Orchard Care Homes.Com Limited

Thornton Hall and Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 and 18 October 2017 and was unannounced.

Thornton Hall and Lodge is registered to provide residential care and support for up to 96 people. The home is purpose built and the accommodation is in four units over two floors. Two of the units within the home are designed to support people living with dementia. The home has aids and equipment to help people who are less mobile and the first floor is accessible by a passenger lift and staircase. During the inspection, there were 79 people living in the home.

At the last inspection in March 2017, we identified breaches of Regulations in relation to how consent to care and treatment was sought, the management of medicines, risk management, care planning and systems in place to monitor the quality and safety of the service. The service was rated as 'Requires improvement' and we issued warning notices in relation to Regulation 12; safe care and treatment and Regulation 17; good governance. During this inspection we looked to see whether improvements had been made but found many of the same concerns and the warning notices had not been met.

At the last inspection we found that medicines were not always managed safely. During this inspection we found that sufficient improvements had not been made and the provider was still in breach of regulation regarding this. Medicines were not always stored appropriately as the temperature of the clinic rooms was too high and that some items requiring refrigeration were not stored in the fridge. We found discrepancies in the stock balance of controlled medicines and systems to ensure medicines were always available, were not effective. Some people's allergies were not clearly recorded and guidance was not always in place for medicines prescribed as and when required.

Records we viewed showed and staff confirmed that they had completed medicine training and had been assessed as competent to administer medicines in the home.

At the last inspection we identified concerns regarding risk management. During this inspection we looked to see if improvements had been made; however we found the same concerns and the provider was still in breach of regulation regarding this.

We saw that risk assessments had been written but not all identified that risks had been fully assessed and clearly recorded and not all had been updated, as people's needs changed. Some emergency evacuation plans were not accurate and the environment was not always safely maintained as not all fire doors closed properly and chemicals were not always stored securely.

In March 2017 we found that consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA). During this inspection we found that adequate improvements had not been made and the provider was still in breach of regulation regarding this. We found that assessments were not always completed when required, such as when people were receiving covert medicines. It was not always clear

that relevant people had been involved in best interest decisions and records indicated that it was not assumed people had capacity until an assessment showed otherwise. We did however observe staff seeking consent from people before providing support.

At the last inspection we found the provider was in breach of regulation as care plans did not always provide sufficient detail regarding people's care needs and were not always updated when people's needs changed. During this inspection we found that insufficient improvements had been made and the provider was still in breach of regulation regarding this. Not all care plans provided sufficient, consistent information to enable staff to support people effectively and were not always updated as people's needs changed. This meant that staff may not have sufficient information to enable them to support the person safely and effectively.

At the last inspection we identified a breach in regulation regarding how the service was managed. During this inspection we looked to see if improvements had been made and found there were still concerns regarding the management of the service. Completed audits did not identify all of the concerns highlighted during inspection and when audits did identify areas that required improvement, it was not always clear whether actions had been addressed. This showed that the audit systems in place were not effective and the provider was still in breach of regulation regarding this.

We found that there was not always sufficient numbers of staff on duty to meet people's needs in a timely way and the provider was in the process of recruiting more staff.

Meetings took place to enable people and their relatives to provide feedback regarding the service, however people did not feel that action was always taken based on their views. Questionnaires were available but there was no evidence when these were last completed.

We made a recommendation regarding this in the main body of the report.

Staff files evidenced that not all safe recruitment practices were adhered to, however all staff had a disclosure and barring service check to help ensure they were suitable to work with vulnerable people.

Staff were knowledgeable about adult safeguarding and how they would report any concerns and people told us they were supported to stay safe in the home.

A system was in place to ensure that applications to deprive people of their liberty were made and monitored appropriately.

New staff completed an induction that was in line with the requirements of the care certificate and regular training was available to all staff. A schedule of supervisions had been implemented to help support staff, but not all staff had received an appraisal.

People were supported by the staff and external health care professionals to maintain their health and wellbeing. People told us they received appropriate care from health professionals in a timely way.

We looked at how people's dietary needs were met within the home and found that staff were knowledgeable regarding people's needs and specialist aids were available to assist people to eat independently. People living in the home told us they liked the food available to them and they had a choice of meals.

People spoke highly of the staff and told us staff were kind and caring and treated them with respect. Most

relatives we spoke with agreed that staff were caring. Although feedback regarding the approach of staff was positive, the provider had failed to address issues within the service which had been raised at previous inspections and continued to pose risk to people living in the home.

We observed people's dignity and privacy were respected by staff in a number of ways, such as staff knocking on people's door before entering their rooms. If people were presenting with behaviours that could compromise their dignity, staff quickly supported them to somewhere more private.

People also told us that they were encouraged to maintain their independence and most staff knew the people they were caring for well, including their needs and preferences. People told us they were supported to meet their religious needs.

Relatives we spoke with told us they were kept informed of any changes to their family members needs and were involved in reviewing their plan of care. Care files included information on people's preferences in relation to their care. This helped staff to get to know people and provide support based on their preferences.

