The Alice Butterworth Charity

Tynwald Residential Home

Inspection report

Tynwald Residential Home
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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 17, 18 and 19 August 2016 and was unannounced.

Tynwald Residential Home is registered to provide personal care and accommodation for up to 26 people. There were 23 people using the service during our inspection; who were living with a range of health and support needs. These included; diabetes, dementia and some people who needed support with their mobility.

The service is a large detached house situated in an elevated residential area overlooking Hythe, with large communal lounge and dining area, a solarium, quiet lounge and an enclosed sun terrace. A large well-kept garden with a veranda, patio and seating areas is located to the rear of the property. Accommodation is provided over two floors, a passenger lift and stair lifts provide step free access to each floor.

Tynwald Residential Home is run by The Alice Butterworth Charity, established to provide a residence or home for people who either live or have ties to Hythe town or surrounding district. The operation of the service is overseen by a committee of voluntary trustees

A registered manager was in post. A registered manager is a person who has registered with the care Quality Commission to manage the service. 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.

Tynwald Residential Home was last inspected in May 2014, where no concerns were identified. At this inspection we found improvement was required in some areas where some regulations were not being met.

Medicines were not stored below the maximum temperature; some medicines were not accounted for properly which had not been identified.

Hot water temperature checks to safeguard against scalding were not sufficiently detailed.

Planning and delivery of training had not ensured a continuous learning process to ensure staff had the skills and knowledge to support the people they cared for.

Elements of care planning did not fully establish some people's needs or reflect their wishes about how they wanted to be supported.

Auditing, for the purpose of identifying shortfalls in the quality and safety of the service provided were not wholly effective or fully developed; some records were incomplete.

Deprivation of Liberty Safeguarding authorisations had been applied for where people were unable to

consent to restrictions in place.

People's health needs were well managed and referrals to outside healthcare professionals were made in a timely way.

There were enough staff to meet people's needs. People were supported by enthusiastic staff and volunteers.

Staff were caring, compassionate and responsive to people's needs and interactions between staff and people were warm, friendly and respectful.

People enjoyed their meals, they were supported to eat when needed and risks of choking, malnutrition and dehydration had been adequately assessed and addressed.

People commented positively about the openness of the management structure and were complimentary of the staff and registered manager.

We found a number of breaches 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 back of the full version of the 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 consistently safe.

Medicines were not stored within required temperatures; measures did not ensure some medicines were properly accounted for.

Some water safety checks were not sufficiently developed.

Recruitment processes were sufficiently robust to ensure the suitability of applicants.

People felt safe and staff knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received on going training to ensure they knew how to provide effective support.

Deprivation of Liberty Safeguarding applications were applied for when warranted.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.

People's healthcare needs were effectively monitored and professional input was sought proactively.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and were considerate of their dignity, and were observed engaging with people in a kind and gentle way.

People were encouraged to be independent where possible and were given choices about their care and support.

People's families and friends were able to visit at any time and were made welcome.

Care records and information about people was treated confidentially.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some individual needs and preferences had not been established.

Changes in health and social needs were responded to and people felt staff were supportive of their needs.

People enjoyed the activities provided.

An effective complaints system was in place; people and visitors were confident complaints would be listened to and dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not well led.

The quality assurance framework was not fully effective and had not ensured continuous oversight of all aspects of the service.

Some records were incomplete or lacked sufficient detail to ensure aspects of care were delivered.

The service sought the views of people about the quality of service.

The service actively engaged with and were supported by the local community.

Tynwald Residential Home

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. We looked at the overall quality of the service to provide a rating for the service under the Care Act 2014.

We undertook this inspection of Tynwald Residential Home on 17, 18 and 19 August 2016. The inspection was undertaken by one inspector.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also reviewed action plans and some progress updates sent by the provider following the last inspections.

We met most people and spoke with eight people who lived at the service and observed their care, including the lunchtime meal, some medicines administration and activities. We inspected most areas of the environment and equipment used at the service. We spoke with three of the care staff, the cook and cleaner as well as a visiting health care professional, the registered and deputy managers as well as three of the trustees of the service.

