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Tiled House

Inspection report

The Tiled House
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 27 and 28 October 2015 and was unannounced.

Tiled House provides accommodation and nursing care for up to 29 older people, most of whom are living with dementia. The home is in the village of Shawford, near Winchester. People have access to gardens.

Tiled House has 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.

Recruitment practices were not safe. Before a member of staff was recruited, relevant checks such as identity checks, obtaining appropriate references and Disclosure

Summary of findings

and Barring Service (DBS) were completed, however the provider did not obtain a full employment history for all staff recruited. There was a risk that staff may be unsuitable for the role.

Some improvements were required to medicines management to ensure staff were able to identify when people might require pain relief. Medicines were administered in a caring and professional manner. The provider used protocols for people who required pain relief such as paracetamol. These gave clear guidelines to staff about when and how often this type of medicine should be given for individual people. However, pain assessments were not in use in the home. We have made a recommendation in relation to pain assessment.

Protocols were not in place for medicines, other than pain relief, which needed to be administered 'as required,' describing to staff how and when the medicine needed to be administered. Therefore there was a risk that these medicines may not be administered appropriately due to a lack of clear guidelines.

Communal areas of the home were clean and smelled fresh, however we found four bedrooms which contained a strong malodour. This stemmed from the mattresses on people's beds which were stained. The mattresses identified were all replaced before the end of the inspection. We have made a recommendation in relation to infection control.

Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. The safeguarding policy was available for staff to review and staff knew where it was kept and where to find relevant telephone numbers for reporting any concerns people had experienced abuse.

A range of tools were being used to assess and review people's risk of poor nutrition or skin damage. There were specific risk assessments for each person in relation to falls, nutrition, moving and handling and mental health and cognition. Support plans were written for people in relation to each identified risk.

There were enough staff on duty to meet people's needs. Staffing levels were calculated by the provider which took into account the number of people using the service and their dependency level. This was reviewed and updated regularly and the registered manager told us she was able to increase or decrease staffing levels over and above the calculated level, if this was necessary. From observation, we saw there were enough staff to meet people's needs and staff took their time assisting people without rushing them. They also used the time supporting people to socially interact with them rather than just 'completing a task.'

The high use of agency staff in the home was mitigated by actions taken by the registered manager to ensure agency staff had the right skills, experience and qualifications to meet people's needs. Actions included training agency staff and using regular agency staff.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, first aid, moving and handling, food hygiene and health and safety. Clinical training was provided for trained nurses. Recently nurses had completed training in wound care, mouth care, diabetes and venepuncture (the process of obtaining intravenous access to people's veins in order to take samples of people's blood for analysis).

Staff had a regular supervision meeting with the registered manager and an annual appraisal. Areas for improvement were discussed during staff appraisals. All staff told us they respected the registered manager and felt supported in their role. Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families.

We saw that care was delivered in line with people's wishes. People chose where they wanted to sit to eat their lunch. We saw that staff were very patient with people while they took time to decide and then supported them to sit in the place of their choice.

1. We checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. We found that staff had received training and were able to describe some of the key principles. Mental capacity assessments had been undertaken which were decision specific.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS)

Summary of findings

which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Relevant applications had been submitted and staff were aware of which people were subject to a DoLS.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day and staff encouraged people to drink. Fruit squash and water was available all day and we saw staff regularly pouring drinks for people. No one was without a drink within easy reach at any time. A tea trolley came round during the morning serving tea, coffee, biscuits and yogurts. We saw staff encouraging people to eat and drink.

The meals offered were home cooked, freshly prepared and nicely presented. There was a choice of two main courses and a vegetarian choice. There were also a hot pudding with an alternative of fruit. People were encouraged to have second helpings.

Staff were aware of any special diets or people's dietary preferences. The chef showed us a list of people's special diets which was kept in the kitchen. She said she was aware of people's likes and dislikes. Care plans included risks assessments in relation to each person's risk of choking or malnutrition and there were plans in place to address any identified risks. Staff explained that they ensured people received sufficent to eat and drink by encouraging fluids and checking monitoring charts.

