Orchard Care Homes.Com Limited

Thornton Hall and Lodge

Inspection report

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Date of inspection visit:
07 September 2016
08 September 2016
09 September 2016

Date of publication:
24 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 7, 8 and 9 September 2016 and was unannounced.

Thornton Hall and Lodge is registered to provide care and support for up to 96 people. The home is purpose built and the accommodation is over two floors. The home has aids and equipment to help people who are less mobile. The first floor is accessible by a passenger lift and staircase.

During the last comprehensive inspection which completed in February 2016, we found the provider was not meeting legal requirements in relation to safe care and treatment, good governance, need for consent, and safeguarding people from abuse and improper treatment and we issued warning notices in these areas. The home was rated as 'inadequate' overall. We placed the service in special measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

During this inspection, there were 88 people living in the home.

There was no registered manager in post, however a manager had been appointed and had been in post for four weeks at the time of the inspection. The manager had made an application to CQC to become the registered manager, however, we have been advised since the inspection that the manager has left and will not be applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the last inspection we found that medicines were not always managed safely within the home. During this inspection, we found that although the systems in place regarding covert medicines had improved, sufficient improvements had not been made and a number of concerns were identified regarding medicine management.

Staff we spoke with were aware of the safeguarding process and how to raise any concerns they may have. People we spoke with told us they felt safe living in Thornton Hall and Lodge.

A new system had been implemented to record and report incidents and accidents. This enabled the manager to review the accidents and incidents and ensure all appropriate actions had been taken.

We found that although a number of risk assessments had been completed, not all risks had been assessed and some assessments had not been completed accurately.

Arrangements were in place for checking the environment and equipment to help ensure it was safe. However, not all checks were maintained regularly, such as those for sensor mats.

We looked at how the home was staffed. Staff rotas we viewed did not always reflect staffing levels described by management. Some relatives and people living in the home raised concerns about staffing levels and most staff we spoke with agreed that there were not always enough staff on duty. Our observations showed that there were not enough staff on duty to meet people's needs.

During the last inspection in February 2016, we found that incidents that had occurred within the home that should have been reported to the safeguarding team had not been. During this inspection, we found that this had improved and a new system had been introduced to help ensure all relevant referrals were made.

We looked at how staff were recruited to the home and found that safe recruitment practices were followed in line with the provider's recruitment policy.

We received mixed feedback from people regarding the quality and choice of meals available.
We found that although referrals to other professionals were made when needed, advice received from these specialists regarding diet was not always known or followed by all staff.

During the last inspection we found that applications to deprive people of the liberty had not been made for all people that required one. During this inspection we found that the home's systems had improved and all people that had been assessed as requiring a DoLS application, had one submitted to the local authority for consideration.

At the last inspection, we found that people's consent was not always gained in line with the principles of the MCA. During this most recent inspection, we found that some improvements had been made and mental capacity assessments were completed appropriately, though best interest decisions were not always clearly recorded.

Most staff received an induction when they commenced in post, however records showed that systems were not in place to ensure staff received supervisions and appraisals to support them in their role.

Training was available to staff and systems were in place to monitor when staff were due to complete refresher training.

We observed the environment of the home and found that the provider had taken steps within the home for people living with dementia, towards the environment being appropriate to assist people with orientation and safety.

People living at the home told us staff were kind and caring and treated them with respect. We found however, that people's dignity was not always maintained and comments from some staff were not always respectful.

Records regarding people's care and treatment were not always stored securely in order to maintain people's confidentiality.

Care plans we viewed showed that when able, people and their families had been involved in the care planning process.

People's needs in respect of their religion and beliefs were considered by the provider. The home had a room which was used as a chapel and a member of the local clergy visited each week to perform a service for those people unable to travel to the church service.

We observed relatives visiting throughout all days of the inspection. The manager told us visitors were always welcome in the home, encouraging relationships to be maintained. Relatives told us they could visit anytime and could spend time with their loved ones in private.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access.

Relatives told us they were kept informed of any changes to their loved one's health and wellbeing. Staff told us they were informed of any changes within the home, including changes in people's care needs through daily handovers, though they often did not have time for verbal handovers between staff.

Care plans informed staff of the support people required. The care plans were reviewed regularly; however there was no record that people had participated in the reviews of their planned care. We found that planned care was not always evidenced as having been provided.

We found that not all staff we spoke with knew people's current needs, especially if they had changed recently.

An activities coordinator was employed within the home and a schedule of activities had been devised, however feedback regarding activities was mixed.

