Lancashire County Council

Thornton House Home for Older People

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Thornton House Home for Older People is a residential care home providing personal care to 31 people at the time of the inspection. The service can support up to 45 people across four separate units providing residential and rehabilitation support. They also provided care and support to people living with dementia.

People's experience of using this service and what we found
Some care plans lacked some information related to people's individual needs and behaviours. The auditing processes in place did not identify the concerns we found around the management of risk and infection prevention. Not all staff followed good practice guidance and company policy, as they travelled to and from work in their uniforms, rather than getting changed when at the care home. People raised concerns related the staff response times when they pressed their call bells. We could not fully investigate this as the call bell system on site did not record staff response times.

The management of medicines was not always safe. We have made a recommendation about the management of some medicines. The registered manager did not have oversight of the training records of all staff working at the home. We have made a recommendation about this.

The management team worked with a variety of agencies to ensure people's health and social needs were met. Onsite face to face visits by families had commenced to promote people's wellbeing. Staff were knowledgeable about how to safeguard people from abuse. Staff had safe recruitment checks before providing care.

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 rated inspection for this service was good (published 11 December 2018).

Why we inspected
We received concerns in relation to medicines, infection prevention and the safe use of equipment. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The provider acted during and after out inspection visit to address the concerns raised and lessen the risk that people may be subjected to avoidable harm.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Thornton House Home for Older People on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to safe care and treatment related to the management of risk and the management of some medicines. We identified a breach of good governance and the effectiveness of some audits at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for 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 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Thornton House Home for Older People

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.
As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors completed the inspection.

Service and service type
Thornton House Home for Older People is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We sought feedback from

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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with seven people who used the service about their experience of the care provided. We spoke with 12 members of staff including the senior operations manager, registered manager, assistant manager, care workers, housekeeping and catering staff.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

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

- Care plans did not always include all risks related to people's support needs. Guidance on how to support people safely with their nutrition was not clearly shared with appropriate people.
- Not all care plans had strategies on how to minimise risk, manage behaviours that challenge, and keep people and staff safe.
- Personal emergency evacuation plans, (PEEPS) which describe the support people need to get out of the home in the event of an emergency, such as a fire, had been completed for everyone. However, three people's PEEP did not include all the information required to support them safely.
- Staff did not always respond when call bells were pressed. One person told us, "You can wait up to half an hour for them to answer the call bell." A second person commented, "Can wait a long time for staff and most of the time I have already had an accident." We pressed a call button to assess staff response time. The call bell system wrongly identified a room on a separate unit and no staff responded. The registered manager arranged for the system to be reprogrammed.
- The provider failed to ensure all staff working regularly at Thornton House Home for Older People had received training to recognise abuse or improper treatment. This placed people who may be vulnerable at risk of avoidable harm.
- Fire plans did not reflect the actions taken by people and staff. We observed three fire doors wedged open. Propping or wedging fire doors open compromised the safety of people, putting them at serious risk, should a fire occur. The registered manager, after the inspection visit, sought professional guidance on assessing the risk.

We found evidence not all risks related to people were assessed and recorded to prevent unsafe care and prevent avoidable harm or risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had systems to ensure equipment was assessed and was compliant with relevant regulations.

Preventing and controlling infection

- Staff were not always using PPE effectively and safely. We observed two staff not wearing masks.
- The provider had a room for staff to change into and from their uniforms at the beginning and end of their shift. However, not all staff took advantage of this. We observed two staff and two agency staff arrive wearing their uniforms.

● We were not assured the provider was making sure infection outbreaks can be effectively managed. After supporting one person who was in isolation, staff did not have suitable equipment to place their used PPE into when exiting their room.
● We were not assured that the provider was promoting safety through the hygiene practices of the premises. In some areas, which included people's bedrooms the home did not look visibly clean and hygienic.

We found evidence not all risks related to preventing, detecting and controlling the spread of infection were being assessed and suitable actions taken. This placed people at risk of avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider completed an assessment of the environment and implemented additional training for staff.

Using medicines safely
● Medicines were not always stored safely. People had unsupervised access to thickening powders on two units within the home. The thickening powder is added to foods and liquids to bring them to the right consistency/texture so they can be safely swallowed to provide required nutrition and hydration. If wrongly administered they can place people at risk of harm.
● One person had unsupervised access to their medicines. Medicines were stored in people's bedrooms. We observed one medicine cabinet was unlocked and no staff were present.
● Not all medicine administration records (MAR) we reviewed showed all medicines had been signed for. This will be addressed in the Well-led section of the report.

We recommend the provider follows current guidance on the storage of medicines.