People were supported to maintain good health through access to ongoing health support. A GP visited every Tuesday but also came on other days if people were ill. Records of GP visits were recorded within people's care plans ensuring that all staff were aware of the advice given by the GP.

We observed staff interacting with people in a kind and compassionate manner. They responded promptly to people who were requesting assistance and they did so in a patient and attentive way. We also noted a considerable amount of warm and friendly exchanges between staff and people which were, when people were able, reciprocated in the same manner. Staff were cheerful and the atmosphere in the home was relaxed. People seemed calm and contented.

Staff spoke with people while they were providing care and support in ways that were respectful. We observed that people were addressed with their chosen names. Staff ensured people's privacy was protected by ensuring all aspects of personal care were provided in their own rooms

People's care plans included a 'This is me' record which gave a brief life history. It included what name people liked to be known as, the places they had lived, their school, job, hobbies and interests. This enabled staff to really get to know people and understand what was important to them. People were involved in decisions about their care and were offered choices in all aspects of their daily life.

Most people required a high level of support to meet their care needs. Staff and the registered manager told us they encouraged independence whenever this was possible.

People's care plans included the range of all expected risk assessments and care plans. For example in relation to skin care, mobility, communication and medication. These were evaluated regularly and showed they had all been reviewed recently. The provider had well organised records and the guidance provided for staff in order that they met people's needs was detailed and comprehensive. The records were written well and provided step by step information for staff to enable them to provide appropriate care that met people's needs.

The registered manager told us they were recruiting for an activities co-ordinator, as there was no-one in post at the moment. However, all the staff were aware of the importance of stimulus and mental exercise for people. Staff involved people in playing games of with soft balls, and a game of rope-quoits. Some people had jigsaws; some were reading newspapers or magazines. Most people were wide awake and involved with whatever was happening.

Summary of findings

People, staff and relatives were aware of how to complain or raise a concern but most people said they had not had need to do so. All said they would approach the registered manager, who they felt would listen and respond appropriately.

The registered manager was required, by the provider, to work two day shifts providing nursing care. This meant she was only available in a management role for three days a week. Without support from a deputy or an administrator, this was insufficient and meant the service breached regulations which may not have happened had the registered manager been able to carry out her management role on a full time basis. The registered manager told us she worked extremely long hours in an attempt to fulfil her clinical duties as well as her registered manager role but was unable to carry out all the tasks she would like.

There was a positive and open culture within the home. All staff were highly complimentary about the registered manager. She was extremely well respected as a leader. Staff said they were actively encouraged through meetings and appraisal to give feedback about the service.

The home had a registered manager in post who was aware of her responsibilities both regulatory and to the home. Relevant notifications had been submitted to the Care Quality Commission (CQC). There was high visibility of the registered manager 'on the floor' and positive interaction between the registered manager, people and staff.

Policies and management arrangements meant there was a clear management structure within the home.

The quality of the service was closely monitored through a series of audits including care plan, catering, medication and night time audits. Quality assurance audits were carried out by the provider. As a result action plans had been drawn up and all actions completed**.**

During our inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The home was not always safe.

People told us they felt safe. Staff had received safeguarding training and knew how to recognise the signs of abuse.

There were sufficient staffing levels to meet people's needs; however recruitment procedures were not always robust to ensure staff employed were suitable for the role.

Medicines were stored safely.

Protocols were not in place for all medicines which were taken 'as required.' There was a risk these medicines may not be administered appropriately.

Infection control concerns in relation to stained mattresses were rectified as soon as they were identified during the inspection.

Is the service effective?

Good

The home was effective.

Staff had received appropriate training to meet people's needs and had a detailed knowledge about people's individual preferences. Staff delivered care in line with people's individual needs and wishes.

People, who were able, gave consent to their care. For people who were unable to give consent, the provider complied with the requirements of the Mental Capacity Act 2005.

