

Thurlestone Court Limited

Thurlestone House

Inspection report

Thurlestone
Kingsbridge
Devon
TQ7 3LY

Tel: 01548560737

Date of inspection visit:
07 September 2017
12 September 2017
13 September 2017

Date of publication:
23 October 2017

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?

Inadequate 

Summary of findings

Overall summary

Thurlestone House is registered to provide accommodation and personal care for up to 26 people who may be living with a dementia, physical frailty or have needs relating to their mental health. People living at the home are older people, and at the time of the inspection there were 19 people living at the home. The home offers both long stay and short stay respite care. Thurlestone House does not provide nursing care. Where needed this is provided by the community nursing team.

This inspection took place on the 7, 12, and 13 September 2017; the first day of the inspection was unannounced.

Thurlestone House has been inspected four times, since April 2015. There have been three comprehensive inspections and one focussed inspection. At each of these inspections we found breaches of regulation and the service were rated 'Requires Improvement'.

Although people are happy living at the home, the risks to them are not sufficiently well managed. Governance systems have not been sufficiently robust over a period of three years to identify and bring about the required improvements.

In April 2015 the service was rated as requires improvement. In June 2016 we judged the service as requires improvement again. We served a Warning Notice, telling the provider what action they needed to take in relation to safe care and treatment.

In September 2016, we found action had been taken to address the issues identified in the Warning Notice. However, the service still required improvement in some areas.

At this inspection we identified improvements were still required. We found four breaches of Regulations with repeated breaches of Regulation 12 (safe care treatment) and Regulation 17 (good governance). We found the provider had not taken sufficient steps to assess, monitor or mitigate risk to people living at the home and quality assurance systems had not been established or operated effectively to ensure compliance with the regulation.

The home did not have a registered manager, although this person's name will show on this report as they have not deregistered with the Commission. The registered manager had resigned from their position four weeks prior to this inspection. A new manager had been appointed and had been working alongside the registered manager. They have not made application to the CQC for registration, and are referred to in this report as the 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 2008 and associated Regulations about how the service is run.

The home's quality assurance and governance systems were not effective. Although some systems were working well, others had not identified the concerns we found during this inspection and there was a lack of management oversight.

Risks to people health and wellbeing were not always managed safely. For example where people had been identified as being at risk of malnutrition, we saw people's food and fluid intake were not always recorded in sufficient detail, recorded correctly, totalled, or analysed. We found staff were not following the Malnutrition Universal Screening Tool (MUST) guidance where people had been identified as high risk of dehydration or poor nutrition.

Where risks had been identified, action was not always taken to minimise these risks. For example one person's falls diary indicated they were at high risk of falls and directed staff to refer this person to the specialist falls team for further assessment. Records showed this had been identified by the home's quality assurance systems in July 2017; however at the time of the inspection this referral had not been made. We asked for the referral to be made, and the manager confirmed this had been done.

Staff displayed a good understanding of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguarding (DoLS). People were encouraged to make choices and were involved in the care and support they received.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. Records showed the registered manager had made six applications to the local authority for authorisation to deprive people of their liberty. This was because people were not all free to leave the home if they wished, due to safety considerations and because they were under constant supervision by staff.

Four of the six people we looked at had not had their capacity to consent to these arrangements assessed prior to applications being made. Another person assessment did not contain sufficient information as staff failed to complete the assessment in full and therefore were unable to determine the person's level of capacity or their ability to consent to these arrangements.

A system was in place to monitor the status of DoLS authorisations and DoLS applications that were in progress. We found these systems and process had failed to identify that people were potentially having their rights restricted unlawfully.

People received most of their prescribed medicines on time and in a safe way. However quality assurance systems had failed to ensure people's medicines were managed safely or administered by appropriately trained staff. People's MAR's were not accurate and therefore staff were unable to assure themselves people were receiving their medicines as prescribed. This meant people may have been placed at risk as staff were not able to tell if people had received their medicines as prescribed by their doctor.

