Presidential Care Limited

Thorndene Residential Care Home

Inspection report

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Doncaster
South Yorkshire
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Thorndene Residential Home is situated on the outskirts of Doncaster and is in easy reach of local shops and amenities. The home is registered to provide accommodation for up to 22 older people. Accommodation is located on both the ground and first floor. There is a small car park at the front and enclosed gardens at the side and rear of the home. At the time of this inspection there were 20 people living at the home.

From this location a domiciliary care service was also provided. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of this inspection 33 people received assistance with their personal care needs.

People's experience of using this service and what we found
People were not always safe. Risks to people's safety had not always been assessed and recorded. For example, one person who smoked created a potential risk to themselves and others. However, there was no risk assessment in place for this. People received their medicines as prescribed. However, some medicine records were incorrect and the medicine audit had not identified this.

People and relatives were generally positive about the staff that cared for them. Staff feedback varied about the service and staffing levels. Most people told us there were not enough staff. People using the DCA service said often staff did not arrive at the agreed time. We saw people living in the care home were left unsupervised whilst eating and for considerable periods throughout the day.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We were somewhat assured the provider was adhering to infection control practices. Infection prevention and control measures were in place and staff understood how to prevent the spread of infection. Staff wore personal protective equipment, although we observed one staff member going outside for their break and not removing and changing their personal protective equipment (PPE) when they returned into the home. There was also no place for staff to put their coats and bags, so these had been left in the dining room.

The registered provider did not have effective governance systems in place to maintain and improve the quality and safety of the service. Analysis of accidents and incidents did not include all accidents that had happened so could not identify any patterns or trends to help mitigate risk and prevent reoccurrence. Quality assurance audits were not always effective. For example, medicine audits had not identified an error with the recording of controlled drugs. Where actions were identified from audits there was not always confirmation of when staff were required to action these by.

Rating at last inspection
The last rating for this service was requires improvement (published 23 September 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

We found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link Thorndene Residential Care Home on our website at www.cqc.org.uk.

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

We have identified three breaches of regulation. People did not always receive safe care and treatment, there was a lack of sufficient suitably qualified staff and good governance systems were either not in place or were not robust enough to demonstrate people's safety was effectively managed. This placed people at risk of harm.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Thorndene Residential Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Thorndene is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Thorndene also provides a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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

Notice of inspection
We gave short notice of the inspection. We wanted to review documentation remotely and plan to speak with people, their relatives and staff by telephone prior to our visit. This helped minimise the time we spent

in face to face contact with the provider, registered manager, staff and people who used the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We e-mailed all staff asking their opinions of the service. Three staff members replied to the e-mail. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and eight relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, administrator, senior care workers, care workers, ancillary workers and the cook. We also spoke with two healthcare professionals who visited the service on the day of the inspection.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at a variety of records relating to the management of the service, including quality assurance surveys, complaints and audits.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data, spot checks and dependency tools.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's safety had not always been assessed and recorded. For example, one person who smoked created a potential risk to themselves and others. However, there was no risk assessment in place for this.
- We found records of pressure care for people were not up to date. On the day of the inspection staff had not completed the two hourly turn charts for people since the day before. This meant we could not be assured people had received pressure relief care as needed.
- A relative said they were concerned about their family member as they often had issues with coughing following eating and drinking. The relative felt their family member was sometimes unsafe as staff were not always present when the coughing occurred. There was no choke risk assessment and no evidence of the person being referred to the speech and language therapist (SALT).
- A person who used the service had their pet dog staying at the service. There was no risk assessment to mitigate the potential risk for people using the service that may not see the dog clearly and could potentially lead to falls. There was no risk assessment about the dog's vaccinations and flea and worm applications. This meant it could pose a risk of cross contamination if not regularly treated.
- The registered manager analysed accidents and incidents on a monthly basis, to try to identify any themes or trends and make continuous improvements to the service. However, not all accidents had been included in the analysis. The registered manager said she would change the way accidents and incidents were recorded to ensure none would be missed from the analysis.

We found no evidence that people had been harmed however, this was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider responded immediately during and after the inspection. They confirmed risk assessments had been put in place and records of pressure care were being kept up to date and regularly monitored.

