Care Quality Commission

Rushcliffe Care Limited

Thorpe House Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
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?	**Requires Improvement**

Overall summary

This inspection took place on 1 October 2014 and was unannounced.

At the last inspection on 30 August 2013 we found that the service was meeting with the regulations we looked at.

Thorpe House Nursing Homes provides accommodation and nursing care for up to 50 people with health conditions, physical and sensory needs including dementia. On the day of our visit there were 40 people living at the home. The accommodation was provided over two floors.

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

The home had a passenger lift that had been out of order since April 2014. Whilst the provider had taken appropriate action to minimise the risks to people and

Summary of findings

staff, this had impacted on the provider's ability to meet some people's needs fully. We found some concerns with regard to fire safety. We reported our concerns to the fire and rescue service.

Staff had received training on how to protect people who used the service from abuse or harm. They were aware of their role and responsibilities in keeping people as safe as possible.

People who used the service had received an assessment of their needs that identified any risks to them or others. Risk assessments informed staff of how to manage and minimise risks from occurring.

Staffing was determined by people's assessed needs and the registered manager regularly reviewed staffing levels. People received their medicines as prescribed by their doctor. Medicines were stored and managed appropriately.

The provider supported staff by an induction and ongoing support, training and development. The Mental Capacity Act (MCA) is legislation that protects people who may lack capacity to consent to their care and treatment. We found some examples that the registered manager was following this legislation. However, MCA assessments and best interest decisions were not always fully recorded. Improvements were required to ensure people's capacity to consent to specific decisions were assessed appropriately

People who used the service had their dietary and nutritional needs assessed and planned for. People received a choice of what to eat and drink that supported them to maintain their health. Plans of care were developed and reviewed regularly for changes. Referrals to health professionals were made in a timely manner and people received support to maintain their general day to day health.

Records used to monitor people's health needs were not always fully completed. There was a need to improve recording to ensure that staff had the information they required to deliver safe care at all times.

People told us that staff were caring, compassionate and respectful. People who used the service including relatives, also said they were able to participate in discussions and decisions about the care and treatment provided. Information about advocacy and other sources of useful information was available for people.

The provider had quality monitoring procedures in place. We found concerns that the systems in place had not identified areas that required improvement.

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?
The service was safe.

Fire safety plans and procedures required action. The registered manager took appropriate and immediate action to reduce risks and keep people safe.

Sufficient staff were available to meet people's individual needs.

People had their needs assessed and where risks were identified, risk assessments advising staff how to manage risks were present. Staff were aware and appropriately trained on safeguarding policies and procedures.

People received their medicines safely, medicines were stored correctly and staff received training on the safe administration of medicines.

Good

Is the service effective?
The service was not consistently effective.

Monitoring records in place to check people's health care needs lacked detail or information was missing. People's changing needs may not have been identified in a timely manner and appropriate action delayed.

The Deprivation of Liberty Safeguards were understood and the legislation adhered to. The principles of the Mental Capacity Act was understood by staff but assessments of people's capacity and best interest decisions were not always assessed or recorded fully.

Staff received appropriate training and support.

People had their nutritional needs assessed and met. This included support to maintain their day to day health. Referrals to healthcare professionals were made in a timely manner.

Requires Improvement

Is the service caring?
The service was caring.

Staff were kind and caring and responded well to people's needs and in a timely manner. People were treated with dignity and respect by staff.

People and relatives were supported in discussions and decisions about the care and treatment provided.

Information was available for people but some people had communication needs that meant information was not easily accessible.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People were asked about their preferences, interests and hobbies and what was important to them with regard to their care.

The home had links with the community and people were encouraged to maintain their independence.

People including relatives and visitors received opportunities to feedback their views about the service including complaints.

Is the service well-led?

The service was not consistently well-led

The registered manager was supportive, approachable and worked at improving the standard of care.

The home had a clear vision and set of values that meant people received care in the way they preferred and respect and dignity was maintained.

The registered manager completed regular checks on the service that reviewed the quality and safety of the service provided. The systems in place had not identified areas that required improvement.

Requires Improvement

Thorpe House 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.

This inspection took place on 1 October 2014 and was unannounced.

This inspection was completed by two inspectors, a specialist advisor in nursing care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for a relative who had lived in a care home.

