Monshaw Limited

Thornhill Nursing Home

Inspection report

6 Thornhill Road
Huddersfield
West Yorkshire
HD3 3AU

Tel: 01484421287

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Thornhill Nursing Home took place on 25 February 2016 and was unannounced. The previous inspection had taken place on 11 March 2014. The service was not in breach of the health and social care regulations at that time.

Thornhill Nursing Home is registered to provide accommodation for up to 42 people who require nursing or personal care. There were 40 people living at the home at the time of the inspection. There was a communal dining area on the ground floor and a communal lounge on the first floor. The home included a specific dementia wing designed to accommodate up to 11 people living with dementia. The butterfly wing had an open lounge/dining area.

The service had a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Thornhill Nursing Home and relatives also felt their family members were safe. Staff and the registered manager had a thorough understanding of safeguarding procedures and knew what to do if they suspected anyone was at risk of harm or abuse.

Staff were recruited safely. Whilst there were enough staff to meet people's needs, there were mixed views regarding whether deployment of staff was effective.

Premises were well maintained and regular safety checks took place.

Risks to people were assessed and measures were put into place to help reduce risks to individuals.

Medicines were stored and administered in a safe way.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards. We found staff had a thorough understanding of these safeguards. Authorisation had been appropriately sought when people's liberty was being restricted.

Consent was not always sought in relation to care and treatment. For example, some people were given medicine without consenting. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 11.

People told us staff were caring and we observed this. People were treated in a kind and caring manner and dignity was respected.

People received care that was personalised to their needs. Activities were varied and appropriate to individuals. Information was shared appropriately which helped to ensure people received continuity of care.

People and staff felt the service was well led. The registered manager was visible throughout the service.

Staff and the registered manager felt supported in their roles.

Regular audits took place to improve quality of service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

The environment and premises were well managed and appropriate safety checks took place to ensure people's safety.

Risks to individuals were assessed and measures were put into place to reduce risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff knew the people who they were supporting well.

Staff had received training to enable them to provide effective care and support to people.

Consent was not always sought in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were caring.

We observed positive interactions between staff and people who lived at Thornhill Nursing Home.

People's privacy and dignity were maintained.

End of life wishes were considered and respected.

Is the service responsive?

Good

The service was responsive.

People received care that was person-centred and personalised.

People were encouraged to maintain a healthy lifestyle.

Is the service well-led?

Good

The service was well led.

Staff felt supported and motivated in their roles.

The registered manager ensured regular audits took place, to improve the quality of service.

Thornhill Nursing Home

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.

The inspection took place on 25 February 2016 and was unannounced. The inspection was carried out by three adult social care inspectors. Before the inspection, we reviewed the information we held about the home and contacted the local authority. This information was used to help plan our inspection and to consider our judgements.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us to understand the experiences of people who lived at the home, including observations and speaking with people. We spoke with nine people who lived at the home, four relatives of people who lived at the home, three care staff, a nurse, the activities coordinator and the registered manager.

We looked at six people's care records, three staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, with their permission, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

One person told us, "Yes love, I feel safe here." We asked a relative whether they felt their family member was safe. We were told, "Oh of course. Yes, they're safe here." Another relative told us, "[Name] is very safe and happy."

The registered manager and staff were clear about safeguarding reporting procedures and were able to outline different types of abuse and the potential signs to look for, which may indicate if someone was at risk of harm or being abused. Appropriate referrals had been made, for example to the local authority and the Care Quality Commission (CQC) and the registered manager had sought advice when necessary. A member of staff said they would have no hesitation in reporting any concerns and another staff member said they were aware of the whistleblowing policy and said they would report poor practice or any abuse. This meant people were protected from abuse and improper treatment because staff had received relevant training and the registered provider had robust procedures and processes in place to protect people.

The registered manager told us risk was managed by assessing risks and putting measures in place to reduce risks, whilst also trying to ensure people maintained their independence. For example, some people had individual risk assessments in place in relation to smoking or accessing the community independently. We saw risk assessments were in place within individual care files, such as in relation to falls, moving and handling, diet and nutrition. These contained information specific to the person being assessed. This helped to ensure staff were aware of who was at risk and what actions to take to reduce risks.

When people accessed the community, as a group, plans were in place to minimise risks. For example, information relating to individual needs was considered, such as whether people required specific medicine or a certain diet.

