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Thistlegate House

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We carried out this unannounced, focused inspection on 23 and 29 April 2015 to follow up on action we told the provider to take in a warning notice after our last inspection.

We carried out an unannounced comprehensive inspection of this service on 9 and 14 January 2015 at which we found breaches of legal requirements. This was because people's care was not delivered in a way that met their needs and they were not being treated respectfully. People were not protected from harm and their consent to care was not clear. Medicines were not administered safely. Staff were not always recruited in a way that protected people or supported to undertake their roles effectively. People were not protected by effective quality assurance systems.

After the comprehensive inspection we told the provider to take action by issuing a warning notice that required improvement in how people's care needs were assessed and how care was planned to meet their assessed needs by 9 April 2015. We also asked the provider to tell us how they would make improvements in relation to the other breaches of regulation identified.

This report only covers our findings in relation to the action we told the provider to take in our warning notice to ensure people's needs were assessed and their care delivered appropriately. We will carry out another inspection to check that action has been taken in relation

Summary of findings

to the other breaches of regulation. You can read the report from our last inspection by selecting the "all reports" link for "Thistlegate House" on our website at www.cqc.org.uk

Thistlegate House provides accommodation and personal care for up to 18 older people. There were five people, some of whom had complex care needs associated with dementia and restricted mobility, living in the home when we visited.

The provider is required to recruit a registered manager for this type of service. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our inspection on 23 and 29 April 2015 we found the provider had not taken the action necessary and legal requirements were not met.

People's needs had not been assessed appropriately and this meant the care people received did not meet their needs.

People experienced continence care that had not been appropriately assessed.

People were at risk of avoidable harm because incidents were not appropriately reviewed and did not lead to changes in the care people received.

People did not have regular access to meaningful activity that reflected their needs.

Professional guidance was not sought as an integral part of assessment and care planning.

Some people told us they were happy with the care they received from staff.

We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
People were not safe because risks were not assessed appropriately.

This rating was awarded at the last inspection in January 2015. We will review the rating at the next comprehensive inspection.

Inadequate

Is the service effective?
People did not always have access to guidance and input from health professionals.

When people required emergency healthcare this was sought appropriately.

This rating was awarded at the last inspection in January 2015. We will review the rating at the next comprehensive inspection.

Inadequate

Is the service caring?
This rating was awarded at the last inspection in January 2015. We will review the rating at the next comprehensive inspection.

Requires improvement

Is the service responsive?
People did not receive appropriate care because their needs had not been assessed appropriately.

This rating was awarded at the last inspection in January 2015. We will review the rating at the next comprehensive inspection.

Requires improvement

Is the service well-led?
This rating was awarded at the last inspection in January 2015. We will review the rating at the next comprehensive inspection.

Inadequate

Thistlegate House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

We undertook a focused unannounced inspection of Thistlegate House on 23 and 29 April 2015. The inspection took place to check the provider had taken action in relation to the warning notice served following our last inspection in January 2015 in relation to the assessment, planning and delivery of care. As a result we only inspected the service against the specific questions that related to the breach in legal requirements we were following up.

The inspection was undertaken by three inspectors. The lead inspector attended both days of the inspection and the other two inspectors attended for one day each. Before the inspection we reviewed the information we held about the service. We did not request a new Provider Information Return (PIR) as the provider had completed one before our January Inspection. A PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during our inspection and spoke with the provider about changes they had made to comply with the notice.

During our inspection we spoke with four people who used the service. We looked at care records for three people. We spoke with two staff members, the registered manager and the co-owner. We asked to speak with more staff and were told by the co-owner that they would not want to speak with us. We observed people receiving support in a communal area. After the visit to the service we spoke with a visiting health professional.

Inadequate

Is the service safe?

Our findings

At our last inspection on the 9 and 14 of January 2015 we found that people were not protected against the risks of receiving unsafe care as care was not appropriately assessed, planned or delivered to keep people safe. There was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We required that the provider take action by 9 April 2015. At this inspection we found that sufficient improvements had not been made.

People were not protected from avoidable harm because risks were not consistently identified, assessed or managed. For example, one person had been identified as being at high risk of falls in January 2015. The assessment form indicated that this should lead to further assessment and professional advice. There had been no referral made to a falls specialist or professional advice sought regarding their falls. No audit of the falls had been undertaken to identify trends. No care plan had been put into place to mitigate the risk and they had continued to have further falls after this assessment was completed. A specific risk assessment document had been completed which described the potential risk of falling in certain circumstances. This risk assessment did not detail an agreed outcome or reflect the Mental Capacity Act 2005. We asked the co-owner if they were taking any measures to reduce the person's risk of falls and they told us that they are all aware that the person may fall. They told us they were not taking any action other than maintaining this awareness. Care delivery records indicated that the person was moving around the house on their own at times when they had been noted as being unsteady and that two falls had been due to slipping on a wet floor.

Care plans of two people who were known to fall did not include any information about how the person should be assisted after a fall; including how a person could be assisted to get up. There was a risk that people may receive inappropriate and unsafe care and treatment following a fall.

