GN Care Homes Limited

Thornton House Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Thornton House Residential Home is a residential care home that was providing personal care to 22 older people at the time of the inspection. The service can support up to 22 people in one adapted building. People were living with age related conditions, including dementia.

People's experience of using this service and what we found
The provider had not fully protected people from the risk of abuse and improper treatment. Incidents and accidents involving people were not consistently reported, recorded and investigated. Lessons were not learned from accidents and incidents to drive improvement or to mitigate future risk.

The provider failed to ensure there were enough trained and competent staff to meet people's needs of people living at Thornton House and to keep them safe. Staff had received mandatory training but had not received training in relation to dementia care and the management of behaviour that may challenge.

A lack of robust governance and daily management oversight had resulted in issues relating to the quality and safety of the care people received. Governance systems in place had failed to identify the concerns we found and whilst regular checks and audits were in place, these were ineffective.

The quality of people's care plans and risk assessments were variable in quality and content. Personal behaviour support plans were not in place to guide staff in the management of people that had behaviour that may challenge. We found the language used in some people's records to be disrespectful and undignified. Staff used language that was not always person centred when engaging with people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Thornton House needed decoration and refurbishment in communal areas and within some people's bedrooms. Signage for people living with dementia required improvement.

Relatives gave us mixed feedback that included positive and negative comments in relation to all areas of the service.

Some communal activities took place within the home however, these did not meet the needs of all people living at the service.

People's food and drink needs were not consistently met. The chef had a good understanding of people's dietary needs.

Medicines were managed safely by trained and competent staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was good (Published 3 August 2021).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding incidents that had not been reported. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Thornton House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to person centred care, dignity and respect, safe care, safeguarding, staffing, premises and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Thornton House Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors.

Service and service type
Thornton House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Thornton House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. The registered manager resigned and

left the service with immediate effect following the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with 2 people who lived at the service and 7 relatives of people who lived at the service. We also spoke to the nominated individual, registered manager, deputy manager, activities co-ordinator, senior support worker, 2 support workers, chef, maintenance staff member and 1 domestic member of staff. We spoke to 4 social care professionals who visited the service. We reviewed a range of records which included 6 people's care records. We looked at 5 staff files in relation to recruitment and staff competencies. A variety of records relating to the management of the service including policies and procedures were also reviewed. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems to protect people from the risk of abuse or neglect were in place but had not been followed. People had come to harm and prompt and appropriate action had not been taken to safeguard people.
- The provider had a safeguarding policy and procedure in place; however, staff were not following the guidance within this. For example, the policy states all staff to ensure that information is recorded and that the safeguarding team is contacted to inform them of the concern or harm and for the registered manager to report any incidents of abuse to relevant parties. This had not happened over several months at the service.
- The service was under organisational safeguarding. Organisational safeguarding is a process employed by the local authority to monitor the service where there are multiple concerns. Safeguarding alerts had not been made to the local authority. During the inspection all safeguarding concerns found were shared with the local authority.
- Staff had all received safeguarding training however, had not recorded all safeguarding concerns identified using incident reports.

Failure to protect people from the risk of abuse was a breach of regulation 13(1)(2)(3) (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- On day 1 of our inspection we identified a first-floor window did not have a restrictor in place. We were given an assurance by the registered manager and provider that this would be immediately addressed. On day 3 of our inspection 6 days later this risk had not been addressed, leaving people at risk of harm.
- We were not assured the provider was keeping people safe through assessing and managing risks to their health and safety. Risk assessments were in place however, they did not always hold sufficient information to guide staff and to mitigate risk.
- Positive behaviour support plans were not in place. People that were supported with behaviour that may challenge did not have detailed risk assessments and guidance in place to support staff to manage this.
- The provider had a process in place to analyse, identify trends or learn lessons to improve on the service provided. However, as the incidents of abuse had not been correctly recorded and reported, analysis had not been completed. This meant lessons learned had not been identified and future risk had not been mitigated.
- The back garden grassed areas and paths were inaccessible to people due to a very large number of dog faeces which had not been appropriately removed. They had been there for an extended period as they were starting to decompose. This was immediately addressed by the provider.

● People's personal emergency evacuation plans (PEEPs) needed review and update as they held unclear and inaccurate information.

Systems were either not in place or robust enough to demonstrate that risk management and safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (1)(2)(b)(c) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Health and safety checks of equipment were in place and the required safety certificates.
● Fire safety checks were in place and evacuations had taken place to ensure staff understood procedures to be followed in the event of an emergency.