People told us they were happy living at Thurlestone House. One person said, "I choose to live here, I was able to pick my room and although it's not my own home I'm happy here," Another said, "The staff are really kind, caring and very helpful, especially [Staff name] she always seems to go out of her way to make sure that I'm ok and have everything I need." Relatives we spoke with told us they were happy with the care and support people received.

People told us staff treated them with respect and maintained their dignity. Throughout the inspection, there was a relaxed and friendly atmosphere within the home. Staff spoke about people with kindness and compassion.

People and relatives told us they were involved in identifying their needs and developing the care provided. People's care plans were informative, detailed, and designed to help ensure people received personalised care.

People told us they enjoyed the meals provided by the home, describing them as "very good." One person said, "there's always a choice and if you don't like something all you have to say and they will make you something else." Another said "I don't have any concerns about the food or the quality".

People spoke positively about activities at the home and told us they had the opportunity to join in if they wanted. The home had a programme of organised activities that included arts and crafts, music sessions, exercise classes, quizzes and regular trips out to local places of interest.

People, relatives, and staff spoke highly of the management team and told us the home was well managed. Staffs described a culture of openness and transparency where people, relatives and staff, were able to provide feedback, raise concerns, and were confident they would be taken seriously.

The home maintained a high standard of cleanliness and steps had been taken to minimise the spread of infection. We saw the premises and equipment were clean and staff had been provided with aprons and gloves. Equipment used within the home was regularly serviced to help ensure it remained safe to use.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

The home was not always safe.

Staff recruitment practices were not robust. The provider could not be assured people were being supported by staff who were suitable to provide care and support.

People were not always protected from the risks associated with medicines. The processes in place to manage medicines had not ensured people received their medicines as prescribed by their doctor.

People were protected from some risks to their health, safety and wellbeing. However, some risks to people had not been identified or effectively mitigated.

People told us they felt safe living at the home.

Staff were trained in safeguarding adults and were aware of how to identify and respond to allegations and signs of abuse and how to raise any concerns.

There were sufficient numbers of suitably skilled staff to meet people's individual needs and keep them safe.

Requires Improvement ●

Is the service effective?

The home was not always effective.

People's rights under the MCA were not always protected. Some people's liberty was potentially being unlawfully restricted.

People were cared for by skilled and experienced staff who received regular training and supervision, and were knowledgeable about people's needs.

People's health care needs were monitored and referrals made when necessary.

People were supported to maintain a balanced healthy diet.

Requires Improvement ●

Is the service caring?

Good ●

The home was caring.

People were positive about the care and support they received and felt staff were respectful, friendly, caring and kind.

People's privacy and dignity were respected and their independence was promoted.

People were supported and encouraged to be involved in their care and support on a daily basis to make choices.

Is the service responsive?

Good 

The home was responsive.

People's care plans were informative, detailed, and designed to help ensure people received personalised care

People were supported to maintain meaningful relationships with those close to them.

People were supported to engage in activities meaningful to them

People were confident that should they have a complaint, it would be listened to and acted upon.

Is the service well-led?

Inadequate 

The home was not always well led.

The provider did not have an effective quality assurance system in place to assess and monitor the quality and safety of care and services provided.

People have been receiving a less than good service for over three years.

Action plans identified to address concerns from the last inspection had not been effective in making the changes needed.

Records were not always up to date, accurate or well maintained.

There was an open culture where people and staff were encouraged to provide feedback.

Staff received a good level of support and could contribute to the running of the home.

Thurlestone House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 7, 12, and 13 September 2017; the first day of the inspection was unannounced. One adult social care inspector carried out this inspection.

Prior to the inspection, we reviewed the information held about the home. This included previous inspection reports and statutory notifications we had received. A statutory notification is information about important events, which the home is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the home for instance, what the home does well, as well as any improvements they plan to make.

