Hartford Care Limited

Tegfield House

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

This inspection took place on the 28 and 30 September 2016 and was unannounced. Tegfield House is registered to provide accommodation and support without nursing for up to 24 older people, some of who were living with dementia. At the time of the inspection there were 23 people living there. The home also provided day care to four people living in the community.

The service had a registered manager. 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.

At our last inspection of this service on 25 and 26 August 2015 we found three breaches of legal requirements in relation to safe care and treatment, fit and proper persons employed and safeguarding. Following the inspection the provider wrote and told us they planned to meet the requirements of these regulations by the end of October 2015. At this inspection we found the requirements of these regulations had been met.

People told us they felt safe at Tegfield House. There were robust procedures in place to protect people from the risk of abuse. Allegations and concerns were acted on promptly and appropriately by the registered and deputy managers. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe.

Staff were recruited safely, the provider carried out all the required pre-employment checks to protect people from the employment of unsuitable staff. These included a full employment history with an explanation of any gaps in employment. A Disclosure and Barring Service (criminal records check) was completed by staff prior to commencing work at the service and thereafter at three yearly intervals. This meant staff were subject to continued checks on their suitability for employment with vulnerable people.

Staff completed incident and accident reports when people experienced events that could or had resulted in harm to themselves or others. The registered manager reviewed and monitored all incidents and accidents to identify trends and take action to prevent a reoccurrence. We saw improvements had been made as a result of this analysis. People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. People told us they were cared for safely and we found staff were aware of people's risks and acted to support them safely. There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There were sufficient numbers of staff available to meet people's needs.

Peoples' medicines were managed and administered safely. Staff completed training in the safe administration of people's medicines and had their competency assessed at regular intervals. Regular audits of medicine management were carried out by the deputy manager and an external pharmacist and action had been taken when improvements were identified.

People's needs were met by staff who were trained and supported in their role. Staff completed an induction into their role and on-going training to enable them to care for people effectively. Staff received regular supervision from managers to identify and support their learning and development needs and monitor their performance in their role.

Decisions about people's care when they lacked mental capacity were guided by the principles of the Mental Capacity Act 2005 (MCA). People's care plans evidenced specific decisions had been made in their best interests when they lacked the capacity to make these. When people lacked the capacity to agree to their care and treatment and it was deemed to be in their best interest to restrict their freedom to keep them safe their rights were protected by an application for a Deprivation of Liberty (DoLS) safeguard. However a best interest process had not been recorded prior to submitting these applications. The registered manager took immediate steps to implement this process during our inspection. We found people's rights under the MCA were protected.

People were supported to have a meal of their choice by attentive staff. People spoke positively about the food served in the home and we saw people's dietary and nutritional needs were met. People were consulted about their food preferences and these were catered for.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. People had been supported to maintain their health and achieve positive improvements in their wellbeing.

People and their relatives told us the staff were caring and compassionate. Staff demonstrated they knew people well including their personal histories and preferences. We observed that staff were caring in their approach and respected people's decisions, privacy and dignity. People at the end of their life received person centred care based on their known wishes.

People's needs were assessed prior to their admission, their care plans were personalised and contained information about the person's likes, dislikes and what was important to them. Staff were knowledgeable about people's needs and acted in accordance with their care plans. Care plans were regularly reviewed and updated and we saw staff communicated effectively about people's changed needs.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest others they would like to complete. In addition to group events people were able to have individual support from activities staff to develop or maintain hobbies and interests. People told us they enjoyed the activities on offer at the home and we saw people participating in a variety of activities during our inspection.

People's concerns and complaints were investigated and responded to in good time.

People, their relatives and staff spoke positively about the leadership in the home. The registered manager and deputy manager worked effectively as a management team to address day to day concerns and service developments. Staff were aware of the responsibilities of their role and were held accountable for their actions when they had not met the required standards.

There was a positive atmosphere in the home and comments from people and their relatives about the home included 'homely, safe and happy'. Feedback from people, their relatives and staff was used to make improvements in the home. An effective quality assurance system was in place which enabled the provider and registered manager to assess, monitor and improve the quality and safety of the service people received.

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 were safeguarded from the risk of abuse. Robust procedures were in place to protect people from harm. Staff had completed relevant training and understood their roles and responsibilities in relation to safeguarding and the registered manager acted on concerns to promote people safety.