Staffing and recruitment
● The registered manager used a dependency tool to assess the number of staff required. A dependency tool collates information about each person in receipt of care and support and calculates how many hours of staff support they need. The tool needed review and update as it did not accurately reflect people's needs. This meant staffing levels may not have been accurate within the service.
● There were insufficient numbers of suitably trained and competent staff employed to meet the needs of the people supported.

A failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 (1)(2)(a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Recruitment processes were safe. Appropriate pre-employment checks were carried out to ensure that only suitable people were employed.
Using medicines safely
● People had medicines care plans in place that included an up-to-date photograph of the person and details of any allergies. Instructions and guidance for 'as required' (PRN) medicines were in place.
● Medicine administration records (MARs) were accurate and up to date. All medicines, including controlled drugs, were stored safely.
● Staff that administered medicines had received training and had their competency assessed.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

The home was open to visitors in accordance with the most up to date government guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were supported by staff who had not received sufficient good quality training to enable them to fully understand and meet the needs of people supported at Thornton House. This included training in the areas of supporting people living with dementia, positive behaviour support, restrictive interventions and human rights.
- Agency staff had not received an induction as they started working at the service and had not been given access to people's care plans and risk assessments.
- The provider had a system in place to monitor staff training needs. However, they had failed to identify that staff had not received training in essential areas to meet the needs of people supported.
- Staff were not being supported with regular supervision in line with the providers policy. The area managers recent audit stated supervisions were not completed in line with policy last year. The supervision matrix showed some staff had not received supervision this year. One staff member stated they had never had supervision although it was recorded that they had on the supervision spreadsheet.
- Relatives gave mixed feedback about support staff skills. Comments included, "Staff maybe don't have the skills to manage", "Staff are really great", "Staff don't speak to people very nicely" and "Staff team are doing their best in difficult circumstances."

People were supported by staff who did not have the right skills or training to meet their needs. This placed people at risk of harm. This was a breach of regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they felt supported. Their comments included, "I've received great support.", "I feel very supported by the management." and "Staff support each other."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been assessed however, we found that written information was not always accurate within assessment documents.
- People were not consistently offered choices and were restricted in their movements throughout their home.
- When people had been affected through other people's actions this was only recorded on the perpetrator's records and not the victims. For example, when one person had been hit with a walking frame this was not recorded in their record.

Adapting service, design, decoration to meet people's needs

● Relatives consistently commented on the need for redecoration and refurbishment at Thornton House. Comments included, "It's the most depressing place, it's sad, just sad.", "The building looks a mess and is falling apart." And "It's tatty and in need of update." Comments from social care professionals included, "[Names] room was odorous of urine.", "The décor within [Names] room was very worn and tired." And "The home décor was found to be in a tired state and in need of re-decorating and refurbishment."

● Hallways on the ground floor needed a full scheme of redecoration. There were cracks in some of the walls upstairs which needed some repair.

● Poor lighting in some areas of the home, corridors and some bathrooms meant people living with dementia were not fully supported with their needs.

● Some people's bedroom carpets needed replacement and their rooms required redecoration.

● Three bathrooms needed refurbishment and redecoration. One bathroom had broken and cracked flooring. A radiator cover had flaking paint. One bath was inaccessible due to the bath lift being out of service and had been for an extended period.

● Signage throughout the service was poor and did not meet the needs of people living with dementia.

Premises and equipment were not always suitable for the purposes being used, and properly used and maintained. This was a breach of regulation 15 (1)(c) (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutritional needs, risks and preferences were assessed and regularly reviewed. Referrals were made to external professionals as and when required.

● We observed the lunch mealtime to be very task focused by staff. There was very little interaction or conversation. One person living with dementia required staff support to guide them to eat and drink. Staff were telling the person not to pour their drink on their meal from a distance rather than sitting and gently encouraging and guiding the person. One person was continually told by staff to sit down throughout lunch.

● People who chose to stay in their bedrooms did not all have access to a jug of fresh water or juice. This was also highlighted by social care professionals who had visited the service.

● One person had been assessed to have thickener in their drinks. There was conflicting information within the persons care plan guidance. Staff were using the correct quantity as prescribed.

● The recording of people's food and fluid intake each day was variable. This had been raised during the provider audits on several occasions and had not been addressed.

