

Presidential Care Limited

Thorndene Residential Care Home

Inspection report

107 Thorne Road
Doncaster
South Yorkshire
DN2 5BE

Tel: 01302327307

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Thorndene Residential Home is situated on the outskirts of Doncaster and is in easy reach of local shops and amenities. The home is registered to provide accommodation for up to 22 older people. Accommodation is located on both the ground and first floor. There is a small car park at the front and enclosed gardens at the side and rear of the home. At the time of this inspection there were 18 people living at the home.

From this location a domiciliary care service was also provided. At the time of this inspection 22 people received assistance with their personal care needs.

People's experience of using this service and what we found

The concerns detailed in this report all relate to the quality of care provided at the care home. We did not find any issues of concern relating to the domiciliary care service.

People lived in an environment that posed some risks to their health, safety and well-being, particularly if they were living with dementia. There was also a lack of robust infection control processes in place and risk assessments were not always effective because they were not always updated to reflect people's current needs. Systems to receive, store, administer and dispose of medicines were safe.

People were cared for by enough staff. However, deployment of staff needed to be thought through to ensure that those people who required more monitoring were not left unattended. Safe recruitment procedures were being followed.

People told us they felt safe in the care of the staff. Staff had a good understanding of abuse and their responsibilities in keeping people safe. However, the Care Quality Commission had not been notified about incidents and safeguarding concerns, in line with regulatory requirements.

People and relatives were happy with the service they received and consistently said the care and support they received from staff was good. Staff knew how to respect people's privacy and dignity.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

A minimal number of activities were available to people. Further work was required to ensure these were available more often and were person-centred and meaningful to people. We have made a recommendation about the development of activity provision in the home.

Governance arrangements were not as effective or reliable as they should be. Further improvement was

needed in the quality assurance processes to identify shortfalls and to drive improvement. Recorded evidence of the auditing and monitoring of the service needed to be embedded into management systems.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 3 March 2017). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected

This was a planned inspection based on the previous rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We found evidence that the provider needs to make improvement. Please see the relevant key question sections of the full report. You can see what action we have asked the provider to take at the end of this full report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Thorndene Residential Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection was carried out by an inspector 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.

Service and service type

Thorndene is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Thorndene also provides a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager who was in the process of registering with the CQC . Once registered, this means they will both be legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

The first day of the inspection was unannounced. However, subsequent inspection days were announced as we wanted to visit people who received personal care in their own homes and we needed the manager to help us plan this.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports and information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection

We spoke with 14 people who used the service and seven relatives about their or their family members experience of the care provided, within the home and within the domiciliary care service. We spoke with 11 members of staff including the provider, the manager, the assistant manager, care workers and the cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The provider had systems in place to identify risks relating to people's care. People had a range of risk assessments for different areas of their care such as falls, skin integrity and use of bed rails.
- However, where a person's needs had changed, risk assessments were not always updated to reflect these changes. For example, one person's pressure care risk assessment had been updated and showed a total score of 20 which put them as very high risk, but the risk assessment was showing them as high risk. The falls risk assessment for this person had also been miscalculated. Also, there was no information in their care records about what action needed to be taken due to the person's risk of pressure wounds and falls increasing.
- During our walk around of the home we saw cleaning fluids had been left in communal areas and toiletries left on show in people's unlocked bedrooms. These were easily accessible to people and could put them at risk of harm of harm.
- In order for people to access the outside space they had to step over a door sill and people needed to be helped by staff. Although this had been recorded in risk assessments, this was a trip hazard and increased the risk of people falling if they were to attempt to go outside alone.
- Self-closures on fire doors were not fitted and we saw wedges were being used to prop doors open which meant effective fire safety practices were not followed.

This was a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Although people's rooms looked clean and tidy we found unpleasant odours in some parts of the care home throughout the day. We also found some equipment, such as wheelchairs and fans were unclean.
- We saw staff used personal protective equipment when needed however, there were numerous times when staff walked into the main kitchen, without using protective wear and after providing personal care.
- There was no sluice in working order, and mops were hung outside to dry, which was not hygienic. The provider told us this had been agreed with the clinical nurse specialist from the local authority, infection prevention and control team. Following our inspection, we asked the clinical nurse specialist to visit the home and carry out a full infection control audit. The provider agreed with this and welcomed their input.