Risks to people had been identified and actions were taken to ensure their safety. Risk management plans were in place to ensure people received safe and appropriate care.

People were supported by sufficient and suitably skilled staff to meet their needs safely.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective

Staff received an induction into their role, on-going relevant training and supervision of their work. People received their care from staff that were appropriately supported in their role.

People rights under the Mental Capacity Act (2005) were protected. Procedures were in place and acted on to protect the rights of people who lacked the mental capacity to make their own decisions or agree to restrictions in their care and treatment.

People enjoyed a varied and nutritious diet which reflected their preferences and dietary needs. People at risk of poor nutrition were supported appropriately to prevent risks to their health and wellbeing.

People were supported by staff to access health care services as required and their healthcare needs were met promptly.

Is the service caring?

Good

The service was caring

People were cared for by kind and compassionate staff who knew them well.

People were given choices and involved in decisions about their day to day care and these were respected by staff.

People's privacy and dignity were respected by staff.

People's wishes and decisions for their end of life care were recorded and available to guide staff. People and their families received the support they needed at this time.

Is the service responsive?

Good

The service was responsive

People's care and treatment plans were person centred and reflected their preferences and decisions. People's care and treatment needs were regularly reviewed to ensure they received appropriate care and treatment.

People's activity and social needs were met through a range of group based and individual activities provided by a team of activity staff, care staff and volunteers.

A system was in place for people to raise their complaints and concerns and these were acted on.

Is the service well-led?

Good

The service was well led

People, their relatives and staff spoke positively about the leadership in the home. The registered manager and deputy manager worked effectively as a management team to promote a positive culture that provided a good quality service for the people they supported.

Staff were supported to understand their responsibilities and to be accountable for their actions.

There were processes in place to enable the provider and registered manager to assess and monitor the service and make improvements. Information from incidents and feedback from people, their relatives and staff was used to drive continuous improvement to the service.

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

This inspection took place on 28 and 30 September 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we spoke with a senior social worker from adult services in Winchester to gather their views on the service. We reviewed the information we held about the service, which included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We requested a Provider Information Return (PIR) and this was completed by the provider before our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We carried out observations in communal areas and to see how people were being cared for and we observed two lunchtimes. During the inspection we spoke with five people and two people's relatives. We spoke with the registered manager, the deputy manager, the chef, and four care staff. We observed a staff handover between night and day staff and a staff member administering people's medicines.

We reviewed records which included five people's care plans and monitoring records relating to people's care, people's medicine administration records, five staff recruitment and supervision records and records relating to the management of the service. These included staff training records, quality assurance records, the record of complaints, accident and incident reports and staffing rotas for the period 1 August to 25 September 2016.

Good

Is the service safe?

Our findings

Our inspection of 25 and 26 August 2015 found that people were not adequately protected by systems to effectively safeguard them from the risk of abuse. This was a breach of regulation 13. In addition the provider had not carried out all of the pre-employment checks required to protect people from the employment of unsuitable staff. This was a breach of regulation 19. A system was not in place to record, investigate, monitor and make improvements following incidents other than falls. This was a breach of regulation 12. Although the provider took immediate action during our last inspection to make improvements to their systems and protect people from harm they required more time to embed this into practice. The provider sent us an action plan telling us what they would do to address these issues and planned to meet the requirements of these regulations by 31 October 2015. At this inspection we found the required improvements had been made.

The provider had amended their safeguarding policy and implemented robust procedures to ensure all allegations of abuse whether reported verbally or in writing were acted on immediately to protect people from the potential of harm. The provider had taken action to ensure that all staff were aware of their responsibilities to report their concerns including using 'whistleblowing' procedures. Whistleblowing is when staff report concerns in confidence and their disclosure is protected in law. Staff we spoke with told us they were confident to raise concerns and that these would be acted on by the registered manager and deputy manager. A staff member told us when they had raised a concern this was responded to immediately and action was taken to ensure the person's safety. They said "I have faith in the managers, anything I have raised they have taken seriously". Staff confirmed and records showed that safeguarding was discussed during their supervision sessions and staff meetings with managers to check staff remained aware of their safeguarding responsibilities. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe.

