Hampshire County Council

Ticehurst Care Home With Nursing

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

'Ticehurst Care Home With Nursing' is a nursing home operated by Hampshire County Council. It is registered to provide accommodation for up to 86 people, including people living with a cognitive impairment. The home is split into two interconnected parts; a nursing unit and a residential unit each spread over two floors. At the time of the inspection 36 people were being accommodated in the residential unit and 41 people in the nursing unit. Six of the people in the nursing unit were using 'discharge to assess' beds funded by the Clinical Commissioning Group (CCG) to support their rehabilitation following discharge from hospital.

The inspection was conducted on 11 and 12 January 2016 and was unannounced. There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe and felt able to raise concerns. Staff understood their safeguarding responsibilities and knew how to prevent, identify and report abuse. People were protected from individual risks in a way that supported their independence and environmental risks were managed effectively.

People were supported to take their medicines safely. Suitable arrangements were in place for ordering, storing, administering and disposing of medicines, including topical creams.

There were enough nursing and care staff to support people on a timely way. Staff recruitment practices were appropriate and helped ensure only suitable staff were employed.

Plans were in place to deal with foreseeable emergencies. Fire safety equipment and procedures were tested regularly; staff were trained to administer first aid and a defibrillator was available in the event of a cardiac arrest.

Staff underwent a comprehensive induction and training programme. They were knowledgeable and skilled at meeting people's needs. They were suitably supported in their role by managers through the use of supervision and appraisal processes.

Staff acted in the best interests of people and followed legislation designed to protect people's rights. They also involved people or their relatives, where appropriate, in discussing and planning the care and support they received.

People were offered a choice of meals and their dietary needs were met. They received appropriate support to eat, when needed, and were encouraged to drink often.

People were supported to access other healthcare services and staff worked well with external professionals. At the end of their lives, people received appropriate care and support to have a comfortable, dignified and pain free death.

Staff had created a positive, relaxed environment that suited the people living at the home. They maintained a calm atmosphere by supporting people in a patient, unhurried way. They cared for people with kindness and compassion, respected people's privacy and treated them in a dignified way.

Staff put people at the heart of the service and were committed to meeting people's needs in a personalised way according to their individual needs. Care plans contained comprehensive information to enable staff to support people in a consistent way and were reviewed regularly.

People were encouraged to make choices about every aspect of their lives and to remain as independent as possible. They had access to a range of suitable activities either in a group setting or on a one-to-one basis.

The provider sought and acted on feedback from people. There was a suitable complaints procedure in place and people were confident any concerns would be addressed.

People and their families felt the service was run well. They had confidence in the management, as did the staff. There was a clear management structure in place. Staff understood their roles and worked well as a team.

There was a comprehensive quality assurance system in place that focused on continual improvement. A wide range of audits was conducted, together with effective oversight and support by the provider's senior management team.

There was an open and transparent culture at the home. CQC were notified of significant events; staff were encouraged to raise concerns; and positive links had been developed with the community to the benefit of people.

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 trusted staff and staff knew how to identify, prevent and report safeguarding concerns.

Potential risks to people were assessed and managed effectively in a way that respected people's independence. Medicines were managed safely and administered by staff who had been suitably trained.

There were enough staff deployed to meet people's needs. Appropriate recruitment procedures were followed and helped ensure only suitable staff were employed.

There were plans in place to deal with foreseeable emergencies.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction and on-going training to enable them to meet the needs of people using the service. Staff were supported appropriately in their role and encouraged to continually develop their skills.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

The environment was appropriate for people living at the home.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion.

People were supported to maintain friendships and important

relationships. Staff protected people's privacy and dignity at all times.

People and relevant family members were involved in planning the care and support they received.

At the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

Staff were committed to delivering highly personalised care that met people's individual needs. Care plans contained detailed information to support staff to deliver care in a consistent way and were reviewed regularly.

People were supported to have maximum choice and control of their lives and were encouraged to be as independent as possible.

The provider sought and acted on feedback from people to help improve the service.

Is the service well-led?

Good

The service was well-led.

People and staff praised the management of the service. Staff understood their roles and worked well as a team.

There was a suitable quality assurance process that focused on continual improvement. These included audits of key aspects of the service.

