BEN - Motor and Allied Trades Benevolent Fund

Town Thorns Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Town Thorns on 15 February 2017. The inspection visit was unannounced.

Town Thorns is divided into four separate units over three floors and provides personal and nursing care for up to 66 people of all ages, including people living with dementia and disabilities. There were 57 people living at the home when we inspected the service.

A requirement of the service's registration is that they have 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 and the associated Regulations about how the service is run. There was an experienced registered manager in post at the time of our inspection visit. We refer to the registered manager as 'the manager' in the body of this report.

Care and nursing staff received training in safeguarding adults and understood the correct procedure to follow if they had concerns. They were confident if they raised concerns with their manager, these would be investigated appropriately. However, we found that safeguarding incidents were not always recorded and referred to the local authority by managers, as some incidents were being addressed as behavioural concerns. The provider had not identified that safeguarding concerns were not consistently reported and investigated as such.

Individual risks to people's health were not always being managed appropriately to ensure people were protected. In addition not all incidents at the home were being investigated and recorded on an accident and incident log, to ensure risks to people were being managed, and any trends and patterns could be identified. The manager reviewed their procedures following our inspection visit to ensure accidents, incidents and safeguarding concerns were recorded and reported consistently in the future.

We received mixed feedback about whether there were enough staff throughout the home. On the residential unit we received feedback that staffing numbers were not always sufficient to ensure people were cared for safely. The manager was introducing quality assurance and monitoring measures to review the number of staff allocated to each unit at the home.

All necessary checks had been completed before new staff started work at the home to make sure, as far as was possible, they were safe to work with the people who lived there. People were supported by a staff team that knew them well. Staff received training and had their practice observed to ensure they had the necessary skills to support people. Staff treated people with respect and dignity, and supported people to maintain their privacy and independence.

People had been consulted about their wishes at the end of their life. Plans showed people's wishes about who they wanted to be with them at this time and the medical interventions they agreed to.

People received their medicines as prescribed to maintain their health and wellbeing. People were supported to access healthcare from a range of professionals inside and outside the home and received support with their nutritional needs. This assisted them to maintain their health.

The provider, manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their freedom. The manager had made applications to the local authority where people's freedom was restricted, in accordance with DoLS and the MCA requirements. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

People were supported to take part in social activities and pursue their interests and hobbies. People made choices about who visited them at the home, which helped people maintain personal relationships with people that were important to them.

People knew how to make a complaint if they needed to. Complaints received were investigated and analysed so that the provider could learn from them. People who used the service and their relatives were given the opportunity to share their views about how the service was run; action was taken in response.

Quality monitoring procedures identified some areas where the service needed to make improvements. Where issues had been identified in checks and audits the manager took action to address them to continuously improve the service.

We found there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People felt safe living at Town Thorns and staff had been recruited safely. However, senior staff did not always act consistently to report and investigate accidents, incidents and safeguarding issues when these arose. Senior staff did not always analyse and respond to risks, to ensure people were supported safely. In the residential unit at the home we found the deployment of staff required review to ensure people were supported safely. Medicines were administered to people safely.

Is the service effective?

Good

The service was effective.

Staff completed an induction and training so they had the skills they needed to effectively meet people's needs. Where people could not make decisions for themselves, people's rights were protected; important decisions were made in their 'best interests' in consultation with people who were closest to them and health professionals. People received food and drink that met their preferences and supported them to maintain their health. People were supported to see healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

Staff knew people well and respected people's privacy and dignity. Staff treated people with respect and kindness. There was end of life care planning in place to involve people in decisions that took into account their wishes and preferences.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in social activities in accordance with their interests and hobbies. People had personalised records of their care needs and how these should

be met. People were able to raise complaints and provide feedback about the service. Complaints were analysed to identify any trends and patterns, so that action could be taken to make improvements.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The management team was approachable and there was a clear management structure to support staff. People were asked for their feedback on how the service should be run, and feedback was acted upon. However, quality assurance procedures did not always identify areas where the service could improve. Not all incidents were being recorded and monitored by the management team to identify patterns and trends, and minimise risks to people. In addition, the provider and manager had not identified that safeguarding concerns were not consistently reported and investigated.

Town Thorns Care Centre

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 February 2017 and was unannounced. This inspection was conducted by two inspectors, an expert-by-experience and a specialist advisor. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care.

Before our inspection visit, we looked at and reviewed the Provider's 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 improvements they plan to make. We found the PIR reflected the service provided.

We reviewed the information we held about the service. We looked at information received from relatives of people who used the service statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home. We also requested feedback from two visiting health professionals, who regularly visited the service.

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex care needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with seven people who lived at the home and four people's visitors or relatives. We gathered feedback from several members of staff including the registered manager, the clinical manager, the care

manager of the residential unit, two nurses, two team leaders, an activities co-ordinator and three members of care staff.