During the inspection, we spoke with seven people individually and met with most people who used the service. On this occasion, we did not conduct a short observational framework for inspection (SOFI) because people were able to share their experiences with us. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care. However, we did use the principles of this framework to undertake a number of observations throughout the inspection.

We looked at care records for five people to check they were receiving their care as planned as well as how the home managed people's medicines. We reviewed staff recruitment, training and supervision files for eight staff including the newly appointed manager. We looked at the quality of care and support provided, as well as records relating to the management of the home. We spoke with seven members of staff, the manager, two senior managers and one of the company directors. We looked around the home, including some people's bedrooms with their permission, as well as the grounds. We spoke with two relatives of people currently supported by the home. Following the inspection, we sought and received feedback from two health and social care professionals who had regular contact with the home.

Is the service safe?

Our findings

At an inspection in June 2016, we rated this key question as 'requires improvement' as we identified a number of areas where people's safety had not been ensured. At our inspection in September 2016 we found some improvements had been made, although the judgement of 'requires improvement' was not changed as further improvements were needed.

During this inspection, we found not all those improvements had been sustained and the risk to people's health and welfare still remained.

People's medicines were not always managed safely. Some people were prescribed medicines to be given "as needed," such as for the management of pain or anxiety. Medication Administration Records (MARs) did not contain any guidance for staff as to when these should be used. We discussed this with the manager who thought they may have been filed away incorrectly. Following the inspection the manager confirmed the guidance had not been available to staff and had now been located and was in place.

We checked the quantities of a sample of medicines with the manager against the records. We found that staff could not account for some medicines received into the home. For example, records showed 100 tablets had been received for one person. Records also showed that staff had administered 24 tablets. This meant there should have been 76 tablets left in stock. When we counted the stock, there were 31 tablets. Staff could not account for the missing tablets.

One person's MAR stated they could have one or two tablets of a prescribed medicine. Staff had not recorded how many tablets they were giving as they should do. This meant it was not clear how much of this medicine this person was receiving and staff could not account for how many of these tablets should be in stock.

Some people were prescribed topical creams, ointments, and gels. During the inspection we saw some topical applications and creams had not been dated when they had been opened. People had topical applications in their rooms that did not appear on their MAR sheets, and were therefore not prescribed. We found one person had been prescribed Timodine cream on 5 August 2017, with directions 'to be applied two or three times a day'. At the time of the inspection this cream remained unopened. This meant people were not receiving topical applications as prescribed by their doctor. People could be at risk of receiving medicines that were out of date and therefore ineffective. We discussed what we found with the company director and manager who told us they would take action to address these concerns.

One member of staff that was responsible for administering people's medicines had not completed medicines administration training nor had their competency assessed by a suitably qualified person. We brought this to the attention of the manager who took immediate action to make people safe by stopping this person from administering medication and arranging for them to attend training.

Risks to people health and wellbeing were not always managed safely. Where people had been identified as

being at risk of malnutrition, food and fluid charts were not always completed. Staff told us they recorded people's food and fluid intake as part of their daily records. However, we saw people's food and fluid intake were not always recorded in sufficient detail, recorded correctly, totalled, or analysed.

For example, records for one person showed staff had recorded this person had consumed a total of 450mls over a period of 24 hours period. Records did not record in detail what this person had for lunch or tea. Guidance had not been provided to establish how much fluid was adequate for their individual needs. There was no guidance to direct staff as to the action they should take if this person's fluid intake fell below an agreed level.

Nutritional screening was being undertaken using a Malnutrition Universal Screening Tool (MUST) to identify people who were at risk from dehydration or poor nutrition. We found staff were not following the MUST tool where people had been identified as high risk. For example records for one person showed they had lost a significant amount of weight in the three months prior to this inspection. Their MUST score indicated they were at high risk of dehydration or poor nutrition and directed staff to monitor food and fluid intake and encourage foods/snacks high in energy and protein. Records showed staff had sought advice from the community nursing team, as they were concerned this person had lost a significant amount of weight. However staff were not specifically monitoring or recording this person's food or fluid intake nor were they providing foods/snacks high in energy and protein. We discussed our findings with the manager who arranged for this person to be seen by their doctor.