Feedback regarding activities was mixed. An activity coordinator was employed in the home and we saw an activity schedule on display. Records showed that although people's preferred activities were known, they were not always met by the service.

People had access to a complaints procedure within the home and we found that complaints made had been investigated and responded to.

There had been a frequent change in the management team at Thornton Hall and Lodge over the previous two years and it was clear that this had had an impact on people living in the home and staff. A new manager had started in post on the first day of the inspection and had begun the process to register with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had notified the Care Quality Commission (CQC) of events and incidents that had occurred in the home in accordance with our statutory requirements. We also saw that the rating from the last inspection was clearly displayed within the home and on the provider's website as required.

Many of the concerns identified during this inspection had been raised with the provider at previous inspections. This showed that the provider had failed to take appropriate action that would mitigate these risks and maintain improvements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

the terms of their registration within six months if they do not improve. This service will continue to be kept under review and if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Medicines were not managed safely.

Risk was not always managed appropriately.

There was not always sufficient numbers of staff on duty to meet people's needs in a timely way.

Not all safe recruitment practices were adhered to.

Staff were knowledgeable about adult safeguarding and how they would report any concerns and people told us they were supported to stay safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA).

Applications to deprive people of their liberty were made appropriately.

Staff were supported through an induction and on-going training, but not all staff had received an appraisal.

People were supported by the staff and external health care professionals to maintain their health and wellbeing.

Staff were knowledgeable regarding people's dietary needs and people told us they enjoyed the food.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were kind and caring and treated them with respect, however the provider had failed to address issues within the service which had been raised at previous inspections and

continued to pose risk to people living in the home.

We observed people's dignity and privacy being respected by staff during the inspection.

People were encouraged to maintain their independence and most staff knew the people they were caring for well.

People were supported to meet their religious needs.

People told us their family members could visit at any time and relatives were able to visit in private if they wanted to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all care plans provided sufficient, consistent information to enable staff to support people effectively and were not always updated as people's needs changed.

Systems in place to gather feedback from people were not always effective.

Relatives were kept informed of changes to their family members needs and were involved in reviewing their plan of care. Care files included information on people's preferences in relation to their care.

Feedback regarding activities available was mixed.

A system was in place to manage complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place to monitor the quality and safety of the service were ineffective.

Warning notices issued after the last inspection had not been met.

Previously identified risks had not been addressed by the provider.

A new manager was in post and had applied to become registered with CQC. There had been an unstable management team over the past two years and this had impacted on people

living in the home and staff.

The rating from the last inspection was clearly displayed within the home and on the provider's website as required.

Thornton Hall and Lodge

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.

This inspection took place on 16 and 18 October 2017 and was unannounced. The inspection team included four adult social care inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance, their experience was in relation to supporting people living with dementia.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service and the local safeguarding teams to gather their views of the service.

We used all of this information to help plan how the inspection should be conducted.

During the inspection we spoke with the new manager, two managers from the provider's improvement team, the chief executive officer, 11 members of the care staff, eight people living in the home, five relatives and the activity coordinator.

We looked at the care files of eight people receiving support from the service, six staff recruitment files, 22 medicine administration charts in detail and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

We also used the Short Observational Framework for Inspection (SOFI) on two occasions during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

During the last inspection in March 2017, we identified breaches of regulation in relation to keeping people safe and the 'safe' domain was rated as 'requires improvement'. The breaches were in relation to the management of medicines and risk management. This inspection checked to see if the provider had made improvements and were meeting the fundamental standards of care.

At the last inspection we found that medicines were not always managed safely as allergies were not always clearly recorded, eye drops were administered after the expiration date, medicines were not all administered as prescribed and there were not always protocols in place to guide staff when medicines prescribed as and when required (PRN), should be administered. During this inspection we found that sufficient improvements had not been made and the provider was still in breach of regulation regarding this.

We found that medicines were not always stored appropriately. Medicines were stored in clean, secure clinical rooms; however daily records demonstrated the rooms on all units were consistently too hot to store medicines safely. Fridge temperature recordings were not always completed daily and maximum temperatures were recorded above the safe range on all units with no evidence of action taken to rectify the problem. We also found that cream which should have been stored in the fridge was stored in the medicine cupboard. If medicines are not stored at the recommended temperature, they could be less effective. We found a powder for thickening drinks was stored in an unlocked cupboard in the dining room. This is a prescription item and should be stored securely as it could pose a choking risk to vulnerable people.

We checked a number of controlled drugs and found two discrepancies, on different units, where the stock balances were not accurate. This meant that medicines had not been administered as prescribed. Controlled drugs are prescription drugs that have controls in place under the Misuse of Drugs Act and associated legislation.

We also found that five people living in the home were missing medication on the day of the inspection, which included medicine for health conditions such as Parkinson's, dementia and insomnia. One medicine had not been available for eleven days. These issues were escalated to the management team during the inspection, they were ordered immediately and we have since been informed that they were all received within three days.

