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Tiled House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10 April 2017. It was unannounced. At our previous inspection in August 2016 we found breaches of six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were to do with providing care and treatment in a safe way, operating effective systems to manage risk and quality, maintaining sufficient staffing levels, providing care and support that met people's needs, meeting the requirements of the Mental Capacity Act 2005, treating people with dignity and respect, managing risks to people's safety and welfare, and treating people with dignity and respect. The provider sent us an action plan and other records describing how they intended to meet the requirements of these regulations. At this inspection we found the provider had made sufficient improvements in some areas to meet the requirements of the regulations, but there were still concerns in other areas.

This service has been in special measures. Services that are in special measures are kept under review and inspected again within six months or soon after. We expect services to make significant improvements within this time frame. During this inspection the service demonstrated to us that improvements had been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of special measures.

Tiled House is registered to provide accommodation, personal care and nursing care for up to 29 older people who may be living with dementia or a learning disability. At the time of our inspection there were 14 people living at the home.

Accommodation was on two floors, both of which were partly occupied. Shared areas included two shared lounges and a dining room. Access to a decked area and the secure garden was from the dining room.

There was no registered manager in post at the time of this inspection. 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. Following this inspection we received an application to register from the manager in post.

Although improvements had been made with respect to the safety, maintenance and cleanliness of the home, we found some examples where appropriate standards of hygiene and cleanliness were not maintained in relation to fixtures and fittings in shared bathrooms. When we pointed these out to the manager they took action to resolve them on the day.

The provider had arrangements in place to protect people from other risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure the provider only employed workers who were suitable to work in a care setting. There were arrangements in place to store medicines safely and administer them safely and in accordance with people's preferences.

Staff were aware of the importance of consent but the provider did not always put into practice the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards where people were unable to consent.

Staff received appropriate training and adequate supervision to maintain and develop their skills and knowledge to support people according to their needs. People were supported to eat and drink enough to maintain their health and welfare. People were supported to access healthcare services, such as GPs and specialist nurses.

Care workers had developed caring relationships with people they supported. People were able to take part in decisions about their care and support and their choices were respected. Staff respected people's independence, privacy, and dignity.

Care and treatment were based on plans which took into account people's needs and preferences. People were able to take part in a variety of group and individual leisure activities. The provider listened to people's experiences and concerns, and acted on them. There had been no recent complaints.

There was a warm, welcoming atmosphere in the home, and people were supported to express their views of the service they received. The provider had systems in place to manage the service and to monitor, assess and improve the quality of service people received. Although the service had improved, these systems were not yet fully effective or embedded in practice.

We found one continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected against the risk of infection because standards of hygiene and cleanliness were not always maintained in relation to shared bathrooms.

People were protected against other risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure workers were suitable for work in a care setting.

Processes were in place to make sure medicines were administered and stored safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always guided by the Mental Capacity Act 2005 where people lacked capacity to make decisions.

Staff were supported by training and supervision to care for people according to their needs.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

Is the service caring?

Good

The service was caring.

People were supported by staff who developed caring relationships with them.

People were able to participate in decisions affecting their care and support.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care, support and treatment met their needs and took account of their preferences.

There was a complaints procedure in place. People's concerns were listened to and dealt with informally before they needed to make a formal complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not taken timely action to make sure regulated activities were managed by a manager registered with us.

A management system and processes to monitor and assess the quality of service provided were in place. However these were not fully embedded and had not identified all areas of concern.

There was a warm, welcoming culture in which people were treated as individuals and could speak up about their care and support.

Tiled House

Detailed findings

Background to this inspection

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

This inspection took place on 10 April 2017 and was unannounced. The inspection team comprised two inspectors 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. On this occasion the expert by experience had professional expertise in nursing and managing health and social care services, and had experience of caring for a family member who used regulated services.