There was an open and transparent culture in which staff were encouraged to raise concerns. CQC were notified of all significant events. Positive links had been developed with the community.

Ticehurst Care Home With Nursing

Detailed findings

Background to this inspection

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

The inspection was unannounced and took place on 11 and 12 January 2017. It was conducted by two inspectors, a specialist advisor with a background in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 17 people who used the service and five relatives. We spoke with the provider's service manager, the provider's strategic quality lead, the registered manager, a deputy manager, four nurses, four assistant practitioners (shift leaders) and six care assistants. We spoke with an administrator, two activity coordinators, two kitchen staff and four housekeeping staff. We also spoke with a visiting GP and a healthcare professional who had regular contact with the home. We looked at care records for 10 people. We also reviewed information about how the service was managed, including staff records and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the

experience of people who could not talk with us.

The home was last inspected in February 2015, when we did not identify any breaches of regulations.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Ticehurst and were able to raise any concerns. One person said, "I have no worries at all about me being safe or about anything else." Another person told us," I know [the staff] will make sure I am alright, so I am fine." A family member told us they trusted staff to protect their relative from harm. They said, "I'm happy [my relative] is safe here; there are plans in place to see to that."

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety and were aware of people who were at risk of abuse. For example, two people living with dementia did not get on and had engaged in occasional physical altercations with one another. Staff were fully aware of this and supported them closely throughout the day to reduce the risk of conflict. A staff member told us, "One of them can be physically challenging [towards the other] and both walk with purpose around the unit, so we have to monitor them closely." Two other people, with fluctuating capacity, had become close and had started holding hands. Staff told us one of them was potentially vulnerable to further intimacy and they were monitoring the situation appropriately.

All of the staff, including those not in a care role, had received safeguarding training. They knew how to raise concerns and were confident that managers would take appropriate action. A staff member told us, "[The registered manager] is approachable and I know they would deal with any concerns properly." We saw examples of where managers had conducted thorough investigations in response to allegations of abuse and worked with the local safeguarding authority to keep people safe from harm.

People were protected from individual risks in a way that supported them and respected their independence. Senior staff had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, one person was at risk of choking on their food and had declined staff support with their meals as they preferred to eat alone. They had full capacity, were aware of the risks and had chosen to accept them. Staff had respected the person's decision but were mindful of the risk; they were clear about the action they would take if the person choked and had access to a suction machine that was maintained in good working order.

There were clear procedures in place to monitor people when they fell, including the completion of neurological observations if a head injury was suspected. Where people had fallen, their risk assessments were reviewed and staff considered additional measures they could take to protect the person. All falls and other accidents were reviewed by the provider's risk panel on a monthly basis. This helped ensure that staff had followed the correct procedures and enabled them to identify any patterns or trends. Where the review showed that people had experienced multiple falls, the provider required staff to complete a detailed risk assessment that looked at a wide range of factors that could contribute to the person falling. Measures were then put in place to minimise the likelihood of further falls. These included reviewing the layout of the person's room to remove hazards, considering the use of bed rails, using equipment to monitor the person's movements and referring them to their GP for a review of their medicines. A family member told us, "There is a plan in place for [my relative] as she has fallen; [staff] now put the bed rails up to stop her falling out of

bed. It was all discussed with us and I'm happy she is safe now."

Procedures were in place to reduce the risk of pressure injuries. A recognised tool had been used to assess people's individual risks and a 'tissue viability checklist' was completed weekly to monitor the condition of people's skin. Where needed, pressure relieving mattresses and cushions had been provided and the mattresses were checked twice daily to help ensure they remained at the right setting for each person. Some people needed to be supported to reposition in bed on a regular basis and records confirmed this was done consistently.

Staff had been trained and were aware of the risks relating to people with diabetes. They showed us laminated guidance cards they used to help them identify when people were experiencing high or low blood sugar levels. They were clear about the action they would take if a person showed these symptoms. Staff also used the 'National Early Warning Score' when people became unwell. This is a system usually used by hospitals to categorise the severity of a person's illness, but staff at Ticehurst told us they found it useful and said it would help medical staff to assess people if they had to be admitted to hospital.