We also spoke with a chef, the maintenance manager, a kitchen assistant and the provider's representative.

We looked at a range of records about people's care including four care files. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation and that staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

The provider had safeguarding procedures in place to protect people from the risk of abuse and safeguard them from harm. For example, a recent safeguarding concern had been fully investigated to protect people at Town Thorns. Following the investigation, the manager had taken action to ensure the concerns were not repeated. This included the recruitment of a new team leader to a specific shift and re-training some staff to ensure people were protected.

However, we found some incidents that should have been reported as a safeguarding concern were being interpreted differently across the different units at the home. This meant that in some instances senior staff had not always identified incidents as safeguarding concerns, and reported them to the correct authority for investigation.

For example, we found there was an incident where one person had placed their hand under another person's clothing. This had not been reported to the safeguarding authority for investigation. The provider had investigated the incident and reviewed people's behaviours to manage the risk of future occurrence. The manager explained they had spoken with the safeguarding team who had asked them to conduct their own investigation, but this discussion had not been recorded. In addition, this incident had not been notified to CQC. The manager explained this had not been done, as the incident had not been formally reported to safeguarding. The manager explained this was due to a lack of clarity about what needed to be formally referred to safeguarding and CQC, not an intentional omission.

We found this was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

We found care and nursing staff were reporting risks to people's safety and reportable incidents to managers appropriately. Staff told us their training assisted them in identifying different types of abuse and they would not hesitate to inform the manager, or the provider, if they had any concerns. One staff member said, "If I noticed poor practice I would step in and stop it." They added, "I would let the manager know." One staff member gave us examples of what they might report to their manager to ensure people were safe, "We have got to report if they are losing weight, or if they have equipment, if we think the equipment is wrong for them we have to report it."

The manager was not always identifying and managing risks to people's health and wellbeing. There was a system in place to record potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce the identified risks. However, identified risks were not always managed appropriately to protect people from harm. For example, we found one person had lost a significant amount of weight. During a seven month period this person had lost 11 kg. Because of this recognised weight loss their risk assessment had identified consideration should be given to recording their dietary intake, weighing them weekly and liaising with a dietician. We found that none of these actions had been taken. We found for this person a referral should have been made to a health professional, and brought this to the attention of the care manager to review the person's care. They stated this had been an

oversight and they would act straight away to refer the person.

In another person's records it was recorded the person had sustained a skin tear that had to be cleaned and dressed by the nurse. Although the incident/accident had been recorded in the person's individual care record, no investigation had taken place to identify its cause. As a consequence the person's individual risk assessments had not been reviewed to help prevent future occurrences. The incident had not been added to the manager's accident and incident log for future analysis, and the incident had not been reported to the safeguarding authority. When we brought this to the manager's attention they immediately conducted an investigation to identify the cause of the skin damage.

We found this was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014, Safe care and treatment .

Where people required regular observations, or needed to be re-positioned in bed because they were at risk of developing damage to their skin, charts were available for staff to record this had been done. This was important so that people could be re-positioned regularly and in different positions to relieve the pressure on their skin. However, on the residential unit one person's care records stated they needed to be turned every two hours because their skin was red and at risk of breakdown. A senior staff member confirmed there were no turning charts in place for this person, but staff were aware of the person's support needs. On the nursing unit there was a daily skin checking system in place for people who were at risk of developing skin damaged.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as fire and flood were planned for, so that any disruption to people's care and support was reduced. There were clear instructions for staff to follow in the event of emergencies. This was to minimise the risk to people in an emergency situation.

The provider carried out regular checks on the maintenance of the premises and equipment used at the home. We spoke with the maintenance manager during our inspection visit. They explained how they conducted regular checks on premises and equipment to ensure risks to people were managed. For example, records confirmed yearly checks were undertaken on gas appliances, electrical equipment and water, to ensure they remained safe.

The relationship between people and the staff who cared for them was friendly. People did not hesitate to go to staff when they wanted support and assistance. This indicated they felt safe around staff members. All the people we spoke with told us they felt safe at the home. One person commented, "Yes, I do feel safe." Another person said, "I've been here twenty five years, I feel safe and happy."

Staff told us and records confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of staff. All prospective staff members had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. Every three years the provider conducted a re-check with the DBS for all staff to ensure there had been no changes in their records. The provider also checked the registration of nurses with their regulatory body to ensure they maintained their professional registration.

We saw how medicines were administered on two units of Town Thorns during our inspection visit. Staff who administered medicines received specialised training in how to administer medicines safely; they completed training before they were able to administer medicines and had regular checks to ensure they

remained competent to do so. This ensured staff were trained to manage medicines to the required standards.

People told us they received their medicines when they should. Comments from people included; "I have a bit of pain sometimes, they give me pain relief for it", "When my relation is in pain, the nurse comes and gives them pain medicine" and, "I get my medicine twice a day."