The registered manager and deputy manager were aware of their responsibilities to report allegations of abuse and we found they acted appropriately in these circumstances. Providers are required to send us a notification about important events such as safeguarding concerns to enable us to monitor the safety of people using the service. We reviewed the notifications they had sent to us and we spoke with the registered manager about these. We found that prompt action was taken in response to concerns raised including investigation and referral to the local authority safeguarding team. A social worker told us "I have found that the registered manager and the team at Tegfield House to be open regarding any concerns that I am looking into. The registered manager also confidently raises concerns to adult services and is always ready with information or prepared to gather information/details as and when necessary." People benefited from a safe service where managers and staff understood and acted on their safeguarding responsibilities.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Following our previous inspection the provider had implemented a process of three yearly DBS checks to ensure staff remained suitable for their role. Records seen confirmed that staff members were entitled to

work in the UK and included a full employment history and an explanation of any gaps in employment. This meant people were protected from the employment of unsuitable staff.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. An effective and robust accident and incident reporting system was in place. Staff completed a record of all accidents and incidents where this had resulted in or could have resulted in harm to the person. This included; falls, safeguarding concerns, pressure ulcers and skin injuries, incidents of behaviours that challenge others, and incidents of a deterioration in a person's health. Records were then analysed by the registered and deputy managers to check the appropriate action had been taken and identify patterns and trends to prevent a reoccurrence. The registered manager said "We look at the root cause and analyse monthly to identify triggers or trends." For example; a person who required insulin to manage their diabetes safely had some incidents of low blood glucose readings. The registered manager took action when they had identified a repetition of these incidents. At the time of the incidents the person's insulin was administered by the district nurses but they were not always able to give this at consistent times. Staff were then trained by the district nurses to administer the person's insulin which ensured it was given at the same times each day and this had resulted in stability of the person's blood glucose and improved their wellbeing.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, where people were at risk of falls there was an assessment that included the factors which could increase the risk such as; sensory difficulties, medicines and mobility difficulties. Actions were identified to support people's needs such as the equipment or staff support and encouragement they would require. We saw people were supported in line with their risk assessments. For example, we saw people were reminded to use their equipment such as walking frames to promote their safety. A person said "Staff tell me frame, frame frame!" referring to the need to have their walking frame with them. Another person said "Here I am safe, I have got every alarm available, staff are always available and I can't say I have ever had to wait for them" Other risks such as those from pressure ulcers, malnutrition, or risks associated with conditions such as diabetes were assessed and monitored to promote people's health and wellbeing. Staff we spoke with were aware of people's risks and how they required to be supported. We saw staff supporting people in line with their assessed needs for example by supporting people to mobilise safely and walking behind people to provide encouragement and safety.

People's falls were monitored for trends and improvements were made to prevent a reoccurrence. For example; an analysis of a person's falls had shown they fell at night. Further investigation found they did not know how to use their call bell to summon staff if they needed assistance. A falls mat has been put in place to alert staff when the person gets out of bed so they could assist to prevent them falling. Another person was falling from their chair and further investigation found they were slipping on a pressure reliving cushion so a non-slip one was provided to prevent further falls.

People skin injuries were assessed by district nurses and treatment plans were in place to monitor and evaluate the treatment of the wound by them. For example, a person with a pressure ulcer that occurred on return from hospital was being treated and their relative told us they were "making a good improvement". Care staff recorded on body maps any marks or injuries to people's skin they identified so these could be investigated and assessed appropriately. Although records showed people's wounds received prompt attention. The records made by care staff did not always include up to date information on the treatment of people's wounds so they could readily identify the actions taken, progress and outcome of their treatment. The registered manager had identified an improvement was required in the completion of notes about medical concerns and was addressing this with staff at the time of our inspection.

People told us there were sufficient staff available to meet their needs. A person said "Yes there are enough staff, they come fairly quickly and I can always shout out if I don't use my machine (call bell)." The registered manager had reviewed staffing allocations with staff to enable people's needs to be met at their preferred times. For example, one staff member was allocated during the morning to preparing and delivering people's breakfast trays whilst other staff supported people with their personal care needs. Staff told us this allowed them to respond more flexibly to people's needs and meet their preferences. Following our previous inspection an additional six care hours had been allocated to the afternoons to ensure sufficient staff were available during this period. A staff member said "There is now (enough staff) a third carer works in the afternoons and it's a lot better, we now get to see the residents a lot more than we did". Existing staff were used to cover staff absence and the registered manager told us they had not used agency staff for two years. This meant people experienced a continuity of staff who knew them well. People were supported by sufficient staff to meet their individual needs and preferences.

