

Thorncliffe Care Limited

# Thorncliffe House

## Inspection report

Thorncliffe  
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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

This inspection took place on 4 May 2016 and was unannounced. We last inspected Thorncliffe House on 1 and 3 September 2015 and found the provider had breached a number of regulations we inspected against. Specifically the provider had breached Regulations 12, 17, 11, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems in place to ensure medicines were ordered, stored and administered safely. There was not an effective quality assurance process to monitor the quality and safety of the service provided to ensure people received appropriate care and support. Consent had not been gained in respect of locking people's rooms. The provider had failed to investigate concerns in relation to safeguarding people immediately upon becoming aware of allegations or evidence of abuse. The provider had not ensured staff received appropriate training and development to enable them to carry out the duties they were employed to perform.

We undertook this inspection to check they now met legal requirements. During this inspection we found that the registered provider had implemented actions and some improvements had been made.

Thorncliffe House is a care home without nursing and provides accommodation and personal care for up to 24 people, some of whom may be living with dementia. At the time of the inspection there were 19 people using the service.

An established registered manager was in post and registered with the Care Quality Commission at the time of the 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.

Quality assurance systems and audits had been introduced but it was too early to assess whether they were effective in driving continuous improvement. Required actions were not always recorded, and when actions were documented it was not always evident if they had been completed or not.

Medicines were ordered and stored in a safe way. There were some gaps in the recording of the administration of medicines but these had been identified by the deputy manager.

Personal emergency evacuation plans had been introduced however they were not accurate and contained out of date information in relation to the rooms people lived in.

Deprivation liberty safeguards had been authorised and we saw evidence of mental capacity assessments and best interest decision making. Best interest decisions did not always evidence consultation with family members or professionals.

Activities were available for people but they were not well advertised and there were no specific activities for people living with dementia.

Systems had been introduced for the recording and investigation of safeguarding concerns, accidents and incidents.

Staff had received the training they needed to support them to care for people appropriately. They received regular support and team meetings were held quarterly. Minutes of meetings were not readily available for staff.

Recruitment procedures were in place however one person had commenced in post without the registered manager having received a reference from the previous employer. This was acted on immediately and we saw a satisfactory reference was received on the day of the inspection.

We observed warm and caring interactions between staff and people. Staff afforded people the time they needed and did not rush people in any way. They respected their privacy, dignity and helped to maintain independence when possible.

Information on advocacy and how to complain or provide feedback was available for people and visitors.

## 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.

Procedures for managing people's medicines had improved but there were gaps on medicine administration records.

Personal emergency evacuation plans were in place but they were not accurate or up to date.

Safeguarding concerns were investigated.

### Is the service effective?

**Requires Improvement** 

The service was not always effective.

Best interest decisions had been recorded for people who had been assessed as lacking capacity but we did not always see involvement from family members or social workers.

Training was up to date, but medicine competencies and medicine refresher training was not logged on the matrix.

We saw involvement from external health professionals such as speech and language therapy, district nurses and cardiology nurses.

### Is the service caring?

**Good** 

The service was caring.

Staff were kind and patient with people, ensuring people had the time they needed to eat meals, or receive the care they needed.

People told us they were cared for and we saw people were relaxed and comfortable with the staff.

Information on advocacy was on display around the home.

### Is the service responsive?

**Requires Improvement** 

The service was not always responsive.

Some information in relation to people's care was not recorded appropriately.

Care plans contained information on people's preferences.

People were engaged with dominoes, painting, bingo and cake making but we did not see activities being advertised.

Information on complaints was available for people and visitors.

**Is the service well-led?**

The service was not always well-led.

Quality assurance systems and audits had been introduced but it was too early to assess the effectiveness in driving continuous improvement.

Not all identified actions had been signed off as complete.

**Requires Improvement** 

# Thorncliffe House

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 4 May 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team was made up of one adult social care inspector and a specialist professional advisor.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority commissioning team, Clinical Commissioning Group (CCG) and the safeguarding adult's team. We also contacted healthcare professionals.

We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke to the registered manager, the deputy manager, three senior care staff, two care staff and two ancillary staff members.

We looked at six people's care records and medicines records for all the people living at Thorncliffe House. We viewed recruitment records for three staff and looked at supervision and training information, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. We spoke with six people living at

the service, but due to the needs of some people we were unable to gain their views about the service. 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.