Medicines were stored safely and securely. Medicines were kept in a secure locked location, and were monitored to ensure they were stored at the correct temperatures, so that medicines remained effective. Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed. MARs contained a photograph of the person so that staff could ensure the right person received their medicines. This was important as the home could use agency staff to administer medicines who might not know the people who lived there. The MARs we checked confirmed people received their medicines as prescribed.

Some people required medicines to be administered on an "as required" basis. There were protocols (plans) for the administration of these medicines to make sure safe dosages were not exceeded and people received their medicine consistently. Daily and monthly medicine checks were in place to ensure medicines were managed safely and people received their prescribed medicine when they should.

Most of the people we spoke with told us there were enough staff to care for people effectively and safely. Comments included; "There always seems enough staff, I have no concerns", "There are quite enough staff", "There seems to be three or four staff on at a time. They seem very under used." These comments came from people who received support on the nursing and residential units at the home. Only one relative we spoke with told us they would like to see more staff, and this was at the weekends.

For most of the time during our inspection visit, we saw enough staff to care for people safely. However, the deployment of the morning staffing levels in the residential unit meant staff were not always available to meet people's needs.

On the residential unit there were 17 people who required support from staff. People had a range of different needs, some people required two members of staff to provide them with support when they moved around, or during personal care routines. Other people had been diagnosed with dementia. Some people were cared for in their room, or had behaviours which might be challenging to others, for example, frequently calling out to staff for assistance.

The residential unit was supported by four members of care staff in the morning, and three members of care staff in the afternoon. In the morning one member of staff prepared people's breakfasts, whilst another member of staff gave people their medicines. This meant for a periods of up to half an hour staffing levels were reduced to two members of staff supporting people with their personal care needs and getting ready for the day. We asked staff how they maintained a presence in the communal areas to keep people safe. They said, "There are occasions when we can't." One member of staff commented, "The floor can be left unattended for up to 15 minutes (with no staff) and that does concern me." Staff also explained that they could be called away to assist in another unit, which reduced staffing levels even further. Another member of staff said, "It is very busy. I love the residents to bits but it is very busy and very heavy work."

We saw that during the morning, staff on the residential unit took their breaks in pairs, which meant there were only two members of care staff working in the unit some of the time. As some people required two members of staff to support them, and staff could be in people's bedrooms, it meant staff were not always

available. As people were living with dementia on this unit, it meant people were at risk of harming themselves or each other if they became anxious. We observed the lounge area where people sat and watched television was left unattended several times during our inspection visit. We asked staff about their breaks, they said, "Two of us will go, and then the other two will go afterwards. We have always done that."

Staff felt extra support at certain times of the day would enable them to be more responsive to people's needs. One member of staff said, "I think we could benefit from at least one other member of staff. We get quite stretched, especially in the morning and mealtimes. There are a few people who require two care staff to assist them, it leaves nobody else available." They added, "They still get the same level of care, we don't rush them, but it means we tend not to finish getting people up until 10.30am to 11.00am and some would prefer to get up a bit earlier."

We brought these concerns to the attention of the registered manager and the care manager, who was in charge of the residential unit. The manager told us staffing levels were determined by the number of people at the home, their needs and their dependency level. We saw each person had a completed dependency tool in their care records. This assessed how much care and support they required. However, the manager was not using this information to determine the numbers of staff that were needed to care for people on each shift and each unit. They were using historical information and feedback from people and staff to determine how many staff were needed. One staff member commented, "When the staffing levels were decided we were classed as a residential unit, but I think people's needs have changed." The manager explained they were putting a tool in place to calculate staffing levels more accurately, but this was not yet in operation. They intended to review this following our inspection visit. The manager assured us they would look at the deployment of staff around the home to address the concerns raised.

We asked the provider and manager about staff vacancies at the home. They told us they were in the process of recruiting more staff at the service. This was to allow more flexibility to cover staff absences. They explained they used agency staff when they were unable to fill the staffing rotas from their permanent staff team.

In other areas of the home (outside the residential unit) we saw there were ample staff to assist people when they required support. Staff were readily available to respond to people's requests for assistance. Other members of staff such as domestic staff were available, so that nursing and care staff could concentrate on providing support to people.

Good

Is the service effective?

Our findings

People and their relatives told us staff had the skills they needed to support them effectively. One relative whose relation lived on the nursing unit said, "Staff are brilliant." Another person said, "They are all professional, I think they know what they are doing."

We saw staff used their training and skills effectively to support people at Town Thorns. For example, some people required assistance to move around the home safely. Staff used their skills to assist people with the correct equipment when moving them from chairs and wheelchairs, whilst protecting their dignity. Staff explained what was happening and provided people with reassurance throughout the procedure. Staff made sure their feet were appropriately placed so that they were protected from injury. Nursing staff used their clinical knowledge and skills to assist people with medical equipment such as syringe drivers and monitoring equipment, to ensure people remained comfortable and free from pain.