We 'pathway tracked' two people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for three other people.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, some quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy; they liked living at the service and felt safe. One person told us, "I think I have found the best care home in town, they are very careful with you". Another person said, "They treat me really well here and if I use my call bell, somebody comes quickly; they always do". A visiting relative told us, "All of the staff are endlessly patient, it matters to each one of them that the people here are well looked after." We spoke with a visiting health care professional, they did not have any concerns, they felt staff listened well to instructions and put into place the actions and processes based upon advice given.

Although people spoke positively about the service, we found areas where improvement was required; this meant the service was not consistently safe.

We assessed the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. Records required for medicines subject to legislated storage requirements were not always fully completed. These medicines must be double signed by staff to show when they were administered or disposed of. The register for these medicines found this had not always happened. Processes required to safeguard against potential loss or misuse of medicines were not fully effective.

Procedures for the return of medicine no longer required were not wholly effective; our checks showed the return of some medicines were unaccounted for within the service's records. This was however resolved during the inspection by the receiving pharmacy. However, processes in place did not ensure complete records were maintained and medication audits were not sufficiently robust to identify this shortfall.

A review of the contents of the medication trolley found an obsolete medication that had not been returned to the pharmacy as was required. Where people were prescribed skin cream, records were not always completed to show they had been applied.

Non refrigerated medicines need to be stored at temperatures not exceeding 25°C, this is because storage above this temperature risks medicines becoming desensitised, not working as intended or potentially ineffective. Records showed in one storage area maximum temperatures were exceeded.

We spoke with the registered manager about safety checks around the service and, although carried out frequently, hot water temperature checks did not record the location of the check or the temperature. This made it difficult to be certain that water temperatures were always set at a safe level to help prevent the risk of scalding. Fire drills had not taken place as often as the service's policy required and a written record of fire drills was not available.

The failure to properly manage medicines and shortfalls in the management of some safety checks was a breach of Regulation 12 (1)(2)(a)(e)(g) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Otherwise, people's individual risk assessments were reviewed and updated in relation to falls and other known conditions. The service had introduced processes to help staff recognise signs of people deteriorating, which could lead to earlier interventions, for example, loss of weight linking to underlying conditions and risks of skin breakdown, malnutrition and dehydration. Environmental risks around the service were taken seriously; modification of bannister rails was underway to reduce the possibility of falls risks. This stair case was closed off until the modification was complete; a stair lift installed on alternative stairs provided step free access and fire evacuation routes were modified and clearly signposted to accommodate the stair closure.

Accident and incident report forms were completed by staff and action taken to reduce or prevent recurrences documented. For example; when people had falls; appropriate preventative measures had been investigated, put in place and, where needed, referrals made for additional help from health care professionals such as occupational therapists. Evaluation and review of incidents and accidents took place and records showed relatively low numbers recorded, evaluation linked to staffing numbers, location or any environmental or physical factors that needed addressing. A call bell system was in place, when needed this linked to pressure mats that activated an alarm call if, for example, a person got out of bed or left their bedroom. This ensured staff were aware of the movement of people where there were falls or mobility concerns and they could support them. The call bell system was also split into various zones and pendant alarms were available for those who needed them. This helped to ensure staff knew if people needed support.

Staff knew how to recognise different forms of abuse and were confident in how to report it. There was a policy and procedure that informed them about what to do. The service also held a copy of the locally agreed safeguarding protocols. They told us they knew people very well and could pick up on any changes in their moods or behaviour; which might be an indication that the person was troubled. People seemed comfortable and relaxed with staff and each other and people told us they felt safe. Information available to staff encouraged them to whistle blow if they felt something was wrong at the service; staff told us they had confidence in this system but had not needed to use it.

There were enough staff in place to meet people's needs; requests for assistance were anticipated and met promptly during the inspection. There were between three and four care staff per shift in addition to the registered and deputy managers. Support at night was provided by two wake night staff. Rotas showed staffing levels were consistent in the month prior to the inspection and ensured a team leader was always on duty. The registered manager explained staffing was based on people's dependency levels and was flexible to accommodate changes in this. Staff had time to chat with people and interact with them. People, visitors and staff felt there were enough staff on duty. Other staff included an activity coordinator who worked 30 hours a week, two cleaning staff, a cook and kitchen assistant as well as a maintenance person. The service worked locally with community volunteers, who supported activities and outings.