We looked at the medicine administration records (MAR) for people living in the home and saw that they contained a photograph of the person to help staff identify them; however not all allergies were recorded within MAR charts. A number of people's records had an allergy documented on the front sheet of their file, but their MAR chart stated 'none known'. This meant there was a risk that people could receive a medicine they were allergic to. We raised this with the manager on the first day of the inspection who advised this would be addressed immediately. On the second day of inspection we reviewed the MAR charts and found that not all people's allergies had been updated.

We saw that when people were prescribed medicines 'as and when required' (PRN), there was not always a

protocol in place to guide staff when they should be administered to ensure people received their medicines when they needed them, even if they could not tell staff when they needed them.

One person's file indicated that they were receiving their medicines covertly (hidden in food or drink). There was information from the pharmacist to advise whether they could be crushed or dissolved, however there was no information within their care plan to advise staff how they should be given to this person. Staff we spoke with described very specific requirements to be followed to ensure the person received their medicines safely. As this detail was not recorded, there was a risk that not all staff would have the required knowledge to ensure this person's needs were met in relation to their medicines.

Many of these concerns had been raised at the last inspection, but had not been rectified. The provider had taken some steps to address the concerns regarding medicines management, such as reverting from a computerised system back to paper records, arranging for medicines to be supplied in blister packs to ease administration and had employed registered nurses to administer medicines when sufficiently trained permanent staff were not on duty. Despite these actions, there continued to be concerns regarding the management of medicines within the service.

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

Records we viewed showed that all staff who administered medicines had completed medicine training and had been assessed as competent.

At the last inspection we identified concerns regarding risk management, as identified risks were not always assessed to enable risk reduction measures to be implemented. Risk assessments that had been completed were not always accurate. Personal emergency evacuation plans (PEEPs) did not contain sufficient detail and call bells were not always available to people to enable them to contact staff when they required support.

During this inspection we looked to see if improvements had been made, however we found the same concerns and the provider was still in breach of regulation regarding this. We saw that risk assessments had been completed in areas such as nutrition, falls, medicines and skin integrity. We found however, that not all identified risks had been fully assessed and clearly recorded. For instance, one person who lived in the home smoked. We found that although information regarding this was available in various places throughout their care file, there was no risk assessment completed to clearly identify risks in relation to this and what measures had been implemented to minimise those risks.

We also looked at a file which indicated the person locked their bedroom door at night and had at times barricaded it to prevent staff entering during the night. We found that there was no risk assessment in place in relation to this so no risks were identified and no measures were recorded as to how the risks could be reduced. We raised this with the manager on the first day of the inspection. On the second day of the inspection we saw that a risk assessment had been completed, however it was not detailed and did not identify how the risk would be managed.

One person's file indicated that, due to their health conditions, they could at times present with behaviours that could challenge. We found however, that there was no risk assessment in place regarding this and no information for staff on how they should best support the person during these times.

We also found that when people's needs changed, risk assessments were not updated to reflect these

changes. For instance, one person's file indicated their mobility had deteriorated in recent weeks and required a greater level of support to maintain their safety when mobilising. However, the falls risk assessment had not been updated since July 2017 and did not reflect the person's current needs. This meant that risk may not be accurately assessed and appropriate measures not implemented to mitigate the risk.

We viewed a file containing personal emergency evacuation plans (PEEPs). This was a file that would be used in the event of an emergency and shared with relevant people, such as the fire service, so they understood what support people required to evacuate the home. The information within the file was not always accurate. For example, one person's PEEP indicated that they fully understood the fire procedure, but their personal safety assessment advised they did not understand the fire procedures. The person's mobility plan also advised they would require the use of a wheelchair in the event of an emergency evacuation; however this was not reflected in their PEEP. The file also contained records for people who no longer lived in the home and the information regarding the location of people's bedrooms was not always accurate as it had not been updated when people had moved rooms. This meant there was a risk staff or the emergency services would not have accurate information to enable them to ensure people were safely evacuated from the home in the event of an emergency.

Staff told us about one person who was at risk of falls and had equipment in place to help reduce the risk. We visited this person in their room with their consent and found that the call bell was not plugged in and was not within their reach. They told us they usually used their call bell during the day and night and was not aware it was not plugged in. We also saw that they had a sensor mat which alerted staff when the person mobilised so they could go and offer them support and reduce the risk of falls. The sensor mat was also not plugged in. This meant that the person had no way of calling staff for support if they needed it and staff would not be alerted if the person had a fall in their room. We raised this with the manager and on the second day of inspection we were told some adaptors had been found to enable both the call bell and sensor mats to be used at the same time and we saw this in place for one person.

Although there were contracts in place to maintain the building and equipment, such as fire alarms, fire equipment, gas, electric and legionella testing, risk within the environment was not always managed safely. For instance, when we walked around the home, we saw that not all fire doors closed securely into their frames. Another fire door had a hole through it where a handle used to be. This meant that people may not be protected from risk in the event of a fire as the doors would not prevent the travel of smoke and fire. We also saw that chemicals were not always stored securely as the sluice rooms on two units were unlocked and contained chemicals that could be harmful to vulnerable people.

Risk was not always identified, assessed or addressed appropriately in order to reduce risk and help maintain people's safety.