Senior staff had also identified and assessed risks relating to the environment and the running of the home. They had taken action to minimise the likelihood of harm in the least restrictive way. Call bells were available to people so that they could alert staff if they needed support or in an emergency and records showed most calls were responded to within five minutes. For those people who were not able to operate their call bell, staff carried out regular checks to enhance their safety. Observations recorded by staff for each person confirmed these were taking place frequently.

People were supported to receive their medicines safely. Staff had completed appropriate training and their competency to administer medicines had been assessed by the registered manager or a registered nurse to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines initialled the MAR chart to confirm the person had received their medicine. Each person's MAR had a sheet with a photograph of the person and information about any allergies. Records showed that people's medicines were consistently available for them. Staff made regular checks of the MARs to make sure people had received their medicines correctly and were aware of the action to take if any mistakes were found, to ensure people were protected.

There was also a procedure in place for the covert administration of medicines when this was necessary. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. The procedures protected people's legal rights and ensured that all relevant people, including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly. Staff followed best practice guidance by offering medicines to people in an open way first, and only reverting to covert administration if the person declined to take them.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. A recognised pain assessment tool was in use for when people were not able to state they were in pain. Additional individual indicators of pain were included in people's care plans to help staff recognise when the person might need pain relief. Guidance was also available for other PRN medicines, such as laxatives.

Some people received medicines that required additional support, such as a medicine that required regular blood tests to check the correct dose. Staff kept the results of these tests with the relevant MAR charts, so

they were able to check they were giving the correct dose. Where people were prescribed creams and ointments, these were usually kept in people's bedrooms and applied by care staff when they provided personal care. Body maps had been completed to show where staff should apply the creams and staff recorded when they had done so.

There were suitable systems in place to ensure the safe storage and disposal of medicines and suitable arrangements were in place for medicines which needed additional security. Refrigerators were available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturers' instructions. There was a medicine stock management system in place to ensure medicines were not used beyond the manufacturers' safe 'use by' date, together with a process for the ordering of repeat prescriptions and the disposal of unwanted medicines. Staff supporting people to take their medicines did so in a safe, gentle and respectful way. People were given time to take their medicines without being rushed. Staff explained the medicines they were giving in a way the person could understand and sought their consent before giving them.

There were enough staff to meet people's needs. The provider had made significant changes to the staffing structure of their homes over the past year. These included the introduction of 'assistant practitioners', who acted as shift leaders in each unit. They were experienced, senior care staff who had received additional training to enable them to administer medicines, under the direction of the registered nurse. They also undertook care planning, the taking of blood samples and minor wound care. The provider's service manager told us the introduction of assistant practitioners enabled the nurses to focus more on people's clinical needs.

We saw that staff were not rushed and responded promptly and compassionately to people's requests for support. The provider's service manager told us staffing levels were based on a 'blueprint' they applied to all their homes according to the number of people being accommodated and their needs. This had been reviewed recently, following the introduction of assistant practitioners, and took into account feedback from people and staff. Where additional staff were needed, for example to provide one-to-one support to people, there was flexibility within the model to provide this.

Staff absence was usually covered by existing staff working additional hours. On occasions, the provider used a small pool of agency nurses to cover shifts; they had all worked at the home previously, so were familiar with operating procedures and understood people's needs. This helped ensure people received continuity of care.

Appropriate recruitment processes were followed and staff were checked for their suitability before being employed by the service. Staff records included an application form, written references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. DBS checks were also conducted for volunteers who supported the home. In addition, the registered manager checked that nurses were registered with their professional body and had a system in place to help ensure their registration was renewed before it expired. Staff confirmed these processes were followed before they started working at the home.

There were plans in place to deal with foreseeable emergencies. A 'grab bag' was readily available in each unit and contained essential equipment, such as torches, foil blankets and contact details for staff. Staff had been trained to administer first aid and there was a programme of fire safety training and fire drills in place. Fire safety equipment was maintained and tested regularly. Personal emergency evacuation plans were in place to help identify the support people would need if they had to be evacuated in an emergency; all but

one were up to date and this was addressed by the end of the inspection. Staff had also been trained to use the defibrillators that had been installed at the home in the event of a cardiac arrest.

Good

Is the service effective?