All staff developed their professional skills when they joined the team at Town Thorns. They received an induction when they started work which included working alongside experienced members of staff. One staff member said, "I did two weeks of different types of training. We covered a lot. We did manual handling for a full day. We also had a period of shadowing (working alongside) an experienced staff member. It gave me confidence to carry out my role." Induction courses were tailored to meet the needs of people who lived at Town Thorns, and the different roles each member of staff performed. For example, care staff received training in dementia care when they worked alongside people who lived with dementia. One member of care staff said, "Dementia training gave me a better understanding of the illness. The training gave us a few techniques to engage with and encourage the residents." Nurses received training in administering specialist medication, end of life care, and conditions such as diabetes and epilepsy.

The standard induction training all care staff attended was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care staff in the UK. Most of the staff we spoke with told us their induction and training provided by Town Thorns was good, and met the needs of people at the home. Staff told us the manager encouraged them to keep their training and skills up to date. The manager maintained a record of the training attended to identify when staff needed to refresh their skills. One staff member told us, "I feel if I needed more training I could just request this and it would be organised."

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The manager and care manager were able to describe to us the principles of MCA and DoLS which showed

they had a good understanding of the legislation and how it should be applied to protect people's rights. We saw people were asked to sign consent to certain aspects of their care, where they could do so.

Staff we spoke with understood the basic principles of the MCA and knew they should assume people had the capacity to make their own decisions. Staff asked people for their consent and respected people's decisions to refuse care where they had the capacity to do so. Where people could not make all their own decisions, a mental capacity assessment had been undertaken. Some of the capacity assessments we reviewed were not related to a specific decision, and therefore did not always detail which decisions people could make themselves, and which decisions needed to be made in their 'best interests'. However, we were confident staff were acting in people's best interests, and were involving people in making decisions about their care wherever this was possible.

Records confirmed that following a mental capacity assessment, more complex decisions were made in people's 'best interests' in consultation with health professionals and people's representatives. One staff member said, "People all have different levels of capacity. All have capacity to choose what they have to drink and what they want to wear. Some people don't have capacity to make more complex decisions such as with their finances. Where this is the case usually a relative who has power of attorney can help with this."

We checked whether any conditions on authorisations to deprive a person of their liberty were being met. The manager reviewed each person's care needs to assess whether people were being deprived of their liberties, or their care involved any restrictions. Several people at the home had a DoLS in place. Several more applications had been made to the local authority and were awaiting a decision. We found one person who lacked the capacity to make all of their own decisions, but a mistake had been made on their capacity assessment document recording their level of capacity. As a consequence the person had not received a DoLS assessment when their liberty was being restricted. The care manager explained this was an oversight, and would be done straight away. We were confident the care manager acted on this information to ensure the person was not unlawfully being deprived of their liberties.

We looked at meals provided to people and people's meal time experience. Each unit had a communal area where people could have their meals. In addition people could eat in the large communal restaurant, or could choose to eat in their room. The dining rooms and restaurant area were calm with tables laid with napkins and cutlery to enhance people's mealtime experience and make it a social event. In the restaurant people could invite friends and relations to dine with them. Dining rooms were attended by sufficient staff to assist people to eat their meal. Where people needed assistance, staff supported people at their own pace and waited for people to finish before offering them more food.

People told us they enjoyed the food on offer at the home, and could make choices each day about what they wanted to eat. A daily menu of the food on offer was displayed on the notice boards at the home in the different dining rooms. People were able to choose from a range of options and staff asked people for their food choices before their meal was prepared. Comments from people included; "The food is very nice, plenty of choice", "You can eat where you like", "You get a choice. They ask us the day before" and, "I do enjoy lunch; I eat downstairs, sometimes upstairs."

Where people were unable to make decisions themselves, staff made choices based on the individual's likes and dislikes. These were recorded in the care records we reviewed. We spoke to the chef at the home who told us, "We prepare food as ordered; however, people can ask for an alternative if they wish." We observed several people asking for an alternative to the standard meal option during the day, these were accommodated by the kitchen staff who made them a different meal.

People were offered food and drinks that met their dietary needs. Kitchen staff knew people's dietary needs and ensured they were given meals which met those. For example, some people were on a soft food diet or were diabetic. Information on people's dietary needs was kept up to date and included people's likes and dislikes. The chef told us, "The staff here keep me up to date with people's dietary needs and if anything changes. We keep this information in the kitchen so it's readily available when we are preparing meals."

Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. People were offered a choice between cold or hot drinks after their meal. People also had drinks taken to their room several times each day. One person said, "They encourage everyone to drink." People told us they were offered plenty of food, and could ask for additional snacks if they wanted these. One person said, "After breakfast I am always offered drinks and toast as well."

Staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. Care records included a section to record when people were seen or attended visits with healthcare professionals so that any advice given was clearly recorded for staff to follow. Records confirmed people had been seen by their GP, a speech and language therapist, mental health practitioner, dietician and dentist where required. The manager told us the doctor and other health professionals visited the home each week, for example, the doctor visited the home twice weekly and the district nurse visited daily. One person said, "The doctor comes when wanted. The chiropodist comes, the optician and dentist." Another person said, "I see the doctor occasionally. We have all the support (needed). I go out to the dentist. They [staff] take me for an eye test every two years."

We found where advice was given by health professionals, it was being followed. Advice was transferred to care documents, and care plans were updated to incorporate the advice provided. For example, one person required support with their nutrition. Advice had been sought by the speech and language team (SALT) to ensure the person was supported appropriately. Advice from these healthcare professionals was followed to ensure the person received the correct level of nutrition and hydration to maintain their health. One health professional who regularly visited the service told us, "I find the staff at Town Thorns helpful and responsive. We have good relationships with the home and the home manager. They respond well to our recommendations."

Good

Is the service caring?

Our findings

People told us staff were kind and caring to them and their relations. One person said, "We are most fortunate. I see day after day how hard they [staff] work. They put in a full day or a full night and they still come up smiling." A relative said, "It's very good. They [staff] are always kind from what I've seen." A staff member told us, "We always put people first. If we can accommodate them we will."

One person sent us feedback about Town Thorns prior to our inspection visit. They said, "Town Thorns is a fantastic home. They did everything possible to ensure my relative had an absolutely fabulous day at our recent wedding. They go the 'extra mile' for people to enable them to live life to the full." One person we spoke with described Town Thorns as their home. They told us they had lived there for many years and said, "It's been a wonderful experience."

Staff told us they enjoyed working at the home because of the interaction they had with people who lived there. We saw staff interacting with people at the home in a respectful and caring way using people's preferred names. One staff member said, "I think this is a caring home and the level of care we provide is exceptional."

People were assigned a specific member of staff called a keyworker. Keyworkers were responsible for maintaining a special relationship with each person they supported, ensuring their social and practical needs were met. Keyworkers also helped to maintain accurate care records for people to ensure they reflected people's current needs. We found keyworkers knew people well. One said, "I'm a keyworker for two residents and I know those residents inside out."

Staff communicated with people effectively using different techniques. Staff touched people lightly on their arms or hands to provide them with reassurance and comfort. Staff assisted people by talking to them at eye level and altering their tone of voice to help people understand them. People smiled at staff and we saw people enjoyed these staff interactions. However, some of the time staff did not take the opportunity to speak with people when they could. For example, we saw staff sitting talking with each other, or working together filling in paperwork, whilst people sat alone watching television. This was during the afternoon when people had eaten their lunch.

People told us staff respected people's right to make their own decisions where they could. One person said, "They are all very respectful." They told us they could make everyday choices themselves, saying, "I go to bed when I want." Another person said, "They [staff] are nice and respectful to me." We saw staff asked people what they wished to do, for example, we saw a member of staff ask someone where they would like to sit saying, "Would you like me to move you to a more comfortable chair. I will bring you a cup of tea and you can sit by the window if you like?" Other comments from staff included; "Would you like to go back to your room or would you like to turn round and watch the television?", "Are you alright with what is on TV or would you prefer to listen to some music" and, "Would you like to walk with me?"

Staff promoted people's independence and encouraged them to do things for themselves where possible.

For example, we saw staff encouraging people to eat and drink independently. People were encouraged to use beakers, specialist cups and plate guards (devices that assist people to eat and drink unaided). We saw people ate at their own pace and staff checked on them frequently to ensure they did not require support to finish their meal.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. This included a number of lounges, restaurant and dining areas. People made choices about who visited them at the home and were supported to maintain links with friends and family. For example, people could choose to have their relatives visit them and eat with them in the restaurant. One person told us they were happy their relation was visiting them and said, "My daughter is coming today. She will take me out." A relative told us they felt welcomed and could come as frequently as they liked saying, "I come five or six times a week."

People told us their dignity and privacy was respected by staff. Staff knocked on people's doors announced themselves before entering. One person said, "They always knock first and ask if they can come in." Some people had keys to their room, which they locked when they wanted to. This meant they had privacy when they needed it.

People had decided how their personal space was furnished and arranged. People's rooms included photographs of family and friends, pictures on the walls, ornaments and furniture personal to them. This was important as Town Thorns was people's home, and having personal items around them helped people to feel comfortable in their surroundings. One person said, "I like my room, because it's mine."