# Is the service safe?

## Our findings

At the last inspection we found the provider had breached regulations. Effective systems were not in place to ensure medicines had been ordered, stored and administered. The provider did not investigate concerns immediately upon becoming aware of, any allegation or evidence of abuse. There were no effective systems to monitor the quality and safety of the service such as analysing accidents and incidents to identify trends, nor were there any personal emergency evacuation plans.

During this inspection we found some improvements had been made.

The home had changed the pharmacy it used for people's medicines and the deputy manager said an audit had been completed by the new chemist. The system for ordering medicines was effective and the chemist liaised directly with the doctor's surgery with regard to prescriptions and information was transferred electronically which provided an audit trail. Monthly medicines were provided with a pre-printed medicine administration record (MAR) and an order sheet which the chemist collected on a monthly basis.

The deputy manager, who was working a senior care shift, was administering medicines on the day of inspection and was knowledgeable about administration procedures and procedures for disposing of soiled medicines, covert medicines and self-administration.

Medicines were stored securely in the treatment room with the key holder being the senior care worker. A handover sheet for medicine keys was in place and had been completed. Treatment room and medicine fridge temperature checks were recorded appropriately which meant medicines were being stored correctly.

There was a signature list in place for those staff who were authorised to administer medicines and photographs of all the people needing support with medicines were in place, apart from one person's.

During the inspection on 4 May 2016 we found prescribed creams were not dated on opening and some medicines had been administered but not signed for on the medicine administration records (MAR). For one person we found they had six tablets which had been signed for but not administered. We spoke with the registered manager about this who said, "That will be investigated straight away and appropriate action taken." A verbal order had been received from one person's doctor to change the dose of one of their medicines. The pharmacist had amended the dosage and the correct dose had been administered but the MAR had not been updated to reflect the change. We spoke with the deputy manager and registered manager about this. We were told, "That's a pharmacy error." The deputy manager said, "I did a drug audit last month and there were errors, I've decided that this needs to be done more often."

We recommend that the service consider current guidance on recording medicine administration and take action to update their practice accordingly.

We also found improvements in the way safeguarding concerns were managed. A safeguarding log had been introduced which included detail on the action taken and the outcome of the concern. Action plans



were in place for individual safeguarding's which detail the action which needed to be taken and by when; this had not been signed off as completed. The registered manager and deputy both confirmed the recorded actions had been completed.

Staff told us they would report any concerns to the registered manager and look for further support if they needed to.

An accident and incident log was also in place which included the details and the action taken. Report forms included specifics on the action taken, such as using different furniture to prevent further falls, and contacting the intermediate care team. Analysis and lessons learnt from incidents were included in the quality assurance records.

Since the last inspection personal emergency evacuation plans (PEEPS) had been written by the deputy manager however they were not accurate or up to date. We noted some people had moved rooms and new PEEPs had not been rewritten to reflect this. In addition some people's room numbers were incorrect as confirmed by the registered manager, who said, "I haven't reviewed them, they are wrong, we need to remember to update them if people move rooms."

Of the 19 people living at Thorncliffe House at the time of the inspection it was recorded that nine people would need two staff to support them with an evacuation due to needing the use of an evacuation mattress or evacuation chair. No overall analysis had been completed to ensure the staffing levels would support a safe evacuation. We spoke with the registered manager about this who said, "I see what you mean, there are probably some people who could use the evacuation chair, they all need to be reviewed. The fire service came in February and said they were ok." We asked if the safe use of evacuation chairs and mattresses was included in the fire training for staff. The registered manager said, "It is but not all staff will have been trained as we haven't long had the mattress." They went on to say, "All staff will have used the equipment but not in a fire drill, they will have used it on themselves."

Fire evacuation chairs were available on each floor of the home. The deputy manager said, "I think about ten people are trained."

Some people who had capacity had chosen to have a key to their bedroom and kept their room locked. We noted this information was not recorded on people's personal emergency evacuation plans (PEEPs) so this information would not be readily available in an emergency.

We asked staff what they would do in the event of the fire alarm sounding. One senior care staff member said, "Go to the fire box to see where the alarm went off, two staff would be sent to get people out of the fire area and one person would phone 999." They added, "We'd check the panel to see if it was real or a fault as well." This meant staff were able to describe the evacuation procedure they would follow.