We read five staff recruitment files to make sure proper pre-employment enquiries had been made. All appropriate documentation had been completed and references, identity and Disclosure Barring Checks (DBS) checks had been recorded. DBS checks establish if any cautions or convictions mean that an applicant is not suitable to work at a service. Interview notes had been kept and these showed the service had made efforts to take on the best staff for the job, this included volunteers and staff working at the service on an apprentice basis. There was a robust recruitment process in place; which helped to protect people using the service.

We looked at most areas of the service including communal areas, some bedrooms, bathrooms, the kitchen and laundry area. It was evident an extensive programme of redecoration and refurbishment was under

way, bedrooms were comfortable and individually decorated. Plans were in place to re-decorate corridors to make them more distinct and help people orientate more easily. A maintenance plan was in place listing works undertaken and those remaining.

Fire exits were marked and unobstructed; fire alarms were tested weekly and logged and fire extinguishers had routine safety checks. An emergency fire grab file was up to date and conveniently located, this contained information about each person and the support they may need in the event of an emergency. Water quality was regularly tested; current certificates were in place for gas safety and portable electrical appliances. The wiring system for the service had been replaced and arrangements in hand for a safety test certificate to be provided. Equipment such as hoists, stair lifts and the passenger lift had been serviced in line with manufacturers' guidelines.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. One visitor told us, "I couldn't speak more highly of the staff". We were told how good the food was. One person said, "The food is lovely, I'm looking forward to lunch". A relative told us, "I've eaten here, the food is very good, there's plenty of choice, it's always lovely". Meals were presented in a an appetising way and dining room tables were laid with coloured tablecloths, condiments and cloth napkins to provide a pleasant environment for eating and socialising. The registered and deputy manager made a point of serving lunch each day, this enabled pleasant conversation with people, an opportunity to chat and carry out observation that staff were attentive and people received the support they needed.

Although people and visitors were complimentary of staff, we found areas where improvement was required; this meant the service was not consistently effective.

Training records showed although new staff had started the training towards the care certificate, a limited amount of course work had been completed. Ongoing training had lapsed in areas or there were gaps in continuity between training being delivered and when it was required to be refreshed. Some training, such as, moving and handling, health and safety, fire and medication training had been booked before our inspection and was due to be delivered shortly. However, records showed training in Safeguarding of Vulnerable Adults, challenging behaviour, dementia and continence care required updating. There was no record that staff had received training in the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). In addition certificates were not available for all training delivered; this made it difficult to establish a complete overview of training requirements.

Staff were not suitably updated and trained with the skills and knowledge to effectively support people within their care. Given the client group of the service, insufficient emphasis was placed on client specific training. For example, dementia, continence, MCA and DoLS awareness training. We discussed this with the registered manager; they were aware of shortfalls around training and had started an exercise to review it. Competency checks and evaluation of training delivered had taken place in addition to staff observation, this provided insight into knowledge levels and training requirement priorities to assist their review.

Staff had not received appropriate training to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supervision and appraisal of staff took place when planned. Supervisions are formal meetings between staff and the registered manager, but also included group supervision of some common practices as well as observational assessments. Supervisions covered achievements, training and individual actions or targets for staff. They gave staff the opportunity to raise any concerns about working practices and focussed on ideas to progress individual development of staff. Staff told us supervisions were useful for their personal understanding development. Supervision processes linked to staff performance and attendance and, where

needed, led to disciplinary action.

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The MCA is to protect people who lack mental capacity and maximise their ability to make decisions or participate in decision-making. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS form part of the (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep them safe.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. We discussed with the registered manager whether referrals had been made where people lacked capacity and were subject to continuous staff supervision. 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 settings are called the DoLS. The registered manager had made seven applications for DoLS. No decisions had been received and the registered manager regularly asked the Supervisory Body for updates.

