Barchester Healthcare Homes Limited

St Thomas

Inspection report

St Thomas Close
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 22 and 23 June 2015 and was unannounced. St Thomas provides residential and nursing care for up to 72 older people, including people living with dementia. At the time of our inspection 53 people were living in the home.

The home consisted of four units situated on two floors built round an internal courtyard. Two lifts and stairs provided access to all floors. At the time of our inspection one lift was out of action, but people were able to access both floors using the second lift. People were protected from harm by the use of keypads on exit doors between floors and units. The reception area was manned by a receptionist during office hours, and a walkie talkie was provided for visitors to contact staff when the reception was unmanned.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Summary of findings

The registered manager had left the service in January 2015. Appropriate actions had been implemented to ensure the home was well managed. The provider had deployed an experienced registered manager from another of their homes to manage St Thomas as an interim measure. They are referred to as the temporary manager in this report. A dedicated manager for this home had been in post for three weeks at the time of our inspection. They had started the process to apply for the registered manager role with the CQC. They are referred to as the new manager in this report.

At the last inspection on 22 and 26 September 2014 we asked the provider to take action to make improvements to ensure that effective measures were in place to address concerns we identified. We found concerns with regards to the management of identified risks to people's health and welfare, and cleanliness and hygiene in the home. Sufficient staff had not been employed to support people's needs at all times, and staff had not been appropriately supported through training and supervision to provide people with effective care. At this inspection we found the improvements required had been made.

The provider had taken steps to ensure risks specific to each person had been identified, and actions taken to reduce the risk of harm. The home was clean, and people and others were protected from the risks of cross contamination and health care-associated infection because staff maintained safe hygiene standards.

Staffing levels were sufficient to meet people's identified needs. Staff had the skills and understanding to meet people's identified needs effectively. Although staff training had not met the provider's identified requirement for 85% completion rate, actions were in place to ensure this target would be met by the end of June 2015. Measures were in place to ensure people's safety was not affected whilst training was refreshed.

Staff had not had the opportunity to attend regular formal reviews of their roles and responsibilities. The new manager had started a programme of supervisory and appraisal meetings. To ensure staff were supported whilst awaiting formal individual meetings, the provider had created opportunities for staff to raise concerns or discuss their development through regular team meetings and the management's open door policy. Staff told us they felt supported by team leaders and managers.

On the first day of our inspection we found recruitment checks had not been sufficiently robust to protect people from unsuitable staff. When we raised concerns regarding employment gaps and evidence of good conduct with the new manager, they took immediate action to address the shortfalls, and ensure people were not placed at risk of harm.

Appropriate measures were in place to ensure people were not at risk of abuse. Staff understood and followed the process to identify and report safeguarding concerns.

Medicines were stored and administered safely. Nurses followed safe protocols to ensure they identified any risks associated with medicines. Checks ensured medicines were stored safely and accounted for.

Risks affecting people's health and the home's environment had been identified, and appropriate measures taken to ensure people, staff and others were not placed at risk of harm. Regular checks and services ensured equipment and fittings remained safe. Staff were trained on the actions to take in the event of an emergency such as fire.

Staff understood and supported people to make decisions about their health and wellbeing. They understood the process of mental capacity assessment and best interest decision-making if the person was assessed as lacking capacity to make specific decisions. Where people's liberty was judged to be restricted, the temporary manager had followed the requirements of the Deprivation of Liberty Safeguards to lawfully restrict people's freedom for their own protection.

People were encouraged to eat and drink sufficiently to meet their nutritional needs. Dietary preferences and needs were understood and met. People at risk of malnutrition and dehydration were supported to maintain their nutritional health. Training was being delivered to ensure all staff understood the importance of maintaining accurate records of people's daily intake.

People were supported to maintain their good health through effective liaison with health professionals, such as the GP and dietician. Documentation was cross referenced to ensure staff were aware of and followed health professionals' guidance.

People were supported to develop and maintain friendships in the home. Staff treated people with respect

Summary of findings

and kindness. They involved people in decision making and conversations, and promoted their dignity and privacy. The provider's values, including recognition of people's individuality, and promoting independence, respect and dignity, were displayed in the way staff interacted with and supported people.

People's needs and wishes were documented and reviewed regularly. Staff understood how to communicate effectively with people. They understood gestures and vocalisations used by people unable to verbally explain their care needs. Activities were planned but flexible to encourage people's participation. The local community was welcomed into the home, and a minibus provided opportunities for people to travel outside.