During a tour of the home we noted wardrobes had been fixed to walls to prevent accidental damage and windows had appropriate restrictors in place. Some automatic door closures had alarms flashing to say the batteries needed to be replaced. This was completed by the handyman on the day. We also noted a few bedroom doors, which are fire doors, were not fully closing. The registered manager said, "Oh, the fire service were here in February and didn't pick it up." They went on to say, "I wonder if it's because of the new carpets. I'll get [handyman] to look at them." We saw checks had been completed on fire doors but it had not been identified that some doors were not closing properly.

A fire log book was in place and the handyman completed regular checks of the emergency lighting and fire

alarm. Fire drills were completed and the time taken recorded however there was no detail on what was being completed in the time frame. For example it did not specify if it was the time staff took to respond, if a full evacuation had happened or if a specific area of the building had been evacuated. The registered manager was unable to confirm.

Documents relating to premises and equipment safety were in place. This included a satisfactory electrical installation report, portable appliance testing and lifting operations and lifting equipment regulation certificates (LoLER). There was no landlord gas safety certificate on site however this was immediately rectified and a copy forwarded to the Commission.

An emergency contingency plan was not on site because it was with the provider who was updating it. The file was brought to the home on the day of inspection and we saw that it had been due for review on 31 August 2015 which had not been completed. The registered manager said, "Some information is out of date but we would just book people into [hotel] if they couldn't stay here." We saw the information on a safe evacuation place was not current otherwise information could be used in the event of an emergency.

We asked people whether they felt safe living at Thorncliffe House. People told us they did and that they were happy. One person said, "Oh yes, I feel safe, I'm well looked after."

We saw one person was diagnosed as living with heart failure but there was no risk assessment in the care records for staff to follow in supporting the person to manage the condition. Otherwise detailed risk assessments were in place for falls, skin integrity and the use of specialist equipment such as hoists and bed rails.

Since the last inspection a recognised dependency tool was being used to calculate staffing levels. We saw that the calculated figure met the staffing that was being deployed. We looked at rotas for four weeks and saw consistency in numbers. During the day there was one senior and two care workers plus a member of staff or an apprentice leading activities and at night there were two staff. We asked why, at times, there was no senior care worker on at night. The deputy manager said, "I'm on call at those times so I stay until the 10pm medicine has been administered and come in if anyone needs medicine overnight." Staff told us they thought there was enough staff, both during the day and at night to meet people's needs.

We looked at three staff who had recently been recruited, two of whom were care staff. Disclosure and Barring Service (DBS) adult first checks had been completed whilst awaiting a full DBS certificate. DBS checks are used to help employers make safe recruitment decisions to help prevent unsuitable people working with vulnerable adults. References had been received, although for one staff member who had worked for a sister service the reference hadn't been received before they started. We asked why the reference hadn't been chased as they worked for a different service. They said, "It's the same company. I did speak to the manager." By the end of the inspection they had received a satisfactory reference.

## Is the service effective?

### Our findings

During the inspection in September 2015 we found the provider had breached regulations. Staff had not received appropriate training and development. The provider had not ensured consent was gained in respect of locking people's rooms.

We found improvements had been made.

We asked the registered manager about training. They said, "We now have [training company] working within the building so all mandatory training is done. There's a rolling programme of training." They added, "I think it's linked to the care certificate but they aren't delivering it." The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. We saw the deputy manager had recently completed Care Certificate assessor training.

The registered manager said mandatory training included, "Fire, food, health and safety, safeguarding, moving and handling, infection control, dementia, DoLS and mental capacity." We viewed a training matrix which confirmed staff had attended all mandatory training. We asked about medicine training. The registered manager said, "The seniors and deputy do it as they are the ones who administer." Medicine competencies had been completed for all staff administering medicines except for the deputy manager. We spoke with the registered manager about this who said they were confident it had been done but would re-do it the next day. We noted the completion of medicine competencies was not included on the training matrix, nor was information on medicine refresher training.

We spoke with two members of staff who had recently started working at Thorncliffe House. One staff member said, "I filled in a form and got a certificate, I did training in person centred care; the role of the carer and I'm doing moving and handling today." They added, "I did three shadow shifts and had a chat to see if I felt competent to do the job."

