Mr Barry Potton

Thornton Manor Homecare

Inspection report

Thornton Manor Bungalow
Thornton Green Lane, Thornton Le Moors
Chester
Cheshire
CH2 4JQ

Tel: 01244301762

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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 the 05 January 2015 and was announced.

Thornton Manor Homecare is registered as a domiciliary care service to provide personal care for people in their own homes. The service provides care and support for two people.

The service has a 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.

The service was last inspected in February 2014 and was not found to be in breach of any regulations.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. You can see what action we told the provider to take at the back of this report.

Care records were in place which contained details about people's needs, however we found that this information was not always accurate or up-to-date. We observed care that was not delivered in line with information contained within care records and saw that records were not updated to reflect changes in people's needs after being reviewed. This meant that people were at risk of receiving inappropriate care and support.

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.

People's mental capacity was not considered within care records. We saw no evidence that the relevant people had been involved where decisions had been made in a person's best interest. Referrals had not been made to the court of protection for people using the service in line the Mental Capacity Act 2005. This meant that people were at risk of having their rights infringed.

Care records contained some personalised information, however we found that the information provided about people was out-of-date and in some cases had not been reviewed since 2012. This meant that information was not reliable, and was not reflective of people's current needs.

Quality assurance systems were not in place to identify where improvements were needed. Neither the registered manager nor the registered provider completed audits of the service, which meant that the service was not able to improve.

Feedback from a questionnaire contained an example where concerns had been raised by a family member,

however no formal response or action plan had been implemented. As a result of this it was unclear whether people's concerns were being dealt with or not.

Records indicated that staff had completed training that was necessary for them to carry out their role. Staff were able to demonstrate a good understanding of how to identify abuse and what procedures they needed to follow to raise their concerns. This meant that people were protected from the risk of abuse.

Staff were respectful and we saw examples of how they worked to maintain people's dignity and general wellbeing. We observed that people were at ease with staff, and saw that staff spoke kindly to people. People's confidentiality was maintained, and documents containing personal information were stored securely in a locked cabinet.

Staff supported people to engage in a number of activities, which included spending time in a sensory room and going out for day trips. Relatives confirmed that people were being supported to access the community. This helped ensure that people were protected from social isolation.

We looked at people's medication records and saw that they had received medication as prescribed. However there was no audit system in place to check for any errors or to ensure that the quantities being stored were correct. We looked at samples of medication and found these to be correct.

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.

Risk assessments were not up-to-date, which meant that people were at risk of receiving inappropriate care.

Staff were able to identify safeguarding concerns and were aware of how to report their concerns.

People received their medication as prescribed which ensured that their health and wellbeing was maintained.

Is the service effective?

Requires Improvement

The service was not effective.

Care records did not contain information regarding people's mental capacity. People had not been referred to the court of protection in line with the Mental Capacity Act 2005. This placed people at risk of having their rights infringed.

Care records did not outline when staff should resort to restraining methods. This meant that people were at risk of inappropriate restraint.

Is the service caring?

Good

The service was caring.

Staff were respectful towards people and worked to maintain their dignity.

People's confidentiality was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records contained some personalised information, however this was not up-to-date and did not reflect people's current needs or preferences.

People were supported to participate in activities and were protected from the risk of social isolation.

Is the service well-led?

Requires Improvement

The service was not well led.

Audits were not completed by the registered manager or the registered provider. This meant that areas of improvement could not be identified.

Senior carer staff were expected to monitor the quality of the service, however this was the responsibility of the registered manager and the registered provider.

Thornton Manor Homecare

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.

The inspection took place on the 5 January 2016. The provider was given 24 hours notice because the location provides a domiciliary care service for people who are often out during the day; we needed to be sure that someone would be in.

The inspection was carried out by one adult social care inspector. Prior to the inspection taking place we contacted the local safeguarding team and the contracts and commissioning team, who did not raise any concerns regarding the service. During the inspection we looked at the care records for the two people using the service, and looked at records pertaining to the management of the service. We spoke with four members of staff including the registered manager and gathered feedback about the service from relatives We also looked at the recruitment records for four members of staff.

People who used the service were not able to talk with us, so 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.