Before the inspection we reviewed information we had about the service, including previous inspection reports, enforcement notices, and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had also sent us action plans and other records to show how they had responded to enforcement notices we issued following our last inspection, including a report commissioned from an independent consultant. We also spoke with a social care professional who had been closely involved with the service since our last inspection.

During the inspection we spoke with the provider's general manager, the home manager, the deputy manager, a registered nurse, three care assistants (one who also worked as a domestic assistant), and the cook. We spoke with or observed the care and support of 13 people who were living at the home. We also spoke with a visitor to one of them.

We reviewed records relating to the care and support of five people. We looked at how medicines were managed, including the medicines records for all the people living at the home. We looked at the staff duty rota for a recent four week period, four staff files, an overview of staff training, and documentation related to

the safety and suitability of the premises. We looked at audits conducted by the provider. Other records reviewed included complaints and compliments, accident and incident reports, current action plans and records associated with the Mental Capacity Act 2005.

Requires Improvement

Is the service safe?

Our findings

At our inspection of 11, 12 and 15 August 2016 we found people were not protected against risks associated with medicines, the risk of unsafe care and treatment, and the risk of infection. There were not always sufficient suitable staff to support people safely. These were breaches of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued warning notices requiring the provider to make necessary improvements by 30 November 2016. The provider sent us a plan of the actions they proposed to take in order to meet the requirements of the regulations, and other records and information we requested to check their progress. At this inspection we found considerable improvements had been made. There were no longer breaches relating to medicines, safe care and support, and staffing levels. We also found improvements in the cleanliness and safety of the home, although there were still areas for improvement here.

One person told us they felt safer than they did "in previous places". "I don't know what makes me feel safe, but I do. The staff make me laugh." They described the manager and deputy manager as "very nice" and told us they had a "nice room". "They keep it clean for me." A visitor told us they had seen improvements and were satisfied their relation's room and bed were kept clean.

At our inspection in August 2016 we had concerns about how medicines were stored, managed and administered. People did not always receive medicines they were prescribed at the right time. Medicines prescribed to be taken "as required" and controlled drugs were not administered and managed safely. (Controlled drugs are prescription medicines controlled under the Misuse of Drugs Act 1971.) Since that inspection the provider had addressed the concerns by means which included staff training and closer governance and monitoring of the management of medicines.

At this inspection we saw a registered nurse as they administered medicines in a shared area of the home. They were patient and tried different methods to encourage people to take their medicines. Where a person was asleep, they waited for them to wake up naturally before giving them their medicines. Where appropriate they made sure the drinks they gave with medicines were thickened so that they were easier for the person to swallow. They made sure one person had taken all their medicines before they went on to the next person.

We spoke with a registered nurse about medicines management, including how medicines were acquired, dispensed and disposed of. We examined the provider's policy for the management of medicines, and the Medicines Administration Records (MAR) for all people living at the home. The nurse told us there were regular training updates offered by external suppliers and the provider carried out regular competency checks. Records were in place to provide an audit trail that this was done.

The administration and management of medicines followed guidance from the Royal Pharmaceutical Society. Nurses did not leave medicines trollies unattended when unlocked and they did not sign the MAR sheets until the person had taken them. There were no gaps in the MAR sheet records. All medicines were delivered and disposed of by an external supplier. Records showed the management of this was safe and

effective, and in line with the provider's policy. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered on individual MAR charts and stored safely. Other medicines were safely stored in locked cupboards. Medicines requiring refrigeration were stored in a locked fridge which was not used for any other purpose. The temperature of the fridge and the room in which it was housed was monitored regularly to ensure the safety of medicines. Appropriate processes were in place for the management of controlled drugs.

Medicines prescribed to be given "as required" were managed in a safe and effective way. The necessary protocols were in place, which outlined why and how people were to receive these medicines, along with possible side effects. We also noted that time-critical medicines were given at the appropriate time. The MARs for these medicines contained clearly visible instructions.

No-one at the home managed their medicines independently and no-one received medicines covertly, that is without their knowledge or permission. The provider had sought and received advice on how to discontinue medicines such as anti-depressants safely.