Staff told us they received supervision and support to carry out their roles. An established staff member said, "Yes, I have supervision and I've had an annual appraisal." A supervision and appraisal matrix was in place which evidenced staff receiving supervision every other month. Appraisals had been completed for those staff who required one, for others they were booked in on the matrix so staff knew when they were due.

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 so that they can 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 and hospitals 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 said, "There are no conditions on authorisations. We have submitted applications but are waiting for authorisations. The local authority aren't prioritising them as they were previously granted authorisations." They went on to explain, "New applications are being prioritised." The registered manager had a file of all applications and outcomes and copies were also in people's care records.

We saw one person's DoLS had been authorised for a short period of time so the placement could be reviewed at the same time. This person had the involvement of a relevant person's representative (RPR). The role of an RPR is to represent and support the person in matters connected to the DoLS authorisation.

We asked the registered manager whether they completed mental capacity assessments and best interest decisions for people. They spoke of one person who uses bed rails and bumpers. A mental capacity assessment had been completed with the outcome that the person did not have capacity so a best interest decision had been recorded with the outcome that the use of bed rails and bumpers was in the person's best interest due to deterioration in physical health. We asked the registered manager if relatives or people significant to the person had been involved in decision making. They said, "They should have been." The MCA (2005) places a duty on the decision maker to consult other people who are close to the person who lacks capacity. We did not see evidence of family involvement in the decision making process.

For another person who lacked capacity to manage their finances a best interest decision had been made, with the involvement of family but the social worker had not attended. The registered manager said, "They did agree to [family] managing finances." There was no evidence of this available.

Some people who had capacity had chosen to have a key to their bedroom and kept their room locked. The senior on shift carried a key to the rooms, and permission had been sought to use this for night time checks if the person required them. For other people rooms were not locked.

We spoke with people about the meals and if they received a choice. One person said, "The food is ok, sometimes I don't get my choice but that's not very often." Meal times were well organised and people were offered a choice of meal and drinks. There were condiments available on the tables, which were nicely set with table cloths and flowers. A menu was on display in the dining area however this was a list so may not have been accessible to a lot of the people living at Thorncliffe House. We spoke with the registered manager about this, they said, "We are in the process of developing something, but I want it to be photos of actual meals that are provided rather than pictures."

The registered manager said, "There's no one on special diet due to risk." The cook was knowledgeable about people's preferences and engaged with people during mealtimes ensuring they had all they needed. People's weights were recorded monthly and documented with the malnutrition universal screening tool (MUST). MUST is a screening tool used to identify people who are malnourished, or at risk of malnutrition. We saw that some people had been prescribed fortified drinks however this was not well documented in care plans.

There was evidence that external healthcare professionals had been contacted appropriately, for example, speech and language therapy (SALT), the respiratory nurse and the tissue viability nurse. District nurses were involved with people who required insulin and also for a person with long standing pressure care needs. All visits were documented in professional visits sections of care records together with visits from GP, social worker, optician, dentist and chiropodist.

# Is the service caring?

## Our findings

We spent time observing interactions and chatting with people. One person said, "I'm well looked after." Another said, "It's fine here." One staff member introduced us to a person and said, "This is [person's name], they've lived here 12 years." The person responded by saying, "It's been 14!" They then added, "You might be right." They went on to tell us they were happy and cared for. One senior worker said, "I also do care shifts, I prefer that as I like to get involved with people."

People seemed happy and relaxed with staff. One person initiated some dancing and singing with staff as they went past them; other people engaged with staff in general chit chat or activities.

We spent time in the lounge and dining room throughout the day and observed positive interactions between staff and people which were caring and meaningful. Staff were discrete in asking people if they wanted support with personal care or to change clothing after meals, offering people choice and giving time for people to decide.

We observed mealtimes and saw people were asked if they wanted to wear an apron to protect their clothing; only person did which was provided. Everyone else chose to use a serviette and their decision was respected. Where people needed one to one support to enjoy their meal this provided in a relaxed and unhurried manner. We noted that one of the staff members supporting people did not engage with the person proactively in terms of making sure they were ready for the next fork of food. They did involve everyone sitting at the table in conversation though. The cook was present in the dining area during mealtimes and they engaged with people, having a joke or asking if they wanted seconds. They acknowledged that one person's favourite dessert was tiramisu and they instantly said, "Oh we'll have to see about having some."