Some people at the home had been consulted about their wishes at the end of their life. We reviewed care records which documented their preferences. Staff told us this was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs. People had up to date 'end of life' care plans which were comprehensive. Plans showed people's wishes about who they wanted to be with them at this time and the medical interventions they agreed to. The manager confirmed that people made these choices in consultation with health professionals, their relatives and staff, so that their wishes could be met. A staff member commented on how important it was for people's wishes to be respected at this time saying, "We have only one chance to get things right, and make the person comfortable."

The manager and clinical lead had received specific training in the National Gold Standards Framework (GSF) on 'end of life care'. This training had not yet been put into practice at the home, however the manager was discussing with the local doctor how people's end of life care arrangements could be improved further using this nationally recognised framework. This showed the provider was working to continuously improve people's involvement and choice at this time.

Good

Is the service responsive?

Our findings

People we spoke with told us staff responded to their calls for assistance in a timely way. One person commented, "The staff are very attentive." Another person said, "They are very efficient answering when I ring." We asked people if this was the same during the night. One person replied, "I only ring my bell at night; they don't take long at all."

During our visit we saw staff responded to people as quickly as staffing numbers allowed, when they needed their support. For example, we saw one person who became distressed and anxious during our inspection. The person was quickly supported by a member of staff who chatted with them and as a result the person appeared reassured and less anxious. On another occasion one person commented they had a sore throat. A member of staff supported them straight away by preparing them a drink of honey and lemon to soothe their throat.

People told us they enjoyed the activities and events on offer at the home. One person commented on the activities and general atmosphere at Town Thorns saying, "It's a good atmosphere." They added, "When it comes to social events, you just all join in together."

A list of planned activities was on display in the communal areas for people to refer to and posters advertised forthcoming special events. The home employed two members of staff to support people with activities, hobbies and interests. The registered manager also expected care staff to spend time with people supporting them with interests and hobbies that might provide stimulation and enjoyment. On the day of our inspection visit we saw a therapy dog was brought into the home by a local charity group. People clearly enjoyed their interaction with the dog.

On the ground floor there was a large room called 'The Hall' which was accessible to everyone who lived at Town Thorns. This was the focal point for most of the activities and entertainments in the home. The hall had facilities for people and their relatives to make drinks, and there were many different craft areas for people to enjoy. For example, people were involved in painting, knitting and drawing. One person said, "We do painting in the hall." Another person told us, "We have a tea dance coming up."

Other interesting things to do at the home were advertised in the main reception area. These included a hairdressing salon which was open three days a week, a mobile library, and a general shop which was open two or three times a week.

People's religious and cultural needs were also met. One person told us about the chapel at Town Thorns. They said, "There are regular church services which I enjoy." Another person agreed saying, "It's a lovely church I go regularly, it's in the building".

A minibus and driver was available to people so people could be transported to local appointments and to get out into their local community. People who were able to go out were supported either by relations or care staff. One person confirmed this saying, "If I want to, I go out in the garden; staff have to come with me.

We also go out in the minivan." One person told us about some recent activities they were involved in saying, "I'm going to a local airport on Monday. I go to pub lunches. I like to go to the cinema, the staff take me. I go shopping but not very often. I go when I want to."

We found most people were kept busy and occupied. We saw one person enjoying a one-to-one activity with care staff in their room. We saw other people chatting with their relatives and friends in their bedrooms. We spoke with a member of staff who organised activities at the home. They said, "We try to organise activities that suit everyone. Some people have one-to-one sessions with us, other people prefer group activities." They added, "People are encouraged to join in activities in the hall."

The activities organiser explained each person had an individual activity plan to record what they liked to do. They held regular meetings and feedback sessions with people to identify events they would like to get involved in, so that events could be planned around people's preferences. They told us that as well as encouraging people to take part in individual interests such as reading, walking and crafts, people were also encouraged to go out. They said, "People go out every week. For example, five people attend courses at the local colleges. People also go out on trips. Over the last six months, these have included a Safari Park, restaurants, the Transport Museum, cinema and garden centres."

However, several staff members told us they would like to see more activities arranged for people on the residential unit. One staff member explained that people could go downstairs to the hall and join in group activities, but they felt more comfortable staying in the residential unit. They said, "We take people downstairs, but that is only about three or four people, the rest don't want to go." They went on to say, "Sometimes the activities staff come up here if they can't use the space downstairs and people will interact more if they come up here. A lot of our residents don't like to leave the unit." Other staff comments included: "They (activities staff) do come up once a week to do nails" and, "If people don't want to leave the unit then the opportunities (to do activities) are limited."

Staff on the residential unit told us because they were busy, they did not have time to engage people in meaningful occupation if they chose not to go to the hall. One member of staff commented; "We don't get to spend time doing things with people as much as we would like. If we had another pair of hands we could do a lot more." They explained a time when they had given a person a hand massage during a less busy period at the weekend. The person had enjoyed this and it had relaxed them and calmed their anxiety. The member of staff said, "They were a different person for the rest of the day."