The provider undertook monthly audits in some areas of medicines management. We noted that issues identified as a result of these audits were acted upon in a timely and satisfactory manner. However, we noted that these audits did not cover the management of "as required", time critical or covert medicines.

At our inspection in August 2016 we had concerns about how risks to people's safety were identified, assessed, monitored and managed. People were at risk of unsafe care and treatment. Since that inspection the provider had addressed the concerns by means which included reviewing and rewriting people's care plans and improving systems for monitoring and assessing the service provided.

Personal risk assessments were in place to identify risks associated with people's care, support and medical conditions. Risks assessed included those associated with behaviour that challenges. Staff used standard tools to assess people's risk of malnutrition or of acquiring pressure injuries every month. Information from the risk assessments informed people's care plans, and was updated if people's conditions changed. Staff we spoke with were confident they had the information they needed to support people safely. Records showed any accidents and incidents were logged and followed up.

The provider kept a risk register of all people living at the home regarding evacuation in an emergency. There were personal emergency evacuation plans for each person. These were kept in a folder where they would be accessible to staff in an emergency. The provider's emergency contingency plan was up to date and accessible. It contained detailed and relevant information concerning the safe management of the service during adverse events such as fire, flood, staff shortages and power cuts. The layout of the home was such that it did not present significant difficulties in evacuating people in the event of an emergency.

We noted suitable equipment such as hoists and wheelchairs were available for staff to use. Slings were each designated for one person's use only. Toilets and bathrooms had a pushbutton call bell on the wall with an opening for a cord to be attached. A member of staff confirmed these boxes were the call bells, however it would be difficult for a person using the bath or toilet to reach them.

The staff members we spoke with had undertaken adult safeguarding training within the last year. This was confirmed by training records. There was information on the home's notice boards about how to identify and report safeguarding concerns. Staff were able to identify the types of abuse and knew the provider's safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as

the local adult services safeguarding team should be made, in line with the provider's policy. There had been no safeguarding incidents since our last inspection.

At our inspection in August 2016 we saw there were not always enough staff deployed to support people safely. Records showed staffing levels were not always maintained at a level considered safe by the manager. Since that inspection the number of people living at the home had reduced, but the provider had not changed the staffing levels. Systems were in place to monitor and check that rotas conformed to the agreed staffing levels.

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for four staff members. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working in a care setting. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people who are vulnerable as a result of their circumstances. There were also copies of other relevant records including full employment histories, character references, job descriptions and contracts in staff files.

The staff duty rota from 6 March to 9 April 2017 showed there was one registered nurse on duty during the day and one at night. There were five care staff on duty during the day and three on night duty. There was no reduction in staffing levels at weekends. In addition, there were activities, housekeeping, kitchen and maintenance staff on duty.

The provider made use of agency staff. For example, agency staff covered most night duty shifts. However, most staff supplied by agencies to the home were engaged on a medium to long term basis. They were knowledgeable about the needs of the people they were caring for and people were familiar with them. We looked at staff profiles sent by the agency to the provider. These contained up to date and relevant information such as employment histories, DBS and immigration status, training, and evidence of professional registration for nurses.

The provider did not use a dependency tool to calculate appropriate staffing levels. The manager told us weekly information about staffing levels and other issues such as external health and social care input was sent to senior managers and measured against key performance indicators. Staffing levels were in excess of what was required on the day of our visit as the home was less than half occupied. We saw staff were able to carry out their duties in a professional, calm and unhurried manner.

At our inspection in August 2016 we had concerns that the cleaning and maintenance regimes in the home did not protect people from risks to their safety and the risk of infection. Since that inspection the provider had carried out refurbishment and redecoration, which was still in progress at the time of our visit. The provider had also changed the staff responsible for cleaning and introduced improved systems for monitoring the cleanliness of the home.

