Barchester Healthcare Homes Limited

St Thomas

Inspection report

St Thomas Close
Basingstoke
Hampshire
RG21 5NW

Tel: 01256355959
Website: www.barchester.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 25, 26 and 28 July 2016 and was unannounced. St Thomas's provides residential and nursing care for up to 67 older people, including people living with dementia. The accommodation is arranged over two floors built around an internal courtyard. At the time of our inspection there were 64 people living at the home.

A registered manager was in post at the time of our inspection. 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 service is required by a condition of its registration to have a registered manager.

The provider had a staff dependency tool in place, however we could not be assured that there were always sufficient staff deployed to safely meet the needs of the people living at the home. The registered manager had made some environmental changes to enable people to have more freedom to move around the home. This had been well received by staff and relatives. However, some further evaluation was required to ensure that staff were always effectively deployed to support people to make the most of this freedom, by ensuring that they were safe, had opportunities for social interaction and that their care needs were met.

The registered manager had made other changes during the past year to develop and improve the service. Some of these changes needed time to bed in to ensure they could be sustained, for example the post falls protocol which had recently been introduced.

Staff told us that there was an open culture at the home and they felt able to talk to the management team about any concerns. Processes were in place to enable people and relatives to provide feedback to the registered manager through residents and relatives meetings. However not all relatives felt they had been listened to if they raised concerns.

Staff did not always demonstrate an understanding of how to deliver good care to people living with dementia. While they were kind and caring towards people when they did interact with them, they sometimes missed opportunities to engage with people and ensure that they were getting the social interaction and stimulation they needed. There was also a lack of activities provision at the time of the inspection. The registered manager was in the process of recruiting a new activities co-ordinator and assistant. The provider had recognised the need to improve the experiences of people living with dementia and was undertaking work around this.

Risks to people's safety had been identified, managed and reviewed. These included potential hazards in the environment and risks when people were supported by staff to move or transfer. They also included an assessment of the risk to people of falls, weight loss, choking and the development of pressure sores. Staff knew what action they needed to take to manage risks and keep people safe.

People were supported by staff who had been trained in safeguarding and were able to recognise the signs of abuse. Safeguarding policies and procedures were in place and staff knew what to do if they had any concerns.

Recruitment procedures were in place to ensure that people were protected from the risk of employment of unsuitable staff. New staff followed a period of induction to ensure that they had the necessary skills and confidence to fulfil their role.

People were protected from the unsafe administration of medicines as there were clear processes and procedures in place for the safe receipt, storage, administration and disposal of medicines which nurses followed.

The provider had a programme of mandatory training to ensure that people had sufficient skills and understanding to meet people's needs effectively. There was a system in place to ensure that training was regularly refreshed. There was a programme of supervisions and appraisals and staff told us that they felt supported by their team leaders and managers.

Where possible, people were supported to make decisions about their care and treatment. Where people did not have the capacity to consent, the provider acted in accordance with the Mental Capacity Act 2005. This meant that people's mental capacity was assessed and decisions were made in their best interest involving relevant people. The registered manager was aware of her responsibilities under the Deprivation of Liberty Safeguards (DoLS) and had made appropriate applications to the local authority. Records confirmed that appropriate procedures had been followed to ensure that decisions about people's care had been made in their best interests and in accordance with good practice.

People were supported to have enough to eat and drink to meet their nutritional and hydration needs. People received support to eat in accordance with their care plans. People were offered choice at mealtimes and drinks and snacks were available. The registered manager had made changes to the dining arrangements to improve people's mealtime experiences.

During the inspection we saw people being spoken to with warmth and kindness when they were being supported by staff. People's independence was promoted, particularly following the recent changes to the environment which meant that people were less restricted in gaining access to different parts of the home. We observed people being offered choice in their daily routines and asked for their views. People told us that staff treated them with respect and dignity and that they had the privacy they needed.

People's care and support needs were documented and regularly reviewed. People were able to gain access to healthcare services to meet their health needs.

The provider had systems in place to manage complaints and concerns. Records showed that formal complaints had been responded to in accordance with the provider's complaints policy.

Audits carried out by the managers at the home had been effective in identifying improvements and action plans had been put in place and completed.