The manager explained that two volunteers who had provided regular support to people with their interests and hobbies had recently left the home. They told us they were using this time to review the activities on offer at the home. The review would be conducted through consultation sessions to get people's feedback to ensure the development of the activities programme met people's individual needs and preferences.

People's care and support was planned in partnership with them and people who were important to them, which enabled staff to deliver person centred care. People told us about their relatives support saying; "My daughter helps me make decisions", and "I have my relations, they help." Where people were able, they signed their consent and to confirm their involvement in planning their care.

Records gave staff information about how people wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, their support needs and their personal preferences about how they wished their care to be provided. Records also provided staff with brief information on people's life history. Care reviews took place every six months, or when people's needs changed.

Staff told us care records were usually kept up to date and provided them with the information they needed to support people responsively and effectively. Staff could describe people's individual support needs, which matched what people told us and the information in their care plans. This demonstrated staff knew people well. Care records were available on an electronic system which all staff had access to. Some records were also kept on paper, which matched the information on the electronic system.

Staff were able to respond to how people were feeling and to their changing health or care needs because they were kept updated about people's needs at a handover meeting at the start of each shift. The handover meeting provided staff with information about any changes in people's needs since they were last on shift. Staff explained the handover meeting was recorded so that staff who missed the meeting could review the records to update themselves. One member of staff told us, "Communication between the team it is exceptional. We are good at keeping each other up to date." They added, "There is always a handover between shifts. We will sometimes have a little huddle (during the shift) if there is something we need to share."

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home and on each separate unit of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. A typical response from people we spoke with was that they had never needed to make a complaint. One person said, "I feel quite happy to raise anything."

In the complaints log we saw that previous complaints had been investigated and responded to by the provider. For example, one relative had complained about their relation's bathroom floor being slippery which had caused them to fall. The bathroom flooring had been changed to prevent the person from falling again. The person and their relatives were content with the new flooring. Another person told us about a complaint they had made saying, "I couldn't sleep because of the person making a noise next door. I made a complaint and the very next day the manager came to see me, they understood completely." The person told us they were going to move to another bedroom.

Complaints were analysed to identify any trends and patterns, so that action could be taken to continuously improve the service provided.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the service. People and staff told us the manager was approachable and they felt the service was well-led. One relative said, "This place has improved my relative's quality of life. We are like part of a family." Other comments from people included; "The managers are all very approachable" and, "Overall the home's pretty good."

The manager was part of a management team which included a manager on each unit. The clinical lead manager supported people on the nursing unit alongside the nursing team. The care manager provided support to people on the residential unit. Other units were supported by team leaders. The clinical lead manager, the care manager and team leaders, regularly worked alongside staff to provide support and to keep in touch with people's needs and ensure their needs were met.

The provider had an accident and incident log to record and monitor events and identify where there may be risks to people's health and safety. The manager carried out an analysis of the log to identify any patterns and trends and prevent future occurrences. However, we found that learning from such events was not always taking place, because not all incidents were recorded and included on the log. For example, from one person's care records we identified there had been two incidents when they had wrapped a cord around their neck, which put them at risk of strangulation. No information from these incidents had been transferred onto the accident and incident log. In another person's records we saw a similar incident had occurred and again this information had not been transferred onto the accident and incident report. Although the manager had made the people concerned safe by reducing the length of cords, there was no review of the three incidents to determine whether there was a link or pattern happening at Town Thorns.

An analysis of the information together, could have provided an understanding of the risk such cords could place to people at the home in the future. These incidents had not been formally reported to the safeguarding team for investigation, although the manager told us they had discussed them with the safeguarding team, who advised them to conduct their own investigation rather than make a formal referral. They had investigated and concluded the incidents were behavioural in nature, and risks were managed for each person individually.

We found this was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Monthly meetings at the home for members of the management team included heads of department meetings, health and safety meetings and monthly clinical meetings. Information was shared between managers about different units of the home and relevant information about different departments. Communication at a senior management level was encouraged during these meetings to identify issues and discuss improvements.

However, we found that although accidents and incidents and safeguarding referrals were discussed at these meetings, the manager and provider had not identified all incidents were not being recorded in the

accident and incident log. The manager and provider had also not identified that safeguarding concerns were not consistently being referred and investigated to the safeguarding authority and CQC.

The manager explained this was due to a lack of consistent understanding about what should be referred, and was not a deliberate omission. Following our inspection visit, the manager organised updated safeguarding training for managers and staff, they confirmed the first of such training was held on 2 March 2017. The session was organised to focus on dealing with reportable incidents, and learning from 'real-life' scenarios. In addition the manager had identified the need for the sharing of information in the staff group, to learn from previous incidents and training, and had appointed a 'safeguarding champion' to lead on the sharing of information on safeguarding issues at the home.