We looked at and reviewed the provider's information return. This 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 reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted the local authority and health authority, who had funding responsibility for people who were using the service. We also contacted health and social care professionals who visited the service. This included a doctor, district nurse and a continuing care team review nurse.

We used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed a SOFI observation for three people who used the service.

We spoke with nine people who used the service and six visiting relatives. We also spoke with a senior manager who was present on the day of our visit. They had responsibility for the home above the home manager, we also spoke with the registered manager, two nurses, two care team leaders, six care staff and a kitchen assistant. We looked at the care records of six people who used the service and other documentation about how the home was managed.

Good

Is the service safe?

Our findings

The people we spoke with including relatives said that they did not have concerns about safely. Comments included, "It's a very safe environment and the staff have a very nice approach with residents."

There were procedures in place to minimise the risk of harm or abuse to people who used the service. Staff employed at the service had relevant pre-employment checks before they commenced work. Staff demonstrated a clear understanding of their role and responsibility in keeping people safe. This included what to do in the event of a concern about a person's safety or welfare. Staff told us they had received training on safeguarding. We saw the provider had a policy and procedure of reporting concerns. Our records showed when safeguarding concerns had arisen, the provider had reported these to the local authority and to us as required.

Staff told us they had received training on health and safety. We saw records that confirmed staff had received appropriate training. Maintenance and safety check records that we saw were all in date. Due to some people's needs associated with their dementia, staff ensured the environment was hazard free and safe. The registered manager gave examples of the action taken as a result of lessons learnt from the monitoring and evaluation systems in place. For example, the flooring had been identified as a fall hazard and a replacement programme was under way.

We found some of the fire safety checks were not up to date. People's personal evacuation plans lacked detailed information about individual support needs. We contacted the fire and rescue service to share our concerns. After our visit we received information from the provider to inform us about the action they had taken. This included a review of the fire safety folder and information. The registered manager had also completed three fire drills. People that used the service, staff and visitors were protected from risks associated with fire and evacuation. Appropriate procedures were in place.

Some people had additional needs, or specific health conditions that put them at greater risk. For example, some people were at risk of developing pressure sores. Some people required their behaviour to be managed and monitored in a certain way. We found risk assessments were in place that informed staff of how to manage these risks effectively. Risk assessments were reviewed and evaluated for any required action.

We observed many examples of staff practice safe moving and handling. However, we also saw one person being moved from a wheelchair to a chair. Due to the flooring the transition was not as smooth as it should have been. This resulted in the person knocking their head against the hoist. We shared this with the registered manager. They told us that the flooring was due to be changed. They also said they would talk to the staff about ensuring people's safety when using the hoist.

People talked positively about staff, one person said, "Staff are absolutely amazing." Our observations found that staff were observant and organised in monitoring people to ensure their safety. Staff had designated areas where they worked and were seen to carry out regular checks and monitoring of people's needs. Some people had additional needs that meant they required a staff member with them at specific times to keep them safe. We found these people had the correct support they had been assessed for.

Staffing levels were determined according to the dependency needs of people who used the service. We observed that requests for support was responded by staff in a timely manner, this included call bells being answered by staff. The registered manager told us that the staffing levels were sufficient for the dependency needs of people. Some staff raised concerns that they felt there were not enough staff for people that required one to one support. There was some confusion amongst the staff team about people who received one to one support. The registered manager said this had recently reduced. However, staff were unaware of this. We found there were sufficient staffing levels provided to meet people's assessed needs.

We looked at the administration and management of medicines. This recorded the person's needs and preferred way to receive their medication. The records and storage of controlled drugs were correct. Other medicines were also stored correctly and there was a system to manage and dispose of medicines. Medication administration charts had been completed correctly. This showed people had received their prescribed medication as instructed by their doctor.

Requires Improvement

Is the service effective?

Our findings

People we spoke with including relatives talked positively about the staff, they told us that staff were aware of their roles and responsibilities. Comments included, "The staff are very good indeed and will do whatever you require." Additional comments included, "The senior staff take the younger staff under their wing, teaching them the right way to do things."

We spoke with newly appointed care staff and staff that had worked at the home for a length of time. Some staff talked positively about their induction experience. All staff told us their induction included a mentor [a more experienced member of staff], that supervised their practice. We spoke with a senior staff member who described the role they had in supporting and supervising new care staff. Whilst some staff said the induction prepared them for their work, others felt it could have been better. We looked at the induction programme and saw this was based on the 'Skills for Care' common induction standards, a well-recognised training organisation in health and social care. Whilst the content of the induction was appropriate, the delivery required a review in response to some of the comments made by staff. We shared this information with the registered manager. They said they would discuss the induction process with staff to see if improvements could be made.

