. One staff told us, "Nobody is rushed; we have time to carry out care. The staffing is generally settled and there's not a great turnover [of staff]."

We found arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. We saw comprehensive records of all of the routine environmental checks made in the home. we saw people using walking frames and wheelchairs to get about, often with staff support, and how these enabled them to do so safely. The lounges and dining areas were spacious enough to allow people to move unhindered, with or without support. Some grab rails were available in bathrooms, and lifting/support equipment was also evident in some bathrooms.

There was fire safety equipment in all areas and we saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home. This helps to ensure effective evacuation of the home in case of an emergency.

All maintenance / safety certificates were up to date we saw records indicating when these needed updating. Overall there was good attention to ensuring safety in the home and on-going maintenance.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails.

When we looked round the home we found it to be clean. There were no unpleasant odours. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. All shared bathrooms/WCs were clean and appropriately equipped for hand washing. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. People living at the home and visitors we spoke with told us the home was always maintained in a clean and hygienic state. Two people told us "It's very clean, somebody cleans my room every day" and "Yes, it's more like a hotel."

Good

Is the service effective?

Our findings

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care. One person told us, "They know what they are doing, they give you confidence." Another person said, "Most of them and if they (agency staff) don't know, they bring somebody else. I couldn't grumble about anything, if you need attention, you get it pretty quick."

The Provider Information Return (PIR) sent to us before the inspection told us, 'Staff start a full induction from day one of employment and this is completed over their first twelve weeks. This gives them the skills and confidence to carry out their role and responsibilities effectively in line with the Care Certificate [set of care standards used for staff to update or to be inducted with]. They also complete a mandatory training programme which covers all aspects of care and support which is updated at regular intervals or as and when required'.

All of the staff we spoke with confirmed they felt supported by the homes training programme. One staff commented, "The training is spot on. It's quite varied and not just 'on line'. Another staff said, "All my training is up to date – it's on-going and we cover everything."

We looked at two staff files and these included copies of training certificates covering many aspects of care including safeguarding, moving and handling, medication administration and infection control.

We spoke with the deputy manager who ran the unit for people living with dementia. We were told about the more specialised training for staff in this area; four of the staff on the unit had been trained to diploma level in dementia care. Staff were able to talk about many of the values embedded in the training and how this had developed care on the unit. One staff said, "Feelings matter most. It's about removing the 'them and us' barriers and creating a 'household' atmosphere." We saw this philosophy evident in many of the observations we made on the unit.

We saw that a high percentage of staff had achieved formal qualifications at Level 2 or above in NVQ or Diploma in Health and Social Care. Senior care staff had been given extra training in medication administration. We saw this had been well monitored and staff administering medication had also been assessed for their competency to deliver safe standards. A recent internal audit noted the home had achieved 91% compliance for meeting all 'statutory' training. The registered manager showed us a copy of the training matrix which also confirmed this.

This shows a good base of staff knowledge to help ensure effective care for people.

Staff support included supervision meetings conducted by the registered manager, and deputy with individual staff. Staff we spoke with felt they were fully supported by the registered manager and could speak with the manager and other senior members of the staff team at any time.

During our inspection we reviewed the care of three people living at the home. We found staff liaised

effectively to ensure that people living at the home accessed health care when needed. One person we reviewed had experienced changing care needs over a space of time and these changes had been monitored by staff in liaison with the person's GP and other health professionals. A visiting health care professional told us, "We have no problems with Tithebarn; they are very proactive and refer any [health] issues quickly. The staff are always knowledgeable and they carry out any instructions we give them." One of the people living in the home said, "They get the doctor very quickly if I get ill."

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The 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).

Two of the people in the home at the time of the inspection were under a DoLS authorisation although the managers had made applications for others and were monitoring these in liaison with the Local Authority.

The staff and registered manager were able to discuss examples where people had been supported and included to make key decisions regarding their care. In one example a person with varying levels of mental capacity had previously been assessed regarding the need to administered medicines 'covertly' [without their knowledge or consent in their best interest]. We saw assessments and documentation which supported good practice in this area and made use of mental capacity assessments with good supporting care plans and liaison with health and social care professionals. The staff showed they understood the process involved in making a best interest decision for a person who lacked mental capacity.