We saw records of regular safety checks and servicing. For example, the most recent gas inspection was February 2016 and portable appliance testing (PAT) was up to date. Lifting equipment had been serviced during December 2015 and regular fire alarm testing took place. We saw there were weekly health and safety checks, for example in relation to call bells, water temperatures, fire doors and alarm testing. This helped to ensure premises and equipment were safe.

Accidents and incidents were logged and recorded. These were then analysed, for example to consider whether there were any triggers or trends. The registered manager explained that, through this analysis, it was identified there was a greater risk of falls at a particular time in a certain area of the home. Staff were therefore deployed in such a way to try and prevent this. Additionally, we saw that referrals were made to a specialist falls clinic when a person had experienced multiple falls. This showed the registered manager analysed accidents and incidents that may result in harm to people and made changes to the care and treatment they provided, in order to reduce the risk.

The registered manager told us they used a dependency tool to determine appropriate staffing numbers and consideration was also given to the layout of the building. Each month, the dependency of each person

was assessed, taking into account mobility and medication needs for example, in order to determine staff numbers. The number of staff identified as being required were deployed. There were five carers, two senior carers and a registered nurse to provide care and support for 40 people who were living at the home at the time of the inspection. In addition to this, the registered manager employed a full time activities coordinator. Having a dedicated activities coordinator meant staff at the home were able to continue to deliver care whilst people participated in activities. A maintenance person, two domestic staff, a laundry person, a cook, a kitchen assistant and an administrator were also employed.

A member of staff told us they felt there were not enough staff on the Butterfly wing. We also observed staff on this wing to be very busy and, although people's needs were met, staff needed to call upon other staff for assistance at times.

Our own observations were that there were occasions on the Butterfly wing where staff were not able to assist people because they were assisting someone else. Two staff were deployed to this wing for the majority of the time. This meant that, if two staff were required to assist someone, other people could not be given assistance. We shared this observation with the registered manager who agreed to consider the deployment of staff within this unit.

We looked at three staff files and found safe recruitment practices had been followed. For example, the registered manager ensured references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at whether medicines were managed, stored and administered safely. Staff had received specific training in relation to the administration of medicines and competency was checked regularly. There were two members of staff administering medicines; a nurse administering medicine for people who required nursing care and a senior carer administering medicine for people who required residential care. When administering medicines, staff wore a tabard which indicated they should not be disturbed. This reduced the risk of errors being made due to the staff member being distracted.

Medicines were prepared in individual pots and we saw, when staff gave people their medicines, staff patiently waited with the person, without rushing them, and ensured the medicine had been taken. Staff talked to people as they were assisted to take their medicine. For example, we heard a staff member say, "Here you are [name]. It's calcium for your bones." We saw staff assisted people to drink so they could take their medicine safely.

When medicines were received they were receipted and checked by two members of staff. We observed medicines were stored securely and staff locked the medicine trollies whenever they were left unattended. Access to the medicine trollies was strictly controlled. Room and refrigerator temperature checks were undertaken daily. This helped to ensure medicines were stored safely.

Some people were prescribed PRN medicine, which is to be taken 'as and when required.' We saw clear procedures were in place and this was given in line with the person's care plan.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and we saw that, whenever these were administered, two members of staff checked the remaining amounts and signed the controlled drugs register. We checked the balance of stock and this reconciled with the records. This showed controlled medicines were being properly managed.

We looked at a sample of medication administration records (MARs). The times that medicine was administered were pre-printed on the MAR, for example, 09.00, 13.00, 17.00. The person administering the medicine was therefore not accurately recording the time the medicine was administered. This increased the risk of people's doses of medicine being given at incorrect intervals. We discussed this with the nurse responsible for administering medicine who agreed to give this further consideration.

Some people were prescribed topical creams and these were kept in people's rooms. Details of the creams were on the MAR sheet with a corresponding cream chart in the person's room, with directions for staff to follow and record when applied. We cross-referenced two people's records and found these to be up to date and correct. Dates were written on the packaging to indicate when the cream was opened and expiry dates were noted. This was good practice and reduced the risk of creams being applied inappropriately.

We looked around the home and found areas to be clean and odour free. We saw notices were displayed adjacent to sinks to highlight effective hand-washing procedures. Staff had access to personal protective equipment such as gloves and aprons and we saw staff using these. This helped to reduce and prevent the risk of infection.