Our findings

People's needs were met by staff who were skilled and suitably trained. One person said, "The staff seem to know exactly what I want, sometimes before I know." A family member told us, "I never worry about leaving my mum, because I know she is well cared for." Another family member said, "I really did not think anyone could look after my husband like I could, but that has proved not to be the case; the staff are wonderful. I am always greeted with a smile; it's a lovely home."

All staff completed the provider's 'mandatory training', which included safeguarding, moving and handling, infection control, dementia and fire safety. Further training, specific to their role, was also available to each staff member. A staff member said of the training, "It's great. If I say I'm interested in something, the manager arranges training in it straight away." Staff were also supported to obtain relevant vocational qualifications; most had obtained level two or level three qualifications, whilst senior staff had obtained management diplomas. Five staff were also studying for level two diplomas in dementia to enhance their knowledge and understanding of the condition. Trained nurses told us they were supported to complete additional training and personal development to meet the requirements of their registration. This included in-depth training in end of life care to meet best practice guidance.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. This included a period of time working alongside a more experienced member of staff. Following this, staff who had not worked in care before followed a training programme that met the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

Staff demonstrated an understanding of the training they had received and how to apply it. For example they were able to describe how they repositioned people who were cared for in bed, were aware of reporting procedures for safeguarding and able to describe how they supported people living with dementia. One staff member told us, "I try to put my [dementia] training into practice. For example, if someone starts saying they want their mum, which is quite common, then we divert the conversation slightly to talking about their mum, what they were like and things they used to do with them. It really works and calms them down; it's much better than trying to change the subject altogether."

People were cared for by staff who were appropriately supported in their role. Individual meetings were held between staff and their line managers on a quarterly basis. These meetings were used to discuss progress in their work, training and development opportunities, and other matters relating to the provision of care to people. Staff told us that these meetings were useful and supportive. One staff member said, "We get thanked when we've done well; it makes me feel appreciated by management." Another staff member told us, "The managers are supportive and want to get the best out of us."

Annual appraisals were carried out to assess staff performance and to consider further personal or professional development. We were told, and observed, that the registered manager had an open door policy. Staff spoke highly of the registered manager and described a supportive atmosphere where

members of the management team could always be approached for advice and guidance.

People received the personal and nursing care they required. A family member told us they were happy with the way their relative's health and personal care needs were met as their loved one always looked well-groomed and received regular baths. Staff recorded the personal care they provided to people, including if people had declined care, such as a shower or bath. There were wound management plans in place which specified the care, the dressings required and the frequency of changes. The progress of the wound was clearly documented, showing that treatments were usually effective. Where they were not effective, advice was sought from wound care specialists.

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Some people had been assessed as lacking the capacity to make specific decisions. During the care planning process, senior staff had made decisions on their behalf and documented why they were in the person's best interests. These included decisions relating to the care and support people received, the use of bed rails and the administration of their medicines. Family members had also been consulted and their views had been taken into account. However, staff had not always used the provider's two part form to document the process they had followed. As a result, it was not always clear which decisions had been made and why. We discussed this with the registered manager and by the end of the inspection most records had been updated to clarify these points. The registered manager also took action to help ensure staff followed the provider's processes correctly in future.

Where people had capacity to make decisions, this was recorded in their care files, which most people had signed to show their agreement with the care and support that was being delivered.
Some people had given authority to a representative to make decisions about their welfare. These are called Lasting Powers of Attorney (LPA) and staff had obtained copies of these to confirm the extent of the representative's authority. Records showed staff consulted and took account of the views of the person's representative at all times. For example, do not attempt resuscitation (DNAR) forms had been completed for some people and they and/or their representatives had been consulted about the decision in advance.

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 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. We found the provider was following the necessary requirements. DoLS authorisation had been granted for those people who needed them and there was a clear system in place to help ensure renewal applications were made before the authorisations expired.

People told us they enjoyed their meals and said they received a good choice every day. One person said, "The meals are always nice and you get a choice." Another person said, "If it is something I do not like I can always have something else, like sandwiches or an omelette." A choice of two main meals was offered at lunchtime. If people did not want either of the options, kitchen staff had an 'alternative menu' they could use to offer people a wider choice. All meals, including those that had been pureed, were pleasantly presented. Drinks were available throughout the day and staff prompted people to drink often.