The provider knew about the Deprivation of Liberty Safeguards and had made appropriate applications in this respect.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

Is the service caring?

Good

The staff were caring.

Staff treated people in a kind and compassionate way. They took time to make sure that people were safe and comfortable and felt included.

Staff described how they provided care to people and respected their dignity.

People and relatives were complimentary about the care received.

Is the service responsive?

Good

The home was responsive.

Staff were able to respond appropriately to people's needs due to the detailed and accurate care plans, risk assessments, daily records and handovers.

Summary of findings

Staff had taken the time to get to know people personally so they could respond to their preferences, likes and dislikes providing personalised care.

There were daily activities in the home; an activities co-ordinator was being recruited.

Is the service well-led?

Requires improvement 

The home was not always well led.

The the provider did not provide enough support to the registered manager, to allow her to complete all tasks to full capacity, even though the registered manager worked many hours over her contract.

There was a positive and open culture within the home where feedback was actively sought and responded to.

Staff and people said they felt listened to, and the registered manager was liked and respected.

The provider actively monitored the quality of care and took appropriate actions where necessary to drive service improvements.

Tiled House

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 and 28 October 2015 and was unannounced. The inspection was carried out by an inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services. Our specialist advisor was a specialist in the care of frail older people living with dementia.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. We requested a Provider Information Return (PIR) prior to the inspection. This is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During our inspection we spoke with 16 people using the service and three people's relatives. We also spoke with the registered manager, the chef, two nurses, four care workers and the area manager. We reviewed records relating to six people's care and support such as their care plans, risk assessments and daily records of care. We reviewed medicines administration records for everyone living in the home.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation of their care and support.

Following the inspection we communicated with four health or social care professionals to obtain their views on the home and the quality of care people received.

We last inspected this service on 22 August 2013 and found no concerns.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with, who was able to express an opinion, said they felt safe and were treated with respect. People told us they knew who they could speak to if they did not feel safe.

Recruitment practices were not safe. Before a member of staff was recruited, identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, the provider had not obtained a full employment history for four people out of the nine recruitment files we reviewed. There were no written explanations for these gaps.The provider could therefore not be assured that everyone had a valid employment history with any gaps explained to check they were suitable to be employed by the home. On the second day of the inspection a full employment history was provided by one of the four people identified above. The registered manager told us she would obtain a full employment history for all of the remaining people as soon as possible.

The lack of full employment histories for everyone was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Fit and proper persons employed.

Medicines administration required some improvements. We observed a nurse undertaking the medicines administration round at the home. They approached people in a professional and caring manner and they explained what the medicine was for, asking for people's consent, or their agreement before dispensing the medicine and then they waited for the person to swallow the medicine. They did not rush people and seemed to have a good rapport with them. Some people took certain medicines 'as required' known as PRN. An example of this type of medicine would be paracetamol. The provider used PRN protocols for people who required pain relief such as paracetamol. These gave clear guidelines to staff about when and how often this type of medicine should be given for individual people. However, pain assessments were not in use in the home. Pain assessments are used to establish whether someone with a cognitive impairment is in pain. There was a risk that people with a cognitive impairment may be in pain but not receive suitable pain relief. A recognised pain assessment tool is the Abbey Pain Assessment which the registered manager informed us she planned to start using for people with a cognitive impairment but had not yet had time to implement the use of this tool.

We recommend that a pain assessment tool is implemented in the home in accordance with current best practice guidance from a reputable source.

PRN protocols were in place for pain relief and homely remedies; however they were not in place for other types of medicines which needed to be given 'as required.' For example two people required medicine to be administered when they experienced a seizure. The guidance for one person was unclear, did not identify a limit of the dose and did not give instruction as to when emergency services should be called. Instructions for the other person were simply 'as directed.' Two other people required medicine to help them with 'agitated behaviour' however the PRN protocols did not identify triggers to the behaviour and indicate at what point the medicine should be administered. There was a risk that PRN medicine would not be administered appropriately due to a lack of clear guidelines.