Although most of the shared areas of the home and people's bedrooms were clean and in a good state of repair, we found examples in shared bathrooms where the standards found elsewhere were not maintained. These included a dirty plastic basket in one bathroom containing a hairbrush, comb, toothpaste and shaving gel, a dirty toilet roll holder, and broken plastic on the upright pole of a bath hoist. A plastic urinal was stained black inside, and a Mowbray frame used to raise the height of a toilet seat and provide support handles for people using the toilet was incorrectly installed and dirty. In another bathroom, part of a bath side panel was loose, there was no call bell and the toilet bowl was marked with faeces.

We pointed these out to the manager, who took action straight away to make sure the bathrooms were cleaned. However, it was a concern that the routine checks in place had not identified these examples of poor hygiene.

We saw care workers supported people to maintain their personal hygiene. They offered to support people to the bathroom before lunch, and gave them hand wipes before and after food and drink. Care workers used the wipes themselves so people could see what they were for and copy them.

The provider had carried out an infection control audit on 16 March 2017. Areas covered included hand hygiene, sharps management, control of substances hazardous to health (COSHH), and the cleanliness of equipment such as hoists and wheelchairs. There were also regular environmental, laundry, kitchen and mattress audits undertaken. There was a programme of regular routine maintenance with dates when tasks were completed. We found issues which had not been identified by these processes. However, where the provider's processes had identified issues, they had put actions in place to address them.

Requires Improvement

Is the service effective?

Our findings

At our inspection of 11, 12 and 15 August 2016 we found people were cared for by staff who were not adequately trained or supported. The legal rights of people who lacked capacity were not always protected. People's intake of food and fluids was not effectively monitored to protect them against the risk of poor nutrition. There were breaches of Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice with respect to Regulation 18 requiring the provider to make necessary improvements by 30 November 2016, and a requirement action with respect to Regulation 11. The provider sent us a plan of the actions they proposed to take in order to meet the requirements of the regulations, and other records and information we requested to check their progress. At this inspection we found improvements had been made such that there was no longer a breach with respect to staff training and supervision. However there were continuing concerns in the area of the legal requirements where people lacked capacity.

At our inspection in August 2016 we had concerns that staff did not comply with the requirements of the Mental Capacity Act 2005 where people lacked capacity to make certain decisions. Since that inspection the manager and staff had received training in this area. The manager had identified new forms to support processes around capacity assessments and best interests decisions. However, the records in place at the time of our inspection were inconsistent, incomplete and did not show that legal processes were followed.

The Mental Capacity Act 2005 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 the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the Act and whether any conditions on authorisations to deprive a person of their liberty were being met.

In three cases we found records in people's care files were inconsistent, contradictory and incomplete. In all three cases there were consent forms for the use of photographs, the administration of medicines, and sharing of information. These were dated December 2016 and had been signed by the manager on behalf of the person. In all three cases there were capacity assessments dated January 2017 which concluded the person lacked capacity to make decisions in these three areas but the best interests sections of the forms had not been completed. In all three cases there were subsequent capacity assessments dated February 2017 which concluded the person had capacity to make these decisions. While it is possible for people's capacity to change and fluctuate, the February assessments should have replaced the earlier assessment and consent forms. The presence of contradictory records meant people were at risk of inappropriate care.

These records did not show the sequence and processes required by the Mental Capacity Act 2005 were followed.

The care file of one of the three people contained a form indicating they should not be resuscitated in the event of heart failure. The form stated the decision had not been discussed with the person because they were "drowsy". Other records showed the person was considered to have capacity with respect to other decisions, but there was no evidence the advance decision to decline treatment had been discussed when they were no longer "drowsy". It was therefore not clear the person had consented to this decision.

The care file of another person contained an undated capacity assessment which concluded they had capacity to consent to their placement at the home. However the handover sheet stated "DOLs granted". The manager confirmed this meant they had received authorisation under the Deprivation of Liberty Safeguards from the supervising authority to deprive the person of their liberty. As authorisations are only required where people lack capacity, this was inconsistent with the undated capacity assessment. There was no record of the authorisation available at the time of our inspection, although the manager had received an email from the supervising authority in January 2016 which indicated an application had been made. This meant we were not able to verify if any conditions imposed were met. The authorisation to deprive the third person of their liberty had expired in January 2017, although the handover sheet stated "DOLs granted". We could therefore not be sure this person was being deprived of their liberty lawfully.