New systems had recently been introduced to assist the manager in gathering people's feedback.

A complaints procedure was available; however information on how to make a complaint was not clearly displayed within the home for people to access. The outcome of complaint investigations was not always clearly recorded.

The provider had systems in place to monitor the safety and quality of the service, though these audits did not highlight the concerns identified during the inspection. Actions were not always recorded.

Safety checks introduced following the outcome of an investigation were not maintained.

Improvements had been made regarding incident reporting and new systems had been implemented to help ensure appropriate actions were taken following any incidents within the home, though these were not maintained by all staff.

We found that as well as resident and relative meetings being held and quality assurance surveys issued, staff meetings also took place. These meetings however, were not frequent and not all staff we spoke with were aware of them.

The manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to monitor information and risks regarding Thornton

Hall and Lodge.

Most staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures.' Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not always managed safely.

There were not enough staff on duty to meet people's needs safely.

Not all risks were assessed accurately. Safety checks were not always maintained.

Referrals were made appropriately to the safeguarding team when needed and staff were aware of the safeguarding process. People we spoke with told us they felt safe living in Thornton Hall and Lodge.

Staff were recruited to the home and found that safe recruitment practices were followed in line with the provider's recruitment policy.

Is the service effective?

Requires Improvement

The service was not always effective.

Advice from health professionals regarding people's dietary needs was not always known or followed by staff.

DoLS applications had been submitted appropriately.

Mental capacity assessments were completed appropriately, though best interest decisions were not always clearly recorded.

Systems were not in place to ensure staff received supervisions and appraisals to support them in their role though training and inductions were completed.

The provider had taken steps to adapt the environment to ensure it was suitable for people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not maintained by all staff and comments from some staff were not respectful.

Records regarding people's care and treatment were not always stored securely in order to maintain people's confidentiality.

Care plans we viewed showed that when able, people and their families had been involved in the care planning process.

Visitors were always welcome in the home, encouraging relationships to be maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were reviewed regularly; however there was no record that people had participated in the reviews of their planned care.

We found that planned care was not always evidenced as having been provided. Not all staff we spoke with knew people's current needs, especially if they had changed recently.

New systems had recently been introduced to assist the manager in gathering people's feedback.

The outcome of complaint investigations was not always clearly recorded.

Staff and relatives told us they were informed of any changes within the home, including people's needs.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place to monitor the quality of the service did not highlight the concerns identified during the inspection.

Safety checks introduced following the outcome of an investigation were not maintained.

Systems were in place to gather feedback but were not undertaken regularly.

The home had a manager in post who had applied to CQC to become the registered manager and this application was being processed. Feedback regarding the management of the service was positive.

The manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory requirements.	

Thornton Hall and Lodge

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. The last inspection was undertaken over two days in December 2015 and a third day in February 2016. This will be referred to within the report as February 2016. During that inspection, the home was rated 'inadequate' overall. This inspection was planned to check whether the provider had made necessary improvements to ensure they are meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 7, 8 and 9 September 2016 and was unannounced. The inspection team included two adult social care inspectors, a pharmacist 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.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

The provider had 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 any improvements they plan to make.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the regional operations manager, a peripatetic manager, the manager, the care manager, administrator, acting chef, domestic, 11 people living in the home, seven relatives and nine members of the care team. We also spoke with four health professionals who provided specialist advice and treatment to people living in the home.

We looked at the care files of eight people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also

observed the delivery of care at various points during the inspection.

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.

Inadequate

Is the service safe?

Our findings

When we carried out a comprehensive inspection of Thornton Hall and Lodge in February 2016, we identified breaches of regulation in relation to keeping people safe. The 'safe' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to incidents not being referred to the local safeguarding team when appropriate, medicine management and care planning.

During the last inspection in February 2016, we found that medicines were not always managed safely within the home. During this inspection, we found that sufficient improvements had not been made and a number of concerns were identified regarding medicine management.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of electronic Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink). Staff told us and records we viewed confirmed, that staff had completed training in relation to safe medicine administration and had their competency assessed regularly.

We looked at medicines on three out of the four units within the home and we checked the medicines and records for nine people. We found that medicines were not always given as directed by the doctor. For example, one person who was prescribed a steroid tablet that should have been taken daily was given this as required. The steroid was being used to increase the steroid levels in the body and should not have been given as a when required medicine. The carer we spoke with had thought the steroid was to reduce anxiety when needed.