Due to a lack of protocols there was a risk that medicines would not be administered safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Safe care and treatment.

The management of medicines was safe. Medicines were stored safely in a locked trolley in a locked room. The temperature in the medicines room were checked daily were were within safe range. There was an efficient system for ordering new stock, which meant there was no overstocking of any medicine. A medicines disposal book was maintained and products for disposal were stored safely. We looked at the provider's controlled medicines record book and storage and monitoring systems. These met legislative and regulatory requirements. Controlled drugs are medicines which require a higher level of security. The cabinets were locked within another locked cabinet and the contents of these were checked and recorded daily. We reviewed the contents of the controlled medicines cabinet and found the recorded details were correct.

Requires improvement

Is the service safe?

Medicines were administered by trained nurses who had received training in medicines administration and management. The training was updated annually and the registered manager carried out competency checks every three months.

Communal areas of the home were clean and smelled fresh, however we found four bedrooms which contained a strong malodour. This stemmed from the mattresses on people's beds which were stained. The mattresses identified were all replaced before the end of the inspection.

We recommend that the service seek advice and guidance from a reputable source, about how to ensure the cleanliness of equipment such as mattresses to minimse the risk of infection.

Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. One staff member told us "It is our duty to keep residents safe and if that means reporting something like poor care then it is our responsibility to do it and I would not hesitate, the residents always come first." Staff said they would take people's concerns seriously if reported to them. The safeguarding policy was available for staff to review and staff knew where it was kept and where to find relevant telephone numbers for reporting. Staff told us they were aware that they could report safeguarding concerns to outside agencies such as the police, the local authority and the Care Quality Commission.

The registered manager ensured people were fully aware of safeguarding issues by carrying out regular training herself. She showed us some training slides which were used to update staff and included tips in relation to good practice. There was also a prompt sheet given to all staff identifying potential acts of abuse such as forgetting about people, leaving doors open, telling people what to wear or withholding information.

We saw a range of tools were being used to assess and review people's risk of poor nutrition or skin damage. There were specific risk assessments for each person in relation to falls, nutrition, moving and handling and mental health and cognition. Support plans were written in relation to each identified risk. For example, one care plan said that if someone was identified as being at risk of malnutrition, the GP must be informed and dietician advice sought. Another person was identified as being at very high risk of falls. To address this risk, the person was supported with one to one support from staff. Staff told us they read care plans to understand risks to people and were aware of the fact that risks needed to be regularly reassessed. Staff were able to describe people's risks in relation to nutrition and hydration, dietary needs such as diabetes, mobility changes and falls. The daily handover sheet included information about people's individual risks in relation to their health, risk of falls, dietary needs and skin care.

There were also general risk assessments in place for staff and visitors to the home. This identified potential hazards such as stairs and wet floors and the measures taken to reduce the risk of any accident or injury.

There were enough staff on duty to meet people's needs. Staffing levels were calculated by the provider which took into account the number of people using the service and their dependency level. This was reviewed and updated regularly and the registered manager told us she was able to increase or decrease staffing levels over and above the calculated level, if this was necessary. At the time of the inspection five health care assistants and one nurse were required for a day shift (plus an extra health care assistant for one to one support) and three health care assistants and one nurse were required for the night shift. Records showed that these numbers and skill mix of staffing were regularly rostered. From observation, we saw there were enough staff to meet people's needs and staff took their time assisting people without rushing them. They also used the time supporting people to socially interact with them rather than just 'completing a task.'