Relatives said staff were responsive to concerns raised, and kept them informed of changes to people's needs, and changes in the home. Events such as meetings and social gatherings provided relatives with the opportunity to raise and discuss concerns. Complaints were addressed in accordance with the provider's policy.

Staff described managers as approachable, and were confident that the new manager would continue to drive improvements in the home. Staff felt valued, and spoke with pride of their achievements. They had opportunities to suggest improvements, and were involved in the evaluation of new practices.

The temporary and new managers led by example, using their experience and knowledge in dementia care to guide and inform staff. This ensured people experienced care that met their diverse and individual needs. Audits carried out by the managers and regional quality team had identified areas for improvement. An action plan held managers accountable for progress and completion. Learning was shared to drive improvements across the provider's portfolio of homes.

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?

Requires improvement

The service was not always safe.

The provider had taken immediate actions to protect people from the risk of care from unsuitable staff when it was found recruitment procedures had not been sufficiently robust.

Sufficient staff were available to meet people's identified care needs. People were protected from the risks of abuse, as staff understood how to identify, report and record abuse.

Cleaning protocols and spot checks ensured people and others were protected from the risks of infection.

People were protected against risks associated with medicines and the environment through appropriate checks and records. Health-associated risks had been managed to ensure people were not at risk of harm.

Is the service effective?

Requires improvement

The service was not always effective.

Staff training had not met the provider's requirement, but had been prioritised to be completed or refreshed by the end of June 2015. Staff rosters were managed to ensure people were not placed at risk of harm from unskilled staff.

Regular individual supervisory meetings had not been held regularly, but appraisals were planned to ensure all staff received formal discussion opportunities during 2015. Staff were able to raise concerns through the manager's 'open door' policy.

People's dietary needs and preferences were met to ensure they were not at risk of poor nutritional health.

Staff understood and implemented the principles of the Mental Capacity Act 2005.

People were supported by health professionals to ensure their health needs were effectively met.

Is the service caring?

Good

The service was caring.

Staff established and maintained caring relationships with people. People were treated with respect, and their interests and abilities were encouraged and valued.

People's dignity and privacy were respected, as staff took actions to ensure they did not compromise people's dignity.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed. Changes had been identified, and appropriate care planned to ensure people received the care they required and wanted.

People and their representatives were able to raise concerns, and the provider listened to people's comments. Improvements were actioned by the provider in response to their comments.

Is the service well-led?

Good

The service was well-led.

Changes to the culture in the home ensured the atmosphere was welcoming and comfortable. Staff were given opportunities and responsibilities to drive improvements to the quality of people's care.

The managers led by example, identified areas of improvement and supported learning to ensure people received the care they needed.

Systems were in place to audit and review the quality of care people experienced. Where issues had been identified, actions had been implemented to drive the improvements required.

Records were held securely and maintained accurately. Only those authorised to do so had access to them.

St Thomas

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22 and 23 June 2015 and was unannounced. The inspection team consisted of two inspectors, and an expert by experience with knowledge of people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the provider is required to tell us about by law. We reviewed information shared with the Care Quality Commission (CQC) by commissioners of care and health professionals, and the local authority's safeguarding team. We had not requested a Provider Information Review (PIR) for this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We obtained this information during the inspection.

During our inspection we spoke with four people and seven relatives of people living in the home. Some people living with dementia were unable to tell us about their experience of the care they received. We observed the care and support these and other people received throughout our inspection to inform our views of the home. We spoke with a range of staff, including housekeeping, catering, administration and activities staff, as well as four care workers and two registered nurses. We also spoke with the regional director, the temporary manager and the new manager.

We reviewed six people's care plans, including their daily care records, and charts documenting six people's specific care and support received, such as maintaining hydration and re-positioning. We also reviewed 25 medicines administration records (MAR). We looked at eight staff files, including induction, recruitment, training and supervision documentation. We looked at the working staff roster for four weeks from 25 May to 21 June 2015. We reviewed policies, procedures and records relating to the management of the service. We considered how people's and staff's comments and quality assurance audits were used to drive improvements in the service.

We considered whether actions implemented by the provider in response to breaches identified at an inspection conducted in September 2014 meant that the requirements of the regulations had been met.

Requires improvement

Is the service safe?

Our findings

The provider's recruitment protocol reflected the regulatory requirements with regards to staff recruitment, in order to ensure people were protected from the risks of care from unsuitable staff. However, we did not see this demonstrated in robust checks completed in all the recruitment files we viewed. Files did not always document that gaps in applicants' employment history had been identified or explained. Not all previous employment placements in health and social care services had been explored to ensure the applicant was of good character.