A second person who was prescribed a weekly pain relief patch, had it changed two days after it should have been, increasing the risk of the person being in pain as they were without pain relief for two days. The same person was taking a variable dose medicine to thin their blood and on three occasions, a lower dose then had been prescribed was administered, which may reduce the effectiveness of the medicine.

A third person was prescribed fluid thickening powder, due to swallowing difficulties. The quantities given and the time administered were not recorded on the MAR sheet or the fluid balance chart, and therefore it was unclear whether this person was having their fluids thickened to the correct consistency.

Controlled Drugs (CDs) were not stored securely or recorded as per legislation as two CDs were not kept in the CD cabinet and two CDs had not been signed out of the register when they had been administered to the person. A controlled drug is a prescription only medicine that is controlled under the Misuse of Drugs Act. A CD patch for a fifth person was received into the home, but was not entered into the register for nine days, which is also not in accordance to legislation.

Medicines fridge temperatures were recorded on most days in the units that we visited, however on one unit the minimum and maximum temperature was not documented, which is not in accordance with national guidance.

During the inspection we observed a medicine trolley to be left unattended in a corridor with medicines left on top of the trolley. The staff member administering medicines was inside a resident's bedroom further down the corridor. This meant that vulnerable people were not protected from risks relating to medicines.

We overheard one person request pain killers from staff and an hour and a half later, when we were talking with this person, they told us that they had not received any pain killers and that, "It's going mad with pain, mad." We discussed this with a staff member who told us the person had to have a certain number of hours between each dose of their medicine, however when they checked, the person had not taken any that day so they administered the pain relief. This meant that people did not always receive their medicines when they needed them.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the last inspection, systems in place to administer medicines covertly were not in line with current legislation. During this inspection, we found that these systems had improved. For example, we looked at the care records for one person who was receiving their medicine covertly and found the necessary agreements were in place, as well as clear guidance on how to administer each medicine.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and skin integrity. These assessments were reviewed regularly and measures put in place to minimise identified risks, such as regular weight monitoring or pressure relieving equipment. We found however that not all risk assessments had been completed accurately. For instance, one person's falls risk assessment highlighted that they had had one fall in the last 12 months; however other records within the care file showed that they had sustained many falls in the recent months.

Another person's assessment regarding falls identified them to be at high risk. The tool used indicated that if people were at high risk, a referral to the falls prevention team should be made for advice. We spoke with the peripatetic manager regarding this and they confirmed this had not been completed, but that they would ensure a referral was made immediately. There was no bed rail risk assessment on file for a person, though their care plan advised they were using bed rails. This meant that risks were not assessed accurately and measures to reduce the identified risk may not be sufficient.

We also found that risk regarding emergency evacuation of the building had not been assessed for all people living in the home. Personal emergency evacuation plans (PEEPs) had been completed for some people and a system was in place to record what support people would require should they need to evacuate the home. These however were not in place for all people and we found that some PEEPs that were in place, had not been completed fully. This meant that staff may not have access to the necessary information to support people in the event of an emergency.

There were a range of internal checks completed by the provider, such as weekly fire alarm checks, wheelchairs, water temperatures, window restrictors and fire doors. We found however, that not all necessary safety checks were completed regularly. Due to an incident that had recently happened within the home, the provider had implemented daily checks on all sensor mats to ensure they were working

effectively. This had also been recommended by the local safeguarding team. Sensor mats are used to alert staff when a person who may be at risk is mobilising. We found however, that not all staff were aware of this new system and records showed that equipment on one unit of the home had last been checked on 21 August 2016. We found during our checks, that one sensor mat was not working as the plug was broken. We alerted the manager to this fault and they made arrangements for the systems to be checked and repaired to ensure the equipment worked.

When looking at the environment, we found that chemicals were not always stored securely. For instance on the top floor there was an unlocked cupboard which contained paint and other chemicals, as well as some open food products. The door to the cupboard, which was a fire door, had no lock and had a hole where the previous lock was located. We raised this with the manager and the chemicals were removed on the same day and the hole in the door repaired.

We observed a fire exit to be blocked by a hoist. We raised this with the manager and they removed the hoist immediately.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements were in place for checking the environment and equipment to help ensure it was safe. External contractors were utilised to ensure regular checks were completed for; gas, electricity, fire alarm, fire-fighting equipment and lifting equipment such as hoists. We viewed the certificates issued from the contractors and these were in date.