The care documentation evidenced that consent to care was very much considered. For example the admission assessment documentation highlighted the need to get people's consent for admission to the home. Other examples included care files showing where people had consented to their plan of care. We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates [family members].

Staff told us about one person who had a relative with Lasting Power of Attorney [LPA]. This is a legal status allowing an identified individual to make decisions on another person's behalf if they lack capacity for this. When we looked at the person's care record we found a lack of information around this. Staff were also not aware of the extent of the LPA and which decisions [finances, health or both] were covered. A copy of the LPA was held separately and we were able to confirm the details. We discussed the need for clearer care records however so staff could have clear and accessible information.

We asked what the food was like. Most people said they felt the meals were good. One person said, "Lovely, there's always a choice of main course for lunch and choice of sandwiches for tea." Other people told us, "Most times it's nice, and the other times it's reasonable, it's enough for me. I don't eat as much as I used to and there's always alternatives available", "It's good and I'm happy with it" and "Excellent, it's really well cooked, the cooking is first class. We had beef on Sunday, it was well done and had the right sauce, and the vegetables are always beautifully cooked."

We spoke to the chef who told us there was a cooked breakfast every day and this varied from day to day.

There is also cereal, porridge toast available as well. The chef had daily briefs from senior carers about food allergies, special diets and people's likes and dislikes.

The overall environment was well maintained and comfortable for people. We saw some positive adaptations to support people with disability; for example assisted baths and walk in shower facilities. On the unit for people living with dementia we found excellent attention to creating a 'dementia friendly' environment with many examples of orientation aids and an abundance of objects for people engage with including books, magazines, soft toys and wall decorations which were both colourful and tactile. We saw people engaging and active with all of these. There was also an easily accessible 'sensory' garden for people to enjoy.

Good

Is the service caring?

Our findings

We observed staff to be caring in their support of people at Tithebarn. Staff were observed to be pleasant and to speak kindly and courteously to people when offering or giving support, or when serving food and drinks. Relationships were evidently good between everyone living and working at the home.

People and visitors told us; "[Staff are] wonderful, they'll have a laugh with you, but they're quite serious about looking after you. They do a good job", "They're nice and they'll listen to you. They always try to be helpful and they treat me well", "They're very pleasant and helpful", "They treat me very well. They're very careful and never patronising" and "They treat [person] with respect and they're very competent."

People were encouraged to be as independent as possible. One person we spoke with had their own phone to keep in touch with friends and relatives. They told us, "Its wonderful here, staff let you make your own decisions; they are very thoughtful."

We saw people had their mobility supported and had mobility aids provided if needed.

We saw very positive interactions between people and staff throughout the day, whenever support was being offered or provided. We also saw some staff taking opportunities between tasks to socialise/interact with people. People living with dementia had constant support and social stimulus. We carried out observations [SOFI] on the unit for people living with dementia and recorded very high levels of positive support from staff on a continual basis. This resulted in people experiencing high levels of 'wellbeing' as evidenced by their positive interactions and facial and verbal expressions.

We asked whether people's privacy was respected. All of the people we spoke with confirmed they felt their privacy was respected by staff. We saw staff knocking on people's doors before entering and, as necessary, opening the door slightly to check they had permission to enter.

When we spoke with staff they came across as caring and interested in their work. Staff were knowledgeable regarding the people they supported. We did feedback two more negative comments regarding people's preferred means of address. Two people reported staff did not address them using their preferred name. The registered manager said they would follow this up.

Care plans we viewed contained evidence of people and/or their families being involved in the care planning process; this was evident through signed consent forms and records of discussion with people and families.

We saw that people had access to advocacy support if needed. Leaflets and information was displayed regarding the local advocacy services on the resident's notice board. There were no people using advocacy services at the time of the inspection but the registered manager was able to give past examples; a person had no family and needed a lot of support because of psychological difficulties and depression in the past and an advocate visited frequently to support their wellbeing.

Good

Is the service responsive?