The provider had introduced a staffing level tool used to calculate the dependency needs of people and the time required to meet their needs. The provider had not yet developed this tool to ensure the information gathered was used to confirm staffing levels remained adequate to meet people's needs. The registered manager spoke to the provider about this during our inspection to agree the next steps.

People's medicines were safely stored in either the medicines trolley or in their rooms in locked cupboards. Arrangements were in place to receive and dispose of medicines safely. Staff had received medicine administration training and had their competency assessed before they were allowed to support people with their medicines and then again at six monthly intervals. A medicines audit was completed at the start of each four weekly cycle to check for errors and identify improvements needed. We saw for example a recent audit had identified the need for a replacement thermometer to ensure medicines were stored in safe temperatures and this had been ordered. Regular audits by a pharmacist were also completed and we saw action had been taken to make the improvements they had identified and recommended. We observed a staff member supporting people to take their medicines safely and documenting when the person had taken their medicines.

We noted that some people's topical medicines (creams) were not dated when opened. Checks on creams were included in the service medicines audit however only a sample of creams were checked. The deputy manager responded to this by immediately implementing a new procedure for all creams in future to be stored in the medicines room until required and be labelled as opened when taken from the room. This would ensure people would be protected from the use of out of date and ineffective topical medicines.

There were arrangements in place to keep people safe in an emergency. A business continuity and emergency response plan was available to staff for guidance in the event of an emergency. This included information and actions staff should take in situations such as; the disruption and failure of utilities, staffing shortages and loss of accommodation. A fire bag was kept by the front door that included individual Personal Emergency Evacuation Plans (PEEP's). A PEEP details the support that an individual requires to keep them safe in the event of an emergency such as a fire. Weekly fire alarms tests were carried out along with the monthly testing of fire equipment. Regular checks and servicing of other equipment such as bed rails, wheelchairs hoists and slings were completed to ensure the equipment used to support people was safe and fit for purpose.

Good

Is the service effective?

Our findings

New staff were supported to complete an induction programme before working on their own. Records evidenced that new staff had undertaken the Care Certificate which is the care industry recognised standard induction to their role to ensure they could provide people's care effectively. Induction included shadowing experienced staff for a minimum of one week to learn about people's needs and a staff member said "Or until I was comfortable". Records showed and staff confirmed they completed induction training or updated training as required if they had previously worked in health and social care.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. We viewed the training records for staff which confirmed staff received training on a range of subjects such as; dementia awareness, safeguarding, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and equality and diversity. Training to meet the specific needs of people such as pressure area care and diabetes was also completed. The records showed there was a good completion rate of training by staff and this was monitored by the registered manager to ensure staff remained effectively skilled. Staff spoke positively about the training provided and a staff member said "They have tried to cut down on 'chalk and talk' we have more practical hands on stuff which is better for me."

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "It's nice to know how well you are doing and to know how you are getting on and I can air things". Staff told us they felt supported by the registered manager, and the deputy manager who a staff member said had been "a brilliant mentor." People were supported by staff who completed training and were supervised by managers to provide effective care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's care plans included a review of people's mental capacity to make specific decisions and agree to their care and treatment such as; bed rails, covert medicines and pressure mats. Records showed people's mental capacity had been assessed and when a person lacked capacity a decision was made in their best interests where these practices were required.

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. The registered manager had identified a number of people who they believed were being deprived of their liberty and they had made DoLS applications to the supervisory body. We found that whilst people's mental capacity was assessed in relation to their ability to agree to their care and treatment.

Applications for a DoLS did not include a specific mental capacity assessment and best interest decision to ensure the correct procedure was followed prior to an application being made. The registered manager took immediate action to implement this procedure. They provided evidence that applications were made following a person-centred approach applied to each individual to determine if their care could be provided in a less restrictive way prior to seeking an authorisation for a deprivation of their liberty. This meant people's rights under the MCA were met.