The registered manager led by example and set high expectations for staff to ensure there was a continuous improvement in the delivery of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff were not always deployed effectively in order to meet the needs of the people living at the home at all times.

People were safeguarded from the risk of abuse. Staff understood their roles and responsibilities in relation to protecting people from the risk of harm.

Specific risks to people had been identified, assessed and documented appropriately.

People were protected against risk associated with unsafe administration of medicines as appropriate checks and procedures were in place.

Is the service effective?

Good

The service was effective

The provider followed appropriate procedures to ensure people's rights were upheld in accordance with the Mental Capacity Act (2005).

Staff received an induction into their role, on-going relevant training and supervision of their work. People received their care from staff that were supported in their role.

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

People were supported to access health care services as required.

Is the service caring?

Good

The service was caring.

People received kind and compassionate care from staff. .

People were given choices and staff respected their wishes.

Staff upheld people's privacy and dignity when delivering their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always demonstrate a good understanding of people living with dementia. There was a lack of activities for people which were individualised to take account of their interests, abilities or need for stimulation. Staff did not always ensure that people's social needs were met.

A system was in place for people and relatives to raise complaints and concerns and these were responded to.

Is the service well-led?

Requires Improvement

The service was not yet consistently well led.

The registered manager had introduced changes and put in place systems to drive continuous improvement in the delivery of high quality care. However time was needed to enable changes to become embedded and sustained.

Staff told us that they felt that the culture was open, that they felt supported and able to talk to managers. Feedback from healthcare professionals was mainly positive. There was some scope for further improvement in communication with relatives.

The registered manager led by example and set high expectations for staff. Any concerns were identified and followed up at supervision and staff meetings.

St Thomas

Detailed findings

Background to this inspection

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

This inspection took place on 25, 26 and 28 July 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, 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; on this occasion they had experience of family members living with dementia who had received residential care. The expert by experience spoke with people using the service and their relatives.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We had not requested a Provider Information Return (PIR) for this inspection. A PIR is a form which askes the provider to give some key information about the service, what the service does well and improvements they plan to make. We obtained this information during the inspection.

During our inspection we spoke with three people living at the home and seven relatives of people living at the home. Some people living with dementia were unable to tell us about their experience of the care they received. We therefore observed the care and support these and other people received through the inspection to inform our views of the home. We also spoke with the registered manager, the regional director, a kitchen assistant, an agency chef, three nurses and six care staff. We also spoke with, or received written feedback from, seven health and social care professionals during and after the inspection.

We reviewed records which included 11 people's care plans and daily records, the medicine administration records for 12 people, six staff recruitment records, nine staff supervision and appraisal records and records relating to the management of the service. These included; policies and procedures, quality assurance records, accident and incident reports and staffing rotas for the period of 27 June to 24 July 2016.

This service was last inspected 22 and 23 June 2015 when no regulatory breaches were identified.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they or their loved ones felt safe at the home. A relative said that they felt their loved one was "safe and well treated". A person told us, "There are no unpleasant staff and I am quite happy and comfortable".

The provider had introduced the DICE (Dependency Indicated Care Equation) staffing dependency tool in 2015 which they felt worked effectively in determining safe and appropriate staffing levels.The registered manager told us that they no longer used agency staff, but occasionally used bank staff, two of which were used regularly. This helped ensure continuity of care for people from staff who they were familiar with.

We viewed staff rotas and saw that there were four shift patterns, with staff working shorter shifts from 8am to 2pm or 2pm to 8am and then some on long days (8am to 8pm) and nights (8pm to 8am). The registered manager told us that there were always two nurses doing a long day shift and two nurses doing the night shift. They advised that there were 12 care staff working during the day and four care staff at night. We viewed staff rosters which confirmed that staffing levels met the provider's identified requirements to provide safe staffing levels across the course of the week, including at weekends.

However, during our inspection we had found that it was sometimes difficult to find staff in the communal areas, particularly after lunch. For example, during this period on the first day of the inspection, we had to go and find staff to assist people on two occasions in the communal areas. One person was distressed and did not know where they were and another was unstable having left their walking frame in their room. The registered manager explained that it may be difficult to find staff after lunch as they were often supporting people in their rooms. However, this had meant that on those occasions there were insufficient staff available to support people in communal areas.