We looked at how the home was staffed. The regional operations manager told us that there were usually four staff on each of the units within the Lodge and three staff on the units in the Hall, as well as one staff member who works between floors on the Hall during the day. Overnight there was usually two staff on each of the four units. Staff rotas we viewed did not reflect that these levels were maintained and there were often three staff on the units within the Lodge.

A relative we spoke with told us they did not feel there were enough staff on duty, especially at night. They explained that because there were only two staff, when they were assisting people that required the support of two people, there were no staff available to answer call bells or assist other people. Their relative often had to wait to receive help to access the toilet overnight. Another relative told us, "There are not enough staff, they need more staff to assist with meals." One person living in the home told us, "They are a bit short of staff during the night" and another person told us, "[Staff] are busy, you get help but you have to wait."

Most staff we spoke with agreed that there were not always enough staff on duty. One staff member told us they did not have time to read the communication book as there was not enough staff on duty. They told us they were however, always told if there were concerns about anybody's health and wellbeing. Another staff member told us, "We are busy today, there should be another carer" and a third staff member told us, "It is hard going."

Our observations showed us that there were not always enough staff to meet people's needs. For instance, we observed one person attempting to leave the lounge through the patio doors leading to the garden. There were no staff in the lounge at this time, however staff later told us the person was unable to access the garden alone due to risk of falls. We were advised that the patio doors were broken and could not be locked which meant the person could access the garden without staff knowledge and be at risk. The doors were due to be repaired.

Another person was attempting to find the bathroom and there were no staff in the dining area to guide them. The manager told us that there should be a member of staff in the dining/lounge area at all times, but we observed this was not always maintained. One staff member told us this was not always possible as when there were only three staff on duty and one was administering medicines and two staff were providing support to people, there was nobody to observe residents in the lounge. This meant that there were not always sufficient numbers of staff to meet people's needs.

We discussed this with the management team and were told that staffing levels had increased recently on one unit following participation in a new system being trialled by the provider. A new dependency assessment had been introduced and was due to be fully implemented later this month. The regional operations manager agreed to ensure that the staffing levels previously described were maintained at all times in order to maintain people's safety.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the last inspection in February 2016, we found that incidents that had occurred within the home that should have been reported to the safeguarding team had not been. During this inspection, we found that this had improved and a new system had been introduced to help ensure all relevant referrals were made. We observed a number of records which showed this system had been followed by staff; however we did identify one incident that had occurred recently that should have been reported, but had not been. We discussed this with the management team who told us the care manager had been overseeing the new system and supporting staff to ensure it was followed, however this incident had occurred whilst the care manager was on leave and they had only returned on the third day of the inspection. A new flowchart had been developed to help guide and inform staff when referrals should be made and what process should be followed.

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. All staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the staff office.

We looked at accident and incident reporting within the home and found that a new system had been implemented. All incidents were now required to be recorded on an electronic accident form. This enabled the manager to review the accidents and incidents and ensure all appropriate actions had been taken. The electronic forms were then also accessible to staff in head office and could be analysed to look for any trends or themes.

We looked at how staff were recruited within the home. We looked at three personnel files and evidence of employment history, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We found that safe recruitment practices were followed in line with the provider's recruitment policy.

During the last inspection we found that care plans did not always provide sufficient information to ensure people's needs could be met by staff. During this inspection, we found that this had improved and care plans we viewed provided detailed information regarding people's needs and how best staff could support people.

People we spoke with told us they felt safe living in Thornton Hall and Lodge. One person told us, "I feel safe living here". Another resident said, "Living in a group is not my ideal but up to now I feel safe."

Requires Improvement

Is the service effective?

Our findings

When we carried out a comprehensive inspection in February 2016, we identified breaches of regulation in relation the implementation of the Mental Capacity Act 2005 (MCA). The 'effective' domain was rated as 'requires improvement'. This inspection checked the action the provider had taken to address the breaches in regulation.

During the last inspection we found that applications to deprive people of the liberty lawfully had not been made for all people that required one. During this inspection we looked to see if the service was working within the legal framework of the MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the home's systems had improved in relation to DoLS. Records showed that all people that had been assessed as requiring a DoLS application, had one submitted to the local authority for consideration. The manager maintained a record of all applications made and updated this once authorisations were in place and noted when they were due to be renewed. This showed that four authorisations were in place. Not all staff we spoke with were aware of who had an authorised DoLS in place, though most staff were able to explain the circumstances when an application may be required. We discussed this with the manager who agreed to discuss this again with all staff and told us this information was available to staff on their daily handover sheets, so all staff should be aware who DoLS applications have been made for and which have been authorised.