Systems and processes to safeguard people from the risk of abuse

- Although the provider and manager worked with the local authority safeguarding team when concerns around potential abuse were identified, such as physical contact between people, that had occurred which

the provider had not reported to CQC. We spoke with the provider and manager about this who said they would address this immediately.

- People who lived in the home and those being cared for in their own homes told us they felt safe in the care of the staff. One person said, "Yes, I'm safe and comfy."
- Staff had received safeguarding training and knew how to recognise and respond to abuse. A staff member told us, "I would report any worries or concerns immediately, to the manager."

Staffing and recruitment

- Staffing levels were enough to meet people's needs. The provider had a tool to assess the number of staff required, based on people's support needs. We saw staffing rotas reflected this.
- Several relatives commented to us about seeing staff sitting outside in the smoking area. Our observations throughout the inspection confirmed staff were often seen outside, chatting and smoking. We spoke with the provider about this who told us most staff seen were community staff who had popped into the home in-between their visits. They said care home staff were only allowed to go outside one at a time for a break. However, relatives told us staff were not always abiding by this rule. The provider said they would monitor this and take any action necessary to ensure people were not put at risk by being left unattended.
- Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

Using medicines safely

- Medicines systems were organised, and people were receiving their medicines when they should.
- The administration process was observed, and we saw the staff member responsible for this demonstrated a caring approach.
- Staff were following safe protocols for the receipt, storage, administration and disposal of medicines.
- Staff responsible for medication had received up-to-date training in this area and had their competency checked regularly.

Learning lessons when things go wrong

- The provider looked to make improvements where things had not gone as planned. They shared examples of incidents where action was taken to reduce the risk of the same thing happening again.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

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 had the appropriate legal authority and were being met.

- Although staff had completed on-line training in the MCA and DoLS, staff spoken with did not have a good understanding of this and did not know which people were subject to authorised DoLS. The provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed.
- During the inspection one person was seen constantly standing by the door asking staff to let them go home, or to let them go outside. We were told the person had managed to go outside on one occasion and was brought back by a passer-by. On another occasion the person had hit the glass in the front door, which had cracked, whilst they were trying to go out. This person did not have a mental capacity assessment or DoLS in place relating to their wishes to return home and go outside.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff had completed training that the provider considered to be mandatory. Staff underwent an induction

prior to working alone at the service. One staff member told us, "We have lots of training and the manager tells us if we need to update something, so we make sure we do it."

- Supervisions and 'spot check visits' were completed at regular intervals. These allowed staff the time to express their views and reflect on their practice. 'Spot check visits' are where the registered provider's representative calls at a person's home during a visit by a member of care staff. This is so they can observe the member of staff as they go about their duties and check they are meeting the organisation's standards and expectations and remain competent to undertake their role.
- Following an incident when a staff member gave medicine to a person at the wrong time, an action recorded stated the staff member would have their competency checked before they could administer medicines. There was a record saying this had been completed but there was no competency form completed.
- The provider told us they had a plan in place to ensure all staff received an appraisal within the year.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- A pre-assessment was completed before people moved into the home or started using the domiciliary care service. This was to ensure the service could meet the persons care and support needs.
- People's protected characteristics under the Equality Act 2010, such as age, disability, religion, gender and ethnicity were identified as part of their need's assessment. Staff knew about people's individual characteristics.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us they enjoyed the food provided. Their comments included, "I've not been very well lately and the food they bring me is lovely," and "There's always plenty of fruit and a cup of coffee whenever I want one."
- People told us staff supported them as needed with the provision of meals, snacks and drinks throughout the day to ensure their dietary needs were met.
- We observed part of the breakfast and lunchtime meal. At lunchtime we saw people weren't offered any choice. Only one meal was displayed on the board and everyone had this. Staff told us they had asked everyone during the morning if they would like the option on offer and they had all said yes. The cook said if anyone didn't want this they would be offered other choices.
- Staff were not in the dining room at all times and when one person became agitated we had to intervene to reassure the person, this meant the mealtime was not a pleasant sociable experience. The provider told us they would carry out some mealtime observations to improve people's dining experience.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

- People had access to healthcare professionals and professionals told us staff were competent and able to identify the need for professional input. A visiting healthcare professional told us, "The staff do listen and take on board our advice. They're also not afraid to contact us for support and direction."
- There was evidence of people seeing the GP, dentist, optician, community psychiatric nurse and care records included evidence of health and social care appointments.