Staff we spoke with told us that they thought there were enough staff to manage people's needs effectively. However, we found that some people, relatives and healthcare professionals gave different views. One person we spoke with told us "occasionally they could do with more. Weekends are not so good". One relative described that they came in to visit at 2.30pm and their loved one was not yet out of bed. They told us that "The lack of staff is very noticeable". Another told us that "there are not enough staff at weekends and I often have to look for someone if I need help" and "There are never enough staff, I sometimes wonder where they are". A healthcare professionals we spoke with told us they felt that "staff seem busy and pressured", another told us they found it "almost impossible" to find a nurse when they visited the home. Another said that on one of their visits, there were around 15 people sitting in the lounge with only one staff member present, while three members of staff were in a nearby office.

In the minutes of a staff meeting from 31 May 2016 we saw that the registered manager had highlighted the need for carers to be present in lounges. The registered manager and more recently the deputy manager had walked around the home and observed lounges to be full with people and 'not a carer in sight.' These observations had been made in May 2016 over the period of a week. The registered manager told us they took action following these observations with the implementation of a new daily care staff allocation form

to ensure that lounges were attended by staff. However, time was needed to review this arrangement to ensure it was working effectively.

We found that there was a need for the provider to continue to review and evaluate the effective deployment of staff to manage risks to people's safety and ensure that their care needs were being met.

The home had clear safeguarding policies and procedures in place to keep people safe. People were protected from the risk of abuse because staff knew the signs of abuse and were able to describe how they would recognise changes in a person's behaviour or actions. They were confident in what action they would take to protect people if they identified these. Relatives we spoke with told us that they felt their family members were safe at the home and that if they did have any concerns they would know how to raise these. One relative told us "Things are much better now. I feel he is safe here. If there is a problem they phone straight away".

Safe recruitment procedures were followed to ensure that people were supported by staff with the appropriate skills and experience and who were of suitable character. We viewed staff recruitment documentation which confirmed that new staff had undergone the required recruitment checks as part of their application process. Documents we saw included details of qualifications, employment histories, references from previous employers and reasons for leaving previous employment. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. A centrally managed electronic system had been put in place by the provider to ensure that all relevant employment checks were made. The provider also checked nurses were registered with the Nursing and Midwifery Council (NMC) which confirmed their fitness to practice safely. There were systems in place to ensure that nurses' registrations were kept up to date.

We saw from people's care plans, that specific risks to people's safety had been identified, managed and reviewed. These included potential hazards in the environment and risks when people were supported by staff to move or transfer. They also included an assessment of the risk to people of falls, weight loss, choking and the development of pressure sores. Staff demonstrated that they knew what action to take to keep people safe when they were supporting people. For example, we observed a care worker supporting a person with sight difficulties to safely make their way around the home, by guiding them with their voice past any trip hazards. The care worker told us" This way [they] can remain independent and walk without having to hold onto someone.

People were assessed monthly for the risk of them developing pressure ulcers. Care plans showed where people had been identified as at risk, plans had been put in place to prevent their skin from deteriorating. People were prescribed topical creams to hydrate and protect their skin in order to minimise their risk of developing pressure ulcers. People who could not change their position independently to relieve the pressure on their skin were supported to reposition regularly and used pressure relieving equipment to protect their skin from pressure damage.

Staff were aware of people's risk of choking and they were supported in line with Speech and Language Therapy guidance with soft and pureed food and thickened fluids, as required. We saw at the shift handover meeting changes in people's swallowing that could put them at increased risk of choking, had been identified and were being monitored to ensure they would remain safe when eating and drinking. Processes were in place to identify and manage risks to people safely.

Where people had been assessed as not being able to use their call bell to request staff support there was

written guidance for staff to check upon them regularly if they chose to remain in their bedroom. Processes were in place to ensure people's safety if they were unable to use the call bell.

Checks had been completed as required in relation to gas, electrical, fire and water safety for the service. This ensured the building was safe for people's use. A business continuity plan was in place which detailed how the service would continue to operate and keep people safe in the event of an emergency such as the loss of an electrical supply or an incident affecting staffing levels.