Where risks had been identified, action was not always taken to minimise these risks. For example one person had come to live at the home in July 2016. Their falls diary indicated they had fallen more than five times since their admission. Their falls risk assessment which was updated in July 2017, indicated they were at high risk of falls and directed staff to refer the person to the specialist falls team for assessment. Records showed this had not happened. We asked for the referral to be made, the manager confirmed this had been done.

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

Staff recruitment practices were not always safe. We looked at the recruitment files for eight staff. We found some recruitment checks had been carried out. For example checking the applicant's identities and obtaining references. However we found disclosure and barring (police) checks had not been completed before staff provided care and support to people or worked unsupervised. The disclosure and barring service helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with people who may be vulnerable.

On the first day of inspection we found a new member of staff had been appointed and had started working at the home on the 14th August 2017. This member of staff did not have a DBS certificate in place and were working unsupervised. We brought this to the attention of both senior managers and asked them to provide the Commission with evidence the provider was in receipt of a valid DBS certificate or put in place suitable management arrangement until this had been obtained. We also noted a night care assistance was due to work a few days later and records showed this person did not have in place a valid DBS certificate.

On the second day of the inspection five days later we found the provider did not have a DBS check for the new manager and suitable arrangements had not been put in place to protect people as requested. The night time care assistant had also been allowed to work unsupervised without having a valid DBS certificate in place. We raised our concerns with the company directors who took immediate action and arranged for

suitable management cover to be provided for the new manager and assured us the night time care assistant would not work unsupervised until full DBS certificate had been obtained.

DBS or police checks are used to help ensure staff are suitable to work in the care sector. Although we did not identify people had suffered harm as a result. The failure to complete necessary checks before allowing staff to provide care had exposed people to unnecessary risk.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People said they felt safe and well cared for at Thurlestone House, their comments included "I do feel safe," "I'm very happy here" and "I would recommend this home to anyone". Relatives told us they did not have any concerns about people's safety. One relative said "from what I have seen people are safe and well looked after" We saw people were happy to be in the company of staff and were relaxed when staff were present.

People living at the home, their relatives and staff all told us they felt there were sufficient staff on duty to meet people's care needs. On the day of the inspection, there was four care staff on duty, which were supported by the manager. Staff were visible throughout the inspection and people's call bells were answered quickly. A number of ancillary staff such as housekeeper, chef, and kitchen assistant were also on duty. During the night, people were supported by two waking night staff. The manager told us staffing levels were determined according to people's needs and staff confirmed that when people's care needs increased, for instance, if they were unwell, staffing levels were increased.

People told us they felt safe and were protected from the risks of abuse and harm. Staff had received training in safeguarding adults and whistleblowing. Staff demonstrated a good understanding of how to keep people safe and how and who they would report concerns to. The policy and procedures to follow if staff suspected someone was at risk of abuse or harm were displayed in the main office. This contained telephone numbers for the local authority and the Care Quality Commission. Staff told us they felt comfortable and confident in raising concerns with the manager. Staff knew which external agencies should be contacted should they need to do so.

Some of the people living at Thurlestone House displayed behaviours that could place themselves or others at risk if they became anxious or upset. Staff knew how to manage these risks and had been trained to 'de-escalate' situations and help support people to remain calm. There was clear information in people's care plans for staff to follow to help and support people with their behaviours and to minimise the impact these might have on themselves as well as others.

Other risks to people's health and safety were well managed. People's care plans contained detailed risk assessments and management plans, which covered a range of issues in relation to people's needs. For example, risks associated with skin care, or medical conditions. Risk assessments contained information about the person's level of risk, indicators that might mean the person was unwell or at an increased risk and action staff should take in order to minimise these risks.