Requires Improvement

Is the service safe?

Our findings

We spoke to relatives who told us that they felt the service was safe, "Yes [my relative] is safe. They provide good support."

We looked at care records for people using the service. These contained information around the management of risk, however this information was not up-to-date or easy to understand. For example, we saw that records indicated that sensors were used during the night, which would alert staff if someone required immediate assistance due to their health needs. Staff told us that these were no longer being used, however the reasons behind this decision were not clear. Staff confirmed that the risk to the individual was still a concern. We saw another example where records stated, "[Name] is at risk of injuring [themselves] and others whilst being supported by staff in the community." There was no information to suggest what the specific risk of harm was to the person or others and there was no clear information available to staff on what to do in the event of any issues arising. Staff were able to give examples of how they managed people's risk, however poor documentation placed people at risk of receiving incorrect care.

There was evidence to indicate that some risk assessments had been reviewed on a monthly basis, however we saw no examples to indicate that updates were being made to reflect any changes. For example one risk assessment around managing a person's health conditions was documented as having been reviewed monthly since May 2013, however there were no changes reflected in records around how this person was supported. This placed people at risk of receiving support that was not reflective of their current needs.

Care records stated the level of support people required during meal times. We saw an example of a risk assessment had last been reviewed in April 2012 and did not contain any information relating to whether a special diet was required, however other areas of information within care records indicated that "soft and moist food" and "syrup thick drinks" were required. During lunch time we observed that this person was eating independently and without supervision whilst the carer was in another room. We spoke with staff who said that this person was now able to eat independently. However we saw no information in the care records to support this and no information to suggest that a formal review from a qualified professional had taken place. We raised our concerns around this with the registered manager who told us that care records would be updated as soon as possible.

There was a restraint policy in place, however there was no information within care records to outline when it would be appropriate to use restraining methods, despite staff having told us that this would be used as a last resort. Accidents and incidents records indicated that one person would at times demonstrate challenging behaviour, however there was no care plan or risk assessment around this, or how to manage the situation. This meant that people and staff were at risk of injury.

Accidents and incidents records did not always contain information around what action had been taken following the incident, and there was no detail about why the incident may have occurred. There was no analysis of accidents and incidents, which meant that trends could not be identified to help prevent future incidents from occurring.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations because risk assessments were not up-to-date or provide a clear response to risk management.

Staff had received safeguarding training, and were able to identify safeguarding issues. Staff gave examples of what signs and indicators may give rise to concerns, comments included; "Abuse can be physical, financial and verbal. This is a small environment so we'd recognise changes in behaviour", "I'd look out for things like bruising or changes in behaviour". Staff were confident about who they should report their concerns to and told us that they would not hesitate to report any concerns.

Recruitment processes were robust and ensured that people's safety was maintained. We looked at the recruitment files for four members of staff and found that they each had two references, one of which was from their most recent employer. Staff had also been subject to a check from the disclosure and barring service (DBS) which ensured that they were suitable to work with vulnerable adults. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. This ensured staff were suitable to work with vulnerable people

Staff rotas for December 2015 and January 2016 showed that there were sufficient staff in place to keep people safe. There were three members of staff in place throughout the day and one member of staff through the night. A staff member who was based at the neighbouring nursing home also completed regular checks on the service. This was sufficient to ensure people's safety.

We looked at a sample of the medication records for people using the service and found these to be correct. Staff were using a medication administration record (MAR) chart, which they signed to indicate that medication had been given. Medication was kept in a locked cabinet in people's bedrooms, with the keys stored securely in a separate room.

Requires Improvement

Is the service effective?

Our findings

Relatives told us that they felt the service was effective, comments included; "[My relative] gets the support they need". Staff told us that they felt they had sufficient training and supervision to enable them to do their job. Comments included; "Yes we receive supervision which is useful", "I feel I get enough training, yes".

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA and found that it was not. Care records did not contain any current information around people's mental capacity, or indicate whether any decisions had been made in a person's best interests. Care records did not contain any information around whether people were able to make decisions or required support to do so. We saw that one person's records contained a mental capacity assessment that had been completed in 2013. The assessment did not contain any information around how the given conclusion had been reached and there was also no indication that key areas such as the person's ability to understand and retain information had been adequately explored. This meant that consideration was not being given to ensuring people's rights were upheld in line with the Mental Capacity Act 2005.