There were clear processes and procedures in place to ensure the safe storage, administration and disposal of medicines. We observed a medicines round and saw the nurse administer people's medicines appropriately. The room temperatures for where the medicines were stored were monitored and we saw that "opened on" and expiry dates were clearly recorded on medicines. This helped ensure that medicines were not used past their expiry date, or after the recommended disposal period, and were therefore safe to be administered. We checked people's medicines administration records (MARs) and saw that medicines stock coming into the home was clearly recorded on these and that people were receiving the correct medication when it was due. We saw that topical creams were also administered appropriately by care workers as part of delivering personal care and that this was recorded on a separate MAR sheet.

The home kept some controlled drugs. These are prescription medicines controlled under the Misuse of Drugs Act 1971 and have additional safety precautions and storage requirements. We saw that these drugs were stored correctly and recorded appropriately in a controlled drug register and on the MAR sheet when administered, in accordance with procedures under this Act. Care plans provided details of people's medicines including instructions for use and details of 'as required' medicines. There were clear records and a protocol in place which documented why the medicine had been prescribed and when it should be administered, and evidence that this was subject to regular review.

We saw that three people at the home received medicines covertly. This is where medicines are administered in a disguised form, for example in food and drink. In these cases we saw best interest decisions had been carried out in consultation with the GP and relatives. We also saw guidance to staff from the pharmacy on the way in which they should administer the medicines covertly for each person.

Appropriate procedures were in place to ensure that people received their medicines safely.

Good

Is the service effective?

Our findings

Staff told us that they felt supported in their roles; that they had received a suitable induction and there were adequate training opportunities. The provider ran an induction programme which was based on the Skills for Care, which is the industry standard for care staff. Staff described completing online and classroom based training (which usually took place in one of the provider's other homes) and completing workbooks to assess their understanding of their learning. They told us that the training was sufficient for them to undertake their role. We saw that the provider had worked hard to make improvements to training since the last inspection and as at the day of this inspection, the home had met the provider's target of 85% completion of mandatory courses, which included training in fire safety, health and safety, moving and handling, infection control and safeguarding. We saw that dates were scheduled for the next tranche of training throughout August. Staff also told us that they had attended additional training, for example in dementia care and end of life care.

Over the previous year, the provider had made improvements to staff supervision arrangements. Staff supervisions were now included on the provider's training schedule, which meant that they were included in the provider's training statistics and they could therefor assure themselves that supervisions were taking place regularly. We saw that supervisions had a completion rate of 93% as at the day of the inspection, and that the registered manager kept a supervision planner to keep track of when supervisions were held and when they were due. We viewed supervision records and saw that they occurred both on a one to one basis and sometimes as a group supervision. Staff told us that there was now a better structure in place around supervision arrangements which has meant that staff were better supported.

People received annual appraisals. Staff told us that these provided an opportunity to review personal development plans. One member of staff described how they had discussed during her appraisal how they wanted to progress their career in the home and wanted to undertake a vocational qualification. We saw from their appraisal record that they had started to undertake this qualification. People were cared for by suitably trained and supported staff.

People were asked for their consent before care or treatment was given. A person told us "Staff always ask me what I want or tell me what is going to happen before they start my morning care''. Staff told us they constantly sought people's consent for their care. Staff were heard to seek people's consent before they provided their care. Staff asked a person if they were ready for their breakfast and checked with another person whether they wished to go to the lounge after their breakfast. People were supported to make their own decisions where they were able.

Where people did not have the mental capacity to independently make decisions about their care arrangements, the provider acted in accordance with The Mental Capacity Act 2005 (MCA). The 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. Mental capacity assessments

had been completed which were decision specific. For example, mental capacity assessments had been carried out for individuals in relation to the use of bed rails and the administration of medicine covertly.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had submitted DoLS applications when required. The applications had been supported by an MCA assessment which demonstrated: the person lacked the capacity to consent to their care and treatment; that they were under constant supervision; and that relevant people had been consulted as part of the best interest decision to submit the application. Legal requirements had been met in relation to the submission of DoLS applications for people.

The meals provided at St Thomas's looked and smelt appetising and people appeared to enjoy them. There was a relaxed atmosphere in the dining rooms with friendly and jovial conversation between people and staff. The dining rooms were arranged in the style of a restaurant to enhance people's mealtime experience and visitors were encouraged to dine with their loved ones.