There was a high use of agency staff in the home, particularly amongst health care assistants. This could present a risk to people as agency staff may not always be familiar with people's individual needs. The registered manager had taken action to mitigate any perceived risk. She ensured she always used the same agency staff. It was clear from observation that the agency staff on duty were familiar with people's needs and had also read risk assessments and care plans. The same agency was used to supply all care staff and the agency sent profile sheets about their staff to the home which included checks which had been carried out to ensure the staff member was suitable and had also received relevant training. The registered manager always knew which staff the agency would be sending and was able to assess in advance whether that person had the right skills and experience. In

Requires improvement

Is the service safe?

addition, agency staff underwent an induction in the home. The registered manager checked agency staff's training and skills with a basic awareness quiz regarding topics such as fire safety, food hygiene, safeguarding, infection control and control of substances hazardous to health (COSHH).

Good

Is the service effective?

Our findings

People's relatives told us they were happy with the care. They told us that staff understood their relative's likes and dislikes and had dealt with behaviour which may challenge extremely well.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, first aid, moving and handling, food hygiene and health and safety. Staff told us about other training they had received to meet the needs of people using the service. One member of staff said "I have completed training in supporting people with dementia and challenging behaviour." Staff received a full induction and the registered manager ensured training was kept up to date by carrying out extra training herself in areas such as communication, listening skills, infection control and food hygiene. Following training, staff completed a reflective learning log which prompted them to consider what they had learned and how they would put it into practice in a work place setting.

Clinical training was provided for trained nurses. Recently nurses had completed training in wound care, mouth care, diabetes and venepuncture (the process of obtaining intravenous access to people's veins). Further training had been planned in November and December 2015 in respect of end of life care, bereavement and nutrition and hydration.

Staff had a regular supervision meeting with the registered manager and an annual appraisal. Areas for improvement were discussed during staff appraisals. All staff told us they respected the registered manager and felt supported in their role.

Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families. Staff described people's individual needs and how they supported them. For example, staff described people's individual dietary requirements. They understood that people were at risk of choking if they did not receive the correct diet.

We saw that staff interacted with people appropriately and kindly, appearing to know them well as individuals, and treating them accordingly. Staff showed knowledge about people's individual communication methods and difficulties. For example people were able to make choices more easily when shown plates of food rather than having choices of food explained to them.

We saw that care was delivered in line with people's wishes. For example people chose where they wanted to sit to eat their lunch. We saw that staff were very patient with people while they took time to decide and them supported them to sit in the place of their choice.

We checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. We found that staff had received training and were able to describe some of the key principles. Mental capacity assessments had been undertaken which were decision specific. For example there were mental capacity assessments in place around people's decision to live in the home and best interest decisions recorded where people lacked capacity to make the decision themselves. Some care plans included consent forms which had been signed by people, which showed us they had the capacity to do so.

The Care Quality Commision (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Relevant applications had been submitted and staff were aware of which people were subject to a DoLS.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day and staff encouraged people to drink. Fruit squash and water was available all day and we saw staff regularly pouring drinks for people. No one was without a drink within easy reach at any time. A tea trolley came round during the morning serving tea, coffee and biscuits. We saw staff encouraging people to eat and drink. On the second day of the inspection the chef made cakes which were suitable for people with diabetes. These were served to people during the day.

Good

Is the service effective?

The meals offered were home cooked, freshly prepared and nicely presented. There was a choice of two main courses and a vegetarian choice. There were also a hot pudding with an alternative of fruit. People were encouraged to have second helpings. Some people found it easier to make their choice of meal by looking at the plates of food rather than pictures or having the food described to them. The atmosphere during lunch was pleasant and enjoyable; we observed lively conversation and interactions between everybody. People who needed support to eat were assisted by staff but encouraged to be as independent as possible. We heard one member of staff say to a person "Do you want to try to eat it yourself, with this spoon?" No one was rushed and lunchtime was observed to be a pleasant social interlude.

Staff were aware of any special diets or people's dietary preferences. The chef showed us a list of people's special diets which was kept in the kitchen. She said she was aware of people's likes and dislikes and was in the middle of preparing a special salad for a person when we spoke with her. A member of care staff accurately described people's dietary preferences and needs. They knew about people's vegetarian, diabetic and pureed diets. Care plans included risks assessments in relation to each person's risk of choking or malnutrition and there were plans in place to address any identified risks. Staff explained that they ensured people got enough to eat and drink by encouraging fluids and checking monitoring charts.