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

We looked at how the home was staffed. The improvement team manager told us that there were usually 13 care staff on duty each day to support the 73 people living in the home and eight staff at night. They advised there had been a lot of changes in the staff team recently and were still trying to recruit more staff.

Feedback regarding staffing levels was mixed. Although one person told us, 'Yes there are enough staff and they are all lovely. I can't complain about them', most people living in the home and their relatives did not think there was always enough staff on duty. People living in the home told us, "There aren't enough of them

[staff], sometimes you have to wait", "There are not enough staff. There are only a few and they are busy rushing around all the time. They are very good and they do their best", "There is and there isn't [enough staff]. If they are short they seem to get staff from somewhere else in the home, I think from upstairs and they help out for a while".

One relative told us, "There seems to be enough staff. If I say [relative] needs the toilet someone will help straight away". However most relatives we spoke with agreed that there was not always enough staff. Their comments included, "There are not enough staff at times. They seem to swap staff around the home from the different units. I wish they wouldn't do this, because it upsets [family member]. They have dementia and people with dementia need consistency as they get confused when there is a new face" and "There are not always enough staff. Sometimes when I have gone looking for them I can't find any. Sometimes if they know I am visiting they leave me to wash and shower [family member]."
Feedback from staff also varied, although most told us they did not feel there were enough staff at times. One staff member told us, "They could definitely do with more staff at certain times" and another staff member said, "When there are agency staff, people who don't know the home, it really puts pressure on us. This impacts on the residents." Other comments included, "There are just not enough staff", "There has been an exodus of staff" and "The main issues in the home are organisation and lack of a stable work-force."

We looked at a sample of staff rota's and found that although the levels the manager described were often maintained and sometimes exceeded, these levels were not consistent. For example, on one week we viewed, staffing levels varied between 11 and 18 staff during the day. The increased numbers were often due to agency nurses being employed to administer medicines when senior staff were not on duty. Staffing levels were based on the outcome of dependency assessments, though an improvement manager told us that they were not truly reflective of the staffing needs on each unit within the home as the staffing levels were based on the home as a whole, rather than each unit.

We spent time in the lounges and dining rooms during the inspection and saw that there was a lack of staff at times, particularly during lunch. On one unit we saw that there was a lack of engagement with people prior to lunch as staff were busy making drinks and setting tables and no staff were talking with people who were sat in the lounge. On another unit, we saw that staff were encouraging people to sit at the tables for lunch. Due to people's health conditions, a number of people were unsettled. One person started to undress and staff had to assist them to maintain their dignity, another person was getting up and down and staff had to support them back to their seat, a third person was very tearful and staff were attempting to support them. A fourth person was becoming anxious and a staff member went to get them a doll which they enjoyed carrying.

After 20 minutes nobody had received any lunch as staff were busy and clearly trying very hard to provide good care to people in a difficult situation. This showed us that there were not always enough staff available to meet people's needs effectively.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We looked at how staff were recruited within the home. We looked at six personnel files and evidence of application forms, interviews, photographic identification and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. Files also contained two references; however it was not always clear who the references were from or whether they were from the most relevant people, such as

the last employer. Additionally, four of the files did not contain a full employment history. This meant that the provider could not be sure staff were suitable to work with vulnerable people.

Staff we spoke with were knowledgeable about adult safeguarding and how they would report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the staff office. We found that appropriate safeguarding referrals had been made. Staff also had a good understanding of the provider's whistleblowing policy and told us they would not hesitate to use it if they were concerned.

People we spoke with and their relatives told us that they felt Thornton Hall and Lodge was able to help them stay safe. Comments included, "I have a phone so I can call my family at any time and I have a buzzer if I need help. The corridors are safe too as there are handrails to help me walk along", "I have no worries and I feel safe" and a relative told us,"[Family member] is very safe here. The doors are locked and no one can just come in off the street. There are also code buttons to get in and out which stops the residents from walking out to danger, plus the staff are all so supportive and helpful."

Requires Improvement

Is the service effective?

Our findings

During the last inspection in March 2017, we identified breaches of regulation in relation to how consent was sought and the 'effective' domain was rated as 'requires improvement'. This inspection checked to see if the provider had made improvements and were meeting the fundamental standards of care.

In March 2017 we found that consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA). During this inspection we looked to see if the service was working within the legal framework of the MCA. This 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We reviewed a number of care files that included decision specific mental capacity assessments and where people had been assessed as lacking capacity to make a decision, best interest decisions had been made involving relevant people. We found however, that this practice was inconsistent and consent was not always sought in line with the principle of the MCA.

Staff told us that two people living in the home received their medicines covertly (hidden in food or drink). Information was evident from a pharmacist on how to administer most of these medicines safely and this had been signed by the GP. We found however, that there were no mental capacity assessments available to indicate whether or not these people lacked the capacity to make decisions regarding their medicines, or that covert medication was in their best interest. This is not in line with the principles of the MCA which states people must be assumed to have capacity until an assessment indicates otherwise.