We identified these concerns on the first day of our inspection. On the second day of inspection administration and managerial staff had reviewed the recruitment files for all staff currently employed at St Thomas. They had had asked staff for explanations of all employment gaps they had identified . They were able to show us the responses received, demonstrating that these gaps in employment had been suitably accounted for. Letters had been sent to all previous employers of staff in health and social care positions requesting evidence of good conduct. The provider had ensured a prompt response to the issues identified during our inspection, to ensure that the requirements of the regulation would be met.

Other recruitment checks, such as proof of applicants' identity, investigation of any criminal record and registration with professional bodies, such as the Nursing and Midwifery Council, had been satisfactorily investigated and documented. This ensured that people were supported by staff of suitable character. Managers understood the regulatory requirements for recruitment of suitable staff, and revised their check lists to ensure this would be fully documented.

The provider had taken actions to address the concerns identified at our previous inspection in September 2014 regarding cleanliness in the home, and ensured sufficient staff were available to support people's needs at all times. A new staff allocation system had been implemented to provide a more flexible approach to staff support for people. At the time of our inspection, there had not been sufficient time for us to judge whether this system had been effectively sustained to meet people's needs throughout the day.

People and their relatives told us the home was clean. There were no offensive aromas, and seating was clean and comfortable. The clinical waste bins were kept locked. We observed there was sufficient protective clothing, such as gloves and aprons, available for staff use, and staff used this appropriately. Housekeeping staff told us equipment purchased since our last inspection enabled them to clean the home more effectively. They stated "Now we can keep on top of it [cleaning]". These measures helped protect people, staff and others from the risk of infection.

A cleaning schedule ensured all areas of the home were cleaned regularly, including deep steam cleaning. The head of housekeeping conducted spot checks to ensure cleaning met the required standard, and reviewed schedules to ensure all areas of the home were cleaned regularly. Unplanned staff absences had on occasion meant that housekeeping tasks had been affected. Cleaning tasks had been prioritised to ensure areas of higher risk, such as bathrooms, were not affected due to short staffing. Additional staff were sourced through agencies or using staff from a nearby home managed by the provider, as necessary. Housekeeping staff told us "It's a good team. We go all out to do our best every day, and help each other out".

People and relatives told us there were sufficient staff available. One relative said "They are all fine and helpful", and had the skills required to care for their loved one. Some staff felt there were not sufficient staff, which sometimes meant a delay "Of a few minutes" responding to people's call bells. We did not note delays to call bell responses during our inspection, and people and their relatives did not raise this as a concern with us. Other staff felt staffing was sufficient, but was not always managed flexibly enough to met people's needs at the busiest times of the day, for example to help people up in the morning.

The new manager explained a new staff allocation plan that was being trialled from 22 June 2015. This would ensure more staff were available to help people during busy periods, including support with their morning routines. At the time of our inspection it was too soon to evaluate whether this would be a more effective deployment of staff to meet people's needs. The nursing staff confirmed that an additional nurse was scheduled to work when the GP visited, and we saw this reflected in the rotas. This ensured that sufficient nurses were available to meet people's needs.

Requires improvement

Is the service safe?

The reliance on agency staff had reduced since our last inspection. Recruitment for care and nursing staff had been partially successful, and was ongoing. Although there were sufficient staff to meet people's needs, nurses told us they regularly worked additional planned hours due to a lack of directly employed nursing staff to cover all shifts. One nurse explained "Extra nurses will help us to keep on top of the paperwork".

The rosters had been planned by the new manager in conjunction with the nursing team. They considered feedback from staff and reviewed people's changing needs to ensure sufficient staff were available, and staff skills were balanced to meet people's varied needs. The new manager told us recent changes to staff allocation would be evaluated, and further roster changes implemented if necessary.

The staff roster demonstrated that staffing levels had not always met the provider's identified requirement for care worker hours. This was due to short notice unplanned absence. Agency staff had been requested, but were not always available. Experienced staff directly employed by the home were deployed to support people with the highest and most demanding needs. This ensured that people requiring one to one support received this from staff who understood how best to support them. This had not been affected by staff shortages. There were sufficient staff to monitor communal areas throughout the day. Short staffing had been managed to reduce the impact on people through flexible working across units and a review of staff allocation during the day. This meant that people's safety had not been compromised.

One person told us "I feel safe here", and no people or visitors raised concerns about their safety. Staff we spoke with understood indicators of abuse, and the actions they should take if they had concerns. They were confident that management would deal with safeguarding issues appropriately, but were aware of the provider's whistle blowing policy should their concerns not be resolved. The provider's safeguarding policy was available for staff reference, and the whistle blowing helpline number displayed in the staff office. Staff had completed and refreshed safeguarding training. The managers had submitted safeguarding notifications appropriately to agencies such as the local authority safeguarding team and CQC. These measures ensured people were protected from the risks of abuse.