Handover notes which were discussed at each change of shift included information about people's dietary requirements such as whether they required a soft diet, supplements, pureed diet, thickened fluids or assistance to eat and drink.

A GP visited the home on a weekly basis. He told us that if there were any concerns about people's weight or the amount anyone ate or drunk, these were highlighted to him during visits. Everyone was weighed monthly and people at high risk of malnutrition were weighed weekly. People's weights were monitored by the registered manager to ensure that anyone losing significant weight was quickly identified, so appropriate action could be taken. If there was a concern about whether people were drinking enough, staff checked the colour of their urine against a chart to determine if they were dehydrated.

People were supported to maintain good health through access to on going health support. A GP visited every Tuesday but also came on other days if people were ill. Records of GP visits were recorded within people's care plans ensuring that all staff were aware of the advice given by the GP. Following the inspection we received feedback from several health professionals who were complimentary about the care. There was evidence within care plans of optician, mental health specialist and speech and language therapist visits and assessments.

Good

Is the service caring?

Our findings

We observed staff interacting with people in a kind and compassionate manner. They responded promptly to people who were requesting assistance and they did so in a patient and attentive way. We also noted a considerable amount of warm and friendly exchanges between staff and people which were, when people were able, reciprocated in the same manner. Staff were cheerful and the atmosphere in the home was relaxed. People seemed calm and contented.

People were very happy with the care they received and complimentary about the care staff. One person said "I've been here the longest. We have top nurses here – I'm always happy." Another person told us "It's good, living here. Life is good! I had a cooked breakfast; I always sleep well. It's fine." Staff went out of their way to support people's individual needs; one person said "I love it here. Nice staff - so lovely. They're very good here. The other week they let me go and put flowers on my husband's grave."

Staff spoke with people while they were providing care and support in ways that were respectful. We observed that people were addressed with their chosen names. Staff ensured people's privacy was protected by ensuring all aspects of personal care were provided in their own rooms. One member of staff said "I make sure I talk to people quietly so that not everyone can hear personal things." One person's relative described their loved one as "very proud" but said that staff did a very good job of promoting their dignity.

The person in charge of laundry was highly regarded by people. They enjoyed chats with them when laundry was sorted and put away in their room. Ensuring people's clothes were kept fresh and clean and that people received their own clothes back again after being laundered, supported people's dignity.

People's relatives gave positive feedback about the home and the support received by their family member. One relative told us that the thing they especially liked about the home was that it was "run like it's your home. Doesn't feel like a nursing home." Another relative said "It's all very jolly here." Most relatives we spoke with explained that their family member could be 'difficult' but felt that staff had dealt with this very well and they were supportive of the care.

We found some aspects of care plans had been written in a thoughtful and sensitive way. For example one person's dementia care plan included 'Staff are not to outpace (the person) when communicating with (them) because this way (they) will feel part of a conversation, not just spoken at.' This statement placed the responsibility on staff to ensure they communicated with the person in ways they could understand. It showed the person who wrote the care plan had knowledge of the needs of people with dementia. Another example of thoughtful care planning was found in another care plan which stated 'reassure (the person) that you know (they) are anxious and that you will try to take appropriate steps to make (them) feel better. Make sure your body language is appropriate for the situation.' Again the responsibility was with staff to ensure they dealt with the situation appropriately providing reassurance not just with words but with their body language. This is an important part of caring.

People's care plans included a 'This is me' record which gave a brief life history. It included what name people liked to be known as, the places they had lived, their school, job, hobbies and interests. This enabled staff to really get to know people and understand what was important to them.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. Some people had signed their care plans. Not everyone was able to contribute to their care plan. Where people were unable to contribute, relatives had been included. Relatives also told us they had been involved in regular reviews of their family member's care plan and were kept informed about any changes. We saw that people were offered a choice of food and drink and choice was offered in a way people could understand. A member of staff told us "We let people choose at the time." People chose what they wore and whether to take part in activities. Staff told us they offered choice and care plans also made this clear.