● The registered manager ordered lockable medicine cabinets so thickening powders could be stored safely in unit kitchens.
● The provider had medicines management policies and procedures which guided staff on best practice. Staff responsible for administering medicines had received training. The provider had a system for checking staff competencies.
● Staff followed people's preferences with the administration of their medicines. Staff administered medicines at times and locations preferred by people receiving them.

Learning lessons when things go wrong
● The provider had systems and processes to investigate when concerns are raised. The provider had completed an unannounced quality assurance visit and completed an action plan to address their findings.
● Opportunities to learn from some incidents had been missed. When people displayed verbal or physical aggression the incidents had not been reviewed to see why the incidents had occurred and to minimise the risk of it happening again.

We recommend the provider follows current guidance on how to support adults whose behaviour may put themselves and others at risk.

Staffing and recruitment
● Staff were recruited safely. The required pre-employment checks were completed to help ensure staff employed were suitable. These included completing a Disclosure and Barring Service (DBS) check and obtaining references. A DBS check identifies if a person has any criminal convictions and cautions. It's an

essential requirement for those applying to work with children or adults who may be vulnerable.
● Staff were deployed to specific units of the home. The registered manager told us this was to provide continuity of support and limit the risk of infection throughout the home.
● We received mixed feedback on staffing levels. One staff member stated, "Staffing levels are a bit thin." One person said, "There isn't enough staff." A second person commented, "You can wait a long time for staff." The provider told us they had reviewed and increased staffing levels and employed agency staff to ensure safe staffing levels were in place.

Systems and processes to safeguard people from the risk of abuse
● The registered manager had ensured care staff had received safeguarding training that was relevant and at a suitable level for their role.
● Care staff were aware of their individual responsibilities to prevent, identify and report abuse. They said they felt able to challenge poor practice and report their concerns to the registered manager. One staff member said, "I am here to look after people and keep them safe."

Requires Improvement

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's systems to assess, monitor and improve the quality of the service had not identified and addressed the shortfalls highlighted in this report. Environmental concerns found had not been identified in internal audits. Records related to people's care did not always include all the necessary information required.
- Systems for learning from all incidents and near misses had not always been implemented. When people had displayed physical or verbal aggression, this had not always been reviewed. This meant staff could not learn from incidents and events to reduce reoccurrences.
- Governance and audit systems were not always followed in a timely way to allow the continuous assessment and improvement of the service. Errors identified on medicine administration records and an incident recorded in one person's diary notes had not been investigated by the management team.
- Staff response times to call bells could not be fully investigated. The system in place did not hold staff response times for review. This meant management could not investigate concerns raised and monitor the quality of support people received.

There had been a failure to assess, monitor and improve the quality, safety and welfare of people who may be at risk. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014

- The management team had clear roles and areas of responsibility. Daily handovers took place each day so that individual needs and concerns could be addressed
- Some staff were working toward achieving vocational qualifications in care. One staff member told us it had made them reflect on their role.

Working in partnership with others

- The registered manager did not manage all the staff who worked at Thornton House Home for Older People. The provider placed catering and housekeeping staff to work there, who had a different management team. The registered manager did not have input and oversight on their deployment, training and development. The registered manager was not aware that some staff had not received relevant training. This was rectified during this inspection.

We recommend the provider implement systems to allow oversight of all staff records so the service would be able to fully assess and respond to risk.

● Care records showed the registered manager and provider were working with other organisations and professionals. Entries in care records included input and advice from different agencies.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Management worked together engaging with people, relatives and staff. Staff said they had team meetings and were updated on changes within the service.

● We received mixed feedback from staff about the management team. One staff member commented, "[Registered manager] does a marvellous job." A second staff member said, "When we share concerns, it falls on deaf ears." We saw some evidence of changes made in response to feedback received.

● We observed people seek out staff to chat, who were then engaged in meaningful conversations. We observed staff anticipate people's needs, so they did not have to ask for support.

● Onsite face to face visits had commenced to promote people's wellbeing. These visits were in accordance with government guidelines and best practice.

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

● Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service. The provider was aware of their responsibilities to submit relevant notification appropriately to CQC.

● The management team actively participated in frank and honest conversations volunteering information on areas that could be improved.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks related to people were assessed and recorded to prevent unsafe care and prevent avoidable harm or risk of harm. Not all risks related to preventing, detecting and controlling the spread of infection were being assessed and suitable actions taken. Regulation 12 (1)(2)(a)(b)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had been a failure to assess, monitor and improve the quality, safety and welfare of people who may be at risk. Regulation 17(1)(2)(a)(b)