People were supported to take their medicines safely. For example, we observed one person helped to sit upright to ensure they were not at risk of choking whilst swallowing their medicine. Nurses checked people's medicine administration records (MARs) to ensure people received their prescribed medicine at the correct time. Medicines taken, refused or wasted were documented on the MAR. This meant that an accurate record was kept of the medicines each person took. Nurses were aware of people's allergies. Known risks, such as swallowing difficulties, were safely managed through the administration of medicines in chewable or liquid form. People were protected from potential and known harm because staff took appropriate safety measures when administering people's medicines.

People's medicines were stored and administered safely. Protocols ensured people received their medicines at the correct time. Medicines were stored in locked cabinets, and medicines trolleys were kept locked when unattended in the home. Nurses followed the provider's and NHS guidance to ensure medicines were handled safely. Weekly stock checks ensured the correct amount of medicines were stored, and all medicines were accounted for. The GP carried out documented medicines reviews. Homely remedies and as required (PRN) medicines were agreed with the GP and documented in people's care plans. A protocol for the use of PRN medicines was available for staff reference. This ensured people received medicines appropriate to their changing needs, for example in response to pain. The pharmacy provided training in medicines administration for new nurses. This ensured people received their prescribed medicines safely.

Risks to people's health and wellbeing were identified through monthly reviews of their care needs. People's care was planned to ensure people would received appropriate support to meet their needs and manage identified risks. People were weighed monthly, or more often if their weight was a cause for concern. Records demonstrated that changes had been identified, and actions implemented to review people's health and promote weight gain or loss as necessary. Other risks to people's health and wellbeing, such as falls, were assessed, and appropriate actions put into place to reduce identified risks. People's care plans included assessments for known risks, such as falls, skin integrity and behaviours that may challenge staff or others. Actions to reduce the risk of harm had been implemented, such as the provision of mobility aids, pressure relieving

Requires improvement

Is the service safe?

equipment, and appropriate response to known triggers to manage people's anxieties. Staff guidance within risk assessments and care plans ensured staff understood the actions required to manage and reduce the risk of harm to people and others. Care plans and risk assessments were reviewed monthly, or after an incident, and updated accordingly. Records demonstrated that actions had been effective, for example in ensuring people did not develop pressure ulcers. This demonstrated that care given to people by staff was responsive to their changing needs. Care plans were cross referenced to risk assessments relating to the risks identified, and where appropriate included staff guidance. This ensured staff were aware of safe procedures to reduce risks to people's health and wellbeing.

The home was well maintained. People were protected from risks in the environment through a programme of checks and services. For example, fire risks had been assessed. Alarms and door closers were checked weekly, and fire extinguishers were serviced annually. Staff completed fire safety training and attended regular drills to ensure they understood how to support people safely in the event of a fire. The maintenance person explained how they used practical quizzes to ensure staff were able to identify fire risks and take appropriate actions.

In addition to internal checks, annual servicing by contractors ensured the home was protected from the risks of unsafe electrical and gas fittings, and water tests demonstrated that appropriate measures had been taken to ensure the home was free from the risk of legionella disease. This is a water-borne infectious disease.

People, staff and visitors had access to the maintenance request book, held at reception. This meant that the maintenance person was alerted to any issues promptly. The maintenance person conducted a daily walk round the home to identify any maintenance issues, and prioritised work to address these within 48 hours of being alerted. People and others were protected from risks caused by an unsafe environment.

Requires improvement

Is the service effective?

Our findings

The provider had taken actions to address the concerns identified at our previous inspection in September 2014 regarding staff training and support. Relatives told us they felt staff had the skills required to support their loved ones effectively. A care worker of long standing told us "It's got better here". Staff said training was updated regularly, and managers were open to requests for further training. Staff were supported to gain further qualifications relevant to their role, and this was related to pay awards. Staff were confident they had the training and skills required to meet people's health needs and improve their wellbeing effectively.

The provider's training log showed that staff had not all completed training identified as required in accordance with the provider's training policy. The provider required a training completion rate of 85%, allowing slippage for planned absences. Although some topics, such as fire training and infection control, met or surpassed this level, other topics were noted with completion rates below 85%. For example, safeguarding training completion was noted at 72%, and moving and handling training was 78%.