Most people required a high level of support to meet their care needs. Staff and the registered manager told us they encouraged independence whenever this was possible. During lunchtime one person was offered a spoon and encouraged to try and eat independently. A member of staff told us "We put a fork or a spoon in their hand and see

Good

Is the service caring?

what they can do." Another member of staff told us that some people were admitted to the home barely able to walk, they went on to say "We encourage them to stand up and do things for themselves."

Good

Is the service responsive?

Our findings

People's care plans included the range of all expected risk assessments and care plans. For example in relation to skin care, mobility, communication and medication. These were evaluated regularly and showed they had all been reviewed recently.

The provider had well organised records and the guidance provided for staff in order that they met people's needs was detailed and comprehensive. The records were written well and provided step by step information for staff to enable them to provide appropriate care that met people's needs.

Some aspects of the needs, risk assessments care plans and evaluations were written in particularly mindful ways. For example, for one person in their mental health and cognition care plan, was written 'Activities of daily living should be followed in the same order daily so that (the person) may be orientated by these as (they) cannot tell the time.' This level of thoughtfulness is unusual in care planning.

For another person their mental health and cognition care plan informed staff that the person may display verbal and physical aggression. The plan included guidance for staff to ensure they always greeted the person with a smile, offered cups of tea and regular walks which the person enjoyed. This led to a positive behaviour care plan which identified triggers for behaviour which may challenge and de-escalation techniques. Advice was also given to staff about how to keep the person safe, for example, removing anything from the immediate vicinity which the person may use to harm themselves. The person was receiving support from the community mental health team.

One person had diabetes. Their care plan included a diabetes risk assessment and care plan. It described the type of diabetes the person had and ensured that all staff (including kitchen staff) were aware of dietary requirements in relation to diabetes. The person's blood sugar level was checked and recorded every day by nurses and the typical range for the person was recorded so that it would be evident if a reading was outside the normal range for that person. Signs and symptoms of hypoglycaemia (low blood sugar) and hyperglycaemia (high blood sugar) were recorded with actions that staff should take if this occurred. The plan ensured the needs of the person with diabetes were being met.

Staff were knowledgeable about people's needs and preferences, for example, the moving and handling equipment they required, what they liked to eat and wear and where they liked to spend most of their time. A handover took place between each shift (day and night) to ensure consistency of care. Handover information was detailed and included information about the type of diet people required, continence care, their mobility and what they were able to do for themselves. Care staff told us they also read people's care plans to ensure they knew how to provide person centred care. Staff were able to deliver person centred care because they had a detailed knowledge of people's individual needs.

The registered manager told us they were recruiting for an activities co-ordinator, as there was no-one in post at the moment. However, all the staff were aware of the importance of stimulus and mental exercise for people. Staff involved people in playing games of with soft balls, and a game of rope-quoits. Some people had jigsaws; some were reading newspapers or magazines. Most people were engaged and involved with whatever was happening.

In another lounge, people were doing jigsaws, or reading, or chatting to staff, and one man was painting small items of pottery, which he was clearly enjoying. One lady told us she liked knitting and we noted that staff ensured she had her knitting next to her. The registered manager told us they the home worked with relatives to ensure that one person could keep involved with their love of stamp collecting. An entertainer visited the home twice monthly and this was displayed on the notice board. Other activities in which people could partake included bingo, floor basketball and board games.

On admission to the home people were given a welcome pack which included details of how to make a complaint. Staff told us they would approach the registered manager if they had any concerns or complaints. They said she always listened and responded to them. There was also an opportunity for staff to raise any concerns at regular staff meetings or their individual supervision meeting. Relatives told us they had not had any cause to complain, but would approach the registered manager if necessary. Regular relatives meetings were also held to keep relatives informed and encourage feedback. A suggestions box was available for staff, relatives or people but this had not been used.

