Althea HealthCare Limited

Thorp House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 14 and 18 April, 2016 and was unannounced. The service provides residential and nursing care for to 41 people over the ground and first floor accommodation. At the time of our inspection 38 people were using the service.

At the time of our inspection the service did not have a registered manager at the service, although a new manager had been appointed and would be commencing shortly. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Since the last registered manager left the service in November 2015. The service had experienced two managers come and go in a relatively short time and had not been in post long enough to become registered. During this time the service had not reported these events to the Care Quality Commission. The uncertainty around the management and leadership of the service had been further complicated by the senior clinical post also becoming vacant. The regional manager for the area had begun to oversee the service and had based themselves there for the past few months. During this time a new deputy manager and clinical led nurse had been appointed which had started to bring back stability to the service. The operations manager had recognised the difficulties around staff recruitment, reporting structure to identify and resolve issues and staff support through regular training and supervision. They had implemented a great deal of work to address these issues.

People were being protected from the risk of abuse as established senior care assistants and care staff were knowledgeable in this area and training had been planned for all staff to attend in the near future. There were emergency plans in place at the service and we saw that people had risk assessments which was reviewed regularly and as required.

People were now supported by a sufficient number of suitably qualified nursing and care staff. The service had appointed permanent nursing staff to replace agency nurses. The provider had ensured appropriate recruitment checks were carried out on staff before they started work. Staff had been recruited safely and completed an induction procedure for working at the service. Further on-going training has been arranged for all staff and a person had been appointed to lead upon the activities at the service.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely. Although the service appeared to have sufficient nursing and care staff day to day needs of people,the service did not use a dependency tool to determine how many staff were required to be on duty to meet people's needs.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Appropriate mental capacity assessments and best interest decisions had been undertaken by relevant professionals.

This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice. The Act, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals. People at the service were subject to the Deprivation of Liberty Safeguards (DoLS). Staff had been trained and had a good understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Understanding and empathic relationships had been developed between people and staff. Staff responded to people's needs in a compassionate and caring manner. People were supported to make day to day decisions and were treated with dignity and respect. People were given choices as far as possible and were supported and enabled to be as independent as possible in all aspects of their lives. A respite service was also provided. The regional manager had limited the number of people using the service with more complex needs to allow nursing staff to settle into their roles and all staff developed the necessary skills required..

The staff knew people well and were trained, skilled and competent in meeting people's needs. Supervision and appraisals were planned. People were encouraged to be involved in the planning and reviewing of their care and support needs.

The service worked with other professionals so that people's health needs were managed appropriately with input from health care professionals. People were supported to maintain a nutritionally balanced diet and sufficient fluid intake to maintain good health. Staff ensured that people's health needs were effectively monitored. The deputy manager had worked with the catering team to provide soft diets and pureed meals to be appetising in appearance and taste.

People and staff told us there was now an open culture and the management staff of the service were approachable and supportive. The focus of the new management team was to provide care that was centred on the individual.

People were supported to report any concerns or complaints and they felt they would be taken seriously. People who used the service, or their representatives, were encouraged to be involved in decisions about the service.

There were systems in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to the service. Audits were carried out to determine the views of staff, relatives and people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Staff knew about safeguarding and who they needed to contact if a safeguarding incident occurred.

There were sufficient staff on duty to provide care to people.

People received their medicines as they were prescribed.

Is the service effective?

Good

The service was effective.

The training for staff had been planned and some had been delivered.

Staff were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was caring.

People told us that they were well cared for and we saw examples of staff providing care with knowledge of the person.

People were involved in their care planning.

Staff treated people with dignity and respect using their chosen names and knocking upon people's door and waiting for an answer before entering.

Is the service responsive?

Good

The service was responsive

People's needs had been assessed and a care plan written in accordance with their assessed needs.

There were systems in place to receive record and resolve complaints and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service did not have dependency tool in operation linked to people's needs to determine how many staff were required to be on duty.

The service had not informed the CQC of the various changes of management and senior staff over the past 6 months.

Staff were able to discuss issues with the new deputy manager, clinical lead and regional manager and felt supported in their roles.