Where people were able to make their own decisions they told us these were respected for example, a person said "I am free and I can choose it was my decision to stay here". Another person said "I am completely free to go around the garden I go out twice a day to get fresh air and see the birds, I go out with my daughter and friends and my aim is to go out by myself but not right now as I have balance problems".

Care plans included information on the legal authority other people held to make decisions about people's finances, and/or care and treatment. We saw that some files contained evidence of the legal authority to confirm this information. This is important to ensure decisions made on behalf of people are carried out by people with the legal authority to do so. The registered manager told us they were requesting this evidence from all people's representatives to ensure people's legal rights were upheld.

Staff completed training in the MCA and DoLS and were able to tell us about how they used the principles of the act in people's day to day care. For example, a staff member said "The MCA is about what people are capable of doing and what their needs would be if they can't say. I make choices as simple as I can and use words people understand like cheese on toast instead of Welsh rarebit. If people refuse care then I report it, we don't make anyone do anything" Another staff member said "It's about assisting people with making decisions and giving them as much information as you can to help them make it". People told us staff asked for their agreement to receiving care and we observed staff asking people to make choices about what they ate and what they wanted to do and these were respected. People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005.

People spoke positively about the food served in the home. A person said "The food is good and what amazed me was the presentation, is really nicely done." We observed lunchtime in the home and saw people were provided with assistance if they required it. People were offered a choice of meals and were prompted to eat or had their food cut up or pureed if needed. A person living with dementia had their food served on a coloured plate with a coloured cup for drinks and was encouraged to eat by staff. Contrast in colours can be helpful for people living with dementia when they experience orientation and perception difficulties. For example; white food cannot be clearly seen on white plates. Staff were attentive to people's needs and enjoyment of their food for example, when a person arrived later for lunch staff made sure they were given hot fresh gravy.

One person's relative told us how their relative was refusing food at times and said "They (staff) are so on the food refusal thing". We saw how staff encouraged this person to eat at lunch and recorded what they had eaten. Staff also respected the person's decision when they were adamant they did not want any more. The chef was aware of people's dietary preferences and needs. This included those people on a fortified diet due to the risk of malnutrition, those with diabetes and people with particular preferences such having their main meal at evening time. People or those that knew them well were consulted about food preferences on admission. The chef told us they asked people what they enjoyed and people were able to request alternatives to the menu. A choice of meal was offered at lunch and supper and snacks were available to people on request.

People's health care needs were monitored and any changes in their health or well-being prompted a

referral to the GP or other health care professionals. For example, we saw that a person recently admitted to the home had prompt attention from healthcare professionals in relation to concerns identified by staff on admission and their condition was improving. A person said "I kept my own GP and they will call them out if necessary". Healthcare professional notes showed people received treatment from the GP and district nurses as well as attending appointments for specialist healthcare treatment. A short term intervention record was used to monitor the care and treatment of people when they experienced a temporary health condition such as a urinary tract infection. This detailed the treatment plan for this condition. Information was available to accompany a person if they required a hospital admission which included; allergies, medical conditions, communication needs, mobility and personal care needs.

A person living with diabetes which required them to be treated with insulin had a clear detailed plan in place that provided guidance on the risks associated with their condition and their needs and preferences. Information included the healthcare checks required to monitor risks to them such as; feet, eyes and skin condition. How to test the person's blood glucose levels and the action to take if it was outside of the individual safe parameters for the person. We observed staff testing the person's insulin levels and saw they responded appropriately to the persons reading which was low. The staff member said "It took a while to get confident with doing this. Their blood glucose readings were erratic before we started this and now they have stabilised. I am confident now we had 10 sessions with the district nurses and they still pop in to check up on us." People's health care needs were monitored and met effectively.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. A person said "They (staff) are all lovely, they are tremendous. I didn't think I was ready to come somewhere like this but I did. There isn't one that isn't lovely; they are interested in me personally." A person's relative said "I think it's a very friendly place and to a degree home from home. My relative is happy here and settled in well". A person summed up their opinion of the staff by saying "funny, thoughtful and very kind".