Another staff member recognised a person needed some support with their drink and asked them if they would like a straw. When they responded the staff member immediately fetched one and sat with the person offering support when they returned with the straw.

Staff were patient and kind with people and we observed support was offered at the person's own pace. One person was being supported to leave the dining area using their walking frame and the staff member stayed at the side of the person offering gentle reassurance and chat to them whilst they took their time to walk. It was noted that their walking frame was situated away from where they were at the dining table so when they stood they were unable to access their frame themselves. We spoke with the registered manager about this who said, "They sometimes walk without their frame so it's possible they went to the dining table without it."

Care plans showed some involvement of the person and their relatives; this was often completed during meetings with doctors when everyone was involved. Some care plans were signed by people and their relatives.

Residents' meetings had been held on a monthly basis since November 2015 and included discussion around meals and activities. 'You said, we did' information was on display on a notice board for residents and families to view.

Information on advocacy services was on display and available throughout the home. There was also a copy of the complaints procedure near the visitors signing in book and a copy of the homes handbook, although a plant had been placed on top of the handbook. The handbook contained information on advocacy, making a complaint, equality and diversity, risk, religious activities and the services and facilities available at Thorncliffe House.

We asked about family and friends visiting. The registered manager said, "The majority of people have no family, so there are few visitors."

## Is the service responsive?

### Our findings

We reviewed care records and found skin bundles were used to record information on the care and support people needed to maintain skin integrity. For one person documentation on positional changes had not been completed appropriately. The person needed a positional change every two hours however on the day of inspection no change in position had been recorded since 7am; we viewed this document after 2pm. We asked the senior care staff member about it. They said, "I will do it later and I know which way [person] will have been turned as we always do it right to left to back to right." We also saw this person's records had not been fully completed for positional changes for a four hour period on 2 May 2016. We raised this with the deputy manager and registered manager. The deputy manager said, "It should be completed immediately." The registered manager confirmed it would be addressed.

Another person had gained one kilogram in one day and was being weighed daily on the instruction of a cardiac nurse. There was no information in the care records with regards to the management of weight or the action to take should the person gain weight. The deputy manager said it had been discussed in handover and she needed to contact the cardiac nurse. This information was recorded in the handover sheet but there was no information in the care records.

Another person had been assessed as needing to use bed rails and bed bumpers in their best interest, but this information was not included in their sleeping care plan.

Care plans were up to date and included signed consent forms. Information in other people's care plans was personalised and comprehensive. Care plans included consent for care, nutrition, communication, personal care, sleep, social needs, medicines, mental capacity and skin integrity. Care records were reviewed on a monthly basis and contained up to date information to support staff to care for people appropriately. If there were changes to people's needs a new care plan had been written.

We observed people were playing dominos in the dining room during the morning whilst other people were engaging with the apprentice who was involving people in activities, including painting and arts and crafts. Some people later moved to the lounge as people were playing bingo. Other people stayed in the dining room for a chat or to watch television. Two people were asleep in the dining room area.

One gentleman was sitting in the hall/reception area of the home. We asked if they were ok and they said, "Oh yes, it was dominoes and bingo this morning and cake making this afternoon, so I'm getting some peace and listening to music."

We asked the registered manager if there was an activities notice board. They said, "It's in between the lounge and the stairway." This notice board displayed the booking list for the hairdresser and information from residents' meetings and 'you said, we did' notices. There was no information on display on forthcoming activities.

We asked the registered manager about specific activities designed for people living with dementia. They

said, "The activities are the same as at the last inspection, nothing specific." We asked what activities were available for people. They said, "Entertainers, singers, a summer barbecue where we invite families." We asked if there were any Church services or visiting people of faith. The registered manager said, "No, the nun's used to come but they don't come anymore, I don't really know why." The registered manager asked the deputy manager who said, "The Methodist Church come in every other week."