During the inspection, we observed that the home maintained a high standard of cleanliness. We saw the premises and equipment were clean and steps had been taken to minimise the spread of infection. There were aprons and gloves available for staff to use and the home had appointed an infection control lead who was responsible for carrying out a monthly audit. Records showed that equipment used within the home was regularly serviced to help ensure it remained safe to use.

The management team and staff carried out a range of health and safety/premises checks and audits on a weekly and monthly basis to help ensure any risks were minimised. For example, water testing and water temperatures checks, fire safety, wheelchair maintenance, electrical testing and gas installations. The home had fire extinguishers, fire protection equipment and clearly signposted fire exits to assist people in the event of a fire.

Accidents and incidents were recorded and reviewed by the registered and senior managers regularly to look for trends that might indicate a change in a person's needs and to ensure the physical environment remained safe. Staff were trained in first aid and first aid boxes were easily accessible. Each person had a personal emergency evacuation plan (PEEP) and the provider had contingency plans to help ensure people were kept safe in the event of a fire or other emergency.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions at particular times 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Some of the people who lived at Thurlestone House were living with a dementia or had needs relating to their mental health, which affected their ability to make some decisions about their care and support. During this inspection we identified some concerns relating to a lack of understanding on behalf of the management team in relation to the Mental Capacity Act 2005. This had resulted in people potentially having their rights unlawfully restricted.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed the registered manager had made six applications to the local authority for authorisation to deprive people of their liberty. This was because people were not all free to leave the home if they wished, due to safety considerations and because they were under constant supervision by staff. Records showed four of the six people had not had their capacity to consent to these arrangements assessed prior to applications being made. Another person's assessment did not contain sufficient information as staff failed to complete the assessment in full and therefore were unable to determine the person's level of capacity or ability to consent to having their rights restricted as they were not free to leave the home if they wished.

This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed they had received training in MCA and throughout the inspection, we observed staff putting their training into practice by offering people choices and respecting their decisions. For example, staff were aware of people's right to refuse support. Staff asked people for their consent before they assisted them and checked with them that they had understood their request. Staff told us they always assumed people had capacity.

People were supported by staff that were knowledgeable about their needs and had the skills to support them. Records showed new staff undertook an induction programme, which followed the Skills for Care, Care Certificate framework. This is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. There was a comprehensive staff-training programme in place and staff we spoke with confirmed they received regular training in a variety of topics. These included dementia care, first aid, infection control, moving and handling, food hygiene, safeguarding, and Mental Capacity (MCA). Other more specialist training included palliative care [care of the terminally ill], and pressure ulcer prevention.

People told us they were well cared for, and had confidence in the staff supporting them. Staff received regular one to one and group supervision with a member of the homes management team. Staff told us supervision gave them opportunity to discuss all aspects of their role and professional development with their line manager. Staff found this style of supervision very useful as it gave them the opportunity to discuss and identify any gaps in their knowledge or raise concerns. Staff comments included "We have a good supportive team," "The manager's door is always open" and "they do listen to what we have to say."

People told us they were supported to use a range of health care services when needed, and had regular contact with dentists, opticians, chiropodists, district nurses and GPs. People told us staff responded to their needs promptly and people's care plans contained details of their appointments. Where changes to people's health had been identified, records mostly showed staff had made referrals to the relevant healthcare professionals. People when necessary received support from the community nursing team, for example with monitoring their blood glucose levels, or when receiving end of life care. The community nurses we spoke with during the inspection said staff communicated well with them and said the staff had the skills and knowledge to care for people well.

People told us they enjoyed the meals provided by the home, describing them as "very good." They said they could have drinks and snacks whenever they wished. One person said, "there's always a choice and if you don't like something all you have to say and they will make you something else." Another said "I don't have any concerns about the food or the quality".

People were able to have their meals in the dining room, the lounge or in their own rooms if they wished. People who did not wish to have the main meal could choose an alternative. The chef and kitchen assistants told us they were provided with detailed guidance on people's preferences, nutritional needs, and allergies and there was a list of people's dietary requirements in the kitchen. We heard staff offering people choices during meal times and tea, coffee, and soft drinks were freely available.