Care delivery notes recorded that one person, who had dementia and could not make decisions about their own welfare, had left the home without staff. The record stated that they were found down the road and had fallen. This incident did not result in a review of risk and was not reflected in their care plan. The home is situated next to a busy road and the failure to assess the risk that the person might leave again put them and others at risk.

Environmental risks were not identified or assessed and as a result no actions were taken to mitigate these risks appropriately. For example, there were environmental hazards including plastic covering on the carpet, a fire place leaning against the wall and an uneven floor under a patterned carpet on the first floor landing that had not been identified or assessed.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection care plans had been updated to reflect concerns identified in risk assessments related to skin care.

Inadequate

Is the service effective?

Our findings

At our last inspection on the 9 and 14 of January 2015 we found that people did not get the support they required to maintain their health and there was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We required that the provider take action by 9 April 2015. At this inspection we found that some improvements had been made but these were not sufficient.

People's care plans had been updated and provided some more information about their health care needs. For example, one person had been unwell and their care plan had been updated appropriately. We also saw that this person had received medical attention quickly in an emergency. Care plans had also been updated to include some information about oral care. One member of staff told us that they supported people with oral care as described in their care plans. However, not all people's health care needs had been assessed appropriately, and the resulting care was not appropriate. One person had an addition to their care plan in March 2015 stating that a soft tooth brush had been purchased and that staff should use it to gently brush the person's teeth at night. This person's care plan said that they suffered from painful teeth and gums and they did not consistently use words to communicate. The toothbrush in their room was hard and this was brought to the attention of the co-owner. The co-owner then described how they would no longer use a toothbrush. No guidance was sought from an appropriate health care professional about the person's oral health needs.

Another person was diagnosed with a progressive health condition. This was not reflected in their care plan. Care delivery records indicated an increase in the impact of their condition on their well-being, due to changes in their mobility and dexterity. Staff told us there had been changes in this person's needs. They told us they discussed these with the co-owner. This had not led to a review of their needs involving appropriate health care specialists or changes to their care plan. This put the person at increased risk of harm. For example it increased their risk of harm resulting from falls and inadequate nutrition.

People told us that the food was good and we saw that people's weights were stable. However, care delivery related to food and drink was mixed. One person had been told to increase their fluid intake following ill health and we saw that they drank from a larger mug to increase their fluid intake. This was the only measure taken to increase their fluids. The same person had been on a fluid monitoring chart for a period of time in February this had not been completed accurately or totalled. This meant it was not being used as an effective assessment tool and would not have identified concerns.

Another person was struggling to eat and drink due to decreasing manual dexterity. A staff member told us that they had considered ways to help this person. For example by giving them a banana instead of cereal. Care delivery records showed that the same staff member had discussed introducing a two handled beaker with the co-owner. The records indicated they would try this to see if it worked. No guidance had been sought from an appropriate health professional to determine the most effective and safe plan to ensure their nutritional needs were met.

There was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

This rating was awarded at the last inspection in January 2015. We will review the rating at the next comprehensive inspection.

Requires improvement

Is the service responsive?

Our findings

At our last inspection on the 9 and 14 of January 2015 we found that people were not always protected from inappropriate care because their needs had not been appropriately assessed. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider to make improvements by 9 April 2015. At this inspection we found the provider had not made adequate improvements in relation to this breach.

Since our last inspection a monthly review had been undertaken of people's care but these were not appropriate and resulted in people continuing to receive inappropriate care. One person required support with their continence. Their care plan had been updated in January 2015 stating that they should be assisted to use the toilet every two hours during the day and night. No guidance had been sought regarding the appropriateness of this response. This meant that the person who had a diagnosis of dementia was having their sleep disturbed every night.

Another person was frequently incontinent in their room and bathroom and this put them at risk of falling. Their room smelled strongly of urine at the time when we inspected. Care delivery records also referred to times when the continence products used were not effective. There had been no guidance sought about how to improve continence care for this person.

Two people had received a diagnosis of dementia since the main body of their care plan was written. There had been no updates to reflect how dementia impacted upon them or how staff should respond to these needs.

People were not engaged regularly in meaningful activity. Poetry was read on the afternoon of our inspection; however records indicated that this was not usual. People also told us they didn't usually have activities. One person who could no longer read due to a visual impairment told us about their love of literature. A means of making literature readily available to them had not been explored.

One person was at risk of social isolation but there was no guidance in their care plan about how to increase the range of social interaction they experienced. One member of staff told us they spend time with this person if the person is awake when they have time in the day. They told us that they did not know what other staff did. The person had a Deprivation of Liberty Safeguards authorisation in place which had a condition that the person experienced more activities. We spoke to the provider about this and they told us that they had not introduced anything to increase the person's activities. The staff members we spoke with were not aware of the condition. This condition was not being met because the person still experienced days when they did not experience any activities other than staff supporting them with their personal care and there was no plan in place to prevent this from happening.

There was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

This rating was awarded at the last inspection in January 2015. We will review the rating at the next comprehensive inspection.