The provider had identified that additional training was required, and had set a completion date of the end of June 2015 for all required training to be brought up to date. Rosters had been managed to provide dedicated training time for staff, and the training manager attended the home weekly to support staff to complete their training. Planned rosters demonstrated that staff were not allowed to cover shifts if required training, such as safe mobilisation techniques, was not up to date. An annual programme of training was planned, and certificates and attendance logs showed that this had been effectively managed in 2015. These measures ensured that people were protected from risk of harm, as deployed staff had the skills to support them safely.

Although staff told us they felt supported, records did not demonstrate that they had been supported with regular opportunities for formal discussion or review of their role and responsibilities. Monthly team meetings provided a forum in which to discuss concerns and consider improvements required. The new manager had planned a programme of appraisals and supervisory meetings to support staff development, to be carried out by heads of department and senior staff. Initial meetings had been held in accordance with this planned programme. All the staff we spoke with felt managers were approachable, and manager's 'open door' policy enabled staff to discuss any issues without delay. This provided staff with opportunities to raise concerns and discuss their development.

New starters were supported through a planned induction programme. This ensured they completed required training and understood how to implement this effectively. Completion of a work book, practical assessment by an experienced mentor and regular reviews with senior staff ensured staff had the skills required to meet people's needs effectively. Staff described the induction as "Fun" and "Helpful", and told us they were not allowed to support people alone until they had been assessed as safe to do so.

People appeared to enjoy their meals. We observed mealtimes were informal and unrushed. People were able to choose whether to dine with others, at a table alone, or in their rooms. One person did not settle at lunchtime. Staff ensured they had finger foods available so that they could eat as they walked. People were encouraged to eat independently, but support was offered as required. Staff were aware of people requiring support, and offered this at the person's pace, quietly chatting with them whilst encouraging them to eat.

Staff were aware of special diet requirements, such as fortified, diabetic and pureed meals. They knew which people had been identified as at risk of malnutrition. The chef ensured pureed diets looked appetising, and was aware of people's food allergies. This was displayed in the kitchen and inside cupboard doors in kitchenettes to ensure people were not placed at risk of harm from foods that were unsafe for them.

Nurses had a good understanding of people at risk of malnutrition and dehydration. They used nationally recognised nutritional monitoring tools, such as the Malnutrition Universal Screening Tool (MUST), to identify people at risk. MUST is a screening tool to identify adults who are at risk from either malnourishment or being overweight. People's MUST had been calculated and reviewed regularly. Care workers documented regular offering of food and fluids for people identified at risk of poor nutrition. They recorded the amounts people had eaten and drunk, and noted when people had declined foods and fluids. Information about people at nutritional risk was shared at the daily meeting of staff department leads, which included the chef and nurses. However,

Is the service effective?

people's food and fluid charts did not document people's daily intake target, and people's daily intake was not always totalled. There was a risk that staff may be unaware if people had not eaten or drunk sufficiently to meet their nutritional needs.

The new manager had identified that charts had not always been completed satisfactorily. They had arranged for an NHS dietician to provide training for staff, and had changed protocols to ensure night nurses took on the responsibility for totalling and reviewing people's food and fluid charts daily. A weekly nutrition meeting, including nurses and the chef, ensured concerns were shared, and actions required to reduce known risks were implemented effectively, such as referral to health professionals for a dietary review. Care plans evidenced that referrals and investigations had been made promptly when people had been identified at risk. These actions meant that risks to people's nutritional health were managed effectively.

Staff understood the principles of the Mental Capacity Act (MCA) 2005. A nurse was able to explain in detail the processes to support people to understand and make decisions about their care. They had recently attended training around aspects of the MCA 2005, such as best interest decision-making and end of life care. They understood the actions and documentation required to meet legal requirements and to assess people's mental capacity if they were unsure of their understanding of the decision required. All staff were able to tell us how they implemented the MCA 2005. One care worker told us "I always assume they [people] have capacity", and another explained how they supported people with decision making and choice by providing options for meals and clothing. People's daily notes demonstrated that people's consent was requested, and documented when people declined care or medicines offered.