Staff were aware of the specific dietary needs of individual people. For example, kitchen staff were aware of which people required their meals in a softer format or had dietary restrictions due to a medical condition. People with special dietary needs were provided with foods suitable for them and systems were in place to remind staff which people needed a higher level of support with meals. A family member told us, "[My relative] was suffering with a sore mouth, so she now has a soft diet and is eating really well."

Staff monitored the weight of people each month or more frequently, if required, due to concerns about low weight or unplanned weight loss and nutritional risk assessments were in place. Where necessary, records of the amount people had eaten or drunk were kept; this meant senior staff could monitor people's intake and consult external professionals where necessary. We saw this had occurred where there were concerns about a person not eating and their GP had prescribed nutritional supplements. We observed they received these at lunchtime when they declined the meal that was offered.

Staff were attentive to people and whilst promoting independence, noted when people required support. For example, we saw one person was not eating their meal independently and was encouraged to eat; the staff member showed the person the spoon and placed it in their hand, helping them to hold it until they started to use it on their own. Another person, who had eaten very little of their meal, was offered an alternative and shown a plate of sandwiches as a prompt.

The provider's service manager told us the home had been part of a 'hydration project' in the area with the aim of encouraging people to drink more. This had increased staff awareness and led to the introduction of a number of initiatives. These included nominating a member of staff to be responsible for topping up people's drinks throughout the day, the use of 'juice stations' where people could access cold drinks and other areas where they could access tea and coffee. They had also created and decorated an area to look like a pub. They told us one person rarely drank during the day, but when taken to the 'pub' area in the evening would always drink well.

People were supported to access other healthcare services when needed. One person told us, "I can see a doctor if I want to without any problem." A family member said, "[My relative] had a cut on her leg and the nurse saw to it straight away." People who were being cared for in the home's 'Discharge to Assess' beds, following a hospital stay, were seen twice weekly by a GP. In addition, a multi-disciplinary meeting (MTD), comprising nurses from Ticehurst, the GP and other relevant health and social care professionals, was held weekly to assess people's progress. We attended an MTD and it was evident that there were positive working relationships between those present. The meeting was focused on achieving the best outcomes for people as quickly as possible. The GP provided examples of how this approach had benefitted people. They said, "It's been very successful. [The hospital] are so impressed, they want to roll out the model elsewhere."

The environment was appropriate for the care of people living at Ticehurst. People's rooms had been personalised to make their rooms feel homely and familiar. This especially helped people living with dementia to settle in and feel at home. One person said, "My room is very comfortable and I have everything I need." A family member told us, "There seems to be a nice atmosphere and it seems homely." All rooms had en-suite facilities and there was a choice of assisted bathrooms suitably equipped to support people with high care needs. There was a wide choice of seating areas for people to meet and engage in activities. In addition, there was a 'military room' containing armed services memorabilia and appropriate music, which people with a military connection told us they enjoyed visiting. There was an area decorated in the style of a pub and another area decorated in the style of a café. Family members told us they often met their relatives in the café, where they could sit and have a drink with them in a relaxed environment. Externally, there was a secure garden which had level access from the home and seating areas for use by people or relatives, together with raised flower beds.

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. Comments from people included: "All the staff are superb"; "The staff are really caring"; "The staff are very nice and have worked with me to make me be much better than I was when I first came in here"; and "[The staff] are always nice to me". Family members echoed these comments. One told us, "My mum loves it here; she jokes with the staff, despite her slight dementia, and they make her laugh." Another family member described staff as "caring" and "understanding".

We observed positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. Staff used touch, appropriately, to calm and reassure people when they became anxious or upset. Occasionally, some staff would break into song and start dancing with people, for example as they supported them into the dining room at lunchtime. When engaging with people, they bent down or kneeled beside them, so they were on the same level. A staff member told us said "I think it is an important part of my job to develop a relationship with the people I care for."

People were supported to maintain friendships and important relationships. Relatives told us they could visit whenever they wished. A person told us, "I can have friends or relatives here whenever I want to." A family member confirmed this and added, "The staff are easy to talk to and they keep me up to date with what is happening." People who got on well were encouraged to sit together at lunchtime and staff promoted conversation between them. Two people in particular had formed a friendship and were supported to spend time together.