The registered manager told us they had taken action to improve the effective use of staff during meal times when this had been identified as an area for improvement during a service audit. We saw a meal time plan in place which identified the roles of staff at each meal time, for example who would be serving the food and who would be supporting each table to ensure people got the support they needed promptly during meal times. During our lunch time observation we saw this plan were implemented to ensure staff were effectively deployed during the lunch time and those people who required additional staff support received this.

The chef could describe people's dietary needs, allergies and preferences. We saw a list of people's dietary requirements within the kitchen to ensure kitchen staff remained up to date when preparing people's food. This matched people's care plans and the food we observed served to people. This ensured people received the consistency and type of food required.

Staff promoted the importance of good nutrition and hydration. Staff were observed to offer people drinks and snacks across the course of the inspection and a visitor told us ''Snacks are readily available.''. People who experience dementia will burn up additional calories if they are very mobile. Staff understood the need to offer people regular food and drink to ensure they remained hydrated and received enough food for their needs. Staff weighed people monthly and their Malnutrition Universal Screening Tool (MUST) score was then calculated. MUST is a screening tool to identify adults, who are at risk from either malnourishment or from being overweight. Nurses were aware of people at risk of malnutrition and could describe the plans they had put in place to ensure people at risk were supported to eat and drink sufficiently. We saw that people were supported to eat their meals in accordance with their care plans. One nurse told us ''The change in the meal time support has improved people's weight. We are now sure they will get the support and encouragement they need during meal times to eat enough''.

One relative told us "There is a local pool of GP's who are called when needed''. People's records demonstrated that in addition to regular GP visits, people had seen dentists, social workers, opticians, chiropodists, tissue viability nurses and community psychiatric nurses. During each shift handover meeting people's changing health needs were discussed to ensure staff would understand what was required for the

person's health care.

We saw that there was a steep slope in the corridor on the second floor which led up to four of the bedrooms. The registered manager explained that there was a level change and that there used to be steps but these had to be replaced by a ramp to enable the use of wheelchairs. They acknowledged that the gradient of the slope was steep but that it couldn't be less than this because of the length of the corridor. They advised that a stair lift was due to be fitted as an alternative and safer arrangement the following week.

Good

Is the service caring?

Our findings

Staff were observed to interact in a caring and kindly manner with people during the inspection. One person told us ''They seem quite caring'' and another said ''They are very good and patient''. Staff smiled at people as they spoke with them, this reassured people. Staff also used touch where appropriate, touching a person on the arm as they spoke with them. When staff noticed people getting confused they took them by the hand to reassure them and gently guide them to where they wanted to go. Staff cared about people's welfare and were heard asking people how they were. Staff were able to tell us what the signs were that some people were not happy and what the potential causes for this might be. They explained how they responded to people in these situations. People were cared for by staff who were concerned about their welfare.

Staff showed an interest in people and chatted with them as they provided their care. For example, a staff member chatted to a person about what they were going to do that day. When a person was waiting to go out a staff member complimented them on how nice they looked whilst supporting them to get a drink. The person smiled in response and told us staff made them feel good about themselves. Staff told us they had the opportunity to spend time with people and get to know to understand what made each person feel valued.

People's care plans reflected their preferences for the provision of their care. For example, they provided information about people's sleeping routines, whether they preferred a bath or a shower and what they liked to wear.

Staff consulted people about decisions they were able to participate in. People were able to bring their own furniture with which to furnish their bedroom. Staff were heard to offer people choice about what they would like to do and what they would like to wear. We saw that people were offered choice at lunchtime by being shown two different plates of food. This helped people to understand the choice offered and provided them with relevant information upon which to base their decision. It also enabled staff to clearly understand people's choices. Staff were seen to bend down to speak with people who were sitting down or to sit next to them where possible to ensure they were on the same level to communicate with them.

People's independence was promoted at St Thomas's, particularly with the recent changes that had been made to the home environment which allowed people to freely access different areas of the home and the outside garden space.

People told us that they were treated with dignity and respect. People described staff always knocking before they entered people's rooms. On person told us that their privacy was maintained "Oh yes, they won't come in unless I say they can". People's relatives told us that they thought staff were respectful of their loved one's privacy. A health professional told us that they had "always observed [staff] to treat patients with respect, dignity and kindness".