The temporary manager had promoted staff understanding of the MCA 2005 through practical training. Guidance for staff and visitors was displayed in staff offices and reception. Nurses were reviewing people's care plans to ensure consent to care was documented. They had ensured that records of mental capacity assessments and best interest decisions evidenced the legal process followed when a person had been assessed as lacking capacity to make a specific decision. The temporary manager had identified that where appropriate, care plans did not always document relatives or others holding legal power of attorney (LPA) to make decisions on a person's behalf with regards to health and welfare. They were in the process of reviewing and documenting people's LPAs. Minutes from a relatives meeting held in March 2015 demonstrated that the MCA 2005 and role of LPAs had been discussed, and copies of LPAs requested. These actions ensured that people were supported to consent to or decline care, and lawful actions had been followed where people lacked the mental capacity to make a specific decision about their care.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty where this is a necessity to promote their safety. The DoLS are part of the MCA 2005 and are designed to protect the interests of people living in a care home to ensure they receive the care they need in the least restrictive way. The registered manager understood and followed the process to review and apply for DoLS. Keypads were used on doors exiting between units, floors and the local community. This was to ensure people who were unable to identify risks were not at risk of harm due to unfamiliar or unsafe environments. Because this restricted people's access around the home, the temporary manager had applied for DoLS for all the people at St Thomas. They understood and followed the local authority's DoLS guidance.

People received effective health care, because staff liaised effectively with health professionals to address people's health issues. One relative explained how their loved one had been supported with GP and hospital visits, and another told us the temporary manager had "Asked us a lot of questions" when their loved one was discharged from hospital to the home's care. This had ensured that staff had sufficient knowledge and understanding of the person's health needs to support them effectively.

Nurses told us people's GPs were responsive when asked for guidance. Nurse rosters ensured a nurse was available to liaise with the GP during visits. This ensured that any actions or recommendations were directly instructed to responsible staff. Instructions of care from health professionals were documented in people's care plans, and cross referencing throughout the care plan demonstrated that instructions had been implemented effectively. For example, one person identified at risk of choking had been

Requires improvement

Is the service effective?

prescribed thickened foods and fluids by the GP during a visit. Their care plan had been updated to include a risk assessment for choking. Daily care notes evidenced that the person received thickened foods and fluids at meal times, and staff understood and followed guidance to support their posture to reduce the risk of choking when eating or drinking. People were supported to maintain good health through effective liaison with health professionals.

Good

Is the service caring?

Our findings

People told us staff were caring. Comments included staff "Look after you very well", and "Look after me nicely". Relatives told us their loved ones appeared content and happy in the staff's care. One relative said "Care here is first class. My mum couldn't be in a better home", and another told us "They are nice staff to talk to and all appear to be very kind and caring." We observed people appeared to be relaxed with staff, and to enjoy their company.

Staff spoke affectionately of the people they cared for. One care worker told us "I love my work. It's like looking after my mum or nan". Another said "I wouldn't treat the residents differently to how I treat my own family". Staff in all roles, including care, housekeeping and catering, knew people by name, and stopped with a smile to chat with them as they passed in corridors or lounges. Staff from all roles sat and chatted with people during meal times, and some staff ate with people at lunch time. Staff conversations were friendly, inclusive and respectful of people. When people were anxious or confused, staff took time to comfort and reassure them. Staff understood effective communication techniques with people unable to respond through speech. They maintained eye contact with people whilst speaking with them, and held people's hands gently to provide reassurance and comfort.

Some staff wore fancy dress, such as a halo, fairy wings and grassy skirts, over their uniforms. People sometimes requested these items from them, and staff shared them readily. One relative commented "They [staff] are trying to put some fun into things. It makes the residents smile".

People's birthdays were known by staff. They gathered in people's rooms to sing 'Happy Birthday' to them. Staff unable to attend people's rooms joined in singing on the home's walkie talkies. The chef baked a birthday cake for people, including a pureed cake for those requiring a pureed diet. This demonstrated that people's differences did not mean they were excluded from celebrations or events.

Staff knew who enjoyed group activities and people who preferred one to one interactions or did not wish to socialise. Staff ensured everyone had opportunities for individual attention. During our inspection we observed staff sat chatting with people, reading newspapers with them, playing games and doing puzzles together. People were encouraged to join in with household tasks, such as laying tables and folding laundry. Objects of reference from people's shared memories, such as prams, sewing machines and painting sets from an appropriate period of time, were available for people to handle and reminisce. Communal clothing and accessories, such as hats and handbags, were placed around the home. People picked these up and carried them around the home with purpose. People's preferred activities were known to staff, and staff requested people's support and praised their talents with tasks and activities. This meant people felt useful, involved and valued by staff.

People's friendships were nurtured in the home. People were supported to sit with people they had established friendships with. Although units were managed to meet people's needs as they progressed through their dementia journey, people were assisted to maintain friendships forged across units. Staff understood people's interests and characters, and encouraged interaction between like-minded people. We observed some people chatted and laughed together during our inspection, and appeared to enjoy the company of those they sat with.