Requires Improvement

Is the service effective?

Our findings

One person told us, "I love being here. The food's nice and all." A relative told us, "We have no complaints and we are very fussy. If there was anything to moan about we would, but it is honestly a fantastic place."

The staff files we sampled contained certificates of training and demonstrated that competency assessments had taken place, following training, to ensure staff understood their roles. The files included a record of thorough induction. Staff had received training in areas such as moving and handling, safeguarding, health and safety, infection prevention and control, fire awareness and evacuation and safe administration of medication. The registered manager kept a comprehensive training matrix which helped to ensure training was kept up to date. This meant the registered manager had taken steps to ensure staff had up to date skills to enable them to provide effective care and support to people.

Staff received regular supervision. We looked at minutes from supervision and saw items discussed included new policies, the importance of documentation, training, progress and infection control. The minutes also stated, 'If any problems, talk to the manager.' The registered manager had planned staff supervisions on a calendar to ensure they were kept up to date. This showed staff received regular management supervision to monitor their performance and development needs.

Staff were easily identifiable, with senior staff wearing a different coloured uniform. This helped to ensure people knew who staff were.

Some staff were designated Dementia Friends, which is an Alzheimer's Society initiative. Staff had received additional training in order to understand what it is like to live with dementia. The activities coordinator was a Dementia Friends Champion. A Dementia Friends Champion is a person who encourages others to make a positive difference to people living with dementia. This showed the registered manager and staff recognised and followed good practice guidelines in relation to providing care for people living with dementia.

People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety. We saw there were some orientation boards on display. The design and layout of the Butterfly wing was appropriate for people living with dementia. Signs and pictures were displayed to assist people to identify different areas, such as where drinks could be found for example or where the dining area or toilet were located. Additionally, there were photographs of people on their bedroom doors, which helped people to find their private rooms.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager told us staff would be expected to ask for consent from people before providing

care and support and we observed this. For example, staff would ask if a person required assistance with personal care. Additionally, care plans contained information relating to consent for photography. This showed that, in some cases, consent was sought from people.

Two people were given medicines covertly. This meant they were administered medicine without knowledge and without giving consent. In this case, a mental capacity assessment would be required, in order to determine whether the person lacked capacity to consent. If the person was found to lack capacity, then a decision could be made in their best interest to administer medicine covertly. However, there was no evidence of a mental capacity assessment or best interest decision being made. We raised this with the registered manager, who surmised the documents must have, "Gone astray." This could mean the person's human rights were not being protected and the registered manager and staff were not acting in accordance with the MCA 2005. The registered manager agreed to address the wider issue of assessing people's mental capacity within the home. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 11 because care and treatment was not provided in accordance with the Mental Capacity Act 2005 and with consent of the person.

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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had attended MCA and DoLS training during October 2015 and had an understanding of the principles of the MCA and associated DoLS. The registered manager had identified some people living at the home lacked capacity and were being deprived of their liberty. Applications had been submitted to the local authority in order for this to be authorised. Two applications had been authorised and the others were awaiting a decision.

The registered manager told us people had a choice of breakfast every day, including a cooked breakfast, cereals and porridge. There were two choices of hot meals at lunch time and a lighter tea, such as soup and sandwiches and lighter cooked meals. Food choices were discussed at resident meetings. Minutes from a resident and relatives' meeting dated 9 December 2015 stated meals and choices had improved and there was a lot more fresh fruit and baking on the tea trolley.

Cold drinks were available throughout the day. We also saw people were offered a choice of drinks, snacks and fruit. Tables were placed near to people so they could easily access their drinks and people were given support where required in order to eat and drink. This helped to ensure people's nutrition and hydration needs were met.

In the dining room there was a calm and relaxed atmosphere. People were discreetly supported where required. Music was playing from the 1950s and 1960s, and some people were singing along to the music. People were given options and choices in relation to their meals. Staff observed one person had not eaten much of their chosen meal, so they asked if the person would like to try something different. This meant people were offered choices and supported to change their mind if they wanted to do so.

On the Butterfly wing kitchen staff brought meals and gave people visual choices. Staff were respectful and friendly, asking, "Which meal do you fancy?" If people struggled to make a choice, staff kindly and patiently assisted them to do so. One person asked for some of their meal to be saved for later. The response of the chef was, "Ok, no prob."