Staff did not have an understanding of basic principles of the Mental Capacity Act 2005, or how they would apply these to their role, comments included; "I can't remember the legislation. I had the training a while ago", "I can't remember the principles, but I have had the training". This meant that staff did not have the knowledge required to ensure that people's rights were protected.

Care records indicated that people were subject to a high level of supervision and control, however an application had not been made to the Court of Protection. One person required the support and supervision from two people during the day and one person during the night. They also required constant supervision from two people when out in the community. The registered manager was not aware that a referral was required to the Court of Protection. We asked that this be rectified immediately. Following the inspection we shared this information to the local authority.

This is a breach of Regulation 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations because the registered provider had not ensured that care and
treatment was provided with the consent of the relevant person and had failed to make applications to the court of protection.

Supervision is a process through which staff and management are able to reflect upon areas of development and improvement. We saw that staff had received regular supervision with the registered manager, and staff told us that they found this helpful.

General training completed by staff included moving and handling, first aid and safeguarding vulnerable adults. This supported staff to keep their knowledge up-to-date and in line with best practice.

Care records indicated that one person had difficulty with swallowing their food and required a soft food diet. At lunch time we observed that this person had been given an appropriate option. We observed that people were encouraged to have drinks during the day and that various options were available, including hot drinks and juice. This meant that people were protected from the risk of malnutrition and dehydration.

Care records indicated that people had received support from a variety of health professionals, including the GP, community psychiatric nurse, optician and dentist. This meant that people were being supported to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

During the inspection we observed that staff spoke kindly to people. Interactions we saw were positive and showed that staff had developed ways of understanding what people were trying to communicate through various gestures and behaviours. Staff spoke fondly about the people they were supporting. One member of staff told us, "I really love working here. I enjoy it, and love working with [names of people using the service]". People appeared comfortable and trusting of the staff who were supporting them.

We spoke to relatives who told us that when they visited the service they were made to feel welcome by staff. They told us that staff were caring and approachable, and told us that their experience of the service had been positive. This is important as it ensured that people were able to maintain social relationships.

Staff told us that there was a low staff turnover within the service, which meant that staff had developed a good rapport with people. Staff were also knowledgeable about people's needs due to the length of time they had been working at the service. This supported people to develop a good rapport with staff.

People were able to make some basic decisions about their care and support with the help of staff. One member of staff gave an example of how they supported people to participate in their care, "In the morning, we go to the wardrobe and [name] will point at what clothes they want to wear for the day". Staff told us that they used people's body language and behaviour to try and understand what people wanted, for example one person wanted to put their shoes on, which indicated to staff that they wanted to go out. This showed that people were supported to participate in their care.

Staff protected people's privacy and dignity. We saw staff support one person into their room so that they could have a shower. Staff ensured that the curtains were closed and that the door was shut. Staff told us that they felt it was important to respect people's privacy and dignity, stating; "I don't talk about people outside of the work setting. It's private", "I ensure that curtains and doors are closed if I'm supporting people with personal care", "It's important to respect privacy. Doors are always closed during personal care tasks". This demonstrated that staff were respectful towards people.

People had not accessed any support from a local advocacy service. Staff told us that people were able to draw upon support from family members. There was no information available for staff or relatives incase people should require support from an advocate. We raised this with the registered manager who said that this information would be made available.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care records for both people using the service. They contained some personalised information around people's care and support, however, we saw evidence that they were not always up-to-date or accurate. For example we saw that one person was being supported by external health professionals due to change in their needs. Staff also told us that this person's needs had changed. We found that no updates had been made to care records to reflect what these changes were or how staff should respond. This meant that people were at risk of receiving care and support that was not sufficient to meet their needs.

Care records did not contain up-to-date information on how staff should support with de-escalating challenging behaviour. A 'de-escalation of challenging behaviour' care plan was in place, however this had not been reviewed since 2012 and no updates had been recorded by staff. The information recorded in the care plan did not outline the methods for de-escalation that staff told us that they had been using. For example making use of the sensory room or reading magazines. This showed that information was no longer relevant or effective, which meant that staff did not have access to up-to-date information.