Formal consent to care and treatment had been signed by people who were able to agree to it and we observed that staff routinely gained verbal consent when they were supporting people by saying, for example; "Can I help you or are you alright to do it yourself?".

People's records showed that they had regular visits from GPs and community nurses to help keep them well. A visiting nurse told us that referrals were made promptly by the service and that the registered manager was proactive in ensuring people's health care was monitored and maintained. For example, people's care records included charts for recording regular checks on areas of the body most vulnerable to pressure wounds. This allowed staff to quickly pick up on any redness or broken skin that might require treatment. Optician and dental appointments had been documented and people had regular check- ups to ensure that any general health problems were routinely identified. Relatives were satisfied with the health care people received at the service.

People had enough to eat and drink. The meals served during our inspection looked appetising. People were encouraged to eat independently and supported to eat when needed. Drinks were provided during meals together with choices of refreshments and snacks at other times of the day. People told us they enjoyed their meals. Staff were aware of people's food preferences or any specific dietary requirements, for example softened foods. The cook was aware of diabetic food requirements and made meals and cakes to cater for this as well as purchasing low sugar jams. Four weekly menus offered a good variety of food and varied with the seasons. Friends and relatives were invited to eat at the service when visiting and told us they were always made to feel welcome by staff.

Good

Is the service caring?

Our findings

People and their relatives gave us positive feedback about their experiences. One person told us, "I'm very happy, I get with staff very well, they are always kind and polite". Another person commented, "The staff couldn't be kinder, they are warm and sincere". A relative told us, "All of the staff genuinely care, I hear them talking to people when they think they're on their own, there is warmth and friendship".

We observed the interactions between staff and people throughout the days of our inspection.
Staff used people's preferred names and spoke with them respectfully, when people sat in a group or at a shared table, this helped people to recognise who staff were speaking to. When one person was unsure about what they were doing and where they needed to go, a member of staff reminded them and orientated them sensitively and with compassion. Staff were mindful of people's dignity. For example, when people needed assistance to use the toilet, staff were discreet in reminding them about this and offering their support. There was a large notice board next to one lounge; it contained a photograph of each person together with their name and a message of welcome. We were told this served two purposes, it reminded staff and visitors it was the people's home and, if needed, people could discreetly remind themselves of other people's names without the need to ask. All staff including cleaners knocked on people's bedroom doors and called out before entering; care staff ensured people's doors were closed while they supported people with personal care.

People and relatives said that they felt involved in care planning. Some people we spoke with were able to tell us about the medicines they took and the reasons for taking them. One person said, "If I have any questions about anything at all, I can ask and staff; they're good at keeping me informed." Another person said that staff helped them with their pills but that they liked to check and count them to make sure the staff were right. Staff encouraged their interest and involvement.
A relative told us the registered manager and staff were "fantastic" at letting them know about any concerns or just giving them a general update. People and relatives said this level of involvement made them feel as though their input was valued and gave them the opportunity to freely ask about anything they wished to know.

People were encouraged to be as independent as possible. Care plans included sections about what people were able to do what they wanted help with. These listed the aspects of care which people were happy to carry out themselves; such as washing their own face and hands; together with other areas in which people required staff support. One person told us, "I always try to be as independent as I can, but it reassures me to have staff there if I sometimes can't manage or need extra help". Staff knew people well and could tell us which tasks people were generally able to do themselves; which meant people were supported in maintaining their independence for as long as possible.

Staff were caring and had clearly built mutually respectful relationships with people. There was light-hearted banter between staff and people; people enjoyed the interaction with visiting volunteers who assisted with some activities. Staff often anticipated people's needs because they knew them so well; for example, by giving one person a fresh hanky before they went into lunch and making sure people who

needed them had their walking aids to hand. Staff gave one person some one- to- one time and attention because they were anxious. They treated the person with warmth and compassion and let them speak about what was worrying them. A short while later, this person was back in the solarium and enjoying an activity with other staff and people. Staff understood people's needs and were well-practised in listening, offering comfort and support.