The service had an on-call system in operation so that the nursing and all staff could seek advice as required.

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Detailed findings

Background to this inspection

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

The inspection took place on April 14 and 18 2016 and was unannounced.

The inspection team consisted of one inspector.

Before our inspection we reviewed the information we held about the service, which included safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service, speaking with staff and observing how people were cared for. Some people had very complex needs and were not able to talk with us. We used observation as our main tool to gather evidence of people's experiences of the service. We spent time observing care in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people who lived in the service and two relatives. We also spoke with the operations manager; deputy manager, clinical lead nurse, a cook, the activities co-ordinator, senior carer and four members of the care staff as part of this inspection.

We looked at five people's care records, two staff recruitment records, medication records, staffing rotas and records which related to how the service monitored staffing levels and the quality of the service. We also looked at information which related to the management of the service such as health and safety records, quality monitoring audits and records of complaints.

Good

Is the service safe?

Our findings

People, who lived at the service, told us they felt safe. One person said. "The staff check upon me regularly that I am ok, which is reassuring." A relative informed us they visited regularly and had no issues with the service other than they had seen a number of staff come and go. They were pleased that in the past few weeks things had settled and they were seeing the same senior staff. Another relative informed us. "Very nice place, always greeted when you come in by someone so that gives you confidence it is safe."

There was a policy and procedure for safeguarding people. Staff we spoke with were all knowledgeable of the policy and had received training in the safeguarding of people either at induction or quite some time ago. Staff we spoke with demonstrated their understanding of types of harm or abuse that could occur and how to report concerns. The operations manager explained to us the work they had done to arrange safeguard training and we saw that further training had been arranged for all of the staff over the next three months.

We asked the staff about whistleblowing. This is a term used where staff alerts the service or outside agencies whey they are concerned about care practice. All the staff we spoke with told us that they would feel confident to whistle blow if they felt there was a need to do so. Care staff felt that the new management team of the deputy and clinical lead were approachable and supportive.

Risks to people's safety had been assessed by the staff. Within each of the care plans we saw, there were individual risk assessments and appropriate plans of care of how to support the person. There were risk assessments regarding moving and handling and staff had received training about how to use equipment to move and transfer people safely. The service staff had worked with other professionals to assess risk and how to provide care to people with complex nursing needs. We saw people moved around the service freely and choose how and where they wished to spend their time. This included use of an internal garden where attention had been given to ensure the foot paths were clear, stable and provided easy wheelchair access. This showed that the provider had taken the necessary steps to provide care in an environment that was safe, suitably designed and adequately maintained.

The operations manager told us about the process used to record any accidents and incidents. We saw records for March which were clearly dated and timed with details of what had happened and the actions taken to resolve the situation at the time. Also learning from these events were then used to inform the staff at staffing meetings which had begun to be arranged again. We saw that future staff meetings had been arranged with plenty of time for the staff to be aware.

People who used the service told us there were enough staff on duty to support them. However some of the staff felt that they were pushed to provide all of the care in the recent past especially when it came to having enough qualified nurses on duty. They thought things had improved with nursing staff being appointed permanently rather than agency staff so that relationships and understanding had been built upon.

One person said. "My call bell is answered when I call for assistance." We were aware that not all people

would be able to use a call bell due to their physical condition or they would not understand the call bell system. From our observations we saw that staff checked upon people regularly to determine that their needs were being met.

The operations manager explained to us how staff were recruited. We saw from the information provided the service had a safe recruitment system. All potential new staff were required to complete an application form and attended the service for an interview. References for successful candidates were sought and the service checked that people were suitable for employment with regard to contacting the disclosure and barring service (DBS). We saw that the service did have an induction process for new staff designed to introduce them to working at the service with support from a senior member of staff.