At the last inspection, we found that people's consent was not always gained in line with the principles of the MCA. During this most recent inspection, we found that some improvements had been made in relation to seeking and recording consent. Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, we saw staff knocking and waiting for a response before entering a person's bedroom and heard staff asking for consent before providing personal care.

Care files showed that people had given consent in areas such as the use of photographs and care planning. This was evidenced through signed consent forms.

When people were unable to provide consent, mental capacity assessments were completed. These were decision specific and they incorporated space to record decisions made in the person's best interest regarding their care. During the last inspection we identified that one person was receiving their medicines covertly without the required agreements in place. During this assessment, we viewed the records in place for one person who was having their medicines administered this way and found that a mental capacity

assessment had been completed and a best interest decision had been recorded following discussions with relevant people, such as the person's GP and next of kin, in line with current legislation.

We found however, that these decisions were not always clearly recorded and records did not always show who had been involved in the decisions. For instance, one person's care file included a number of mental capacity assessments for various decisions regarding their care. They were assessed as lacking capacity to make these decisions and the best interest section stated, "Staff will act in [person's] best interest." This did not provide clear information on what the decisions were. Care plans however, were in place and identified where people lacked capacity to make decisions regarding areas of care and support and described how best to support the person.

We recommend the provider considers current legislation regarding best interest decisions and reviews their systems accordingly.

We looked at how the provider ensured people's nutritional and hydration needs were met. We observed jugs of juice available in people's rooms and staff served hot drinks regularly throughout the day. A menu was available to inform people what was available each day and the menu provided choice and variety. We joined people for lunch in one of the dining rooms and found that tables were set with serviettes and table cloths, though no condiments were available and only cold drinks served during lunch. Staff were on hand to assist people when required and we observed support to be provided in a kind and dignified way.

We received mixed feedback from people regarding the quality and choice of meals available. When describing the lunch on the day of the inspection, one person told us, "The cake is a bit dry, even with custard" and another person told us, "The pizza was too hard, I could not bite into it." A third person told us, "If I don't like the food, they give me omelettes; I am fed up with omelettes." However other people told us, "There's plenty of choice, it suits me" and "The foods alright, if you ask them [staff] they will tell you what's on the menu."

One relative we spoke with told us they thought the found was 'tasty', but that their relative had difficulty chewing some meats, so they were often served omelettes or jacket potatoes. Staff told us there was always a choice of meal with the main meal being served at tea time. One staff member told us that for people that prefer finger foods, some meals could be difficult, such as roast dinners and that there was often no suitable alternative provided.

Records showed that when there was a concern regarding a person's diet or fluid intake, this was monitored and recorded and referrals were made to the dietician and speech and language therapist for specialist advice when necessary. We found however, that advice received from these specialists was not always known or followed by all staff. For instance, one care file we viewed showed that the person had been assessed by the speech and language therapist and advice was provided as to the type of diet that was most appropriate for them to eat to maintain their safety. Completed diet recording charts showed that this type of diet was not always followed and foods were provided to the person that could be a risk to them. We discussed this with the manager who told us they would arrange further training for staff and ensure appropriate diet was provided to all people living in the home.

Staff we spoke with did not all fully understand people's diet and hydration needs. For instance, one person's care file reflected that they required their drinks to be thickened due to swallowing difficulties. Drinks can be thickened to different consistencies dependent on people's assessed need and this person's care file showed that they required drink thickened to stage 1. One staff member we asked about the person's needs told us they required fluids at stage 2. This meant that people may not receive appropriate

fluids. We observed one staff member giving out drinks and providing jugs of juice for people in their rooms. We asked the staff member whether any people on the unit had any specific requirements regarding fluids, such as the need for thickener in their drinks and they told us they did not know but that the information would be in people's care plans. We spoke with the acting chef and they were not aware of all people's dietary needs, such as whether people required a special diet due to their medical needs. Another person had recently been assessed by the speech and language therapist and one staff member we spoke with was unaware of this assessment or the recommendations made regarding the person's care and treatment. This meant that staff may not have the necessary knowledge to ensure people's nutrition and hydration needs could be met.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at on-going support available to staff. Records showed that eight out of 80 staff employed, had received supervision in July 2016. No individual supervisions had been completed since then and there were no records available to show what supervisions were undertaken prior to this date. Staff we spoke with told us they did not have regular supervisions or an annual appraisal. One staff member told us they would like a supervision as there are a few things they would like to raise.