The home had a chapel during which regular church services were held for people. Staff told us how one

person's relative had recently got married and the person was unable to attend. The home arranged for the service to be restaged in the chapel so that the person felt that they had been able to attend and experience the wedding, albeit in a slightly different way. The registered manager told us that they were currently planning to undertake the same thing for another person. Staff cared about the experiences of the people living at the home.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed prior to them moving into the home and the information used to plan people's care. Records showed people's care plans had been reviewed routinely with input from their relatives to ensure staff would have the information they needed to meet people's changing needs. Shift handover meetings provided staff with a daily update on changes in people's health and behaviours so that they had up to date information in order to care for people safely and effectively.

Many people in the home lived with dementia and we looked at how their needs were being met during the inspection. People living with dementia are largely dependent on staff to interact with, who are able to be creative and show initiative in order to support and stimulate them to make sure their life is fulfilling. When we spoke to staff they confirmed that they had received relevant training and could describe to us what life would be like for a person living with dementia. However we did not always see this understanding being displayed in the way that care was delivered.

We saw there was an inconsistent approach when staff supported people living with dementia. Some staff communicated and presented care tasks to people living with dementia in a way that enhanced their understanding and participation in their care. However, we also saw examples were staff had presented information and undertook tasks in a way that frustrated people who could not understand, for example; we saw one person with limited understanding, being asked if they would like to move from their wheel chair into a lounge chair. They said ''Yes'', only then did the staff member try to find a hoist and a second member of staff to support them. They left the lounge and returned 10 minutes later with the hoist. During this time, the person had been trying to stand and had become increasingly agitated. They then refused to be hoisted. This task had not been planned and delivered in a manner that enhanced the person's understanding and choice.

While staff promoted and respected peoples choices, a relative and a healthcare professional told us that they thought that peoples answers to questions were sometimes taken at face value by staff rather than staff exploring whether people understood what was being asked of them. The provider explained that staff at the home underwent dementia training to understand how to respond to a negative response. This included returning to the individual at a later point rather than causing a person to become distressed, or asking someone else to rephrase the question.

As noted in the caring section, when staff engaged with people, they did this in a caring way. However we also saw that staff missed opportunities to engage with people to help them to maintain their social skills. We observed some areas of good practice with regards to social stimulation, but this was not consistent and there were instances where people were left for periods of time with little or no interaction. Some families and relatives told us that they felt that there was a lack of planned routine and stimulation for people at the home. During our inspection we saw some staff interacting with people chatting, looking through magazines and asking after their relatives. However, we also saw periods with people sitting in lounges where staff were present but not engaging with people. We observed some people appearing lost or disorientated in corridors, sometimes worrying about things, but not always receiving reassurances from staff. For example,

one person was distressed because they thought their shoes were different colours rather than matching. As staff weren't engaging with them, they weren't aware of this in order for them to talk it through with them and offer reassurance. We observed some people tried to engage with a staff member by calling out and talking to them but they did not pick up on people's attempts to try and interact with them. We saw staff at times moving people out of the way without talking to them or taking the time to offer them some social interaction. We observed two people sitting in a corridor one afternoon with a radio heard to be playing nearby. The radio was not correctly tuned in, however we did not observe that staff came to assist with this. Staff did not always respond to people's social needs and support them to have positive experiences.

The provider ran a programme of morning and afternoon activities which included skittles, table top tennis, music sessions, time in the garden and church services. We saw that occasional trips were also run, for example to the local zoo, and events were sometimes held, such as an entertainer coming into the home. The activities board in reception included activities planned for the week, however we did not see any activities taking place for people during the three days of our inspection. The provider has, however, provided activity evaluation reports since the inspection, to evidence that activities took place. These included skittles on the first day of the inspection which four people took part in and a "Motivation and Co" session on the second day which was delivered by an external resource. There was a 40 minute discussion around the day's news on the third day of the inspection, which seven people took part in. Another activity on the third day was watching TV, which six people took part in and the registered manager told us people chose to do rather than the planned karaoke session. However, these activities were not observed during the inspection and the evaluation sheets did not evidence that the activities programme was meeting the social needs of everyone living in the home.