The provider had their own training department that organised and delivered training to staff. In addition to this staff received training from external organisations such as the local authority, visiting health professionals and distant learning courses. This ensured that staff had received the training that they needed to equip them to meet the needs of people they cared for.

Staff received support to reflect on their practice and opportunities to further develop. This was through meetings with their line managers to discuss their practice, training and development needs. The registered manager showed us the supervision and appraisal plan for the year, this included observational competency assessments on staff's practice. This showed staff received appropriate support and staff confirmed these meetings were beneficial to them.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), is legislation that protects people who are not able to consent to care and support, and ensures people are not unlawfully restricted of their freedom or liberty. The registered manager had a good understanding of their responsibility of DoLS. They had made referrals to the local authority where there were concerns about restricting a person. Whilst we found some examples that people's consent to care and treatment had been assessed, we found some concerns. Formal MCA assessments and 'best interest' decisions were not always fully recorded. A best interest decision is made on behalf of an adult lacking capacity, and has to be in their best interest.

We found many examples where the person or their representative had not signed plans of care. This is important to show consent had been sought. The registered manager showed us a letter they had sent to people's relatives and representatives about the need for plans of care to be signed to confirm consent. The registered manager was aware that consent from relatives or representatives required appropriate authorisation. For example, a lasting power of attorney or the agreement from the person using the service.

People who used the service told us they liked the food choices and that they had plenty to eat and drink. One person said, "The food is very good. It's everyday food that suits me, such as hot puddings." Two relatives spoke favourably about the food provided. One relative said, "The choice of food is good, the menu choice is offered the day before. It can be changed to suit the person if needed." Another relative described the food as, "Great."

We saw throughout the day that people were offered and supported with drinks to maintain adequate hydration. Snacks were also offered with people's drinks. Staff were knowledgeable about the importance of meeting people's nutritional needs. We saw staff offer people choices of what to eat and drink and meals were nutritionally balanced. People's food and drink met their religious or cultural needs. For example, if people required a specific diet such as vegetarian food this was provided. We saw from the assessment of need and plans of care completed, that dietary needs had been identified and planned for. This informed staff of what the person's needs were.

Some people had specific dietary and nutritional needs. We saw how the staff had worked with health professionals such as dieticians and speech and language therapists to meet people's needs. Where recommendations from health

Requires Improvement

Is the service effective?

professionals had been made, we saw examples these had been included in people's plans of care. For example, some people required their food and drink to be provided in a specific way to reduce the risk of choking.

We also saw examples where recommendations were missing. For example, a dietician had advised that meals were to be provided when a person was awake at night and missed meals during the day. This information was missing from the plan of care and so there was a risk that they might not have their needs met.

People had individual monitoring charts. These recorded people's food and fluid intake and other needs such as when the person was repositioned to avoid pressure damage developing. These records were important to enable staff to monitor a person's health and ensure that needs were being met and risks minimised. We found examples when these records had not been completed fully enough. The lack of recording could have impacted on the monitoring of people's healthcare needs and delayed appropriate action taken to respond to any changes.

Relatives told us that they felt confident and assured that people's health care needs were met. A relative told us, "If I have any concerns about health matters, they [staff] are on to it and they straight away react like getting the doctor in if necessary." Relatives also told us that they felt involved in discussions and decisions about their relatives health needs. We saw from care records that people received support to maintain their health. For example, people received visits from the optician, chiropodist, doctor and community nurses. Where people were required to attend hospital outpatient appointments, support was provided.

We spoke with a visiting community nurse who told us they found the staff made appropriate and timely referrals. For example, where concerns had been identified about weight loss, a referral had been made to the doctor and dietician for guidance and support. We found staff were knowledgeable about people's health care needs.

Good

Is the service caring?

Our findings

People we spoke with made positive comments about the staff, they described them as kind and caring. One person we spoke with told us, "If I need something they get it no bother and I couldn't ask for anything more." Relatives were also complimentary about the attitude of staff. One relative told us, "Staff call in regularly to check on [name], and chat they are very friendly. I have no concerns." Another relative said, "I visit daily I can't claim anything is not right. Staff, I can't say enough about them. They are really lovely people."