Adapting service, design, decoration to meet people's needs

- We found areas of the home which needed refurbishment or improvement, such as bathrooms and corridors. Bedrooms were varying in size and in the way they were furnished and decorated. Some had people's own possessions and furniture and looked very homely, others were sparser and in need of re-decoration.
- The provider told us they did not have a plan for improving the environment as they had other priorities.

The provider said their immediate priorities were making improvements to care plans, activities, and ensuring the safety and well being of people.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives spoke positively about the care they received. People's comments included, "The staff are very kind and we're well looked after," and "I know all the staff and they're all lovely."
- Relatives told us, "There are posher places, but the quality of food and the care here is better. We're happy with this place" and "I have peace of mind knowing [name] is looked after well. It's very nice, there's nothing wrong with it here."
- Staff got on well with people and we observed positive interactions. Staff and people looked comfortable together and there was a lot of laughter and friendly 'banter'.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives told us they had been involved in decisions about the care and support provided when the service was first provided but had little input in the development of their support plan thereafter. However, people told us this was not something they were concerned with. Comments included, "We've had no discussions [about the care plan], but I'd tell them if something was wrong," and "I can't remember talking about a care plan, but they [staff] know me well enough."

Respecting and promoting people's privacy, dignity and independence

- Everyone spoken with, except for one, said staff knew how to maintain their privacy and dignity. Their comments included, "The staff are getting better and they treat me with respect," and "Staff know about respect. They call me by my Christian name because that's what I like."
- One relative told us they had raised some concerns about personal care being carried out in the bedroom and staff not closing curtains. They told us the manager was aware of their concerns and was dealing with this.
- We observed staff treated everyone with dignity and respect. They respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas.
- People's independence was promoted and encouraged according to their capabilities and abilities. For example, some people were able to undertake some tasks relating to their personal care and to self-administer their medicines.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Each person had a care plan. Care plans were signed to confirm they had been reviewed and updated each month. However, some information in the care plans we checked was out of date and incorrect. For example, one stated the person needed staff assistance to use the toilet when they were unable to use the toilet. Another referred to a person eating adequate amounts of normal diet when the person was only eating small amounts which needed to be fortified and served as a soft diet.
- When we brought this to the attention of the provider, they took immediate action to review all care plans and ensure they were up to date and clearly reflected people's current needs. However, these shortfalls had not been identified by their own checks on the quality of the service.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

- People had access to some activities, but they were not person-centred and regular. People and staff told us there were no regular or planned trips out.
- People told us they were bored and did not have enough to do. One person told us, "There are days I sit and do nothing." A relative said, "People sit around all day doing nothing but staring at the walls."
- People were seen to spend large amounts of time unoccupied, with televisions playing without people actively watching them or engaged in any other types of pastime. It was not evident how people's preferences, interests and hobbies had been considered.
- There were no arrangements in place to support people who preferred to stay in their rooms to pursue activities they enjoyed or help to prevent them being socially isolated.
- The provider told us they had advertised for an activity worker for 10 hours per week. They said an external person came for one hour each week to provide an activity, and at other times care staff were expected to offer activities.
- Following the inspection, the provider told us a care worker was working five additional hours per week, in addition to the activity hours already provided. The provider also told us people had access to a home library service, a four weekly church service and that staff also took some people out to play bingo.