Information on how to complain was available around the home. There were also postcards next to the visitor's book for people and visitors to complete and return if they wanted to provide feedback. A complaints log was in place and since the last inspection there had been one complaint logged. This had been made by a visiting professional who was concerned that care plans had not been completed or started for someone. The registered manager said, "They moved in a couple of weeks before the complaint, there's no excuse the care plans weren't in place." The action included written acknowledgement of the complaint and the outcome of the investigation and an update that care plans had been written the day after the receipt of the complaint. We asked how this had happened. The registered manager said, "[Person] had been in hospital and we were asked if we had any vacancies. The person was visited in hospital and they then attended for a viewing and refused to return to hospital, it was a Friday visit. The hospital agreed to hold the bed over the weekend. We had assessment documentation and the social work report but care plans weren't in place." They added, "They have since moved to [another care home]."

An organisation called 'Over2You' had been involved in seeking feedback from people living at Thorncliffe House. Over2You aims to raise the aspirations of what people expect from health and care providers and gives people a voice in driving up the quality of the services they access. Comments from people they spoke with were generally positive and included, 'it's nice to have more help with my mobility; staff help me feel safe and look after me; and staff are friendly.'



## Is the service well-led?

### Our findings

During the inspection in September 2015 we found the provider had breached a regulation relating to the governance of the service. They did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure people received appropriate care and support.

We found some improvements had been made. Quality audits had been introduced but we were unable to assess whether they were effective in driving sustained improvement. Audits had not identified all the concerns noted during the inspection; action plans had not always been produced and where they were they had not always been signed off as completed.

A quality assurance file was in place which included a matrix of when audits needed to be completed. This included audits of medicines, care plans, accidents and incidents as well as audits in relation to the kitchen, dining experience and housekeeping.

Care plan audits involved a list of documentation that were in the care records which were given a score of one to five. For one person we saw that their medicine risk assessment scored two for which there was an action that it was to be completed by 4 February 2016. Care reviews scored one as they hadn't been reviewed but there was no action point stating when they should be reviewed by and who had responsibility for this.

Accident and incident audits and catering audits had been completed on a monthly basis. Dining audits had been completed which was a tick list of specific areas such as the environment and observations. We could not see if the quality of the dining experience had been assessed as there was no narrative or comments from people included in the audit.

A daily registered manager walk around was recorded. This listed the number of staff and people spoken to, the time of the walk around and a tick list. There were no comments or detail on the findings or observations from the walk around.

The deputy manager had written PEEPS for each person living at Thorncliffe House; they had also reviewed all the PEEPs on 12 April 2016. The reviews had not identified incorrect room numbers; they had been signed off as no changes required. We also noted that none of the PEEPs had been signed by the registered manager, even though there was space for them to do so. The registered manager said, "I need to sign them off, but they need to be redone first."

A staff meeting file was in place which contained documents titled 'sharing of information, communication tool records.' These included specific policies and procedures and a signature sheet for staff to complete once they had read and understood the documentation. We noted the signature list contained the names of 26 staff however the most staff that had signed any documentation was 12, who had read the holiday rules; only nine staff had read the policy on pain management.

We asked staff if they had team meetings. One senior worker said, "I can't remember." Another staff member said they did have team meetings but, "No one say's anything and they [staff] don't use meetings as a way to raise issues." There were no team meeting minutes in the file and the registered manager had to contact the provider to forward minutes of minutes as they said, "The provider chairs all the meetings and it'll be quicker for them to forward them rather than me look through my emails." We saw team meetings had been held in January 2016 and March 2016 however the minutes of meetings were not readily accessible for staff. The registered manager said, "I make the agenda available for people but they rarely add anything to it, they might speak up in the any other business section." We saw discussion included DoLS and mental capacity, care plans and reviews of people's care, relationships with professionals, record keeping and staff training.

The staff we spoke with felt the registered manager was always there for them and listened to their opinions and was open to discussion. One staff member said, "We are very happy here and [registered manager] is very supportive. A lot has been done since the last inspection after which we were all devastated."

We spoke with the registered manager about their role. They were aware of their responsibility to submit statutory notifications to the commission. They also spoke with us about ensuring staff did their job and the needs and wishes of people were met. They said they kept up to date with best practice by attending a well-being provider forum, the Tyne and Wear Care Alliance network group and attending the My Home Life Programme. My Home Life is a UK-wide initiative that promotes quality of life and positive change for older people living in care homes.

The registered manager said they spoke with the owner when they visited about three times a week and described these as 'management meetings.' We asked if there was a record of these meetings and were told no. We were also told there had been meetings with the registered manager of a sister service to discuss training and share ideas but there was no record of these meetings either.