We found staff were caring and attentive to people's needs and positive engagement was seen We observed staff had a caring and respectful approach and attitude towards the people they cared for. This was reflected in the atmosphere that was, friendly and relaxed. Staff used people's preferred names and used appropriate communication skills when talking with people. For example, staff communicated at eye level with people and showed they understood people's individual communication needs. Other forms of communication was used to understand people's needs such as gestures, body language and behaviour.

We observed the lunchtime period in both dining rooms. We found that table dressings were not routinely used in both areas. This showed a lack of respect and dignity. We were told that people had to choose their meal the day before. This meant people with communication needs associated with their dementia may have found this difficult. However, the registered manager told us they were in the process of implementing a different approach to how people could choose their meals to make it more meaningful. This included the use of visual aids such as pictures.

Staff demonstrated how they respected people's privacy, dignity and compassion in the day to day care provided. This included involving people as fully as possible in choices and decisions. Respecting people's privacy when personal care was provided and recognising when people required additional care and support. Care staff said they would share any concerns about a person such as a change in their needs to the nurse as soon as possible. Staff showed a good understanding of people's needs.

A relative said, "People are always smiling, there's a difference between people who are just being paid to do a job and people who care, staff here are definitely the latter."

People told us they felt involved in decisions about their care and treatment. Relatives also told us that they were consulted and felt involved. We saw care files recorded contact with relatives, this showed how relatives were communicated with and included in discussions and decisions. We saw people who used the service and relatives had information available to them, this included advocacy services and information about the Alzheimer's society. The registered manager gave an example where a person was supported to seek the assistance of an independent advocate. This was to support a person who had no family or relative to review the care they received.

People told us they had a choice of where to spend their time, this included their individual rooms and communal areas. We saw that the home had a large enclosed garden that people used. The registered manager told us that some people who used the services enjoyed the garden and had grown and set some plants. This enabled people to have their privacy and independence respected. A person told us that their personal possessions were safe. They said they were able to lock their doors, but did not feel the need to do so.

Good

Is the service responsive?

Our findings

A person who used the service told us they had a call bell that they were able to use and that they found staff responded quickly when they called for assistance. This person showed us they had a copy of their plan of care in their room. They said they and their relative had been involved in developing it. We saw peoples plans of care were reviewed and evaluated monthly for any changes and action required. This showed there were systems in place that enabled the staff to be responsive to people's changing and fluctuating needs.

We observed that requests for assistance, including answering call bells were responded by staff in a timely manner. We noted that four people remained in their wheelchair for lunch but there was not a clear reason for this.

Whilst some staff showed knowledge and understanding of people's preferences and personal histories, other staff said they were more aware of people they were keyworker for than others. Some staff told us that they felt the quality of time spent with people was limited and that they felt rushed. Comments included, "We are often short staffed and this affects the quality of care. People's needs take time." People that used the service did not raise concerns with us about the length of time staff spent with them.

The passenger lift had broken in April 2014. We had been kept informed about the action taken to reduce the risk to people. This included not accepting any further placements and the installation of a stair lift. Some people with their agreement had moved to a ground floor room. This meant steps had been taken to reduce the impact of the lift being out of order on people that used the service. However, for one person they had been unable to go out into the garden. This was something they would have liked to of done but had been prevented from doing so for a considerable amount of time. This impacted on the control the person had about how they chose to spend their time.

Two people told us they had received a recent questionnaire asking about their preferred interests and hobbies that they would like to pursue. One person told us they received a weekly foot spa which they said they, "Greatly enjoyed."

We observed that 'memory boxes' were used. This is a collection of photographs or memorabilia important to the person. We saw a person was looking through their box of old photographs and a member of staff was talking with them about their memories.

We saw the provider used a document referred to as 'This is me'. This was used to record a person's history, preferences, routines and what was important to the person in the way they wished to be cared for. This information accompanied plans of care that instructed staff about how to meet people's needs. This showed a personalised approach to care.

People told us they had a choice of what time they got up and went to bed and that this was respected by staff. People had their spiritual and religious needs met, staff told us that a holy communion service happened every Sunday for those that chose to attend. Other examples were given where staff had worked with relatives to develop their understanding and knowledge about meeting people's specific cultural needs. The registered manager told us some people were able to go into the local community and that they were encouraged to do this to maintain their independence.