The manager told us they knew supervisions had not been completed recently and due to being new in post, they planned to meet individually with each staff member in the coming weeks. We were also told that some group supervisions had taken place, but that these were more information sharing than supervisions. This meant that staff may not have the support necessary to assist them in their role.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how staff were inducted into their job role. Most staff told us they completed training before commencing in post and shadowed a more experienced staff member for at least three days until they felt confident to work alone. We observed three completed induction booklets for staff that had recently commenced in post and these were in line with the principles of the care certificate. The care certificate requires staff to complete appropriate training and be observed in practice by a senior colleague or manager before being signed-off as competent.

An electronic system was in place to monitor staff training and alerted the manager when refresher training was due to be completed. We looked at the electronic system and found that staff had completed training in areas such as medicines management, safeguarding, moving and handling and dementia awareness.

Staff we spoke with told us they completed training regularly and this was a mixture between eLearning and face to face training. Staff were supported to complete qualifications in health and social care and we observed this during the inspection as a staff member was meeting with their allocated assessor.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the G.P, speech and language therapist, district nurse, dietician and optician. Comments from people living in the home included, "[Staff] get the GP when I am poorly", "The staff are very good with me, they will send for the GP when I am unwell" and "The GP will come out when I am ill." One relative told us staff had contacted them immediately when they noted their loved one was unwell.

We observed the environment of the home and found that the provider had taken steps within the home for people living with dementia, towards the environment being appropriate to assist people with orientation and safety. For instance, there were pictorial signs on doors to inform people what was inside, such as a bathroom or dining room. Doors and handrails had been painted different colours so they were easy to recognise, there was memorabilia along the corridor wall as a point of stimulation and discussion and green crockery was used in the dining room for people who were living with dementia. Pictorial menus were also displayed on the walls of the dining rooms so people could see what meals were available that day. This helped enable people to maintain their independence and assist with orientation.

Requires Improvement

Is the service caring?

Our findings

Records regarding people's care and treatment were not always stored securely in order to maintain people's confidentiality. For instance, we found records regarding people's weight, dietary intake and care reviews in unattended files in dining rooms. This meant that people could access this information that did not need to. We discussed this with the management team and folders had been removed and stored securely by the end of the inspection.

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

People living at the home told us staff were kind and caring and treated them with respect. People told us, "I am quite happy with the staff, I have no complaints", "The staff are very good with me" and one person described staff as, "Very good." Relatives told us, "There are no problems with the staff, there are only compliments" and, "In general we are quite happy with the care."

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms and referring to people by their preferred name. People were given plenty of time to eat their meals; they were not rushed in any way. Interactions between staff and people living in the home were mostly warm and caring. We heard staff speak with people in familiar and friendly manner and during discussions staff spoke about people in a caring way.

We found however, that people's dignity was not always maintained. For instance, we attempted to make conversation with one person living in the home as a staff member was supporting them past us in their wheelchair. The staff member passed an undignified comment regarding the person's ability to respond to us and continued down the corridor. The manager was present when this comment was made and addressed it with the staff member immediately.

We also looked at records regarding incidents that had occurred and found that comments recorded by staff in terms of lessons learnt form the incident, were not always dignified or respectful. For instance, when a staff member had been struck by a person living with dementia, the section of the form to record what had been learnt, read 'to duck.' We discussed this with the management team and they told us they would ensure staff completed appropriate training to help ensure inappropriate comments were not made either verbally or within written records.

Care plans we viewed showed that when able, people and their families had been involved in the care planning process. This was evident through signed consent forms, records of people's choice and preferences and completed life histories. Preferences were recorded in areas such as meals, activities and drinks. Care files also included a summary of care needs and this detailed people's preferred daily routine each morning, afternoon and overnight. We also observed records in care files that explained what was important to the person and what was important to their family. For instance, one person's file reflected that the most important thing to them was to be able to make their own choices and the most important thing to

their family member, was to be kept informed.

People's needs in respect of their religion and beliefs were considered by the provider. The home had a room which was used as a chapel and a member of the local clergy visited each week to perform a service for those people unable to travel to the church service. The manager told us they planned to update the area and ensure it was suitable to be used by people of various faiths.

We observed relatives visiting throughout all days of the inspection. The manager told us visitors were always welcome in the home, encouraging relationships to be maintained. A protected meal time policy was in operation to ensure people were given time to eat meals, however visitors were able to join their relatives for a meal should they choose to. Relatives told us they could visit anytime and could spend time with their loved ones in private.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access. The manager told us there was nobody in receipt of these services, but that they would support people to access them should this be required.