People and their relatives gave us mixed views about the activities available in the home and whether they enabled people to remain meaningfully occupied, with opportunities to socialise and pursue activities they enjoyed. When asked about activities, their comments included ''Always something going on'', ''I would like to walk around a bit but there are not enough people to take us outside'', ''Not much – what is it today? Movies - no thanks'', ''He does enjoy the bands and charity events'', ''There is no activities person at present, but he doesn't join in anyway" and ''He likes to get involved but it is hard to communicate. There haven't been many lately''. It was not evident that the provider's activity programme was adequate or suitably personalised to keep people sufficiently stimulated.

The registered manager explained to us that the current activities co-ordinator had recently taken on a new in house training role and was therefore splitting her time between activities and her new role. However, a new activities co-ordinator had been recruited and was due to take up post on 12th August. There was also a vacancy which was being advertised for an activities assistant.

The provider had recognised that there was scope for improvement in ensuring people were stimulated and that people needed to be provided with opportunities to enable them to keep mentally and physically active. The home had been chosen to take part in a provider pilot, focussing on enhancing dementia care. The registered manager explained to us that as part of this, the provider was undertaking work around activities across their homes to test out a different approach in activities provision, which centred on care workers doing more activities with people as part of their regular routines. Plans also included activities taking more of a "lifestyle" approach rather than traditional activities, which would enable people to replicate the types of activities they might be doing if they were still living independently at home. The provider's aim was to support people to keep occupied and maintain their life skills.

We saw that the home's environment had been adapted to support the need of people with dementia. At the time of the last inspection, St Thomas consisted of four units situated on two floors. People were

protected from harm by the use of keypads on exit doors between floors and units. Relatives raised concerns that this was restricting some residents and contributing to their frustration when faced with a locked door. The home responded to these concerns and removed coded key pads to two doors. This meant that people coul freely access other areas of the home. This had seen positive outcomes, with people being able to move independently around the home. Staff and people's relatives told us that this had been a beneficial move and that there relatives were happier and more relaxed now. We also saw that the environment of the home was painted boldly and brightly, with lots of different colours used. Use of colour is important to people with dementia so that they can distinguish between different objects and help orientate them. We also saw that some items from people's past were place around corridors to help people reminisce, for example, old style typewriters and sewing machines.

There had been six formal complaints since the last inspection which had been investigated appropriately. Where concerns or complaints focussed on staff conduct or performance we saw that appropriate action had been taken in accordance with the provider's staff management policies and procedures. People's relatives told us that they would know how to raise a concern or complaint.

We saw that the provider sought feedback on the service through annual relatives' and residents' surveys. We saw that the responses from a relatives' survey conducted in November 2015 was displayed in the reception area. At the time of the inspection this included information on "What you said". Information on "What we did" was added on the day of the inspection.

The manager sought feedback from relatives and held a relatives' meeting approximately once a quarter. We viewed two sets of minutes and saw that relatives were asked for feedback on changes in the home such as the opening up of the internal doors and changes made to the environment to improve the mealtime experience for people. We saw from the minutes that relatives felt able to speak up and ask questions at the meetings and these were responded to. The manager had also set up a system whereby relatives could leave comments or requests for a meeting in a communications book if they were not available to speak to.

Requires Improvement

Is the service well-led?

Our findings

The regional director told us the registered manager had made improvements to the home since they took up their post around a year ago. During the inspection we saw that there was a clear management structure in place which included a deputy manager who had recently taken up post to support the registered manager, alongside strong clinical leadership. The registered manager was proactive in improving the quality of care delivered and had strengthened governance procedures to ensure that people received safe and high quality care. The service was being developed by the registered manager to in accordance with current best practice guidelines. However because some of the changes put in place were still recent, further time was needed to ensure their consistent application across the service and to enable their effectiveness to be evaluated.

An example of such a development was the implementation of a post falls protocol. The provider had a requirement in place for 72 hours post falls observations to be completed following a fall. These observations would enable staff to identify any falls related injuries that might require medical attention. However there was no structure in place to ensure that staff would always complete and record these observations to support the registered manager to monitor that they had been completed. The registered manager had therefore taken the initiative to create a post falls protocol herself, which she shared with us at the inspection. She explained her plans to cover this at the next staff meeting that week and for it to be embedded during August 2016. As part of this procedure the registered manager was also implementing additional guidance on medication that could increase falls risk and guidelines for the writing of falls care plans. Because these procedures were about to be implemented at the time of inspection rather than being in place, further time was required to enable the provider to be assured that they were being consistently followed by staff and achieving effective results.