The quality of food looked fresh and appetising and the people we spoke with told us the food was of good quality. One person told us, "I've had a lovely tea. They're very good, the girls, we always have good food here."

Staff were aware of people's individual dietary requirements, as some people required a soft or pureed diet. Home-made soup was available every day and kitchen staff made different foods for people if they requested this. This helped to ensure people's individual care needs were met.

People had access to health care and we saw referrals were made to other agencies or professionals. For example, we saw in people's records they had been referred to general practitioners and district nurse or tissue viability nurse as appropriate. This showed people living at the home received additional support when required to meet their care and treatment needs.

Good

Is the service caring?

Our findings

One of the people we spoke with who lived on the Butterfly dementia wing told us, "You can't fault this place." Another person said, "I'm fine love. They look after me." A further person said, "It's grand. Everything is just as it should be."

A relative said, "The care seems ok. They're very good with [name]. They take her out for a cigarette." Another relative told us, "They're lovely lasses. They really are." However, this relative was also concerned because their family member had been waiting for a hearing aid for a month and they were concerned this was having a negative impact on their family member's quality of life. We raised with the registered manager who advised an appointment had been made to rectify this.

We spoke with another family member who told us they were extremely happy with the care. They said, "Staff are all bubbly all of the time," and another said, "The care staff are all so lovely. I can't fault them."

A member of staff told us, "I love working here. I like getting up and coming here."

Another member of staff told us how a person who did not talk when they first moved into the home was now conversing with staff, after being gently encouraged and being listened to. The staff member told us it was rewarding to feel they had contributed in some way to this person's quality of life improving.

We observed a pleasant atmosphere in all areas of the home. Our observations were that people felt at ease in the presence of staff. We saw people laughing and joking with each other and with staff. Throughout the day, we observed staff smiling and being kind, caring and friendly towards people. Staff supported people at an appropriate pace and there was no sense of being rushed or hurried.

We observed a carer assisting a person to drink a cup of coffee on the Butterfly wing. The staff member was careful to not rush the person and the person remained in control. The staff member spoke in a kind and caring manner to the person, whilst assisting them.

We observed carers using people's names and it was evident they knew people well. For example, staff asked people about their favourite football team or family members or places people had been to. This was well received by people and we observed positive interactions. We saw staff use appropriate touch and gestures in order to put people at ease.

As well as carers, we observed the cook and kitchen staff engage well with people. For example, they asked people if they had finished eating before taking plates and cups away. People were asked whether they enjoyed their food.

We observed kitchen staff brought food to people who had chosen to remain in the lounge area for their lunch. The staff knew people's names and engaged in a caring manner, ensuring that food was placed within reach. We saw a staff member move a table closer to a person to ensure they could eat their dinner

more comfortably. The staff member spoke with the person and asked them if this was more comfortable for them. This showed that staff had a caring manner.

We saw staff on the Butterfly wing assisting people to eat their meals. Staff moved patiently between people to offer support and made good eye contact. Staff smiled and chatted with people as they offered assistance. However, with only two staff, it was difficult for staff to provide the support that people required. A member of staff commented, "Sometimes with only two staff it's hard."

We observed a carer bend down to a person's level when speaking with the person. The person was asked if they would like assistance to move to the dining room. We heard the carer say, "Take your time and follow me."

We observed two carers assisting a person to move, with the use of hoisting equipment. The person was given reassurance throughout. Carers used phrases such as, "You're going up now," and, "You're going down into your wheelchair now." We also saw the person's legs were kept covered with a blanket which helped to protect their dignity.

On another occasion we saw staff giving reassurance to a person who they were assisting to move. Staff said, "You are safe. You are going up. How do you feel now?"

There was a board which displayed information in relation to 'What dignity looks like.' This was in a prominent place and could be seen by staff and people living at the home. This helped staff and people to understand how to ensure people's dignity was respected and we observed this in practice. People's privacy was also maintained. For example, we saw staff knock on people's doors.

At lunchtime we observed people being given appropriate support in a caring and discreet manner. People were asked whether they would like to wear serviettes and clothing protectors. This demonstrated that staff treated people with dignity.

A nurse and a carer were completing some training in line with the Gold Standard Framework (GSF). The aims of the GSF are to promote quality of care for people nearing end of life, with coordination between teams creating outcomes that matter to people, particularly reducing unwanted crises and hospitalisation.