● The chef was knowledgeable about people's individual needs and preferences as well as dietary requirements.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● We received some feedback from visiting social care staff. Their comments included, "At times staff seemed to engage well and at other times they were focused on the task rather than the person.", "The person I visited appeared unkept and their room was odorous." And "I have made a referral for a person in relation to their swallow as it was recorded that they struggled with harder texture foods. The staff confirmed a referral had not been made."

● The provider told us people were supported to access a range of healthcare facilities and health professionals as required.

● Care plans did not always hold sufficient information about people's health needs. Staff had some understanding of people's individual health issues and how these were supported.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● DoLS had been applied for by the registered manager, however these had not always been escalated when people's needs changed and further restrictions had been put in place.
● Where people could not make specific decisions for themselves, a best interest decision was not consistently in place. Consultation with people, their relatives or healthcare professionals as required under the principles of the MCA was not consistently in place.
● Staff knew about people's capacity to make decisions through verbal or non-verbal means; however, this was not always documented. This meant there was a risk that decisions made for people might be unlawful or not in their best interests.
● During the inspection people's needs were reviewed and all required DoLS were put in place.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated well. Some people had been harmed through staff not having received appropriate training or guidance to meet people's needs. There were many records where people may have experienced avoidable harm.
- We found the language used in some people's care plans and records to be disrespectful and undignified. For example, "Told [Name] that their behaviour was unacceptable and would not be tolerated in the future", "[Name] is unaware when they are aggravating other residents" and "[Name] was removed from the table and put back in their room." The actions by staff and the choice of language within some records on occasions was uncaring.
- We observed that interactions between people and staff were variable. At times we saw some positive and kind interactions, but at other times staff were task focused, interactions were less positive, and staff spoke about people in derogatory terms. For example, "Going to do the bed bounds", and "Do the bed bounds" referring to people being supported in bed.
- Relatives comments were variable in relation to staff. Their comments included, "When some staff open the door, they don't even say hello.", "[Staff Names] are very good with [Name]", "Staff are very pleasant" and "Staff make me feel awful if I ask anything."

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People's privacy, dignity and independence was not always respected or promoted. We saw many examples of staff not treating people with dignity who were living with dementia. Staff persistently used the following phrases, "[Name] sit down", [Name] go back to your room", "Sit down until I get your pudding", "Sit down until you have had your pudding" and "Sit down [Name], you've got to."
- People had attended a recent residents meeting held by the registered manager. Actions identified had not yet been put in place.
- Two relatives told us that they undertook personal care tasks including showering and nail care due to them feeling this support had not been consistently offered to their loved ones. They described their loved ones having very dirty and long fingernails.

People were not always treated with dignity and respect. This was a breach of regulation 10(1) (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were variable in completion. Some held accurate information for staff to follow to meet people's assessed needs. Some care plans held inaccurate and misleading information meaning people may not receive appropriate support.
- People had care plans in place that gave some guidance to staff about how to meet people's needs. Information within people's care plans did not always reflect their most up to date needs. For example, two people's care plans stated they did not show signs of behaviour that may challenge, however there were multiple recordings on behaviour charts that stated otherwise. One person's plan stated they were emotionally stable, however recordings on behaviour charts suggested otherwise.
- People living with dementia did not have any clear plans or guidance in place to guide staff about how best to support people on their dementia journey. This had resulted in a high number of potentially avoidable incidents where people had been harmed.
- Social care professionals comments included, "[Name's] care plan documents were confusing and unclear. They did not hold the most up to date information. Staff were hesitant when discussing people's care. They did not have name badges on, so it was difficult to know who staff were."

The provider's quality assurance systems and processes were not effective and had not identified areas for development and improvement within people's care records. This was a breach of regulation 17(1)(2)(a) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People had a basic communication plan in place to offer guidance to staff. Consideration was not given for people living with dementia.
- The provider had an easy read service user guide available for people to read however, other easy read documents were not available.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were encouraged to participate in communal activities within the lounge which mainly involved listening to music and watching films. Some people appeared to join in and sing along. This was very loud, and some people appeared unsettled by this. On two occasions a person went to sit in a quieter area away from the lounge and was told to go back. They were not offered a choice to stay where they were.
● The activities co-ordinator was enthusiastic and keen to learn more about activities that could be utilised within the service. However, they had not received any training in this area or in supporting people living with dementia. When the service was short staffed the activities co-ordinator would be required to work as a support worker.
● People who chose to spend time in their bedrooms were not offered any engagement. For example, 1:1 time, reminiscence or reading.
● Relatives told us they visited their loved ones. Feedback from relatives was very mixed and included, "I visit regularly and [Name] loves it here", "Name has never asked to leave", "It's not welcoming and it does make me feel sad that [Name] has to live here.", "I visit as there is nothing else going on in the home" and "Something is wrong every time we take [Name] out. [Name] was wearing pyjama bottoms one time I collected them, another time they were not wearing a jumper and it was freezing outside."