Requires Improvement

Is the service responsive?

Our findings

Relatives we spoke with told us they were kept informed of any changes to their loved one's health and wellbeing. Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handover sheets. Staff told us that care plans would be updated if people's needs changed, though some staff told us they did not often have time to read through care plans and often relied on the information provided through handover records. Some staff told us there was often no time for verbal handover's between staff.

We observed care plans in areas such as personal care and physical wellbeing, mobility, nutrition, oral care, family involvement, medicines and overnight care. Care plans informed staff of the support people required and most provided information about people's preferences. One care plan we viewed provided detailed information regarding a person's behaviour management and guided staff on the best way to support the person should they become anxious.

The care plans were reviewed regularly, however relatives we spoke with told us that although they had been involved in the development of the care plans, they not been involved in any recent reviews. There was no record that people themselves had participated in the reviews of their planned care.

Care plans were not in place to guide staff about all of people's identified needs. For instance, one person had been assessed and provided with a new piece of equipment; however this was not reflected within the person's care file. Staff we spoke with however, were able to tell us how this equipment should be used to maintain the person's safety.

We also found that planned care was not always evidenced as having been provided. For example one care plan advised a person required regular support to reposition every two hours; however this support had not been recorded for four days at the time of the inspection.

Care files included information regarding people's life histories; these were detailed and enabled staff to understand people's backgrounds and experiences. Most staff we spoke with knew the people they were caring for well. For instance, we observed an incident in which a person became agitated in the dining room and staff intervened to support the person in a way that was effective for the individual and maintained both their safety and that of others around them. A staff member later described to us what the person responded well to and how they used this information to best support them.

We found however, that not all staff we spoke with knew the people they were supporting well. For instance, one staff member had been transferred from another area within the home due to staffing levels and did not know the people they were supporting. Other staff we spoke with were unsure of people's specific care needs, especially if there had been a recent change in the person's needs. For instance, one person had recently been reviewed by a community matron and one staff member told us they had advised the person has their feet elevated during the day and this was recorded in the person's care record. We observed the person sitting in a chair without their feet elevated at various times throughout the inspection. When we

discussed this with another staff member, they were unaware of the community matron's recommendation and did not know the person had been reviewed by them. This meant that staff may not have the necessary information to ensure they could meet people's needs effectively.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An activities coordinator was employed within the home and a schedule of activities had been devised. We found that available activities were advertised around the home and a weekly pictorial schedule was displayed to advise people what activities were on each day. The regional operational manager told us that the provider had arranged discussion throughout their services regarding activities and relevant staff now had access to a regular conference call. Best practice and seasonal activities were discussed at these meetings and guidance then provided to all of the providers services.

We observed people watching television or listening to the radio in communal areas throughout the inspection. One person told us, "There's nothing on to do today, nothing to do but watch TV" and another person told us, "I don't like activities, I am not bothered." We observed staff painting people's nails; we heard the activity coordinator running a quiz for people in one unit of the home and we observed four people being supported to go to a local luncheon club. The manager told us the activity coordinator had devised activity boxes for each unit within the home and these included games and items for discussion. These were developed to enable the staff to initiate activities when the activity coordinator was not within their unit. Staff we spoke with told us they did not often have time to provide activities. Minutes from the last residents meeting recorded that people felt activities had improved.

We looked at processes in place to gather feedback from people and listen to their views. The care manager told us quality assurance surveys were issued regularly. Each month the quality assurance surveys had a different theme, such as admission to the home, meals and activities. Records showed that the last completed surveys were from October 2015. The care manager told us that although these were issued regularly and always before resident and relative meetings, they received very few back. Resident and relative meetings were held throughout the year and records showed that topics such as activities, meals and changes in the home were discussed.

The provider had recently introduced a new system to help assess the quality of care and gain feedback from people. The 'resident of the day' had meetings with the manager and key staff within the home to discuss the care and service they had received and whether any changes were required. It also provided an opportunity for their care records to be discussed and reviewed and a discussion or telephone call to the person's relative to discuss the care provided and seek any feedback and this was evident in some of the records we viewed. There were also comment cards available to people around the home, though relatives we spoke with were not aware they were available.