Relatives and friends were able to visit people whenever they wished and they were made welcome. Visitors were offered drinks and biscuits; the atmosphere was friendly, open and accommodating, visitors told us they were always made to feel welcome. Two lounges gave people a choice of where they wanted to sit and what they wanted to do; people could watch TV or read in a quieter area or join in with group activities. The lounge, dining room and solarium offered views into the garden; there was a shaded veranda area where people could sit and chat with each other or to their visitors. This gave people choice about where they would like to spend their time.

There was no one receiving end of life care at the time of the inspection. However, most care plans recorded details of end of life care arrangements; when needed, this was provided in conjunction with local nursing and hospice services. The service had adopted a system of 'Just in Case' boxes to support anticipatory prescribing and access to palliative care medications, for people who were approaching the end of their life. People often experience new or worsening symptoms outside of normal GP practice hours. The development of 'Just in Case' boxes seeks to avoid distress caused by poor access to medications in out of hours periods. This is done by anticipating symptom control needs and enabling availability of key medications in the service.

The registered manager told us a member of staff was always present when a person had moved to end of life care; staff would ensure they were comfortable and address any needs with dignity and compassion. Staff would always sit with a person in their final hours. Care files clearly noted if people had a Do Not Attempt Resuscitation order in place; which was prominently displayed inside the file. This helped to ensure that people's end of life choices were respected.

People's care plans showed discussions took place at the time of admission to ask if their family members wished to be contacted in the event of any serious illness or accident. We saw where needed, this had happened.

Requires Improvement

Is the service responsive?

Our findings

People and visitors were happy with care and support provided, a visitor commented, "There's nothing bad to say here; I can't speak highly enough of the home, it's wonderful". Another person told us "I've never needed to raise a concern, everything has been discussed with me, I'm happy, and there is really nothing more to say". A relative commented "I'd speak to staff or registered manager if I had a complaint, but I can't see that happening." People said they were happy with the range of activities and particularly commented about the pleasant aspect the garden added and how they enjoyed using it. None of the relatives raised any concerns at all about the quality of care people received from staff.

Although people and visitors spoke positively about the service, we found an area that required improvement. This meant the service was not consistently responsive.

Pre-admission assessments were intended to ensure the service would be able to meet people's individual needs. These informed initial aspects of care and formed the basis for care planning after people moved to the home. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed around those needs. Care plans included information about people's next of kin, medication, dietary needs and health care needs. However, some aspects of care planning were not sufficiently developed or detailed to be individually meaningful. For example, continence support plans were not personalised specifically for the people they were intended to support. They did not indicate people's daily routines, their preferences for support, or provide guidance about how people may wish their continence to be supported, such as, taking them to the toilet upon waking, prompting them to use the bathroom throughout the day or a plan to consider any other support required. Other aspects of care planning, for example, Stoma site care, again did not include sufficient guidance to be informative for staff or individually meaningful. Daily care records were not always detailed enough to track that specific care needs were undertaken.

Individual needs and preferences had not been established. The provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met. This was a breach of Regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had invested in technology, all care plans were computer based. Staff accessed and updated records using hand held tablets. The system afforded the registered manager at a glance information and reminders when events were due. The system was fully supported by an IT service and they worked in conjunction with the staff to develop and enhance the system. Back up paper files were maintained with select important information for ease of reference and emergency use.

Changes in health or social needs were responded to with short term care plans for people with acute conditions, for example, chest and urinary infections. Where weight loss was noted for another person, relevant external bodies had been consulted such as their GP and a dietician. Where advice and instruction was received from District Nurses, their directions were put into practice. A visiting health care professional told us staff took on board what they said and acted accordingly. They did not raise any concerns and felt

that communication within the service was good. This showed evidence of staff being responsive to the changing needs of people who lived at the home.

The registered manager told us that people and relatives were encouraged to speak with her at any time if they had even minor concerns. There was a comments and suggestions box, people were able to sit in on trustee meetings and resident meetings took place regularly. People told us that the registered manager was always visible in the service and that she was "conscientious, committed to the home and always approachable". There had been no formal complaints since our last inspection; however, a proper procedure and log were in place should they be required. A large number of compliments cards and letters had been received from people and their families. Many of them spoke of the professionalism of staff and thanking them for the care, respect and compassion shown.