We recommend the provider refers to good practice guidance to support the development of the activity provision in the home.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider understood people's information and communication needs. These were identified, recorded and highlighted in care plans.
- For one person in the home, English was not their first language. We saw words in the person's first language were translated into English to help staff to communicate with the person. The provider also had an account with 'Language Line,' which was a telephone translating service, which staff could use if they were unable to understand what the person was communicating to them.
- However, the provider was not meeting the AIS for all people they supported. There was a range of information available to people within the service, however not all of it had been adapted to support people. For example, menus providing information about the meals that were available, were written on a chalk board and were not supported with other types of communication that might aid people's understanding and choice, such as photographs and pictures.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy. People and their relatives told us they knew how to complain. They told us they would inform the provider or manager if they were unhappy with their care. One relative we spoke with said they didn't always think their concerns were taken seriously, although others said they found the provider and manager very understanding and supportive.
- Since the new provider had taken over the service in April 2019 there had been six complaints. These had been resolved and showed appropriate action was taken in response to the complaint. The complaints audit tool had been completed at the end of each month but did not include information about themes, trends and lessons learned and only showed a tick list that confirmed the complaint had been responded to and signed off.

End of life care and support

- One person was receiving end of life care. We saw this person in bed, looking comfortable and well cared for.
- The care plan for the person receiving end of life care detailed their wishes for how they would like their care to be carried out at the end of their life, and what their funeral arrangements were.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider and manager were knowledgeable about people who used the service. They could talk in detail about their care and support needs. They told us they audited all areas of the service, which included accidents and incidents, complaints, safeguarding, staffing, health and safety and medicines. However, evidence that audits were completed was not always recorded.
- Whilst the provider and manager had good insight into the service being delivered and were acting to improve the quality of the service, they had not always ensured that good governance systems were in place. For example, ensuring risk assessments and care plans were accurate and up to date and ensuring where needed, DoLS authorisations were applied for.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered provider did not always fulfil their statutory reporting duties to the Commission. We found information relating to four incidents at the home which had not been reported to us. When we discussed this with the registered provider and manager, they said they were not aware of their responsibility to do this. During the inspection the provider printed this information from the CQC website and made themselves familiar with their responsibilities.
- Reviews and updates of care plans and risk assessments had been completed in part but had resulted in some information being out of date, conflicting, and could put people at risk of inadequate care and support. Following on from reviews of care plans the audit tool in place was only completed yearly and therefore had not picked up on the shortfalls.
- Governance and oversight systems had failed to ensure the provider was working consistently in line with the principles of the Mental Capacity Act (2005). There were no systems in place to ensure applications for DoLS authorisations were applied for or to monitor the expiry dates for people who had approved DoLS.

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A staff meeting was held on 8 May 2019, when the new provider introduced themselves. Twelve staff were

present. A separate shift runner (senior staff) meeting was then held, although there were few recorded minutes from this. A further staff meeting was held on 31 July 2019.

- The last 'residents' meeting was held in July 2019; seven people were present. Discussions were held about fire procedures, laundry, activities, food and complaints. People had commented about wanting more activities and that their laundry whites did not always come back white. Similar issues had been raised at the previous meeting held in May 2019 but there was no evidence of the actions taken in response to the issues raised. The manager said there was no recorded evidence of the action taken but they had advertised for an activity worker for 10 hours per week and staff were continually talked to about laundry.
- The provider told us they had plans in place to send out quality assurance surveys to people, within the year, so people had the opportunity to give their feedback on the quality of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Throughout the inspection the provider and manager were honest and open with us. They acknowledged the shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.

Continuous learning and improving care

- The provider and manager were not maximising opportunities to continuously learn and improve because monitoring systems were not used effectively.
- One relative told us, "The new owners are trying to make improvements. The others that were here before have just let it go downhill."

Working in partnership with others

- The provider and management team were responsive to the input of other professionals. We saw they were liaising with other professionals and responded appropriately to concerns identified during our inspection.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered provider had not ensured risk assessments were up to date, all risks to people had been identified and good infection control processes were in place.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The registered provider had not ensured, where a person lacks mental capacity to consent to their care, that a best interest process in accordance with the Mental Capacity Act 2005, Deprivation of Liberty Safeguards was followed.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Personal care	The registered provider had failed to ensure good governance systems were in place.