We observed the lunchtime meal. Where people needed assistance, this was provided appropriately and discreetly. Meals times were relaxed, social occasions where people and staff engaged in conversation, and light-hearted banter whilst enjoying their meals. Care records highlighted where people required a specialist diet for example soft or pureed meals. Staff we spoke with were aware of any specific needs people may have as well as their likes and dislikes.

Thurlestone House provided a comfortable environment for people to live in. The home was set over two floors and had a large dining room, a large and small lounge and conservatory area. The grounds were well maintained and attractive with seating areas where people could relax with friends and family.

Is the service caring?

Our findings

People told us they were happy living at Thurlestone House. One person said, "I choose to live here, I was able to pick my room and although it's not my own home I'm happy here," Another said, "The staff are really kind, caring and very helpful, especially [Staff name] she always seems to go out of her way to make sure that I'm ok and have everything I need." Relatives told us they were happy with the care and support people received. One relative said, "they have made mum and me very welcome. All the staff I've met have been kind, caring and compassionate. You can tell just in the way they speak to people that they care."

There was a calm and friendly atmosphere within the home. Staff spoke fondly about people with kindness and affection. People responded well to staff and we observed a lot of smiles, laughter, and affection between staff and people they supported. Staff knew how each person liked to be addressed, and consistently used people's preferred names when speaking with them. Staff told us they enjoyed working at the home and they received a great deal of satisfaction from caring for people.

Information about people's needs and preferences were obtained and recorded as part of their pre-admission assessment. People's care plans were clear about what each person could do for themselves and how staff should provide support. People told us they were involved in making decisions about their care and support. People told us they made choices every day about what they wanted to do and how they spent their time. People felt their views were listened to and respected. Staff demonstrated they knew the people they supported and were able to tell us about people's preferences. For example, staff told us what people liked to eat, how they liked to spend their day, when they liked to get up and go to bed.

People said staff treated them respectfully and encouraged them to remain as independent as possible. When people needed extra support this was provided in a considerate way, and in a way that suited each person's ability and pace. Throughout the inspection, we saw and heard people being supported, staff spoke with them in a calm, respectful manner, and allowed people the time they needed to carry out tasks at their own pace.

People told us staff respected their privacy and we saw staff knocked on people's doors and waited for their response before entering their rooms. People's bedrooms were personalised, decorated to their taste, and furnished with things that were meaningful to them. For instance, photographs of family members, treasured pictures from their childhood, favourite ornaments, or pieces of furniture. Relatives and visitors were free to visit at any time and told us they were always made to feel welcome.

Where people were being cared for in bed due to poor health we saw they appeared comfortable and pain free. Staff recorded when they attended to their care needs and the home was able to support people's care at the end of their lives and had attended training in palliative care. The home regularly received positive feedback and a number of thank you cards from relatives were displayed within the home. For example one relative had recently written. "Thank you once again for the care and understanding you give to all residents especially our mum. The new leadership has improved the standard of care and we hope you know all your efforts are appreciated."

Is the service responsive?

Our findings

People were involved in identifying their needs and developing a plan as to how care would be provided. The registered manager carried out an initial assessment of each person's needs before and after they moved into the home. This formed the basis of a care plan, which was further developed with the person, their relatives, and as staff got to know them.

People's care plans were personalised and provided staff with detailed guidance about each person's specific needs. Information included what the person could continue to do for themselves and how they liked to be supported. Each section of the plan covered a different area of the person's care needs, for example, personal care, mobility, physical health, continence and skin care, communication and mental health, emotional support, family and friends and life story.

People's care plans were informative, easy to follow, and accurately reflected people's needs. They were reviewed monthly or as people's needs changed. Staff told us that people, who were able, were asked to be involved in planning and reviewing their own care. Where people lacked the capacity to make a decision for themselves, staff involved family members or other advocates in the review of their care. People were given the opportunity to sign their care plans if they wished.