People received care and support from staff who had got to know them well. Staff told us about people's likes and dislikes for example, a staff member said about a person "They love their own company, their family and watching property programmes. They are funny and we share a sense of humour, they love to eat chocolate and sweets". A person's relative said "The care staff are genuinely fond of the residents and they (staff) bring out the best in them (people) it's almost like a family really." People were asked about their preferences such as their gender preference for care staff and their life histories such as where they were born, grew up, the things that made them laugh and relax. This information guided staff on people's preferences and experiences to enable them to build relationships with people. A person's relative said "Already there is a heart on the wall with all the memories we have just discussed with staff, how he met my mum etc. He has a lovely room and it feels homely, they put some bright cushions in and a nameplate on his door suddenly appeared with all the images I had told them about." We observed staff pointing out a plane flying past to a person and said "He likes to watch planes" the person also had a book on planes and staff told us they had an employment history connected to aeroplanes. The person was clearly pleased to see their book when it was offered. A person's relative said "The minute we set foot in here we realised it was a home, everyone was smiling. There is a consistency of staff who know him." People were supported by staff who knew people well.

We observed staff responded to people in a caring and compassionate way. For example; a person living with dementia appeared anxious and asked staff "can I fold this" referring to a tea towel. The staff member was reassuring and said "yes of course" and spent some time chatting to the person. We heard a staff member patiently and kindly encouraging a person who had difficulty walking in making their way to the dining room enabling them to take their time and retain their independence. We observed a person knocking at the kitchen door; the chef came out and offered them a cup of tea. A person's relative said "I have heard staff talking to him, they are caring, appropriate and beyond. If I was to come up with a dream environment and a dream set of interventions it would be here."

A person told us their preferences and decisions were respected by staff. This included their choice to spend most of their time in their room and not to develop 'overly close' relationships with staff. Whilst they gave staff "full marks" for trying to engage them in activities they said "I don't want to be rounded up – good lord no! My choices are respected and I am allowed my privacy".
Another person said "Yes staff treat me with dignity and respect when doing personal care, its fine and I can see visitors in private in my room if I like." Staff told us how they promoted people's dignity when delivering care for example, a staff member said "I take people into bathrooms or their room and I make sure the curtains and doors are shut. I put a towel over the person's top half and then the bottom half. I always try to

make people as comfortable as possible. I view people like they were my nan or granddad".

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by community healthcare services and equipment and medicines were provided as and when needed to enable people to be as pain free and comfortable as possible. People's wishes and decisions were recorded and available to guide staff. This included where people had made an advance decision to refuse medical treatment, who people would like present and where and how they preferred to spend their last days. Feedback given by a person's relative about their end of life care stated "My mum was treated with dignity, and I cannot fault the friendliness and compassion shown to my mother at a very difficult time."

Good

Is the service responsive?

Our findings

Care and treatment plans were personalised. The examples seen were thorough and reflected people's needs and choices. For example; peoples' preferred daily routines; when to get up and when to go to bed, where they preferred to have breakfast and how they liked to be addressed. Care plans included what the person could do for themselves such as; brush their teeth or shave and the level of support they required from staff. Care plans were developed from pre admission questionnaires and needs assessments covering what is going well for the person and what they are finding difficult. They were comprehensive and holistic and included people's spiritual and emotional needs along with their physical and mental health and day to day care and treatment needs. Staff confirmed they had read people's care plans and were kept updated on changes through daily handover. We found staff were knowledgeable about people's needs for example; a staff member described to us the needs of a person recently admitted to the home and how their needs were to be managed and this was consistent with the person's care plan.

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. A person's relative told us "The registered manager and deputy came out to assess my dad on the day I called, and since he has been here they have reported to me all the issues they discovered as they continued to assess him. What I am seeing is an improvement in him and more moments of clarity. What they have done here is to reconnect him with the rhythm of the day". A social worker told us about a person who had been accommodated at the home in an emergency situation and said "Upon the review of this person I found them to be more settled with the addition of medication and a change in antibiotics (having identified that the person was allergic to the first prescription). The freedom to walk inside and in the garden freely would have undoubtedly made a difference as did the relationship with the staff as well". People were supported to make improvements in their health and wellbeing.

Care plans evidenced people's needs were reviewed monthly and as required if their needs changed. People's nominated representative or relatives contributed to their care plan review and were invited to attend reviews every three months. A person's relative said "They (staff) keep me informed, they are vigilant."