One person told us they decided what time they wished to rise in the morning, and what they ate for breakfast. Staff knew which people preferred to lie in during the morning, and their preferences were respected. People were complimented on their choice of clothing during the day. People personalised their rooms with pictures and objects important to them, and memory boxes and pictures on the outside of each room helped people to orient themselves to their own room.

The chef assisted at lunchtimes, serving meals and drinks to people. They chatted with people to seek their feedback on the meals provided, to ensure they met people's preferences as well as their dietary needs. Plated lunch options were offered to people to ensure staff understood people's preferred choice. Staff listened to people's comments to ensure they provided the meal requested, and amounts were varied to meet people's preferences. One person asked for a smaller amount at lunchtime, and this was provided. The care worker checked that the amount offered was an appropriate size for them. People were supported to make decisions about their care.

Staff treated people respectfully. They ensured personal care was provided behind closed doors to promote

Good

Is the service caring?

people's privacy and dignity. When staff used walkie talkies, their language was respectful when requesting assistance to support people's personal needs. They attended to people's needs discreetly to promote the person's dignity.

Good

Is the service responsive?

Our findings

The provider had taken actions to address the concerns identified at our previous inspection in September 2014 regarding provision and implementation of staff guidance to appropriately manage risks to people's health and wellbeing.

One relative told us their father was "Well cared for. They [staff] phone me regularly if there are any issues, and I have just had an annual review [of his care needs] with the nurse". Another relative confirmed that staff were aware of their loved one's weight loss, and were "Keeping a careful watch" of their health.

Daily handover sheets ensured nurses and care workers were informed of people's known or current health issues, support required, and any planned appointments. This meant staff were kept informed of people's changing needs.

An initial assessment prior to people's admission documented their health status and any known risks, areas where they required assistance, and their likes, preferences and routines. Daily records demonstrated that people's preferences and routines were met, for example in the activities they attended. Staff were knowledgeable about each person's needs and wishes. The home's 'resident of the day' programme ensured nursing staff and heads of departments discussed people's care and wishes with them on a monthly basis. This provided people with an opportunity to influence changes to their care or environment.

Care plan guidance ensured staff understood how to interpret people's gestures and expressions if they were unable to explain their wishes or concerns verbally. This meant staff were able to respond appropriately when people indicated they were in pain or discomfort, or declined offered care or support. The new manager was supporting nurses to ensure people's care plans were more personalised, and emphasised people's abilities and independence as well as their support needs and identified risks.

Care plans documented how people or those important to them were involved in assessments and reviews of their care needs, and relatives confirmed they had been involved. One relative told us how an annual review provided them with an opportunity to formally discuss changes in their loved one's health condition. Care plans documented that issues raised by people or their representatives had been acted on. For example, one person's end of life care wishes had been updated following a care review.

Activities were planned by the activity coordination team, but were provided with flexibility to meet people's preferences on the day. We observed a range of activities during our inspection, including arts and crafts, a musical entertainer and one to one pampering sessions. Planned activities included games and gentle exercise, visiting pets and farm animals, and trips to local amenities such as shops and garden centres. Regular church services were held in the home. The home's minibus meant transport was readily available for people's use. Craft and summer fairs invited the local community into the home, and links had been established with local schools to share events and establish relationships. This supported people to maintain social, religious and cultural contacts.

Relatives told us staff dealt with concerns effectively. One relative stated "The nurses are good at feedback. I have no complaints", and another relative explained how a concern had been resolved promptly. The provider's complaints policy was displayed for reference at reception, and was included in the provider's information booklet. This meant people and their representatives understood the formal process to raise complaints. The complaints file demonstrated that complaints had been managed and resolved in accordance with the provider's complaints procedure.

Relatives' meetings were held every two months, and planned dates for these were advertised in reception. Minutes demonstrated meetings provided an opportunity for relatives to raise and discuss any issues of concern. They were sometimes held in conjunction with a social event, such as a BBQ. This helped to make relatives feel welcomed and included in the home. Concerns raised during relatives' meetings were shared at staff meetings, and actions taken to resolve issues. For example, the perceived lack of staff at weekends had been noted at the following staff meeting, and addressed through the provision of a walkie talkie at reception. This meant visitors were able to locate staff promptly when reception was unmanned.

There had not been a survey to gather the views of people and their representatives since or last inspection, but this

Good

Is the service responsive?

was planned. The provider's regional team conducted regular quality visits to St Thomas, and during these visits discussed people's concerns with them and their relatives. For example, changes in staff support at meal times had changes due to concerns raised by visitors, and the observations of the audit team. These visits, and other opportunities for feedback such as meetings and events, ensured that the provider listened and responded to people's comments.