Failure to act in accordance with the 2005 Act was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff were conscious of the need only to support people with their consent. When supporting people they explained what they were about to do, gave people enough time to understand and reply, and respected people's decisions to decline care or support.

Although records of capacity assessments were not always complete, there were records in place to show assessments and best interests decisions were taken into account with respect to other specific decisions. These included decisions around dental care, foot care, flu injections and bed rails. In one case a best interests decision had meant the person avoided an unnecessary hospital appointment.

At our inspection in August 2016 we had concerns that staff were not supported by adequate training and supervision. Since that inspection the provider had clarified the training required by all staff and made sure staff received the required training.

The Skills for Life Care Certificate training was in place for all new staff and informed planned refresher training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The manager had an effective system for monitoring staff training. Their records showed clearly where staff had completed training, and when it was due. Training certificates were filed to show which courses had been completed by staff members. Staff were able to access training in subjects relevant to the care needs of the people they were supporting. The provider had made training and updates mandatory for all staff in infection control, health and safety, moving and repositioning, fire awareness, safeguarding adults, first aid and food hygiene. Staff had also received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, dementia awareness, equality and diversity, behaviours that challenge, nutrition and hydration, managing difficulties swallowing, and continence management. Specific training for registered nurses was

available in areas such as the management of syringe drivers, end of life care and catheterisation.

We looked at the supervision and appraisal records for four staff members, in addition to the staff supervision planner. Records of supervisions were detailed and individualised. Issues of importance were discussed. Action plans were drawn up as a result of these, with timelines and responsible staff identified. We noted the supervision records did not contain much input from staff members. It was therefore not clear that supervisions were an opportunity for two-way communication or that staff were encouraged to raise concerns or contribute ideas.

However staff told us they felt supported. They told us the manager and deputy manager made themselves available and were approachable. Staff spoke positively about the training they had received and gave examples of how it had improved their practice in supporting people, particularly in the area of moving and repositioning people.

People were supported to eat a balanced, appropriate diet. One person told us, "[The food] is good. They have cut down what I have because of my diabetes." The food appeared appetising and was served according to people's preferences. Breakfast was informal with most people taking it in chairs in the shared lounges. Lunch was arranged to be a pleasant, social event with most people taking it in the dining room. Staff encouraged people to be as independent as possible when eating and drinking. Where people needed individual support to eat, this was done in a discrete and sensitive way.

The menu for the day was displayed outside the kitchen. People were offered choices. A choice of hot and cold drinks was on offer during the day. People could eat a diet which conformed to their medical needs or preferences, for instance softened , mashable or pureed food, or thickened fluids. One person preferred a vegetarian diet, which was provided for them.

If people were at risk of poor nutrition, staff recorded their intake every day. Amounts of fluids were totalled so that any day to day trends would be apparent. People's weight was monitored monthly and used to measure and monitor the risk.

People were supported to access other healthcare services. One person said, "I see my doctor here if I need to. The girls phone him and he comes every Tuesday." People's care files contained records of referrals to speech and language therapy, mental health teams, GPs, memory assessment nurses, dentists, opticians and specialist nurses.

Good

Is the service caring?

Our findings

At our inspection of 11, 12 and 15 August 2016 we found people's choices were not always respected and people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement action with respect to Regulation 10. The provider sent us a plan of the actions they proposed to take in order to meet the requirements of this regulation, and other records and information we requested to check their progress. At this inspection we found improvements had been made such that there was no longer a breach of Regulation 10.

There were caring relationships between people and staff who supported them. One person described the staff as "very nice". All the interactions we saw between people and staff were caring and respectful. Staff were cheerful and helpful. They shared jokes with people which contributed to the pleasant atmosphere.