One person did not speak English well, but a staff member spoke a version of the person's first language and was able to communicate with them more effectively. Staff had also developed links with a local community support group with ties to the person's country of birth. A member of this group had acted as an interpreter when it was necessary for staff to discuss complex aspects of the person's care with them in more detail.

Staff created a calm atmosphere in the home by supporting people in a patient and unhurried way. When people were helped to mobilise, staff allowed them to move at their own pace whilst giving encouragement and reassurance. The atmosphere was further enhanced by the operation of a silent call bell system that avoided the need for audible bells that would have disturbed the peace and tranquillity of the environment.

People were treated with dignity and respect at all times. One person told us, "The staff are always polite." Dignity, respect and equal opportunities formed a key part of the provider's induction process and were considered during supervisions and appraisals of staff. A staff member told us, "We're taught to respect each other and be professional. It is these people's home and we have to make it homely for them and take time to chat. I try and behave in the same way as I would if I was a guest in their house." The provider's service manager told us, "The whole induction process is value-based. We try to instil that we are guests in people's homes and guard against becoming institutionalised.

People confirmed their privacy was maintained during personal care. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. A staff member told us that when a person moves to the home, they often waited a week before offering them a bath. This enabled them to "build up their trust" so the person would feel comfortable receiving such intimate care.

People received care from staff who were flexible and identified innovative ways to provide care to meet people's needs. For example, one person was reluctant to receive support with their personal care. This put them at risk as they were incontinent and prone to skin breakdown. A nurse told us that the person did not engage well with the majority of staff, but got on well with a member of the night staff. This staff member made a point of supporting the person with personal care whenever they were working and had supported them to have regular baths. This had helped maintain the person's dignity and the integrity of their skin.

Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

People and, when appropriate, people's families were involved in discussions about developing their care plans. Family members confirmed they were always kept up to date with any changes to the health of their relatives. A family member told us they were "actively involved in any care plan consultations". They said they knew the staff had to talk to them about "a difficult decision to be made in respect of their relative" and said staff had given them "all the time they needed" and supported them "to make the right decision".

At the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death. Written feedback from the family member whose relative had received end of life care at Ticehurst stated: "Your care and attention to make dad comfortable was nothing short of 100%." The service was working towards accreditation with a nationally recognised framework for end of life care. Nursing staff had attended training to enable them to better manage symptoms people may have at the end of their lives. The registered manager was aware of who they could contact for additional support if required. Information about people's preferences for their end of life care were included within care files. Nurses were aware of how to obtain and administer symptom management medicines, should these be required, and the importance of good mouth care. Where necessary, medicines to manage symptoms were held within the home so they would be immediately available should the need arise. In addition, a relatives' room was available where family members could stay overnight to be close to their loved ones as they approached the end of their lives.

Good

Is the service responsive?

Our findings

People consistently told us they received highly personalised care from staff who understood their care and support needs. A family member confirmed this and gave an example of how care was centred on the needs of the individual. They said, "[My relative] doesn't like getting up early and [staff] know to bring her round slowly; she's normally the last one to get up." Another family member told us, "We're happy [our relative] is well looked after; [staff] ring us if she's not well and keep us informed."

All staff we spoke with showed a shared commitment to putting people at the heart of the service and meeting people's needs in a personalised way in accordance with their preferences and wishes. This was confirmed by written comments from staff in a recent staff survey. These demonstrated an ethos of putting people first, treating people as individuals and with respect, promoting independence and encouraging choice. A staff member told us, "It's very much about us trying to fit in with what [people] want rather than the other way round. One person wanted to stay in bed today, so we changed her nightie and she stayed there for the morning. It was what she wanted and the [managers] were happy with that." Another staff member said, "I'm employed for the residents; it's about supporting them."

Assessments of people's care needs were completed by one of the managers before people moved to the home. The registered manager was clear that people were only accepted into the home if they were satisfied that existing staff could meet the person's needs fully.

The provider had introduced a new format of care plans in September 2016 and staff had recently completed the task of transferring information from people's old care plans into their new care plans. Whilst there were still a few inconsistencies that staff were working through, most care plans were well organised and provided comprehensive information to enable staff to deliver care and support in a personalised way. The care plans were centred on the needs of each person and took account of their medical history, their preferred daily routine and how people wished to receive care and treatment. They included information about people's medicines; continence; skin integrity; nutrition; and mobility.