Improving care quality in response to complaints or concerns
● The provider had a complaints policy and procedure in place.
● Relatives gave mixed feedback in relation to raising concerns. Their comments included, "My comments have been listened to, sadly nothing ever happens", "I feel confident to raise any concerns and think they would be listened too", "I haven't had cause to raise a complaint" and "As soon as I raised concerns and complained I got treated differently. Staff stopped speaking to me."

End of life care and support
● Care plans demonstrated personal wishes were documented. Some people had chosen not to discuss this aspect of their care. This wish was respected.
● Where appropriate, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders were placed prominently in care files.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance systems were ineffective and did not assess, monitor and drive improvement in the quality and safety of the service being provided. They did not mitigate risk to the health and welfare of people living at the service.
- Where the providers systems had identified areas for development and improvement these had not been addressed in a timely manner by the registered manager.
- The appearance of the physical environment had deteriorated since the last inspection and although a refurbishment plan was in place this had not been actioned in a timely manner.
- Staff did not have regular supervision to receive feedback on their performance and constructive feedback on how this might be improved. This meant the provider was unaware of areas for development and improvement. People were at risk of being supported by staff that were not competent and confident in their role.
- There was a registered manager in post at the beginning of the inspection. However, they left before the report was published. The nominated individual and area manager were managing the home on an interim basis until a new manager was recruited.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17(1)(2)(a) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and nominated individual were open and transparent throughout the inspection and took immediate action to address some of the concerns that were brought to their attention.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People did not consistently receive person-centred care and daily records held information that was not person centred.
- Relatives gave very mixed feedback in relation to communication. Their comments included, "Communication has been really poor. [Name] had a fall and attended hospital and I was not informed.", "Staff let me know if anything changes as I don't visit often.", "I wasn't informed when [Name] had COVID19.", "Communication could be a little better." And "I always have to ask and prompt for feedback, it is never freely given."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was aware of their responsibilities to submit notifications to CQC when needed however, had not consistently sent in notifications as required.

● The registered manager had not alerted the local authority safeguarding team or the CQC when significant incidents had occurred within the home and people had been harmed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We saw limited evidence that staff meetings or meetings with people and their relatives were taking place. This meant people and their relatives were not involved in the service, provided with key updates or given an open forum to raise suggestions or concerns.

● Staff told us the registered manager was approachable and supportive and they felt able to raise any concerns about people's care with them or personal issues.

● No recent satisfaction surveys had been undertaken. The 2022 survey results from relatives highlighted a need for more updates from the service. An action was agreed for the registered manager to send monthly newsletters to relatives. This had not taken place. The residents survey had identified that more activities were required, and that people did not always feel they were treated well or with dignity. We found these areas had not improved.

Continuous learning and improving care

● The service was under organisational safeguarding and was being overseen by local authority commissioners and safeguarding adults' team.

● The provider had systems in place to learn lessons from accidents, incidents and safeguarding adult concerns. However, these were not effectively used as incidents and safeguarding concerns had not been recorded or reported correctly. This meant future risks had not been mitigated and incidents had reoccurred.

Working in partnership with others

● The registered manager did not always work in partnership with other agencies. We received concerns from health and social care professionals stating the registered manager had not shared changes to people's needs or acted promptly to report events that had occurred at the service.

● Local authority social care professionals told us they had concerns about this service and the care and support provided.

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 People's care plans were not always person centred. Some people did not have essential care plans in place to give guidance to staff for the best way for them to be supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy, dignity and independence was not always respected or promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Incidents had not been consistently recorded or reported. Lessons were not learned from accidents and incidents to drive improvement or to mitigate future risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not fully protected people from the risk of abuse and improper treatment.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Thornton House was in need of refurbishment and redecoration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were ineffective as they had not highlighted and addressed the areas of concerns found during this inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received training to meet the needs of the people supported.