The home enabled people to share their experience about the service through various methods. A suggestion and complaints box was available in the reception area. The registered manager routinely checked this for any feedback. There was a 'family and residents association' that met monthly. We saw the meeting record for September 2014 and saw there was good attendance and the registered manager was present. A relative told us they had recently attended this meeting for the first time and found it a good source of support and information. The registered manager had also introduced weekly opportunities for relatives to meet with them. This was at specific times to enable them to meet on an individual basis to discuss any issues or concerns.

People who used the service including relatives told us that they felt able to raise any complaints if necessary. A person said if they had any concerns they would speak with their social worker. A social worker is employed by the local authority. Some people have a social worker associated with their age, health or disability. We saw people had the

Good

Is the service responsive?

complaints policy available to them. However, the complaints policy and procedure may not have met people's individual communication needs. This may have impacted on them making a complaint.

We looked at the complaints folder and saw there were no recorded complaints since out last visit. The registered manager confirmed this. We had a discussion with the registered manager about informal issues and concerns raised by people. They said they would consider recording these to enable them to look for any themes or trends.

The provider sent people who used the service, relatives and representatives an annual feedback questionnaire. The feedback received was analysed and shared by displaying the information in the reception area of the home. The registered manager told us that the questionnaire had been sent to people and was with a senior manager to be analysed. The registered manager told us depending on the findings they would develop an action plan.

Requires Improvement

Is the service well-led?

Our findings

The registered manager ensured they met their legal responsibilities and obligations. This meant they adhered to the registration conditions with us. This also included the contractual obligations with external organisations such as the local authority and health commissioners. These organisations told us how the provider worked with them and addressed any areas of improvement when required. These are organisations that have funding responsibility for some people who used the service.

People and relatives told us they felt the home was well managed and organised with open and transparent communication. Comments included, "The manager attends the family and residents meetings." We looked at the 'family and relatives' meeting record in September 2014. We saw that the registered manager had responded to issues and concerns but relatives were requesting some of their concerns were answered by more senior managers within the organisation. The senior manager gave examples of how they listened and acted upon suggestions for improvement. This included a plan to change the entry of the home as a direct response to relative's suggestions for improvement.

We saw the provider had information on display for people, staff and visitors that informed people of the values and vision of the service. We found that the registered manager strived to promote a positive and personalised approach to care. We saw how they had developed ways to support staff about the importance of compassion, dignity and respect. For example, we saw on people bedroom doors a sign that read 'what have you done today to maintain my dignity?' We looked at staff meeting records and there was a constant theme raised by the registered manager about maintaining and improving standards of care. This demonstrated a positive culture within the home.

The registered manager told us and staff confirmed that they often worked alongside staff. The registered manager told us this was important to them to provide staff support and have a greater understanding of the needs of people who used the service. We were told by the senior manager and staff confirmed that they regularly visited the home.

We saw staff meeting records that showed the senior manager was present. This demonstrated good leadership because they made themselves available to people who used the service, relatives and staff.

Staff spoke positively about the registered manager who was described as approachable, supportive and a good leader. Staff understood their roles and responsibilities and those of others. Whilst care team leaders told us they worked closely with nursing staff, care staff and nursing staff had separate handover meetings. Staff told us there had been some communication issues between nursing and care staff but this had been addressed and had improved. It may have been more productive if both nursing and care staff attended the same handover meeting.

The registered manager told us it was important to continually improve the quality of care provided. They told us this was achieved in many ways including supporting staff by reviewing their practice, learning and development needs. Staff meetings were also an opportunity for open discussions to develop and improve care. Staff told us they had opportunities to attend staff meetings and that they felt able to raise any issues, concerns or suggestions.

We found the registered manager had a good understanding and knowledge of the people in the home. Comments included, "If I'm in the office and I see that someone needs assistance I will go and help that person." Throughout our day we saw the registered manager interacted with people who used the service, they were responsive, friendly and supportive in meeting people's needs.

The provider had systems of monitoring the quality and safety of the service provided. This included weekly and monthly audits in a variety of areas including, staff training and development, the environment and equipment and care provided. The registered manager reported the monitoring outcomes to senior staff in the organisation that had overall responsibility and control of the home. However, we found some concerns with the assurance systems in place that monitored quality and safety. Issues that we identified in our inspection in relation to care planning, fire safety checks and requirements of the Mental Capacity Act 2005 had not been identified as areas that required improvement.