Our findings

People told us they were free to spend time as they wished. We were told, "I read and watch television, I always join in the activities. Sometimes we go out to the shops or theatre", "I watch the telly, read and join in a few activities. I like listening to music", "listening to Radio 4 or listening to books", "I talk to people and watch a little bit of television" and "I like music, I join in the activities and go on outings." The majority of people joined in the planned morning activities and afterwards they told us they enjoyed them.

The activity coordinator gave us a long list of numerous activities planned for people. There was good variety which included trips out of the home. There was input from the local community. For example, the scouts had visited. There was also involvement with the local church. The home funded all the trips and we heard about a forthcoming trip to Blackpool illuminations followed by fish and chips that was being arranged; this had been agreed in consultation with people living in the home.

People told us they could make daily choices. They said they could choose how and where they wished to spend their day and what time to get up and retire at night. One person we spoke with spent much of their time in their room and liked reading the daily newspaper. They said, "There's no rush for anything here; we can take our time and it's very relaxed; the staff are very considerate."

We found the unit for people living with dementia [Maud Sullivan House] exemplary in providing a stimulating environment which, in turn, promoted exceptionally high feelings of wellbeing for people. The atmosphere was very homely, with furniture and knick knacks from the 1950s. There was 1940s music playing and although there was a television in the lounge, this was inside a wooden cabinet and the member of staff told us it was only turned on at a people's request as the aim was for people to be positively engaged in other activities. There was a multitude of things for people to pick up, plenty of 'rummage' boxes; "The idea", a staff reported, "Is people can rummage and potter and it brings up all sorts of memories." Every space was taken with a large variety of objects that the older age group would be familiar with. Many of the memory boxes outside bedroom doors had pictures of the person when they were young and this acted to promote discussion and conversation. There was a quiet area on the corridor which had a seaside theme, another with a walled street theme; there was no area on the unit that did not have a positive focus of activity. This promoted a calm atmosphere as well as an environment where staff continually interacted with people living there.

We conducted a SOFI observation on this unit and recorded 24 positive staff interactions with four people we observed over a 30 minute period. There were no negative interactions. All four of the people we observed were engaged in some activity, either with staff or with the general environment or with other people. The level of observed 'wellbeing' for people was very high with all four having a positive recording for 'mood' over the whole of the observation period. We found this level of person centred activity encouraged a high level of inclusion and belonging as staff recognised people's uniqueness by interacting and involving them in ways they preferred. A good example of this was one person engaged with a staff member in a book of photographs; these were photographs the person immediately related to from their past and the activity promoted a positive atmosphere as they were able to reflect about their own past

experience. Another person was engaged in doing some painting, which they preferred as an activity.

People observed had limited verbal expression but some comments made included, "It's nice here isn't it?" and "It's very relaxing." One person replied to our questions by just singing along to a DVD, obviously happy and relaxed; the DVD was of a musical that the person knew well and preferred.
We spoke briefly with one person who was mobilising about the unit with a walking aid. They smiled and looked relaxed. Staff explained that the person had refused to come out of their bedroom for a period following admission as they had been to apprehensive but now visited the day areas regularly. The increased interaction had been brought about by constant reassurance by staff and once introduced to such a positive environment they had relaxed and been reassured by the numerous orientation aids and areas of interest; staff told us the importance of allowing people to do things at their own pace.

The unit manager explained the philosophy of the care; "We are proud that staff have a high level of training which gives them an understanding that we 'live with' the people here and join in their day as much as possible. We have a cup of tea with them and the routine of the day is their choice." Another staff said, "[People] feel involved because they feel it's their home." This was described by the unit manager as 'The household model of care'. We were told there was a very low level of agitation and disturbance for people living on the unit.

Relatives of people living on the unit were also enthusiastic about the care and support. One relative commented, "It's absolutely brilliant. The good thing is that [person] is with staff [they] recognise; there is very little change of staff so they really get to know the people they are looking after." We also heard about how one person's quality of life had improved on the unit. They had been 'very anxious' prior to being admitted had struggled at home because of increasing inability to carry out tasks. Because of the homily environment and regular one to one attention by staff the person was now "Much more relaxed; [person's] whole demeanour has changed and [person] is really settled and happy."