Newly in post of a few weeks, the Clinical Lead Nurse had taken responsibility for medicines at the service. Staff told us about the changes that had been made and the clinical room had been re-organised and cleared out so that there was more space in which to work and clinical items were logically stored together. The medicines were stored safely in a locked medicines cabinet and when not in use, locked in a designated medicines room. The service had a policy and procedure for the management of medicines. We carried out an audit of the controlled drugs in use and checked the stock balances which were all correct. The temperatures of the room and fridge were checked daily and were within acceptable limits. We saw that the Medication Administration Records (MAR) charts for people living on the first floor were accurate and up to date. There was a procedure for the return to the pharmacy for out of stock or unrequired medicines which the service was using appropriately. We saw as required medicines were being offered to people appropriately. This was supported by regular nurses being employed who had got to know people well and hence would be aware of changes in their condition and in need of pain relief.

Good

Is the service effective?

Our findings

The people we spoke with told us that they were well looked after and their care needs were met. One person said. "I have come for a short time for respite care and have not faults to find."

We found that that the operational manager had addressed the training requirements for a diverse range of staff. They had identified training that had been provided in recent times and that which needed to be delivered and involved the staff to understand the training that was required. We saw that training had been planned and was being delivered for staff. The service provided training to staff during their induction. All the staff we spoke with told us they were happy with the arrangements in place and felt that they could meet the needs of the people living at the service. One member of staff told us. "I have worked here for years and I am pleased to see now, how very well organised the training and support is, such as supervision and staff meetings". All the staff we spoke with told us that they now had regular supervision, some had lapsed in recent times but they were now planned as were yearly appraisals.

Staff had been provided with both training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) 2007. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. They understood their role and informed us how the service was working with people to pursue their choice of lifestyle. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards . Applications with regard to DoLS at the time of our inspection had been submitted correctly and the service had sought advice from the local authority appropriately. We saw that the appropriate records had been completed correctly. The regional manager informed us that further training was in the process of being arranged in order that all staff would have an increased awareness of best interest meetings and lasting power of attorney.

Staff we spoke with were knowledgeable about how to protect the rights of people who were not always able to make or communicate their own decisions. The service had worked with the family and an interpreter to support a person who experienced difficulties using English as their capacity deteriorated through their illness. The person was able to converse for a time with a better understanding in their first language, which was not English. The service staff had learnt some words in the persons first language to explain and understand basic words such as drink, hungry and pain and also used pictures to assist with communication.

People told us that the food provided was good. One person said. "The meals are really good." Another person told us. "I like the meals, look nice and good to eat". We saw that for each person cared for in bed their food and fluids were monitored and appropriate meals were provided with regard to their individual needs. We spoke with the cook to understand how they cooked meals with regard to people's choice and to recognise their individual needs with soft diets for example. We were also aware from the clinical lead nurse,

the work they had done with the catering team to organise and record when food supplements were provided. We observed a lunch time meal and saw that people were not rushed and supported appropriately to enjoy their meal. The regional manager told us that since they had been present at the service they had worked with the catering team to purchase some food moulds designed to increase the presentation of pureed food. We saw examples of this and everyone was impressed with this new innovation.

All people living at the service had their own GP and dentist. People were supported as required to visit local services to maintain their health, such as opticians and the deputy manager would also arrange for professionals including district nurses to visit people at the service as required. The operations manager was aware of the difficulties that needed to be addressed when a service experiences rapid changes of senior staff and the nursing staff are not regular. They had commenced with the new senior team to build relationships with other professionals which recognised the expertise within the service while also using the skills of other professionals. The operations manager informed us that they had positive relationships with the local GP's and they attended to people at the service as required. We also noted in the care plans that the service had worked with GP's and other professionals to identify the care people required and how this was to be implemented.

Good

Is the service caring?

Our findings

Staff treated people with understanding and empathy. One person told us. "The staff care and it is a pleasant setting, I particularly like the peacocks." A relative told us the staff were kind and worked hard in a quiet and caring manner." During our inspection we saw staff speak to people with respect giving them time to make choices. We also saw staff use non-verbal communication and sat down next to people so that they were at eye level. Staff offered people a choice of drinks and took time to make this a pleasant time and explained options. Staff told us they respected people's views, preferences and how they wished to spend their time. For example, people who preferred to get up late and those who liked to eat their meals in their rooms. A member of staff told us they encouraged people to socialise at meal times and other opportunities. They were aware that sometimes some people would do so with support and encouragement, but they were aware of respecting the person's choice.