Staff were patient with one person who repeatedly asked when they were going home. Each time staff explained the person had fallen and could no longer look after themselves, so they were living in a nursing home. This satisfied the person for a while. A care worker explained they had written down with the person where the person was, when they came here, the name of the care worker who helped her to write this down and the fact they used to like ballroom dancing. The person read it to us, although they did not remember that they had written it. Staff tried to find individual ways to comfort and reassure people.

Another person asked why they were going to bed. The care worker explained they were helping them into a wheelchair because it was lunchtime. Other care workers reassured a person who was worried because others were going to lunch first.

Staff took steps to make it easy for people to understand them. They made sure people could see their faces, they spoke slowly and clearly and gave people time to answer. Staff engaged with other people in the room when they were supporting one person. They respected people's decisions if they declined care and support. We saw they came back later, and one occasion a different care worker was asked to see if the person responded better to them. Staff encouraged and praised people. We heard one care worker say, "Try and sit back for me please." And then, "Well done!"

Where people expressed choices about their care and support, staff respected their decisions. For instance one person asked for more biscuits and another asked for a banana with their hot drink. The care worker said they would look for them, and came back with what had been asked for. Another person asked for their colouring book. The care worker noticed it was full, so they went to look for a new one.

Staff prompted people to express their choices. We heard them say, "Would you like cream on your porridge?" and, "Do you prefer cold milk?" When another person checked whether they had sugar on their cornflakes, they were reassured they did.

Where people were able to they were involved in planning their care. One person said, "Yes, when I wasn't

taking my tablets we did this together." Care plans prompted staff to involve people in decisions. One person's plan stated "[Name] usually goes to bed at 10:30 or when he chooses." Arrangements were made for people's interests to be represented if they were not able to communicate directly. One person had an independent mental capacity advocate nominated by a local charity to speak up for the person and represent their interests.

Staff respected people's dignity and privacy. Care workers gave us examples of how they respected people when supporting them with personal care. We saw that staff treated people as individuals and encouraged them to be as independent as possible. Staff asked before they removed food trays. When people were offered cold drinks staff asked if they would like to pour their own. One care worker said, "Shall I help you, or would you like to help yourself?"

When a care worker saw that a person was not eating, they said, "Would you like me to sit down with you and help?" They supported the person to start eating. When the person started to eat independently the care worker left the table. Another care worker encouraged a person to try and hold their drink. They told us, "Just because he couldn't do it yesterday, it doesn't mean he can't do it today."

Staff told us nobody living at the home had particular needs or preferences arising from their religious or cultural background. The care assessment process was designed to identify if the person had relevant needs or preferences in this area. Staff were aware of some of the adjustments to people's support that could arise from this. Equality and diversity was included in the staff training programme.

Good

Is the service responsive?

Our findings

At our inspection of 11, 12 and 15 August 2016 we found people did not always receive care and treatment that met their needs and took into account their individual choices. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement action with respect to Regulation 9. The provider sent us a plan of the actions they proposed to take in order to meet the requirements of this regulation, and other records and information we requested to check their progress. At this inspection we found improvements had been made such that there was no longer a breach of Regulation 9.

At our inspection in August 2016 we found care plans did not contain consistent information staff needed to support people according to their needs and preferences. People did not always receive care in line with their plans, and their care did not always support their mental and physical well-being. Since that inspection the provider had rewritten people's care plans and put in place improved processes for monitoring people's care and support. Care plans had been reviewed and audited in February 2017. The provider had put in place group and individual activities to improve people's experience of social interaction and support their mental well-being.

People received treatment and assistance with their personal care that met their needs and took into account their preferences and wishes. One person told us about how they were supported to manage their diabetes. They told us, "I didn't used to take my tablets and insulin and the doctor had to rush me into hospital because my blood sugar was so high." Then, "One of the nurses spoke to me about my tablets and insulin and how important it is to take them." They told us their blood sugar levels were better now, staff checked them "every day" and they had insulin "every morning".