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the home. Staff were able to tell us detailed information about people's backgrounds and life history from information gathered from families and friends. Each person's care plan contained a life story, which covered the person's life history, their family and personality. This gave staff the opportunity to understand a person's past and how it could influence who they are today. Relatives told us they had been asked to share information and provided photographs where possible. One relative said, "All the staff have been keen to take the opportunity to ask questions about my mum, what she likes and dislikes and it's been good for me to share the information."

Where people needed support to manage long-term health conditions, for instance diabetes, we saw the registered manager had consulted with the person's GP. They had provided staff with information on how to recognise signs and symptoms that would indicate this person was becoming unwell and what action staff should take. Where people had specific needs relating to living with dementia, guidance was provided for staff in how best to support people. For instance, one person was known to become distressed and anxious. The home had sought guidance from the 'older person's mental health team' and developed a plan for staff to follow to support this person's well-being and minimise the impact this might have. Staff were able to describe how they supported this person during these times.

People were supported to follow their interests and take part in a range of social and leisure activities. Each person's care plan included a list of their known interests and staff supported people on a daily basis to take part in things they liked to do. People who wished to stay in their rooms were regularly supported by staff in order to avoid them becoming isolated. The homes mini bus the home provided weekly trips out to local places of interest. People told us they regularly went out with family members and we saw people were free

to come and go as they wished.

People spoke positively about the level of activities and entertainment provided by the home. One person said, "There is always something going on." Another person said, "I will join in with things I like".

We saw a range of activities were available including music therapy, arts and crafts, arm chair exercises, board games and quizzes. The home had recently purchased a projector and the on the first day of inspection we saw people were having a film afternoon which they told us they enjoyed. Activities were designed to encourage social interaction, provide mental stimulation and promote people's physical and spiritual well-being. Throughout the home we saw a range of dementia friendly sensory cushions that people could pick up and interact with, which had different textures to stimulate their senses.

People and relatives were aware of how to make a complaint, and felt able to raise concerns if something was not right. One person said they would speak to [person name] the deputy manager if they were unhappy. Relatives told us the manager was always available and they felt able to approach them or staff if they had any concerns. One relative said, "I would raise any concerns that I have and I'm confident staff would deal with them in a timely way." The home's complaints procedure provided people with information on how to make a complaint. The policy outlined the timescales within which complaints would be acknowledged, investigated, and responded to. However it was not clear who the provider was or how they could be contacted if they were unhappy with the response they received from the homes management team. We brought this to the attention of both senior managers who told us they would look into making the providers contact details clearer for people and their relative. We reviewed the homes compliant file and saw that where people had raised concerns these had been investigated in line with the homes policy and procedures.

Is the service well-led?

Our findings

This is the fourth inspection of Thurlestone House since April 2015. There have been three comprehensive inspections and one focussed inspection. At each of these inspections we found breaches of regulation and the service were rated 'Requires Improvement'.

In April 2015 the service was rated as requires improvement. In June 2016 we judged the service as requires improvement again. We served a Warning Notice, telling the provider what action they needed to take in relation to safe care and treatment.

In September 2016, we found action had been taken to address the issues identified in the Warning Notice. However, the service still required improvement in some areas.

At this inspection we identified improvements were still required and there were four breaches of Regulation 11, 12, 17 and 19. Breaches of Regulation 12 and 17 had also been identified at the inspections in July 2015, June 2016 and/or in September 2016. Although the management team had introduced a range of quality and risk audits systems, these had not been effective in addressing the quality and risk issues identified by CQC during this and previous inspections.

The home did not have a registered manager, although this person's name will show on this report as they have not deregistered with the Commission. The registered manager had resigned from their position four weeks prior to this inspection. A new manager had been appointed and had been working alongside the registered manager. They have not made application to the CQC for registration, and are referred to in this report as the manager.