The operations manager in discussion with people and staff was aware that since the last activities co-ordinator had left and not been replaced this had created a gap in the service provision in order to care for people. A new person had been recruited and although only in post for a few weeks had set to work quickly upon the most pressing need of arrangements to recognise the Queen's birthday. We saw that the service had been decorated with bunting and arrangements were in place to recognise the day.

The activities co-ordinator saw their role as listening to people and making arrangements as a result to have an effect upon the person's care in particular the psychological support. They had spoken with all the people that could engage with them and had begun to converse with families to understand what people would like from this function of the service. As well as provide group opportunities they also wanted to look at how individual activities could be provided for those people that chose on the whole not to join in group activities. The view of the activities co-ordinator was that people matter and if they are not happy with the activities then they will not be happy with the care provided by the service.

During our inspection we saw that as a result of consultation a small cupboard at the end of a corridor had been opened up and replaced with decorative shelving so that books and ornaments could be displayed. This change had been made at the suggestion of staff with the support of people using the service to improve the environment. One person showed us their room and said. "Pleasant room, nice view, good food, lovely staff," They told us that staff always knocked on their door and waited to be invited in before entering. They also informed us about personal care arrangements and that staff shut their room door to protect their dignity.

The staff we spoke with demonstrated their knowledge and understanding of how they supported people to maintain their privacy and dignity. They explained that they always knocked on people's doors which we witnessed during our inspection and waited to be invited in. One person told us they preferred to have their room door open, so they could welcome people and staff in. They also explained that the staff would close the door if providing personal care to protect the person's dignity. Staff described how they supported people to pursue their individual interests and take part in the arranged activities, which included word games and visiting entertainers. We also noted that the service had made arrangements with

representatives of various faiths who visited the service to support people with their religious needs.

We observed during our inspection that positive relationships had developed between the people who used the service and the care staff. We observed on various occasions, staff joked with people. The staff we spoke with were aware of people's life histories, were knowledgeable about people's likes and dislikes and the activities people enjoyed. This was because they had taken the time to get to know and care about people. A member of staff explained to us that one person was fiercely independent and they supported them to maintain that independence although they did require support with many of their needs.

Good

Is the service responsive?

Our findings

The people who used the service informed us that the service provided them with good care and support that was personalised and responsive to their individual needs. One person told us. "No problems and I have been here quite some time, I do remember them coming to see me and carrying out an assessment before I came here. " A relative told us. "[My relative] has not been here long, but I was impressed with the speed with which they came out to assess and they have not let us down."

Prior to entering the service people's needs were assessed in order to determine if the service could meet their individual's needs. We saw that the regional manager had been working with all staff to develop the care plans so that they were person-centred. We saw that information had been checked and written into the plans to identify peoples choices and what they could do for themselves and with what they required assistance. Thorp House provides a nursing service and some people's needs were complex. We saw that the care plans were specific with a diagnosis, the difficulties this created for the person and how the responding care was to be organised and delivered.

People's views, interests and things that were important to them were recorded, which included information about the person's life history, their preferences, cultural and spiritual needs, likes and dislikes. We noted that specific information had been recorded with regard to essential needs and how the staff were to support the person with those requirements.

Throughout our inspection, we saw people chose how they spent their time. We saw people spent time reading, doing crosswords and others entertained their visitors. Staff spent time with people individually, for example talking to them about current affairs, their lives and the work they did. This helped them to reminisce and recall memories. The staff we spoke with considered that on the whole they had sufficient time to spend with people to meet their needs and record information in the care plans. This situation had improved over the past few months as the staffing group had become stable.

At the time of our inspection the service was providing a respite service. We saw from the care plans that people's needs had been assessed prior to admission and a care plan written to explain how the needs would be achieved. The original care plan had been developed over 48 hours to further explain how the person's needs would be meet. The plan was then reviewed again to take account of how the person had settled into the service and build upon the person aspects and choices of the person as they and staff got to know each other.

During our inspection we saw that the complaints procedure was on display for people to see. The regional manager informed us about the complaints policy and process. We saw that complaints had been recorded and the procedure followed through to a satisfactory conclusion for all concerned. One person told us. "I have no complaints the staff are caring and would sort anything out." Another person told us. "I have no complaints but would be sure to raise if needed but I doubt that very much and I am sure they would sort out."