Another person's file contained a range of capacity assessments which indicated the person lacked capacity to make decisions in areas such as personal hygiene, dietary needs and third party decisions. Best interest decisions had been made, but there was no evidence that relevant people had been involved in these decisions, such as the person's next of kin. One of the capacity assessments had recorded the decision as the need for staff to act in the person's best interest. This indicated that the person's ability to make the decision had been made prior to the assessment being completed.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they always asked people for their consent before providing care and people we spoke with agreed. One person told us, "They [staff] are very polite and always explain what they are doing. They always ask if I am alright and happy to have something done."

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 and hospitals are

called the Deprivation of Liberty Safeguards (DoLS).

Records showed that nine authorisations to deprive people of their liberty were in place and a further 36 applications had been made. A document was in place which recorded when applications were made, the date they were authorised, when they were due to expire, any conditions involved in the authorisation and whether CQC had been informed of the authorisation. This helped to ensure that DoLS applications were managed appropriately.

We looked at systems in place to support staff in their roles. New staff completed an induction that was in line with the requirements of the care certificate, which is an identified set of standards that health and social care workers work towards and have their practice assessed and signed off by a senior member of staff.

Staff we spoke with also told us that they had access to a range of training courses and felt that these were sufficient to provide them with the knowledge required to meet people's needs. We looked at the training matrix and saw that courses were provided in areas such as dementia, health and safety, mental capacity and DoLS, infection control, moving and handling, safeguarding and fire safety. People living in the home told us they felt staff were well trained. One person said, "'They [staff] are very good. They know how to look after me." However, due to staff shortages, a number of agency staff were covering shifts each day. Some people did tell us that they did not feel all agency staff had the same understanding of how to care for people living with dementia.

Staff told us that due to the absence of a stable management team during the previous months, they worked together and supported each other, so always had someone to turn to if they had concerns. A schedule had been implemented to help ensure staff received regular supervisions and appraisals, although not all staff had received an appraisal. The management team were aware of this and staff had appraisals scheduled in.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, physiotherapist, occupational therapist, pharmacist, dietician and speech and language therapists. For instance, one person had begun struggling to swallow some foods and coughed when they ate, so staff had made a referral to the speech and language therapist for further advice and assessment. When a person's mobility had deteriorated, we saw that a referral had been made to the physiotherapist for advice.

People living in the home told us, "I have had a few falls. The staff are good; they got me to hospital and they called my family straight away", "They [staff] called a doctor to look at my [injury] and he arrived very quickly" and "They [staff] are very good. I wasn't well and they called a doctor straight away. I had to go to hospital and the ambulance came very quickly." Relatives also told us that healthcare professionals were contacted in a timely way when needed. One relative told us, "[Relative] sees the doctor, chiropodist, district nurse and optician" and another relative said, "The staff keep a close eye on [relative] and if they feel [relative] needs to see someone they will call someone in straight away."

We looked at how people's dietary needs were met within the home. All files we viewed contained a risk assessment in relation people's risk of malnutrition. We saw that when there were concerns with people's intake, referrals were made to the dietician and speech and language therapist as required. Care plans also contained information regarding any specialist dietary needs. For instance, one person's file indicated that they were diabetic and required a reduced sugar diet and another person required their drinks to be

thickened due to a swallowing difficulty. We found that this was reflected in their care plan and staff we spoke with were aware what consistency the person's drinks needed to be.

People living in the home told us they liked the food available to them and they had a choice of meals. One person told us, "The food is very good. You have a choice for each meal. If I don't like it they will always give me something else. I have never been hungry here and we can have seconds if we want."

We viewed menus displayed on the wall outside dining rooms, which evidenced choices were always available. There were however no menus available on the tables and one person told us that although staff offered them choices, they would like to sit and look at a menu and make their mind up slowly. During lunch in one of the units, we heard staff informing people of the options available for lunch and one staff member held plates with both options in front of a person to help them make a decision as they were having difficulty understanding the choices. In one unit a menu board was on display in the dining room and this would assist people to make choices who may have difficulty reading a menu. However, a staff member told us it was no longer in use as they did not have the pictures which corresponded to the meals currently on the menu. We discussed this with the improvement manager who told us these pictures should be available and would ensure staff were aware of this so that the boards were utilised.

We also saw that some people were provided with a meal that was not one of the choices on the menu that day and staff told us this was because they knew that some people did not like either of the choices available, so alternatives were provided.

Most relatives we spoke with told us they were satisfied with the meals and assistance available to their family members with regards to their dietary needs. One relative told us, "[Name] likes the food and eats more here than [they] did at home" and another relative said, "The food is good. [Name] gets plenty to eat; we don't have to bring anything extra in. If the staff think [Name] hasn't eaten enough they will coax them to eat more or have something else."

Staff showed us specialist equipment they had available to assist people to maintain their independence when eating and drinking. These included cups with lids on to prevent spillage, deep bowls for cereal and specially designed plates with a wide rim on one side so it could be held. We saw that lunch time was a very busy time of the day, but staff offered support to people as much as possible during these times.