Good

Is the service responsive?

The home and staff often received compliments from people's relatives. These were kept in a book and included comments such as 'staff went the extra mile' and that the home was a 'well organised and caring environment.'

Requires improvement

Is the service well-led?

Our findings

The registered manager worked two full day shifts 'on the floor' each week and this meant she was not available to manage the home every day. The provider did not employ a deputy manager or an administrator to support the registered manager. In addition to managing the home and providing nursing care the registered manager had to answer the telephone and carry out tasks such as filing. As a result the registered manager worked extremely long hours and always strove to deliver a high level of care for people, however there were simply 'not enough hours in the day.'Staff told us that the registered manager worked excessive hours to keep the home running and the visiting GP commented that she always seemed to be working in the home evenings and weekends, in addition to her day shifts. The lack of support for the registered manager had contributed to the identified breaches of regulations. Even though the registered manager had been aware of the potential for breaches she had not had time to complete all tasks because she was required to carry out nursing care for two days a week. Nursing care had to be provided as a priority.

There was a positive and open culture within the home. Staff said they felt able to raise concerns with the registered manager, and were confident they would be responded to. One member of staff said "This is a great home. It is well run by a great manager. She makes it her business to know what is going on but she does it in a supportive way, the residents love her too. If there is a problem we trust her to manage it in the best way and fairest way possible. She has our respect and is respectful in return." Another member of staff said "I bet she is one of the best home managers, she is fair but kind with it and works goodness knows how many hours she works but it works because this is the best home I have ever worked in because of her." The registered manager was respected and admired by staff, not just because of how many hours she worked, but because of the way she managed. One member of staff told us "(the registered manager) is a hands on manager she often does shifts and mucks in with care, she leads from the front not the office kind of person, she has huge respect here but she is also likeable and kind." Staff said they were actively encouraged through regular supervision meetings and appraisal to give feedback about the service. During our inspection we observed that the registered manager was well liked and respected by relatives, people and staff. She enabled and encouraged open communication with people and staff.

The home had a registered manager in post who was aware of her responsibilities both in terms of ensuring that regulations were complied with and ensuring that the home was safely and effectively run. Relevant notifications had been submitted to the Care Quality Commission (CQC). There was high visibility of the registered manager 'on the floor' and positive interaction between the registered manager, people and staff. The registered manager was aware of the challenges the home faced, particularly around the retention of care workers. The high use of agency staff was necessary due to the rural location of the home and the difficulty in recruiting staff who had their own transport and were willing to travel. The registered manager told us she was particularly proud of the 'feeling' of the home and the positive relationship between people, staff and relatives. This had been demonstrated throughout the inspection and commented on independently by people, staff and relatives. An annual improvement plan for the period December 2014 to December 2015 showed that all actions had been completed.

Policies and management arrangements meant there was a clear structure within the home which ensured the service was effectively run and closely monitored. There were policies in place which included a staff recruitment policy, an induction training policy, safeguarding policy and an infection control policy.

The quality of the service prided by the home was closely monitored through a series of audits including care plan, catering, medication and night time audits. There were also risk assessments in relation to first aid and lone working. Pressure mattress settings were checked daily to ensure each person received the appropriate pressure relieving effect of the mattress. Quality assurance audits were carried out by the provider. As a result action plans had been drawn up and all actions completed**.** A business continuity plan was in place to ensure the continuing care to people in the event of an emergency.

Requires improvement

Is the service well-led?

The registered manager responded appropriately to incidents and accidents recording appropriate actions and driving learning which was imparted to staff at handover and through team meetings. This was to ensure continuous improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met: The registered person did not ensure the proper and safe management of medicines.** **Regulation 12 (1) (2) (g).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met: The registered person did not ensure that all the information specified in Schedule 3 was available in relation to each person employed.** **Regulation 19 (3) (a).**