Requires Improvement

Is the service well-led?

Our findings

A person who used the service informed us. "These new managers are good they come around and see us, nothing is too much trouble." People and their visitors told us that they were confident to approach any member of staff or management team if they had any concerns. We saw the regional manager and deputy regularly engaged with people who lived at the service.

At the time of our inspection the operations manager explained to us the recent history and turbulence experienced by the service with managers only in post for a short time. A new manager had been appointed and would be commencing shortly. The regional manager had agreed time with the provider for them to continue to base themselves at the service until the new manager was confidently settled into their role.

The operations manager had appointed a deputy manager, clinical lead nurse, activities co-ordinator and confirmed nursing staff in post which had begun to provide stability. They had also based themselves at the service to provide management experience and support for the staff. We discussed a number of issues which had been brought to our attention and agreed that the service could have kept the Care Quality Commission better informed of recent management changes.

We considered that the service now had a stable group of staff on both day and night duty and as well as replacing senior staff and creating a deputy post, did at that time have sufficient staff to meet people's needs. However an area which required improvement was for people's needs to be regularly assessed and in turn determine how many and the skill mix of staff required to be on duty to meet those people's needs. This was particularly important as providing care to meet people's needs can increase rapidly and hence the need to accurately assess and in turn know the number of staff required. The operations manager informed us that they would look into using a dependency tool to establish the needs of people and in turn determine the number of staff required to be on duty.

From listening to the plans of the operations manager and senor staff, we were aware that they had prioritised ensuring that all necessary training was in place and planned for the future. They would also be ensuring all staff received supervision as per the policy of the organisation and this would be on-going for the new manager to continue. We also noted that a keyworker system was to be developed so that staff would be able to focus their attention at times on a small number of people as well as provide care to all of the people within the service. The regional manager also explained to us that staff would be supported to develop roles which would make them champions with the service of certain aspects of care such as dignity and dementia. This would develop the staff skills and in turn enhance the service to the people using the service. During our inspection we meet with an independent trainer who had been employed by the organisation to support these and management development.

We asked the operations manager how they thought the service was well-led. They referred to the statement of purpose for the service and that new staff appointments would underpin the value base of the service. They further explained that staff handovers were informative and supportive and they were looking at ways of effective team meetings for day and night staff.

They also explained to us that the philosophy of the service was to be person-centred and hence the recent work upon the care plans that had taken place. Staff told us that the regional manager was approachable and supportive. The regional manager considered the staff had begun to perform well as a new team and focussed upon supporting people to be as independent as possible and to meet their needs.

The service had an on-call system managed by the deputy manager and included senior members of staff, so that the person leading the shift would be able to call upon the knowledge and support of senior staff as required.

The operations manager had monthly meetings with the provider and could discuss any matters with them more frequently if the need arose. The regional manager also compiled a monthly report for the provider. The report included information about the vacancy rate, support provided and staffing issues. In turn this role would be taken on by the new registered manager and would be for the attention of the regional manager. We asked that attention be given in these reports to concerns that had been brought to our attention before the inspection regarding the staffing rota, skill mix, staff training, supervision and monitoring of falls. Hence any issues should be quickly identified and the regional manager could support the new registered manager identify and take actions to resolve.

We saw that the service carried out weekly fire checks and all fire-fighting equipment had been maintained as required by the manufactures instructions. This was so that the service protected people by reducing the risk of fires.

The operations manager informed us that as well as audits and reports, they considered meeting and talking with people who used the service on a daily basis as an important component of service governance. The staff felt this aspect had improved recently. The care plans reflected an increased number of reviews had been arranged and had started to come into operation. These reviews included auditing to check that peoples care needs had been accurately recorded. We saw that under the direction of the regional manager this was happening as were staff meetings and supervisions. Although this was extremely positive as yet there was not enough evidence recorded because of the length of time that the regional manager had been able to implement. We could be assured that this key line of enquiry was consistently good. However we noted the improvements that the new team had made in a short time.