The unit had been audited by 'Dementia Care Matters' in October 2016 and achieved a level 1 rating which is a 'home providing exceptional person centred dementia care of the highest quality of life level'. The auditor, a consultant nurse in dementia care, cited many positive examples of exceptional care including; 'an excellent team, well led', 'no negative care observed', '[people] alert and ready to smile and laugh', 'knowledge of person centred approaches are obvious with the whole team', 'no neuroleptic drugs are used', 'people at the latter stages of their dementia are skilfully supported' and 'Maud Sullivan House looks, sounds and feels like a home from the moment of arrival'.

The report stated that only one percent of care environments audited achieve a level one rating.

For the whole home, care records were completed and included personalised information about people such as, personal care and physical wellbeing, medication usage, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and social care.

Care plans were specific to the individual and there was reference to people's life history to get to know people's social care needs and background in more detail. One person told us, "Staff spent a lot of time with me going over my past and my family history; Its great they are so genuinely interested." These records, along with staff's daily written evaluation/notes meant care files contained important information about the person as an individual and their particular health and care needs.

Staff were aware of the importance of these records for monitoring people's health and welfare. We looked at a sample of these records and they were kept up to date by the care staff. We saw care plans were

regularly reviewed and people were consulted periodically about their care.

A visiting health professional said, "The care is very personalised; I would have no hesitation in placing a relative at Tithebarn."

People had access to a complaints procedure and this was available to people within the home. A person said, "I'd ask for the manager. I can speak to all the staff – things get sorted out." A system was in place to record and monitor complaints. There had been one recorded complaint since our last inspection. This had been responded to satisfactorily by the registered manager.

Good

Is the service well-led?

Our findings

The registered manager was well established at Tithebarn and had worked there for a number of years. They were supported by a deputy manager. The management structure for the organisation was clear from the Board of Trustees through to a director of care, senior managers [both clinical and quality managers], and an area manager who all supported the registered manager's role.

The registered manager and deputy were able to espouse a positive ethos of care in the home. The feedback from all of the people we spoke with, as well as staff, was that the registered manager was providing positive leadership as well as good clinical skills. The registered manager was described as supportive, easy to approach and consistent. There was a willingness to develop standards in the home and we saw both managers could reflect positively on the feedback we gave throughout the inspection.

We saw the home's philosophy was clearly referenced in some of the literature available for people and in the PIR provided prior to our inspection. The PIR stated; 'Our mission statement is underpinned by a set of values which include honesty, involvement, compassion, dignity, independence, respect, equality, safety and empowerment'.

The registered manager told us they had completed a leadership training programme which has also been completed by other senior members of staff. The registered manager explained the need to be consistent, lead by example and be available to staff for guidance and support.

When we spoke with staff they confirmed this approach and said they felt supported in their role and the registered manager was always available if they needed support. People we spoke with commented positively, "Yes, I know her, I see her and she's very approachable" and "Yes, she gets things done if there's a problem."

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. Internally, we saw audits carried out for medication safety, infection control [hand hygiene], accidents and falls, maintenance of equipment and routine checks for health and safety regarding the environment such as fire safety. We saw some of the audits had been effective in identifying areas for improvement. For example an infection control audit carried out in May 2017 highlighted areas for improvement; most of these had been actioned. We were told two members of the staff team were leading on infection control and attended meetings with the infection control, advisors externally.

Key information form the audits were fed into the 'Care Dashboard' and sent for senior managers to review. These were key indicators of care such as safeguarding referrals, hospital admissions and number of pressure sores. This showed a clear pathway for information up and down the organisation. We saw the minutes of a 'Regional Meeting' from January 2017 which clearly identified how management process should 'empower managers' and develop other members of staff.

There were systems for getting feedback from people living at the home and their relatives as well as staff.

We saw a series of surveys and meetings aimed at seeking feedback about the home. These forums, such as resident and staff meetings as well as surveys conducted, returned positive comments about the home and a high satisfaction rating. We discussed some of the meetings [staff and resident] in terms of identified areas for improvement. We saw there was not always a plan of action identified following these meetings [minuted] although the registered manager did explain that anything outstanding was included in the continuous improvement plan [CIP] which we saw and was continually reviewed.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. The rating from the previous inspection for Tithebarn was displayed for people to see.