Good

Is the service well-led?

Our findings

The regional director referred to a "Culture change" in the home. They felt this had created a more relaxed, comfortable and happy atmosphere. The home's booklet, made available for people and their relatives, referred to people's care as professional and respectful, tailored to meet people's individual needs. It described a culture where people's independence and self esteem were valued, and noted people were encouraged to make choices and retain life skills. We observed staff demonstrate these values in their practice.

A relative told us "Communication is very good", and staff told us they felt more involved and listened to than they had previously. Staff who referred to themselves as "Back room staff", such as laundry and housekeeping, told us they felt more included within the home, and all staff said communication within the home was effective. We observed a daily meeting where senior staff met to discuss and resolve any issues identified. Staff respected each other's views, and listened and contributed to ensure people received the care they required and wished for.

Staff were involved in decision-making in the home. Nurses helped to plan staff rosters, and staff feedback was welcomed to evaluate new procedures, such as staff allocation. Staff told us they were thanked when they performed well. Long term service was recognised and rewarded by the provider. Staff spoke with pride of receiving these awards. The provider had invested in the home through a range of improvements, and senior staff had been given budgetary responsibilities to manage funds appropriately. The maintenance person told us they had sufficient funds to maintain the home in good order, and were trusted to manage the maintenance budget. Staff were empowered and valued by the provider.

Staff told us the temporary manager was approachable, and spoke positively of the new manager. One care worker told us "I feel very hopeful with the new manager, she's approachable and honest, but she can't do it all overnight". The temporary and new managers led by example. We observed they sat and chatted with people and their relatives in the home, and helped staff clear up after lunch. They used their practical experience and knowledge to inform and encourage staff to deliver quality care in the home. Nurses told us management listened to feedback at meetings. They had developed a good working relationship with the temporary manager, and said managers were available at any time to discuss issues.

Staff meeting minutes demonstrated two way discussion, with management praising good practice and providing guidance on areas of improvement required. A letter from the regional director to staff, sent at the beginning of the year, assured staff of the provider's willingness to listen. It explained actions in hand to address issues identified within the home, and reminded staff of their responsibility to effect changes and drive improvements. Contact details on the letter meant staff had direct access to the regional director to raise any concerns or share ideas to ensure people received high quality care.

The regional director had supported the home through the changes implemented in 2015, and visited regularly to monitor that improvements were delivered and sustained. The new manager was being mentored by the temporary manager. This ensured that people and staff experienced continuity of management support.

Confidential records were stored securely. Staff records were kept in locked cabinets, and could only be accessed by those authorised to do so. People's personal records were stored in staff offices. Archived documents were stored securely in a dedicated room. Keypad locks and self closing doors ensured records were stored securely. One office door stuck, so there was a risk this door may not fully close when staff vacated the office. Staff knew the requirement to check this door was locked when they closed it. The new manager had ordered locking cabinets to ensure people's personal information was kept confidentially.

Records had not always been filed. There was a risk that back-dated records may not be found easily for reference. A nurse explained there was a backlog due to leave and shortage of nurse time to attend to filing. They had a specific paperwork day planned on the roster to help them to catch up with filing and other paperwork duties.

Admissions to the home were being managed to slowly build up to full capacity. Pre-admission assessments were reviewed by the new manager. This ensured the provider was able to satisfactorily meet the needs of people admitted to the home, and the impact of new arrivals would not be detrimental to people currently supported.

Good

Is the service well-led?

An annual programme of audits ensured the quality of care people experienced was monitored and assessed. This included manager audits of infection control and medicine administration, and audits conducted by the provider's regional management team to review topics such as health and safety, and quality of care. Actions required to address issues identified during these audits were recorded on a central action plan. This could be scrutinised at regional and national level to ensure planned actions were completed in a timely manner. Actions plans were reviewed at each audit visit, and managers and other named individuals were held to account if planned deadlines had not been met.

The action plan for St Thomas showed evidence of progress. For example, it had been identified that there was a lack of guidance for PRN medicines, and head of department meetings were not held in accordance with the provider's protocol. At the time of our inspection, PRN guidance was provided, and weekly heads of department meetings were documented.

Incidents, infections and hospital admissions were logged electronically, and could be viewed by the provider at regional and national levels. They were monitored to ensure appropriate actions were implemented to reduce the risk of recurrence, and to identify trends. These were discussed at regional meetings to share learning and actions across homes. This demonstrated a desire to drive improvements to the quality of people's care.