We observed the morning handover between night and day staff. The handover was detailed and included information about people's health needs, continence support, how they had spent the night and whether staff had identified any particular concerns that required following up by day staff. From the information given by staff it was evident people's individual needs at night were responded to. For example; staff shared information about who had required company, who had requested to get up early, people's request for food during the night and how these were met. Staff reported about one person "They said they wanted to be alone in silence so we respected this and didn't push anything". Staff showed they were attentive to the information given about people and updated each other with relevant information to support their care and treatment. For example; who required encouraging to drink more fluids, who may be tired because of how they spent the night and how people were doing since staff had last been on shift. A staff member said "We are made aware of people's risks at handover and in the daily notes. If new people come in we are told about their risks". This meant people were supported by staff who were informed about their current needs

and risks.

People living with dementia had a care plan in place which described the support they may need in relation to the symptoms of their dementia. This included when they had behaviours that may challenge others. Guidance was included for staff on how to respond to people in these circumstances including the topics they were interested in that may help to distract them when they became agitated or confused. We observed that when a person became confused staff responded to them with sensitivity and provided a distraction to calm and engage them in something of interest to them. Guidance included encouraging people to maintain their independence as far as possible, encouraging people to eat, participate in activities and supporting people to make choices as far as they were able. Records showed where people's needs had changed their care plan had been updated to reflect this such as where a person had experienced deterioration in their understanding and changes in their behaviour. These changes were being monitored to enable staff to evaluate how their changed needs may be met.

People's rooms were personalised with their own belongings and a person said "I love my room it's comfortable and nice and has pictures of my family and my garden is on the window sill" (referring to a group of potted plants). Corridors were decorated with pictures of people and staff enjoying activities together and people's bedroom doors were individually decorated with pictures of interests to them. This can be helpful for people living with dementia to assist with orientation in the building and to find their room.

The home provided a range of activities including those designed to support people living with dementia. People living with dementia benefit from participation in meaningful activity and occupation which can improve their physical and mental symptoms and provide a better quality of life. Activities people participated in were recorded and this included their mood before and after the activity, and the skills they used during the activity. For example; a person's activity care plan described a person living with dementia had been happy to participate in making beads. The skills they had used included; understanding of simple instructions, concentration and co-ordination. The person had joined in with encouragement and enjoyed the activity. We saw that other activities were provided which encouraged mental stimulation such as giant crosswords, hang man and name games. Art work completed by people was on display and photographs of recent activities showed people enjoying a diverse range including; a donkey ride for a person over 100, parachute games, decorating jam jars, brass cleaning, making scones, live egg hatching, food from around the world and a family day for staff and families of residents. During our inspection people were seen to be enjoying a talk and presentation on Australia and a celebration of a person's 103rd birthday with sherry and cake. A person said "We have various entertainments, I love it. There is enough done although I don't always join in"

A residents meeting in August 2016 had consulted people on the activities they would like and these included; cookery, keep fit, quizzes and crosswords, arts and crafts and family tree. We saw these activities were provided. Activities staff spent time with people on an individual basis if required. One person told us how they had discussed their interests with the activities worker and they (person) were deciding what they would like to do. Another person preferred not to participate in activities and said "I have always been a loner, I've got my books, telephone and TV I have no complaints" People were able to choose what activities they took part in and suggest other activities they would like to complete and these were provided.

We reviewed the record of complaints and saw the registered manager had investigated, responded to and resolved complaints made in line with their procedures. Duty of candour forms part of a regulation that states providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable

support, truthful information and a written apology. We saw records which showed a system was in place and had been used to meet this requirement. People and their relatives told us they would discuss their concerns with the staff and the registered manager. A person's relative said "It's been very good and my relative is very happy here, it's been excellent I have no cause for complaint and the registered manager is approachable and interested I usually have a chat with her"

Good

Is the service well-led?

Our findings

The service promoted a positive culture. The registered manager told us how they had worked on developing a positive person centred culture in the home since our previous inspection. They said "I have tried to get the team to be more friendly and supportive of each other. I am bringing them back to the residents and the impact that poor teamwork can have on residents I remind them we are here for the residents". We saw the provider's regional manager and the registered manager had facilitated team building events to support team development and a team member said "We had a team building meeting and spoke about person-centred care, it was useful and fun." Another staff member said "There was an issue with teamwork and I feel this has got a lot better and everyone has put their own problems aside. I am proud to say I work at Tegfield and we look after our residents to the best that we can".