We saw a person's care plan which contained a do not attempt cardiopulmonary resuscitation (DNACPR) order. This had been discussed with the person and their daughter and their views had been shared and documented. The plan stated the DNACPR information had been shared with all staff. The helped to ensure that people's end of life wishes were respected.

Good

Is the service responsive?

Our findings

A relative told us, "The staff know what [name] needs." This person had seen their relative's care record and told us they could see the person was weighed regularly. We were told, "Relationships with staff are very good. Communication is everything."

The registered manager advised that care plans were reviewed monthly and there was a key worker system in place to ensure that a named worker was responsible for reviewing plans. People's social history and background information was gathered, with input from the person and their family if appropriate and this helped staff to gain a better understanding of the people they cared for.

We looked at six people's care plans. Plans contained a photograph of the person and included a document which highlighted key risks such as in relation to eating and drinking, mobility, risk of pressure sores and risk of falls. There was a one page summary which highlighted information such as what was important to the person and how the person felt they could best be supported. Information, personal choices and preferences were detailed, such as the person's preferred activities and life history.

Care plans contained detailed information in relation to the support and care the person required in areas such as maintaining a safe environment, eating and drinking, continence, mobility, breathing, personal care and dressing, social needs, sleeping, communication, pressure care, cognition and end of life care. Each section of the care plan was personalised and contained information relating to the person's choices and to the required support.

Care plans were evaluated monthly. However, in one of the care plans we sampled we saw the plan had not been updated to reflect a recent change in need. For example, the plan had last been evaluated on 16 February 2016 and stated, 'No pillow to be put under leg.' However, notes from a tissue viability nurse visit dated 23 February 2016 stated, 'To keep the pillow under the leg and keep heel off from the bed.' This information had not been transferred to the care plan. We raised this with the registered manager, who advised this had been addressed and some appropriate equipment had been ordered, upon the advice of the tissue viability nurse, in order to assist the person to be comfortable whilst keeping their heel from the bed. The registered manager agreed to update the care plan immediately to reflect this.

The activities coordinator at the home shared with us information about a wide range of activities that had been discussed with people and arranged. The activities coordinator had excellent skills at engaging with people. This meant that people's social and emotional needs were met, as well as physical needs. A member of staff said, in relation to the activities coordinator, "[Name]'s done a lot for morale with residents."

Activities were planned in a person centred manner and information gathered by the coordinator was made available to other staff, which meant all staff were better able to engage with people. Consideration had been given to which activities people would choose to engage in and which times of day would be more appropriate. The activities coordinator told us, in relation to the Butterfly wing, "People are more ready to

engage first thing and they're loads more settled for the rest of the day. You can see a difference in their mood."

People were encouraged to maintain a healthy lifestyle. For example, the activities coordinator told us, "Zumba Gold is a really good way to get physical and get people moving around."

Some staff had recently undertaken a 6 week training course provided by the Alzheimer's Society in 'singing for the brain'. This is a technique used to encourage staff and people who live in the home, to sing. The activities coordinator explained that whilst some staff were shy initially, they gradually realised the impact that singing could have and often people recalled words of songs they used to sing even if they were unable to remember day to day events. This enhanced the lives of people living at the home.

The home promoted a national dementia charity's 'Make time for a cuppa' week and was holding an event during the week following the inspection.

We saw people were given choices. One of the care plans we looked at stated, 'ensure [name] is given a choice of clothes to wear.' Staff told us they offered people choice by holding up different clothes from their wardrobe. In relation to food, staff told us they showed people plates of food so people could choose and we observed this in practice. We observed a person change their mind and ask for a different meal at lunchtime to the two choices that had been offered and this request was also accommodated. We saw people were given choice throughout the day, for example in relation to food, drinks, activities and where they wanted to sit. This demonstrated that people had some choice and control in their day to day lives.

A relative we spoke with told us they felt welcome to visit the home at any time. Another relative said, "We are welcome anytime. We come at all hours and we are here every day." This demonstrated people were supported to maintain relationships and friendships with people who were important to them.