The provider completed other regular checks on the quality of the service they provided. This was to highlight any issues and to drive forward improvements. For example, the provider directed the manager to conduct regular checks on care records, medicine administration and infection control procedures. The management team produced quarterly reports into how the home was performing against business plans. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. Action plans were monitored for their completion by the provider. This included enhancing and improving the premises at Town Thorns with re-decoration and the purchase of new carpets, flooring and equipment when required. However, such regular checks had not identified that risks to people, were not always identified and managed.

Staff told us they received regular support and advice from their immediate line managers and the nurses, which enabled them to do their work. There was an 'on call' telephone number they could call outside office hours to speak with a manager if they needed to. One staff member said, "We have a very good manager." Staff told us their immediate line manager listened to their ideas and suggestions. However, one staff member commented that senior managers were less responsive to their suggestions. This staff member explained how the provider was trying to address this issue. They said, "A staff forum had been instigated." The manager told us senior managers attended the forum to provide staff with an opportunity to discuss concerns and improve staff communication across the organisation.

In addition, each unit or team had an appointed a 'values champion' whose role it was to promote a number of values including passion, respect, inclusion and empowerment. We spoke with a member of staff who had been appointed as a 'values champion.' They explained one of their key roles was to identify with their colleagues an area that staff felt could be improved. An area that had been highlighted for improvement was communication between staff and senior managers. To address this, the provider had introduced a quarterly staff bulletin to keep staff informed of any changes or developments to the service. In February the charity was also due to launch an initiative called 'listening groups' involving members of the staff team with senior managers.

Regular team meetings and individual meetings between staff and their managers were held at Town Thorns. These gave staff an opportunity to discuss their performance and any training requirements. Staff team meetings gave staff an opportunity to provide feedback about the running of the home, and staff could be kept up to date with any changes or developments at the home. One staff member said, "Throughout the year we have job chats with our manager and during that we go over our competency." One member of staff commented that they would like more time with their manager to discuss their professional development and training saying, "I don't feel we have anywhere we can park feelings, problems or emotions." A manager told us staff could request to speak with a manager at any time.

We reviewed the minutes of a number of staff meetings held at Town Thorns. These involved teams that

worked together, rather than a full 'all staff' meeting. We saw regular items on the agenda for such meetings included feedback about the needs of people in each of the units, care records and policy and procedural updates. Also discussed at the meetings were congratulations to staff members for their achievements and hard work. One member of staff commented that they would like to have 'all staff' meetings. They said, "Because we can't get the staff all together, we have two lots of meeting, so there is a communication issue, but we are trying to sort that out (the staff forum was an example of this)."

We saw suggestions made by staff were considered by the manager and the senior management team. For example, a recent proposal to cease printing out paper copies of care records had been considered to cut down on the use of paper at the home. This had been implemented and all staff could access electronic care records to review the information they needed.

People and their relatives told us they were able to be involved in developing the service they received. This was because they could provide feedback to the manager, clinical lead manager or care manager at any time, as they were on site and operated an 'open door' policy. We saw the manager's office was open to people, their relatives and staff to visit during our inspection.

The manager organised regular meetings for 'residents' and relatives at Town Thorns where people were asked for their feedback. At each meeting the minutes and actions of the previous meeting were discussed, to ensure people were provided with responses to any concerns or suggestions they had raised. We saw the meetings were advertised around the home, and a senior manager attended. Outcomes from meetings were fed back to people and their relatives with a regular newsletter distributed around the home. The manager also told us people were also able to provide feedback regarding the service in annual customer satisfaction survey, and in a comments box in the reception area. We saw the results of a recent customer satisfaction survey and found that a high percentage of people were happy with the quality of the service provided. Where people had made comments regarding the improvement of the service, these had been analysed by the provider to highlight any areas that may need action taking. For example, we saw an improvement plan had been drawn up to address people's comments about whether there were enough activities at the home.

Records showed that people were spoken with each month by a member of staff to gather their feedback. For example, people had been asked their views on the laundry service, the meals, staff attitude and whether they had any concerns or complaints. One person had raised an issue that one night their call bell had been left out of their reach. This had been resolved by day staff handing over to night staff that they must ensure the bell was left in reach. Another person raised an issue about the carpet in their room. The carpet was replaced. These regular feedback sessions with people were used as a forum to gain people's views and to pick up concerns and deal with them quickly.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(a) All potential risks to people's health and safety were not assessed, and risk management plans were not always in place to protect people. 12(2)(b) The provider had not done all that was reasonably practicable to manage and mitigate risks to people. Incidents were not always reported internally and to relevant external authorities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13(2)(3) Systems and processes were not established and operated effectively to prevent, and investigate immediately, abuse or allegations of abuse to service users.