A complaints procedure was available in the home; however information on how to make a complaint was not clearly displayed within the home for people to access. A complaints log was maintained and the regional operations manager showed us an electronic log of recent complaints. We found however, that the outcome of complaint investigations were not always clearly recorded. For instance, one complaint recorded in the log identified receipt of the complaint, but no investigation or outcome. We spoke with the regional operations manager about this and they confirmed that the care manager had met with the family to discuss their concerns and that the complaint had been resolved. We spoke with the care manager who confirmed there were no on-going actions; however they had not recorded the discussion they had with the complainant. Complaints were also monitored by head office and formal response letters were evident for

most complaints.

Inadequate

Is the service well-led?

Our findings

When we carried out a comprehensive inspection of Thornton Hall and Lodge in February 2016, we identified breaches of regulation in relation to how the service was ran. The 'well-led' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation. The breaches were in relation to ineffective auditing systems, which did not identify all of the concerns highlighted during the inspection.

During this inspection we looked at how the manager and provider ensured the quality and safety of the service provided. The provider arranged visits from the internal quality team, who assessed the home's compliance and quality. The last visit in July 2016 identified some areas for improvement and this was recorded on a verbal feedback sheet, though no specific actions for improvement were recorded. For instance, the audit identified a number of issues regarding medicines management, but no actions were recorded to identify what measures would be taken to make improvements. The manager told us however, that required actions were communicated to them and that these were followed up during future visits.

We viewed completed audits which included areas such as infection monitoring, complaints, pillows, air mattresses, accidents and incidents, catheters and weights. There was also a system of daily, weekly, monthly, quarterly, bi-annual and annual checks that were planned and recorded to ensure the environment and equipment were maintained. The audits in place did not identify the issues we highlighted during the inspection, such as those relating to storage of chemicals, internal checks not being completed, risks assessments not up to date and accurate and issues relating to staffing levels. We also found that safety checks introduced following the outcome of an investigation were not maintained.

We found that communication systems in place were not always effective to ensure people's care needs were known and met by staff. For instance, not all staff knew who had an authorised DoLS in place. We spoke to staff about people's dietary needs and staff were not always aware of their current requirements and not all staff we spoke with knew when health professionals had visited and provided advice regarding people's care and treatment. This meant that people's needs could not always be met safely.

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

During the last inspection, we found that although accident and incident records were reviewed by management, appropriate actions were not always taken, such as referrals to the safeguarding team. During this inspection, we found that improvements had been made and new systems had been implemented to help ensure appropriate actions were taken following any incidents within the home. Records we viewed showed that most incidents had been recorded and reported appropriately; only one incident had not been referred to the safeguarding team that should have been and this had taken place a couple of weeks prior to the inspection. We were told that the care manager had been monitoring all incidents and ensuring relevant actions were taken. However the care manager had been on leave at the time of this incident and only returned during the inspection. Since the inspection we have been advised that a referral to the

safeguarding team has now been made. This meant that systems in place to ensure appropriate measures were taken following incidents, had improved since the last inspection.

The provider had introduced new systems that aimed to help the manager in checking the quality and safety of the home. For instance, a new manager's daily checklist had been created and was due to be commenced. This looked at areas such as staffing, completion of medicine records, environment, completion of daily records, bedrooms and a check of one person's medicines. A 'resident of the day' programme had also been created and had been implemented within the home, though we found this was not consistently completed. This looked at one person's care records to ensure they were accurate, up to date and completed appropriately, checks of any equipment they used and gathering feedback from the person and their relatives regarding the service.

We looked at processes in place to gather feedback from people and listen to their views. We found that as well as resident and relative meetings being held and quality assurance surveys issued, staff meetings also took place. These meetings however, were not frequent and not all staff we spoke with were aware of them. Records showed the last general staff meeting was held in October 2015, though the manager and staff told us a meeting had been held the previous week and minutes were not available on the day of the inspection. A themed health and safety meeting had taken place in February 2016 and the manager told us they planned to hold staff meetings regularly. Records showed that areas such as safeguarding, medicines, breaks, policies and accidents were discussed during these meetings.

The home had a manager in post who had applied to CQC to become the registered manager and this application was being processed. Since the inspection, we have been advised the new registered manager is no longer in post and the peripatetic manager will remain at the service until a new manager is appointed. We asked people their views of how the home was managed and feedback was positive. Relatives we spoke with knew who the new manager was and one relative told us, "The management style has tightened up." A staff member told us, "We are working in a happy environment" and another said, "It is a lovely place to work."

The provider had an extensive set of policies and procedures available within the home, to help guide staff and measure performance. The manager was able to provide evidence to support the inspection process in a timely manner and was knowledgeable about their role and responsibilities. The manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to monitor information and risks regarding Thornton Hall and Lodge.

Most staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.