The manager had reviewed the environment and opened up different areas of the home to allow people to move freely around the different rooms and corridors. This was a positive move which addressed people's wellbeing as they had previously been frustrated in being unable to access different areas of the home, which had in turn impacted on their behaviours. This move had been welcomed by staff and relatives, as it addressed those previous restrictions and enabled people more freedom and independence. However, there was no agreed strategy or oversight in place to manage the additional risks that came with this move, for example; we saw people were often unsteady on their feet, and as they could be anywhere at any time, it was not clear how long it would be before they would be found if they were to have a fall. There were no monitoring arrangements in place to ensure that staff would always know, for example, if a person had fallen, or if they needed the toilet, or whether they were receiving any social interaction, where they could not independently ask staff for this support themselves.

The manager was keen to ensure that people were not restricted by onerous or intrusive checking procedures while living at St Thomas's. They explained that risks were managed through a system of allocating responsibility for five people to each member of staff on any given day. Staff members we spoke with confirmed this and were able to tell us which people they were looking after that day. The registered manager also told us that the home also promoted a culture where staff had a collective responsibility for all

residents. However as records were not available, it was not evident that people's welfare was being checked throughout the day.

We saw through the home's accidents and incident reporting procedures and clinical governance reports that there had been 42 unwitnessed falls across May and June 2016. Both witnessed and unwitnessed falls had been reported to the provider, and we saw that falls were analysed for trends and themes by the registered manager on a monthly basis, and quarterly at Health and Safety meetings.

The feedback received from healthcare professionals was mainly positive. One told us that the registered manager "was a good manager and has a clear vision for St Thomas". They described the positive changes they had observed at St Thomas over the past year. These included improved staff training and a more positive and open culture which in their opinion had benefitted both staff and residents, both of whom appeared happier and more relaxed.

Staff told us that there was an open culture and felt able to talk to the registered manager, their deputy and supervisors if they had any concerns and that these would be addressed. One care worker described how they had complained that the batteries for the hoists never seemed to be charged. They had spoken to the clinical lead, who then made sure that the batteries were always recharged every night.

A relative was able to give an example of how she had requested for antiseptic hand gels to be provided around the home and that these were now in place. However, another said that they didn't feel that their concerns in relation to aspects of the care of their loved one had been listened to.

The provider had recognised that the nature of supervisions could be more two way and individualised to the needs of each member staff. In response to this, they had put plans in place to arrange a programme of workshops to improve the supervision process and enable managers to deliver more effective supervisions.

Regular audits were in place with evidence that action was being taken to address any identified areas of concern. For example, we saw that an out of hours night visit conducted by the registered manager in June 2016 had identified that clean linen was being transported on wheelchairs which had not yet been cleaned. We saw that this had subsequently been followed up at staff supervision. We also saw that an audit had picked up that food and fluid charts were not always being completed properly. Again we saw that this issue had been addressed in a group supervision session.

We saw that the registered manager ensured that checks and audits were carried out regularly so that she could assure herself of the quality of the care provided in the home, for example; medicines audits were completed monthly. We saw that the deputy manager undertook a medicines audit on 12th July. This picked up on a number of concerns and we saw that the registered manager wrote individually to all registered nurses on the 13th July as a result of the audit. A clear action plan was put in place in response to the concerns identified and these actions had been completed by 22nd July. The manager told us that as a result of the issues found in the audit, they would be completing medicines audits weekly for the next month to ensure that the changes had been embedded.

We viewed the minutes of four staff meetings which had been held since the beginning of the year. It was clear from the minutes that the registered manager had high expectations of staff, but was also fair. We saw that she took a robust approach to improvement in the delivery of care and the culture within the home. The minutes of meetings addressed, for example, issues around the need for effective review and update of care plans, the completion of records, the need for confidentiality and ensuring that staff used more personalised language when speaking with or about people. We saw that the minutes reflected on improvements that

had been made and gave staff praise where due, but also reminded staff that they were on a journey and needed to "continually strive to ensure that we are providing the best care we can".