We observed the environment of the home and found that the provider had taken steps within the units for people living with dementia, to assist people with orientation and safety. For instance, there were pictorial signs to indicate where specific rooms where, such as bathrooms. Bedroom doors were painted different colours and contained a photograph of the person, their name and a room number, to help people identify their room. Corridors were wide and well-lit and contained some pictures from past times and objects that could stimulate interest and conversation, such as old telephones and records. However, some areas required further work due to ripped wallpaper and scratched paint work. One relative told us, "I am not happy with the standard of decoration in this dementia unit. The walls are dirty and dark. They should be painted a bright colour like in [the residential side], it seems much nicer over there" and another relative said, "I feel the management should do something about the decoration on the corridors it is very poor." We saw that in the units known as Thornton Hall, corridors were painted a neutral colour with contrasting hand rails and the environment appeared bright and clean.

Requires Improvement

Is the service caring?

Our findings

People living at the home spoke highly of the staff and told us staff were kind and caring and treated them with respect. One person told us, "[Staff] are lovely and they are very kind. I cannot fault them. They will do anything for you" and another person said, "[Staff] are lovely. They are very helpful, I like them all."

Most relatives we spoke with agreed that staff were caring and their comments included, "The staff are very approachable. If I ring up they will inform me about [relative]. They are very honest and tell me exactly what is happening. The way they talk to [Name] is perfect they have the right manner", "[Staff] are approachable and they speak to [Name] very nicely", "The staff are lovely and are very nice with [Name]. Staff deal with her in an excellent way." One relative however, told us they had mixed views and said, "I have observed some staff being abrupt with people in this dementia unit, although some staff are excellent and have just the right temperament to cope with the difficult demands of people."

Although feedback regarding the approach of staff was positive, the provider had failed to address issues within the service which had been raised at previous inspections and which continued to pose risk to people living in the home. These risks include those related to medicine management, completion of risk assessments, appropriate care planning, seeking consent and maintaining effective oversight of the service. This does not evidence that the provider demonstrates a caring approach.

During the inspection we observed people's dignity and privacy being respected by staff in a number of ways, such as staff knocking on people's door before entering their rooms and referring to people by their preferred name. Personal care activities were carried out in private and if people were presenting with behaviours that could compromise their dignity, staff quickly supported them out of communal areas to somewhere more private.

People told us they felt their privacy and dignity was maintained by staff and comments included, "I never feel embarrassed when [staff]shower me as they are careful to make sure you are mostly covered up when they are there", "If I am in my room and the door is shut, [staff] always knock before they come in. They know I like to sit quietly in my bedroom and they will leave me there when I want" and "[Staff] respect my privacy and leave me in my room alone at times."

We also saw that care files were stored securely in order to maintain people's confidentiality. This meant that only people who needed to know this private information about people's care, had access to it.

People also told us that they were encouraged to maintain their independence. One person told us, "[Staff] leave us to be as independent as possible. They will only help if I really need support" and another person said, "I dress myself and feed myself, but if I am ill, staff will help me."

Interactions between staff and people living in the home were warm and friendly. We observed staff supporting one person to transfer using a hoist. Staff explained each step to the person and offered reassurance throughout the transfer.

We also found that most staff knew the people they were caring for well, including their needs and preferences. For instance, staff we spoke with regarding a person's specific dietary requirements, were all knowledgeable about what foods and drinks were safe for the person to have. We also saw that staff adapted their approach when providing support to people as they knew what worked best for each person.

We found that people's family had been involved in the creation of care plans and relatives told us they were always kept updated of any changes in their family members care. One relative told us, "I was involved in the plan right from the start by giving the home details about [relatives] life" and another relative said, "'When [relative] first came here I was involved in her care plan." Relatives all agreed that they could access the care plan whenever they wanted.

We looked to see if the service supported people's cultural and religious needs. Staff told us there was nobody living in the home at the time of the inspection that had any specific cultural needs, but they did support people to continue to practice their religious beliefs. For instance, the home had a room which had been converted to look like a chapel. Records showed that clergy from local churches visited the home regularly and one person told us, "Staff do respect my values. I am catholic and a priest comes every week to give me communion." Another person told us, "A vicar comes to see me often."

We observed relatives visiting people throughout both days of the inspection. The manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us their family members could visit at any time and relatives told us they were able to visit in private if they wanted to. One relative told us, "I can talk to [Name] in her room or go to a quiet lounge. I can take her anywhere there are no restrictions." We also saw that staff encouraged people who had a relationship prior to moving into the home, to maintain this relationship. For example, staff assisted one person to move to another part of the home so that they could spend time with a family member who also lived in the home.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access. Staff told us they would support people to access these services if required. None of the people we spoke with were receiving support from an advocate at the time of the inspection.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in March 2017, we found a breach of regulation with regards to care planning and the responsive domain was rated as 'requires improvement.' This was because care plans did not always provide sufficient detail regarding people's care needs and were not always updated when people's needs changed.

During this inspection we looked to see if improvements had been made. Some care plans we viewed provided detailed information regarding people's care needs and how staff should support them. For instance, one person's file included a care plan on a specific health condition the person had. It explained what the condition was; signs and symptoms staff could look out for which may suggest the person required medical review and how staff could support the person with this condition on a day to day basis. The care plan was detailed and informative.