During this inspection we found the home's quality assurance and monitoring systems were not effective. Systems and processes had failed to identify a number of concerns we found at this inspection. For instance, quality assurance systems had failed to ensure people's medicines were managed safely or administered by appropriately trained staff. Although there were checks and medicine audits in place, staff had not identified that people's medicine stocks levels did not tally with the numbers of medicines recorded on their medicine administration records and could not account for the missing tablets.

Care plan reviews and audits were taking place, however these had failed to identify that some risks to people had not always managed safely. For example where people had been identified as being at risk of malnutrition. Audits had not identified that staff were not recording people's food and fluid intake in sufficient detail or following the guidance which had been provided.

Arrangements for recruiting staff did not adequately protect people. Although, the provider had a recruitment procedure and policy in place, the quality assurance systems had not identified where checks had not been completed. This meant the home did not have a robust system in place to ensure all staff recruited were safe to work with people who are vulnerable due to their circumstances.

Where concerns had been identified by outside agencies, such as the CQC, the provider had failed to take sufficient action to ensure the care provided was safe. For example, at the end of our first day of inspection we raised a number of concerns with members of the management team about the homes recruitment procedures. We asked them to provide the Commission with evidence that the provider was in receipt of a valid DBS or put in place suitable management arrangement until this had been obtained.

When we returned for the second day of our inspection five days later we found the provider had not put in place suitable arrangements to protect people as requested as they did not have DBS for the newly appointed member of staff. In addition the management team had also failed to take action to prevent a night time care assistant from work unsupervised without having a DBS in place. We had also drawn their attention to this five days earlier.

There was oversight by senior staff but this was not robust enough. Regular spot checks and audits were undertaken by the senior management team. These included monitoring people's food and fluid intake, pressure area care and medication. These were used to identify any areas of concern and plan ongoing improvements. Where issues or concerns had been identified, the senior manager produced an action plan with timescales for improvements to be made. However, we found that these spot checks had not identified the issues we found that required improvement and had not been effective in improving practice.

Spot checks which had been carried out by both senior managers prior to the inspection identified that the referral had not been made however no action had been taken to address this. We discussed what we found with both senior managers and who were unable to tell us why action had not been taken

Spot checks and audits did not include looking at the detail contained within people's care records or risk assessments. Therefore, senior managers were not aware that risks to people were not being identified or acted on until our inspection. For example we found the home was not working within the principles of The Mental Capacity Act 2005 (MCA).

Systems and process had failed to identify that people were potentially having their rights restricted unlawfully. A system was in place to monitor the status of DoLS authorisations and DoLS applications that were in progress on a monthly basis. Records showed applications had been reviewed by the senior management team in July 2017 and had recorded 'no shortfalls ' We found four of these people had not had their capacity assessed to consent to these arrangements and one person MCA had not been completed correctly.

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

The management and staff structure provided clear lines of accountability and responsibility. Staff knew who they needed to go to if they required help or support. There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through handover meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns.

Records showed the manager and provider held regular staff meetings. Staff meetings were used to discuss and learn from incidents, highlight best practice and identify where any improvements were needed. For instance, we saw from these meetings the registered manager had discussed concerns relating to people care needs, medication, infection control in the environment and activities.

People were encouraged to share their views and were able to speak to the manager when they needed to. Senior managers told us they encouraged people and their relatives to provide feedback about the care and support they received. We saw that the home employed the services of an external company to seek the views of people and their relatives about their experience of the services they received. A random sample was completed on a monthly basis the result collated and returned to the provider and manager for review. We reviewed the most recent report and found that the responses of the people surveyed were positive.

The manager knew how and when to notify the Care Quality Commission (CQC) of any significant events which occurred, in line with their legal obligations. They also kept relevant agencies informed of incidents and significant events as they occurred. This demonstrated openness and honesty. The manager understood and was knowledgeable about the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to operate an effective recruitment procedure exposed people to unnecessary risk. Regulation 19(1)(a)(2)