A selection of activities was available to those people who wished to take part. There was a designated activities coordinator post, enthusiastically supported by volunteers. People engaged in a range of entertainments and events to interest them. These included visiting musicians, musical exercise, bingo ball games and quizzes. The service regularly hired a mini bus for day trips and people reflected fondly when staff had accompanied them on walks into Hythe. Electric mobility scooters were available at the service to help people get up the hills. People said there was sufficient going on to keep them from being bored. In particular, people liked garden events, strawberry teas and celebrations of national events, for example, the Queen's birthday. We spoke with some people who preferred not to join in organised activities. They told us that they liked their own company and chose to stay in their rooms; but staff would drop in for a chat with them. Staff tried to ensure that people were not socially isolated, but recognised this had to be balanced with people's right to choose to be alone if they preferred.

People's religious and spiritual needs had been recorded where applicable and local churches visited the service to give Holy Communion for those who wished to take it. The local church also provided carol concerts at Christmas for everybody to enjoy. Staff kept records of the activities people took part in and these were discussed at resident meetings so that people could give feedback about what they liked best.

Requires Improvement

Is the service well-led?

Our findings

People and visitors were complementary about the manager and staff, commenting positively about how approachable they were. People told us they felt staff made time for them. Relatives and visitors to the service told us they were made to feel welcome. Staff and people were positive about the registered manager, describing them as "dedicated, enthusiastic and an asset". However, we identified some shortfalls which meant the service was not consistently well led.

Some auditing and checking procedures were in place within the service. The registered manager, key staff and some trustees undertook regular checks of the service intended to make sure it was safe and people received the support they needed. However, the registered manager acknowledged checking processes needed to be expanded to include detailed infection control audits, encompassing, for example, mattress condition checks and antibacterial cleaning of equipment. Further development was needed around hot water temperature checks and setting of proposed completion dates for outstanding maintenance.

Some care records were incomplete because they did not provide a complete assessment of people's individual needs or always adequately record the support people had received. For example, in relation to continence and Stoma care planning. In addition, records of topical creams were generally incomplete. This made it difficult to determine if people had received creams when they were supposed to.

Other concerns identified during this inspection illustrated the service's quality assurance framework was not fully effective. These included concerns about medicines, training and care planning. Systems had not ensured continuous and effective oversight of all aspects of the service.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and maintain complete and contemporaneous records was a breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Established systems sought the views of people, relatives, staff and health and social care professionals. Regular meetings and a suggestions system ensured people and their families felt involved in the service and listened to. These included suggestions about activities and menus.

The service worked extensively with the local community; people with learning disabilities from a local service came to Tynwald and tended to the garden. The town of Hythe has a dementia safety initiative and, if needed, Tynwald is designated in the community to act as a place of safety for older people who may have been found disorientated or distressed and needing support.

Staff were positive about the service, they were proud of their work. Each member of staff told us they would recommend the service, they felt it was an important to the community and would have no concerns if a member of their family lived there. Staff said there was an open culture at the service and they felt able to speak out about anything. Staff told us, if needed, they felt confident about raising any issues of concern

around practices within the service and felt they would be supported by the registered manager.

Staff told us the values and behaviours of the service included treating people as individuals, being respectful, working as team giving people fulfilled and independent lives. Staff understood the values of the service and could see how their interaction and engagement with people affected their experiences of the service. Staff felt they worked together with a collective determination to achieve positive outcomes for people.

Policy and procedure information was available within the service, it was up to date; staff knew where to access this information and told us they were kept informed of any changes made. Work had started to evaluate every process at the service to ensure it met with all policy requirements.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure individual needs and preferences were established; care and treatment was not designed with a view to achieving people's preferences and ensuring their needs were met. Regulation 9 (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines and some safety checks were properly managed. Regulation 12 (1)(2)(a)(e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure appropriate systems or processes were in place to assess, monitor and improve the quality and safety of services and maintain complete and contemporaneous records. Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received appropriate training to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)