We found however, that not all care plans provided appropriate information to enable staff to support people effectively and were not always updated as people's needs changed. For example, one person's care file indicated that their mobility had deteriorated recently and that they required support from two or three staff to mobilise. However, their mobility care plan indicted that they were able to mobilise short distances independently with the use of a walking aid. The plan had not been updated since the change in the person's need. This meant that staff may not have sufficient information to enable them to support the person safely and effectively.

We also found that information within care plans was not consistent in relation to people's needs. For instance, one person's personal evacuation plan stated they fully understood the fire procedure; however their personal safety assessment indicated that they did not understand the fire procedures. This meant it would be difficult for staff to ensure they provided appropriate support in the event of an emergency as it was not clear what the person's needs were.

Care plans we viewed showed that planned care was not always evidenced as provided. For instance, one person's care file reflected that they required staff to support them to reposition every two hours. Staff we spoke with told us this support was provided, but there were no records to evidence this care. A staff member told us records of repositioning support were only maintained when district nurses were involved in people's care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at processes in place to gather feedback from people and listen to their views. Records showed that meetings took place with people living in the home and their relatives and included topics such as laundry, meals, staffing and activities. We found however, that relatives did not feel that action was always taken based on their feedback. For example, one person told us, "I brought up the issue of there being no seating in the garden outside and the lack of activities, but nothing has been done" and another relative

said, "I have completed surveys that are sent out just before a meeting. I have attended meetings too. Nothing is ever done."

The service has a system in place to enable them to gather feedback from people on a different subject area each month, through the use of questionnaires. We found however that these questionnaires had not been issued for some time. The last surveys issued were to professionals who visited the service and they were issued in June 2017. There was no evidence when surveys had last been issued to people living in the home or their relatives.

We recommend that the provider reviews and updates its practices accordingly, to ensure systems to gather feedback from people are effective.

Although people living in the home did not recall being involved in regular reviews of their care plans, most relatives we spoke with told us they were aware of regular reviews and were kept informed of any changes. One relative told us, "Every so often they show me [relatives] care plan. It doesn't change much and I am happy with it" and another relative said, "I can access the care plan any time I wish. My [family member] and I attend reviews; we get a letter to invite us."

The care files we viewed contained a pre admission assessment; this ensured the service was aware of people's needs and helped to ensure that they could be met by staff from the day the person arrived at the home.

Most staff we spoke with during the inspection demonstrated a good knowledge of people's individual choices and preferences in relation to their care and support. However, due to staff shortages a number of staff from agencies were used and not all of these staff knew the people they were supporting well. One such worker told us that although the staff in the unit were very supportive, they had not received a handover about the people they were caring for that day and had never supported them before.

Care files we viewed included information on people's preferences. This included what time people liked to get up and go to bed, their preferred meals and any particular dislikes in relation to food and drinks, activities they liked to take part in and how they liked their room at night time, such as whether they liked a light left on overnight. People living in the home told us they thought staff knew them well. One person told us, "Staff know I don't like butter on my toast so they never give it to me. They also know I like a little glass of wine every night. They bring it to me in my room" and another person said, "[Staff] sit and chat with me about my daughters because they live a long way from here" and a third person told us, "[Staff] never give me food which they know I don't like. They know I like fruit so they give me that. They know I like to wear my jewellery so they help me put it on each morning." This helped to enable staff to get to know people and provide support based on their preferences.

We asked people to tell us about the social aspects of the home and the feedback was mixed. One person told us, "Sometimes we have quiz and it is a good one" and another person said, "There are a few activities sometimes." However, a third person living in the home told us, "I don't really do the activities, there are not many" and a relative we spoke with said, "We are very disappointed with the lack of activities provided over the last year." Another relative told us, "I think they should also encourage the use of more music being played, they only seem to have the TV on all day. They should also provide more activities for the residents to do and the garden needs seating."

An activity coordinator was employed in the home and we saw an activity schedule on display. This included films, a quiz, table top games and arts and crafts. The schedule did not advertise activities every day. During

the inspection we observed a band that came to the home to entertain people. We saw that people living in other areas of the home were supported to the lounge to participate. People enjoyed the music, were dancing with staff and others joining in through the use of tambourines and maracas.

One person's social interest care plan reflected that they liked to sit out in the garden as they had been a keen gardener in the past. We found however, that there were no seats available in the garden for the part of the home in which the person resided. This meant that this person's preferred activities could not be met. We raised this with the manager and since the inspection, have been informed that garden seating is due to be purchased.

People had access to a complaints procedure within the home. People living in the home that we spoke with told us they had not had to make a complaint, but would inform staff if they had an issue. Not all relatives we spoke with knew who to raise their concerns to. One relative told us, "I have never made a complaint, but if I had to I would go to the manger, but I'm not sure who that is at the moment." Some relatives we spoke with told us they had made a complaint and had received a full response.