Staffing and recruitment

- We were not assured there were enough staff deployed to keep people safe. The provider did not use a dependency tool to ensure there was a safe number of staff and had arrangements in place to cover shifts in the event of absence or sickness.
- There was not enough staff to provide assistance to six people who had their meals in the lounge. For example, one person was struggling to eat their meal with a fork and was pushing the food onto the small table which was in front of them. Another person was eating the person's food who was sat next to them. Other people had food on their clothing which was not changed at the end of the meal.

● One staff member told us, "Work has been really tough, more hours to cover, not enough staff and a lot of sickness. The rota is done at the last minute. The manager has too much to look after with the care home and community service."
● Most people and relatives said the service did not have enough staff. Comments included, "Sometimes the care home staff are used for the domiciliary care service and we wait a long time for assistance," and "My [family member] gets frustrated waiting for someone to come and help him and ends up doing it himself."

The lack of sufficient suitably qualified staff is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Using medicines safely
● Medication audits were not robust or effective as discrepancies had not been identified.
● The controlled drug (CD) register was used to record medicines that required additional security. However, we found no evidence to confirm they had been regularly checked.
● Two records of CD drugs did not tally with the drugs stored. The registered manager took immediate action to investigate the discrepancies. The registered manager contacted us after the inspection to confirm the discrepancy had been resolved.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were somewhat assured the provider was using PPE effectively and safely. We observed staff wearing and changing PPE at regular intervals. However, the cook was dressed in their outdoor clothing and did not always change the plastic apron when they returned to the kitchen from taking a break outside.
● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. Staff's coats and belongings were not stored appropriately. They were in the dining room on top of a small piece of furniture. The registered manager took immediate action to remove them. Pain tins were stored in the lounge at the side of seats that were occupied. The registered manager removed them to more appropriate storage area.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● Staff understood the importance of keeping people safe.
● The registered manager was aware of their responsibilities when reporting allegations of abuse.
● People who used the service and relatives said they felt safe and were happy with the care they received. Comments included, "I have a good relationship with the carers they know me and I know them," and "The care is brilliant with no hiccups and [name] is very happy."
● Where incidents had occurred, referrals had been made to the appropriate agencies, such as the local

safeguarding authority and CQC.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- Governance systems were in place but not always effective. The registered manager's quality audits for medication, risks, infection prevention and control were not effective and had not identified the issues found on this inspection.
- Care plan audits had not identified the required actions had been taken when a person's malnutrition screening tool (MUST) risk assessment score was 'high risk.' For example, there was no record of the person the person being weighed monthly or referred to the dietician.
- Analysis of accidents and incidents did not include all accidents that had happened so could not fully identify any patterns or trends to help mitigate risk and prevent reoccurrence.

We found no evidence that people had been harmed however, due to poor governance of the service people were placed at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed actions had and were being taken to address the quality of the governance systems.

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

- Some people who used the service and their relatives spoke positively about the registered manager and said they felt able to raise any concerns with her. Comments included, "I made a complaint about a carer who didn't listen to my requests. I asked them not to be sent again and they haven't," and "I am happy with the care, we have a good relationship and know how each other work."
- Other people were not as positive about their care and support. They told us, "I have numerous issues, the service is varied and am not getting what I want," and "Initially when I raise concerns it goes back to being good, but then goes back to the same."

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

- The provider completed a residents, relatives and staff survey in May 2021 and an analysis of this had been completed.

● In the main positive results were received with people stating staff were approachable, respectful, friendly and aware of their health conditions. Relatives had also provided positive feedback.
● The actions identified from the survey were very generic and listed things like to continue to receive feedback, to continue with refurbishment programme and to maintain good quality care. There were no specific actions to address any individual concerns raised.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Registered providers are legally obliged to inform CQC of certain incidents which have occurred within the home. These statutory notifications are to ensure CQC is aware of important events and play a key role in our monitoring of the service. The provider understood the duty of candour and kept people and relatives informed about key changes within the home.

Working in partnership with others
● We saw evidence the management team were working in partnership with community professionals and organisations to meet people's needs.
● Two healthcare professionals spoken with told us they worked closely with staff at the home to provide effective care for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care were not always mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or were not robust enough to demonstrate risks were effectively recorded, managed and comprehensive records of care delivered. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers were not always sufficient to ensure people were kept safe.