There was no up-to-date information in care plans around the level of support people required during the night, despite staff telling us that people required a high level of support. We looked at staffing rotas which provided evidence to support that the required level of support was available for people. The information contained within care records was not sufficient to enable staff to know what level of care they should be providing.

Care records contained details of people's likes and dislikes, however this information was not current, for example one care plan stated "[name] enjoys watching top gear and the simpsons", however this had been written in January 2013. A discussion with care staff indicated that this person's likes had since altered. Another care plan stated "I dislike having a shower or getting wet". Care records did not contain any information around how staff could minimise any distress during personal care interventions.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations because information contained within care plans was inaccurate and out-of-date.

Activities were available for people and it was clear from speaking with staff that they knew what people liked to do. People had access to a sensory room which we observed one person spending time in. Staff told us that one person enjoyed going out in the car to visit different places, and that they would alter destinations to keep it more interesting. We spoke with a family member who told us "They go out quite a lot. Sometimes they will come and visit us which is nice". This showed that people were protected from the risk of social isolation.

We spoke with relatives who told us that they would feel comfortable making a complaint or raising any concerns. We saw an example where a concern had been raised by family around one person's weight. Staff told us that they had been limiting the number of sweets available to this person, however no formal

response or action plan had been implemented around this. This made it unclear whether complaints were being dealt with in the correct manner. We raised this with the registered manager and senior care staff to follow up on.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post. Staff spoke positively about the registered manager, and told us that she had an "open door policy", was approachable and would listen to their concerns. Relatives also spoke positively about the registered manager and told us that she was "approachable and friendly".

There was a lack of effective management within the service. The registered manager informed us that senior staff completed the audits for the service, however when asked, staff told us that they did not. Neither the registered manager or the registered provider had carried out any audits of the service, to ensure that quality was being maintained. This meant that areas of improvement were not being identified and that the service could not improve.

The role and responsibility of senior care staff was not always clear. There was an expectation from the registered manager that they should also be monitoring the quality of the service by completing monthly audits, however It is the responsibility of the registered manager and the registered provider to implement effective systems to identify where improvements are needed in service delivery. This indicated that the service was not well led.

The registered manager and the registered provider had not identified that care records were out-of-date and it had not been identified that people using the service required a referral to the Court of Protection. Accidents and incidents were not being monitored or analysed to identify any trends, which meant that appropriate action could not be taken to prevent issues from reoccurring. This demonstrated that there were no systems in place to identify issues, or make improvements.

Questionnaires had been given to people's families to determine their view of the service. One of the questionnaires highlighted concerns that one person was gaining weight, however there was no indication of whether this had been explored, or what action had been taken by the registered provider. This showed that whilst attempts had been made to identify areas of improvement, no formal action had been taken to make use of this information.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations because there were no effective systems in place to measure and improve the quality of the service.

There was no evidence to suggest that links had been developed with other community groups that may have been supportive for people using the service. This may have included groups which offer specific support to people with learning disabilities. We raised this with the registered manager, who told us that she would look into this.

We saw evidence that staff meetings were held and that staff received supervision. Supervision allows the manager and staff to identify and discuss areas of development, and supports improvement. This indicated that support was available to staff if they needed it.

Relatives knew who the registered manager was, and told us that they would go to her if they had any concerns about the service. The registered manager did not hold resident's and relative's meetings, however family members told us that they felt they would be able to approach the registered manager at any time. Comments included, "I don't have any concerns but I would go to her (the registered manager) if I had any". This showed that the registered manager was approachable.

We reviewed the service policy and procedures manual. All policies had been reviewed and updated by the manager in 2015 and reflected current law and legislation. We saw updated copies of the complaints, safeguarding and recruitment policies during our visit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's mental Capacity had not been considered within care records and no best interest decisions were documented, where people were not able to make decisions for themselves.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not up-to-date and did not the information needed to keep people safe.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Referrals had not been made to the Court of Protection in line with the Mental Capacity Act 2005

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no effective system in place to monitor the quality of care and services provided at the service.