When we spoke with staff, they demonstrated a good understanding of people's needs and preferences. They knew how each person liked to receive care and support. For example, they were able to describe the support people required to meet their personal care needs, their nutritional needs and how they should be supported with moving and repositioning. One person had a catheter, which is a device used to drain a person's bladder through a flexible tube linked to an external bag. Catheters are prone to blockages and infections if good fluid throughput is not maintained. Staff were clear about how and when the person's intake and output was monitored and there was a clear plan in place to support this.

A process was in place to ensure care plans were reviewed every month by one of the assistant practitioners, using a new 'resident of the day' system. This required all staff to focus on one person each day, in each of the units. On this day, the care staff reviewed and updated the nominated person's care plan; the housekeeping staff deep-cleaned their bedroom; the activity coordinator engaged with the person on a one-to-one basis; and the person's 'key worker' tidied their room, checked they had enough toiletries and got

any shopping they needed. The system was still bedding in, but in most cases records showed the necessary tasks had been completed and the person's care plan had been updated.

Staff had recognised that they were no longer able to meet the needs of three people whose dementias had progressed and who had started to act in a way that put themselves and others at risk. They were working with health and social care practitioners, including the community mental health team, to identify more appropriate placements for them. In the interim, they had developed support plans, that incorporated the advice of specialists, to provide guidance to staff and enable them to meet people's needs as effectively as possible. This included the recording of incidents in a way that helped identify factors that led to each incident and strategies that supported people most effectively when they occurred.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. A staff member described how they supported people living with dementia to make choices. They said, "If it's the menus, we talk through the foods, what they taste like, ask what they like and try and jog their memories. If it's about clothes, I'll open their wardrobe and talk about the weather, and if it's hot, cold, wet or sunny. We talk through the choices and what would be best for each day." Staff also encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, they described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach or by gently reminding them when they lost track of where they had and hadn't washed.

People were provided with appropriate mental and physical stimulation through a range of varied activities. A relative told us about a Christmas party they had attended that people had enjoyed. Another family member said of the staff, "They do activities and [my relative] enjoys them when she chooses to take part. She goes to bingo, quizzes, music and the external entertainers are really good." During the inspection, we observed a range of activities taking place, including a cake making session, a musical quiz and indoor bowling. People and their families were kept informed of events and daily activities though activities notices displayed throughout the home. Other events, such as coffee mornings and church services were also held regularly.

Ticehurst employed two activities co-ordinators and were in the process of recruiting a third. They were responsible for organising activities, both in groups and individually. People, who remained in their bedrooms, by choice or through care needs, were given the opportunity to receive one to one activities of their choice. Care plans included information about people's previous hobbies, interests and life histories meaning staff could incorporate these into activities and in conversation when talking to people. For example, one person's interests were listed as watching sport and doing quizzes. When we visited them, they told us they were supported to pursue these interests. They had TV in their room to watch sport and had been given a range of magazine quizzes they were working through. Another person's care plan said they liked puddings, plain crisps and watching TV; their daily care records confirmed that they had done all of these things during the previous week.

The provider sought feedback from people, relatives, staff and external professionals including through the use of questionnaire surveys. Responses showed a high level of satisfaction with the service. Where issues were identified, these were investigated and used to improve the service. For example, the previous survey had identified concerns relating to the laundry. In response, the service had recruited an extra member of staff to work in the laundry to help reduce the incidence of clothes going missing or becoming damaged. Residents and relatives' meetings were also used as an opportunity to seek feedback from those using the service and had led to changes in the menu and the activities programme.

People knew how to complain or make comments about the service and the complaints procedure was displayed in the entrance hall. Most relatives and people told us they had not had reason to complain, but would contact a staff member if needed. One person told us, "I would know exactly who to talk to if I needed to complain and I know they would listen to me". Another person said, "We see the [registered manager] about a lot. They're always very friendly and talk. If we have any concerns at all, we just go to them and bring it up. We always get a good response." We viewed the records relating to a complaint about a sticky carpet in a person's room; prompt action was taken to replace the floor covering and the complainant was informed of the outcome.

Good

Is the service well-led?