Another person had acquired a pressure injury on their heel. The provider's wound management file contained a treatment plan. This showed the wound had been managed, dressed, and checked by the person's GP and a specialist nurse. There was a body map which showed the location of the wound, and photographs documented the healing process. The latest check showed the wound was "very nearly healed".

Care plans were individual to the person. They included a "This is your life" form developed by the provider which contained information about the person's personal history, and social and family contacts. Some also had a "This is me" form developed by the Royal College of Nursing and Alzheimer's Society designed to contain important information for people living with dementia when they moved between services.

Care plans were organised to identify people's needs, the desired outcome from an activity and the actions staff needed to take to support the person. Plans covered people's preferences, mobility, falls risks, hygiene, mobility and personal care. Where appropriate there were plans for supporting people living with dementia, diabetes and other medical conditions. Where people were prescribed medicines to be taken "as required", there were instructions including when to offer the medicine, the correct dosage and how often the medicine could be administered. Some people had been supported to think about advance plans for how

they wanted to be cared for at the end of their life.

Staff told us the care plans contained the information they needed to support people according to their needs and preferences. They recorded the care and support delivered in daily logs which contained morning and afternoon reports and records of night checks. The manager monitored the care people received by reviewing the daily logs and other records such as fluid charts. They were also able to speak with people and observe their individual care while the home was not fully occupied. The manager had an audit tool to assist in and record reviews of care plans. Systems were in place to make sure people received care and treatment according to their plans.

The provider had introduced a number of group and individual activities since our last inspection. During our visit we saw people enjoying sitting exercises led by an external supplier. Other activities in place or planned were visits by a singer, and other visitors to lead sessions called "Creative Talks", "Fifty years of Comedy and Heroes" and "Wild Science". A visitor told us they were particularly pleased that a boat trip was being planned for the summer. This was something their relation used to enjoy, but it had not been available recently.

During our visit we saw staff offering people books and magazines to look at, and staff sitting with people playing games and supporting them in individual activities, such as colouring. People who did not want to take part in the games were encouraged to watch. At one point staff switched the TV in one lounge to a radio station because people were not watching it. Staff, including kitchen and housekeeping staff and the manager, spent time with people, chatting and laughing. This contributed to a lively atmosphere in the two shared lounges during the day. On the day of our visit the home was being decorated for Easter which would help people to keep in touch with the passage of seasons and give opportunities for reminiscence and enjoyable activities.

Staff told us they were able to support people to maintain interests and hobbies, such as football, gardening, sewing, shopping and going out for a meal. One person told us, "I like gardening. I have been outside for the last few days and staff take me round the block in a wheelchair."

As part of their refurbishment of the home, the provider had changed the use of one room from a lounge to the dining room. As this room gave access to the decked area of the garden, it encouraged people to sit outside after lunch to chat with visitors and staff. A visitor told us they thought this was beneficial because it allowed people to get fresh air and enjoy the garden.

The manager listened to people's experiences, concerns and complaints. They told us they had an "open door" policy which enabled people and their families to raise concerns with them which they dealt with before they became a formal complaint. One person told us that if they had any concerns, "I would speak to [the manager] because I feel she would listen." A visitor confirmed that "any problems are sorted out quickly".

There was a complaints procedure which was displayed in the home and included in people's welcome pack when they moved into the home. There had been no complaints recorded since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our inspection of 11, 12 and 15 August 2016 we found the provider did not have adequate systems to monitor, assess and improve the quality of service people received. The provider did not maintain accurate and timely records of people's care and treatment decisions. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice with respect to Regulation 17 requiring the provider to make necessary improvements by 30 November 2016. The provider sent us a plan of the actions they proposed to take in order to meet the requirements of the regulations, and other records and information we requested to check their progress. At this inspection we found some improvements had been made, however there were still more improvements to be made. Where improvements had been made they were recent, and yet to be embedded and shown to be sustainable.