The provider's mission statement was to provide 'care, comfort and companionship in a safe and happy environment for all'. People and their relatives told us the home was a 'happy, safe and homely' place. They spoke positively about the caring and compassionate approach of staff and managers and the home had received many compliments, for example "I love the security of knowing you have someone here all the time. The management and staff are all very kind and caring. Nothing is too much for them. I am able to live the way I choose in a really warm, safe and comfortable environment". Staff told us about their understanding of the values and their comments included "I think of it like if your family went here. To meet their needs and look after them as if they were your family, I love it here" and "Be happy live life to the full and remember people are at the centre of everything we do, it's their home and maintain their dignity."

Staff, people and their relatives consistently described the leadership of the service as 'good'. People we spoke with knew who the registered manager was and people's comments included "The registered manager is lovely and so is the deputy, if there is a 'perfect' then they are for this sort of job. They are always available and I'm sure I could make an appointment if I wanted to but the door is always open" Another resident said "I like the registered manager she is charming". We saw the registered manager and deputy manager worked effectively together as a management team. For example, they shared an understanding of the priorities and challenges for the service and delegated tasks appropriately between them. The registered manager was undertaking the provider's leadership programme, part of which involved mentoring by a director. They told us this had helped them to "personally develop as a leader". They went on to explain how they were using the learning and support from this programme to look at their own approach to leadership and develop skills in coaching staff to support their learning and development. For example, through delegating tasks and empowering the senior staff through allocated responsibilities. A social worker said "I can say that we have found (the registered manager) has a professional yet compassionate approach to her work."

Staff were supported to understand their role and responsibilities and to be accountable for their actions. Staff comments included "I am comfortable with what is expected of me". Another staff member said "They (managers) are nice bosses and they do have a strict side, but it's not personal it's about the residents". We saw that when concerns had been raised about staff practice these were fully investigated and appropriate action was taken to address these. Regular staff meetings were held with all staff and minutes showed these

meetings addressed staff responsibilities along with the opportunity for staff to contribute their feedback. Staff confirmed that they were listened to. People were cared for by staff who were accountable for their actions, behaviour and performance in their role.

People, their relatives and staff were asked for their feedback on the quality of the service and this was responded to. For example, the registered manager had responded to each of the completed satisfaction surveys by people's relatives. An example of this was relatives had suggested there was a named carer to support each person on admission to the home to provide consistency and continuity during this period and a carer has been allocated as requested. In response to a request for more feedback about their relatives care, relatives are invited to attend reviews. People's relatives told us the feedback from the managers and staff was prompt and informative. A resident's survey had been completed in February 2016 and people had been asked about their views on the safety and quality of care, food, activities and raising concerns. Whilst most responses were positive, some people identified some improvements were needed in relation to activities and concerns. We saw the registered manager had met with the residents to discuss and address the feedback. For example; activities were reviewed and people's suggestions were acted on. A staff member told us how staff had been consulted about how to deploy staff effectively to meet people's needs. They said they had noticed how when the deputy manager helped with breakfasts this had worked really well and so they suggested a staff member was allocated to this and said "we had a long discussion about this and now the colour coding scheme (staff allocations) has come in its working better" People, staff and relatives were empowered to contribute to improve the service.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The registered and deputy managers carried out a range of regular audits. These included; monthly infection control, medicines and care plan audits and six monthly health and safety audits. Improvements had been made as a result of actions arising from audits such as; improved cleaning resources and improved personalised daily notes and review formats. Other improvements were planned such as refurbishment of the lounge area and replacement furniture.
Regular monitoring visits were carried out by senior managers and weekly reporting from the home on quality and safety indicators such as; incidents, falls, safeguarding concerns, pressure ulcers and medication errors were reviewed by them. Action plans were produced as a result of monitoring and review and we saw actions were completed. The provider was currently reviewing aspects of the care delivered to identify best practice and improvements. For example; we saw the 'dining room experience' was being reviewed. The review had identified improvements such as; medicines were not to be administered during the lunch period and the medicines trolley was not to be in the dining room. Information was made available on how to make pureed food appetising and attractive. This meant the provider had systems in place to drive continuous improvements to the service people received.