A full record was maintained of all complaints received and included information regarding the actions taken to investigate the concerns and feedback provided to the complainant. There had been 16 complaints received since the last inspection and included themes such as staffing, falls and cleanliness of the home. Records showed that all these complaints had been fully investigated and responded to.

Inadequate

Is the service well-led?

Our findings

At the last inspection in March 2017, we identified a breach in regulation regarding how the service was managed and the well-led domain was rated as 'requires improvement.' This was because actions identified during the audit process were not always addressed, records from staff meetings were not always accurate and the provider had failed to make sufficient improvements to mitigate previously identified risks.

During this inspection we looked to see if improvements had been made, however we found there were still concerns regarding the management of the service.

We looked at how the manager and provider ensured the quality and safety of the service provided. Records showed that audits were completed in areas such as medicines, care planning, safeguarding, infection control and clinical data. We found that completed audits did not identify all of the concerns highlighted during the inspection, such as those relating to consent, the environment, medicines, risk management, staffing and lack of effective systems to gather people's feedback.

When audits did identify areas that required improvement, it was not always clear whether actions had been addressed. For example, one care plan audit identified two actions that needed to be addressed; they were included on an action plan at the end of the audit but had not been signed off as completed. We reviewed the care plan to see if the improvements had been made, but they had not.

A system of review known as 'resident of the day' was in place and this included a full audit of one person's care file each day. We found however that few reviews had been completed recently and were informed this was due to one of the relief managers not adopting the system. The new manager told us they would ensure this review process was reintroduced straight away and we saw that one had been completed by the end of the inspection.

The provider had notified us of a large number of medicine errors since the last inspection and had implemented daily stock balance checks to enable any errors to be quickly identified and managed. A member of the management team informed us that more comprehensive medicine management audits should be completed monthly in line with the provider's policy. We found however, that they were not completed monthly and records showed that none were completed between July and October. This meant that concerns such as the inaccurate stock balance of controlled drugs and the high temperature of clinic rooms, were not identified or acted upon.

This showed that the audit systems in place were not effective.

Following the last inspection we issued the provider with warning notices due to the concerns that were identified. The warning notices explained the areas of concern in detail and informed the provider they had to make improvements in these areas to ensure they were meeting the fundamental standards of care within a set timescale. We found however, that sufficient improvements had not been made and the warning notices had not been met.

Many of the concerns identified during this inspection have been raised with the provider at previous inspections, such as those relating to the management of medicines, seeking and recording consent, risk management systems and staffing. This showed that the provider had failed to take appropriate action that would mitigate these risks and maintain improvements.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been frequent changes in the management team at Thornton Hall and Lodge over the previous two years and it was clear that this had had an impact on people when we asked them their views on how the home was managed. Comments included, "It is difficult to have a view about the management as there have been so many changes", "We have no idea who the manager is", "There has been no consistent management for some time" and "There has been a lot of changes with management. I don't know who the manager is now."

Staff we spoke with had also been affected due to the lack of a stable management team. Comments from staff included, "It's all been a bit disorganised because of the constant change of management and structure", "There have been lots of different ways and procedures. Staff don't know if they are coming or going", "The main issues in the home are organisation and lack of a stable work-force", "Recently staff have been relying on senior staff for support when really a stable management system should be taking matters on" and "There has been an exodus of staff because of poor management."

Staff from the local safeguarding team told us that despite regular requests and reminders, the service have not provided responses to requests for information in a timely way and this had likely been due to the frequent change of management.

A new manager had started in post on the first day of the inspection and had begun the process to register with the Commission. The provider had also installed an improvement team to try to ensure the home continued to by ran well in the absence of a registered manager. Despite staff talking to us about the recent lack of stable management, they also told us they had confidence that a new manager would improve things. One staff member told us, "I've seen a glimmer of hope in recent weeks as senior management seem to be getting to grips with the issues and a new manager has been appointed" and another staff member told us, "I am actually proud about the way staff have managed to keep up good standards of care despite poor management."

We asked people about the atmosphere within the home and one person told us, "It is very nice here, there are no problems" and another person said, "It has a very friendly atmosphere." A third person living in the home told us, "It is a very friendly relaxed place, where there is no nonsense." Staff we spoke with told us that they enjoyed being part of the team within the home. Although one staff member told us that morale had 'plummeted', we found that most staff were positive about the service and their comments included, "I have faith it will turn around", "The home is really nice" and "It's lovely when the staffing level is right and you can spend time chatting to people."

Records we looked at showed that staff meetings took place to enable feedback to be gathered from staff; however the records showed that not many staff had attended these meetings. Issues discussed included the lack of registered manager which led staff to feel uncertain as to who they should raise their concerns to and whether they would be dealt with effectively. At a meeting held in August 2017, concerns had been raised regarding the handover process as staff did not feel they received sufficient information regarding people's needs. During this inspection staff told us that the handover process had changed and one staff

member said, "It used to be good, but they are not lately." This showed that the issued raised in August had not been effectively addressed.

The provider had notified the Care Quality Commission (CQC) of events and incidents that had occurred in the home in accordance with our statutory requirements. We also saw that the rating from the last inspection was clearly displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.