The provider did not have a registered manager in post as required by a condition of their registration. The last manager to be registered at Tiled House had resigned on 11 March 2016. The manager in post when we inspected in August 2016 had left and withdrawn their application to register with us in November 2016. The provider had appointed a new manager, but they had not applied to register with us at the time of this inspection. They told us they had recently received an up to date Disclosure and Barring Service (DBS) certificate which they needed to do before they could apply. They told us they would apply to register as soon as possible, and we received their application two weeks after the inspection.

The manager had experience as a registered manager at another service, and had been deputy manager at Tiled House. There was a new deputy manager, who was a registered nurse, in post. The provider's general manager, also a qualified nurse, had provided support and was frequently on site at the home. The manager also had peer support from the registered manager at one of the provider's other homes.

The management team had worked with the local authority safeguarding team and the local clinical commissioning group to address concerns in the areas of keeping people safe, and infection prevention and control. Both these organisations had noted significant improvements. The provider had engaged an independent consultant to review the service in December 2016. The same consultant had visited the service shortly before our inspection. Although their second report was not available at the time, the manager had received an email which referred to improvements being apparent since the consultant's visit in December 2016.

The manager and staff we spoke with were positive about the changes that had been made. Staff told us things were more organised and structured. They were cheerful and optimistic, spoke of good teamwork and support from the manager. They were confident they could raise concerns and that these would be listened to and dealt with appropriately. Staff were encouraged to share experiences and learning from training courses to improve the service people received. They had noted the provider's investment in redecorating and refurbishing the home, and this had improved their morale.

The manager told us they thought improvements were "progressing well". There was a good atmosphere.

They said the staff team had been "waiting to be led" and had responded positively to the required changes. Our observations confirmed that people, their families and staff could speak with the manager at any time. The provider's welcome pack for people moving into the home stated that visitors were welcome at all times. Children and pets were also welcomed, although the service asked for advance notice of these visits. The provider had summarised their values as "The Hallmarks of Saffronland Homes". These focused on individuality, compassion and equality.

Systems to manage the service were in place, but not always embedded and followed up. The manager had held a "residents and relatives" meeting on 11 January 2017. The minutes showed issues of importance to the effective running of the home were discussed, such as staff attitudes, the quality of care, and communication. However, there was no agenda set, no review of previous meetings' minutes and no formal action planning. Consequently, it was not possible to tell if and when any issues were resolved.

The manager kept logs of routine checks and audits of health and safety. These included weekly water temperature monitoring, weekly hot water safety testing, legionella testing, weekly hoist checks, waste management, environmental health policy, testing of electrical equipment, and lift servicing and maintenance.

Other audits were used to give an overview of the service and ensure the ongoing delivery of safe and effective care. Auditing systems were in place to cover nutrition and hydration, end of life care, activities and occupations, complaints, staff recruitment, use of agency staff, staff supervisions, food and fluid charts, air mattress pressures, repositioning charts and records of prescribed creams and ointments.

A weekly medicines audit covered the supply, storage, administration, recording and disposal of people's medicines. A clinical audit covered assessments, care plans, risk assessments, care booklets (daily log), care plan reviews, activities, accidents and incidents, falls, complaints, safeguarding, training, disciplinaries, and staff meetings. Checks were in place that nurses' registrations were in date.

The manager took action when these audits identified issues, with timelines and named responsible staff members. When the manager discovered confidential information had not been treated appropriately, they took disciplinary action and put measures in place to prevent a recurrence.

There was a wide-ranging system of internal checks and audits, but no formal systematic method of assessing the views of people, their families and others, such as use of satisfaction questionnaires. The manager told us they kept in touch informally, but it was not possible to link the impact of these informal contacts with the improvements and other changes. The checks and audits in place had not identified shortcomings we discovered on our visit in the areas of mental capacity assessments, best interests decisions, cleanliness and the prevention of infection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 where service users lacked capacity to give consent. Regulation 11 (1),(2) and (3)