We saw a feedback book was placed in the reception area, entitled, 'How was your visit today?'. This was to encourage people to give feedback. The complaints policy was also displayed and the registered manager outlined the complaints policy to us. Complaints were logged and recorded appropriately and we found complaints had been responded to in line with policy. We looked at one complaint in more detail and could see the complainant had received a written apology and the concerns had been escalated to the regional manager by the registered manager. The complainant was responded to and appropriate actions were taken to a satisfactory outcome.

Appropriate information was shared between staff at the commencement of each new shift. This took place during a staff handover and information was shared verbally as well as through written records about people's care needs in a structured way. This meant that important information was shared between staff so people received appropriate care and support.

Good

Is the service well-led?

Our findings

The home had a registered manager in post, who was registered with the Care Quality Commission and had been managing the home since September 2015.

Speaking about the registered manager and if they had any concerns, a person told us, "Yes [registered manager]'s very nice actually. I'd approach her before I talked to the staff."

A relative we spoke with told us they were confident the registered manager was running the home well. They said, "The manager is hands on and approachable."

The staff we spoke with told us they felt well supported and had regular opportunities for training and supervision. One member of staff told us, "We have lots of supervision. That's a good thing." Staff told us their practice was observed, such as in relation to administering medicines for example, and staff realised this was to ensure they were competent and provided opportunity to improve practice.

A staff member told us they would be happy for a relative of theirs to live in the home and said, "All the staff work well together. There's good teamwork. Training is regular."

The activities coordinator had been nominated by the registered manager for a British Care Award and, as a result, was selected to attend a celebratory function for finalists of the award. This showed that staff were valued and their contribution was recognised.

The previous inspection report was displayed, as well as the most recent food hygiene inspection rating. The home had been awarded five stars which equates to, 'Very good' at the most recent food hygiene inspection. Information relating to the philosophy of care and service user guides were also displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.

Regular staff meetings took place and we saw minutes of these. Meetings were held specifically with different groups of staff, including night staff. This ensured that important information was regularly shared with all staff.

The regional manager visited the home weekly to provide support and leadership. In addition to this, there was an on-call regional manager who was available to support the registered manager if required at evenings and weekends. The registered manager told us they felt supported and had access to a wider network within the provider group, such as training and estates, which helped to support the running of the home. The registered manager attended health and safety meetings every three months in order to share any concerns or discuss good practice. This showed the registered manager was supported in their role to provide effective management at the home.

The registered manager told us they attended a quarterly forum with the local hospice to consider how effective working with the hospital discharge team could benefit people. Additionally, the registered manager worked with the care support team which aimed to provide smoother transition from hospital to home. The registered manager felt well supported and felt they had a positive relationship with local community health professionals such as district nurses, community psychiatric nurses and general practitioners.

Links with the local community were evident. For example, a story telling competition had been held at the home, in collaboration with a local school. Local children had been invited to read their stories to people living at Thornhill Nursing Home. A favourite was then chosen by people living at the home and the students received a token prize. People living at the home accessed the local community, for example by using the Access bus service to visit garden centres, parks and local amenities.

Regular audits took place and these included action plans. For example, we sampled audits in relation to mattress quality, nutrition plans, kitchen safety and infection prevention and control. We also saw that medication audits took place regularly. Any action required was documented and it was clear who needed to take action and the date the action was taken was also recorded. This demonstrated that systems and processes were in place, such as regular audits, to assess, monitor and improve the quality of service.

The registered manager and regional manager were working together in order to align audits to the five key areas that the care quality commission inspect, that is, whether the service was safe, effective, caring, responsive and well led. The regional manager shared the new system of auditing with us and, although this was in the early stages of development, the audits were thorough.

The home had been working with the local authority to address some environmental issues and had recently replaced carpets in different areas of the home and there was a programme to make further improvements.

Professional visitor surveys had been issued to various professionals during May 2015. We saw a questionnaire, completed by a general practitioner which stated, 'Yes,' to the question, 'Would you recommend this home?' and 'Excellent,' to questions in relation to staff knowledge, the home manager and staff training. A representative from the Alzheimer's Society had stated, 'Very friendly and professional environment that seems to encourage participation in events amongst residents, family and staff.'

A family and customer survey had also been issued during May 2015. One of the comments included, 'I am very happy with the care and kindness given to mum over the years she has been at Thornhill. If I had any issues these have been quickly resolved.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided in accordance with the Mental Capacity Act 2005 because consent from the relevant person was not always sought. Regulation 11(1).