Our findings

People consistently told us the service was well-led. One person said "The manager is lovely and really does know what she is doing." Another person told us, "The manager and all the staff work very hard." These comments were echoed by family members who told us they had complete confidence in the management of Ticehurst.

Staff told us they enjoyed working at the home because the standards were "high". They spoke positively about the support they received from management on a day to day basis. Comments from staff included: "[The registered manager] is amazing; she is so supportive; her door is always open"; [The registered manager] is supportive and very approachable; I can go to her with any concerns"; and [The registered manager] sees us every day and greets us with a smile; she makes the place feel like home".

Staff understood their roles and told us they worked well as a team. One staff member told us, "It's a good place to work and everyone works well together." There were effective systems in place for staff to share knowledge and information about people and their health needs. A 'handover sheet' was prepared each day with key information about people's current needs and a 'handover' meeting was held at the start of each shift to verbally share information about people.

There was a clear management structure in place at the home, supported by the provider's service manager and other senior managers. A temporary deputy manager was providing additional management support until a permanent deputy manager, who had recently been recruited, started work. We observed positive interactions between the service manager, the registered manager, staff, people and relatives who appeared comfortable discussing a wide range of issues in an open and informal way.

The registered manager told us they had access to appropriate advice and support from the provider. The managers of each of the provider's homes met on a six-weekly basis to share good practice, discuss ideas and learn from one another. The service manager also organised an annual conference for all the provider's registered nurses, to promote networking and the sharing of good practice. In addition the registered manager attended meetings of the local registered managers association which they said helped them keep up to date with contemporary issues in health and social care.

An appropriate quality assurance system was in place that focused on continuous improvement. This operated at different levels and included robust oversight of the service by the provider's senior management team, the service manager and the registered manager. Each had a part to play in assessing and monitoring the quality and safety of the service and driving improvement. For example, following a review of the care planning system, a new care plan format was rolled out to the provider's homes last year. A review of the staffing structure had led to the introduction of assistant practitioners to lead the shift and take some of the pressure off registered nurses. The registered manager told us the organisational changes were slowly being embedded and had already benefitted people. For example, there had been a reduction in the number of medicine errors and improvements in the quality of the care plans.

A systematic programme of audits was conducted throughout the year, focusing on key aspects of the service, such as care planning, medicines, health and safety and infection control. These were conducted by the provider's quality and governance team, the service manager and the registered manager. Where changes were needed, specific action plans were developed and implemented. For example, care plan audits had identified that aspects of a person's care plan needed updating and we saw this had been done. During an audit of medicines, the staff member administering them was interrupted, so appropriate advice was given. The infection control audit identified curtains that needed cleaning and this had been done.

A programme of staff and management meetings was also in place to aid the flow of information and provide opportunities for the whole workforce to give their views of the service and make suggestions for improvements. Staff felt managers listened and acted on their comments. For example, a staff member told us they had suggested creating a board of staff photos to show people and visitors who was working each day and this had been implemented. Another staff member said, "If I ever question something, I always feel listened to."

There was an open and transparent culture at the home. Visitors were made welcome at any time and could stay as long as they wished. The previous inspection rating was displayed on the home's notice board for people and visitors to see. There was a duty of candour policy in place which required staff to act in an open way when people came to harm and the registered manager was clear about how and when this should be used. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the safeguarding authority or CQC if they felt it was necessary. There were positive working relations with external health professionals, including with a local university to arrange student nurse placements in the provider's homes. The registered manager told us the placements benefitted the service. They said, "It helps keep us up to date and it's good to have a fresh pair of eyes to identify improvements. It also makes us work properly as you can't cut corners when you're mentoring and showing them how to do things. They are also potential recruits in the future."

Links had been developed with external organisations and these had benefitted people directly. A local charity frequently organised fund raising events that enabled the service to buy furniture or equipment to support people, including with the running of activities. Another charity took people on trips to local attractions. A local support group had raised funds to enable a person to re-settle in the country of their birth and provide interpreting services for one of their members. The army had set up a memorial area at the front of the home out of respect for people from the home who had service in the armed forces; they had also provided memorabilia for the 'military room', where people with military connections enjoyed spending time. In addition, a 'Friends of Ticehurst' voluntary group supported the home by raising funds and organising activities. These had included running a summer fair and a Christmas party.