Thorpe House Specialist Adult Mental Health Unit Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding ☆
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of Thorpe House took place on 12 August 2016 and was unannounced. We interviewed the registered manager on 19 August 2016 as they were unavailable on the day of our inspection. The service was last inspected on 17 October 2013 and met the Health and Social Care Act 2008 Regulations in operation at that time.

Thorpe House Specialist Adult Mental Health Unit Limited is registered to provide accommodation/nursing care for people with mental health problems. The service is registered for 23 people. There were 20 people living there on the day of our inspection.

The service had a registered manager in post who had been registered since 2011. 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.'

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

The service had a positive approach to risk. They assessed how people could be supported to live the life they wanted and worked with people in an enabling way when independent living had been identified as an achievable goal. They encouraged people to identify and manage their own risks.

We found the environment to be maintained to a high standard and was extremely clean with good infection control practices in place. Staff were observed to follow good practice guidelines in the management and prevention of infections.

Staffing levels were determined to support people well with their physical, social and emotional needs. They worked an on call system to ensure when people's needs changed at short notice; there were always staff on hand to assist. The service recognised the potential of a multi-disciplinary approach and the benefits this brought to the people using the service and the staffing complement included registered mental nurses, nursing assistants and occupational therapists.

The registered manager understood their obligations under the Mental Capacity Act 2005 and Mental Health Act 1983 and worked within the legislative frameworks. Staff had received training and were fully informed of any changes at team meetings to ensure they continued to provide care within the law.

People received care and support from a highly trained, motivated group of staff. Staff received an induction and training to ensure they had the skills to meet the needs of the people at Thorpe House. Staff

were supported to continually develop by obtaining nationally recognised qualifications and by on-going supervision and appraisal. They were keen to develop new skills to provide the best level of support to people.

People told us how much they enjoyed their meals and they were given appropriate and sensitive support by care staff. People told us they were offered choice about what they wanted to eat, where they wanted to eat and at what time they wanted to eat, demonstrating the service was flexible in its approach.

Staff were responsive to people's individual needs, preferences and wishes and were passionate about providing a high standard of care and support. The service was inclusive when plans were being drawn up to ensure outcomes were achieved.

Without exception, people, their relatives and professionals told us they were very happy with the caring approach and attitude of the staff team who they described as kind and friendly. We observed caring relationships had been built between staff and people using the service and some people told us they considered staff as friends.

We observed staff knocked on doors before entering people's rooms, demonstrating staff respected people's need for privacy. Confidentiality was respected at all times with staff recognising the importance of keeping information about people private.

People were encouraged and supported to be as independent as possible, and the service had employed two occupational therapists to develop this area of practice. The service had invested in facilities to maximise people's independence with the ultimate goal for some people to return to living in the community of their choice. This included four apartments and a therapeutic kitchen area. The service also devised goal orientated care plans to identify achievable targets which encouraged and motivated people to develop skills and abilities.

The home was well-led and the management team encouraged an open and transparent culture where people were able to make suggestions for change and improve the quality of the service. The senior staff were innovative and creative and constantly strived to improve the quality of people's lives, by working in partnership with other professionals and academia. Planned improvements were focused on raising the standard of service provision to be the best they could be.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Risks were managed at the service and there were systems and processes in place. The provider demonstrated their support of appropriate positive risk taking approaches. We found minor issues with the management of medicines, which the registered manager acted upon immediately.

Staffing levels were determined to support people adequately and appropriately.

Is the service effective?

Good

The service was effective

People received care and support from a highly trained, motivated group of staff. Staff received an induction and training and were regularly supervised and supported to ensure they had the skills to meet the needs of the people at the home.

Staff fully understood their responsibilities under the Mental Capacity Act 2005 and the Mental Health Act 1983 and ensured the service worked to the legislation.

Staff involved other professionals and worked in collaboration to ensure the service was effective in meeting the needs of the people using the service.

Is the service caring?

Outstanding

The service was very caring.

People, their relatives and professionals all told us staff were extremely caring and compassionate in their approach and spoke very highly of staff at the service. All staff were passionate about improving the quality of life for people living at the service.

People were supported in a way that fully protected their privacy and dignity. There were dedicated dignity champions at the home to promote and develop staff in the practice of dignified care.

The home had an enabling and empowering ethos where people were actively encouraged to identify and achieve goals to enable them to live independent and fulfilled lives at the service or with the intention of returning to their previous living arrangements.

Is the service responsive?

Good

The service was responsive.

Staff were focused on person-centred care and involved people in ways that encouraged and enabled people by working with them to find out what was important to them and how they wanted to be supported.

Activities formed an important part of people's day and staff worked with people to plan their day to ensure whatever they chose to do brought meaning and fulfilment to their lives.

People knew who to complain to but told us they had no complaints about the service.

Is the service well-led?

Good

The service was well-led

The service was continually striving to improve; they monitored what they did well and considered how they could improve. The registered provider financially invested in the service to ensure the home had the resources to be successful.

The registered provider had an effective system in place to assess and monitor the quality of service provided.

The service worked in partnership with the local authority and with local groups. They could see the benefits in working with others to continually improve the service they provided and to provide a high standard of service provision.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 12 August 2016 and was unannounced. We interviewed the registered manager over the telephone on 19 August 2016 as they were not at the service on the day of our inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information to help inform the inspection.

We reviewed all the information we had about the service including statutory notifications and feedback from professionals. We contacted the local authority safeguarding, and commissioning team and the infection control team, who provided us with information about how the service was being provided.

We spoke with the registered manager, the senior registered mental nurse, a registered mental nurse and a director who was also a registered nurse, an occupational therapist, a nursing assistant, a team leader, and the cook as part of our inspection process. We spoke with seven people living at Thorpe House. We spoke with two of their relatives following the inspection. We reviewed the care files of all the people on a Deprivation of Liberty Safeguard and those on Mental Health Act sections. We reviewed the care files of three people in detail.

We also spoke with a visiting district nurse and a social worker over the telephone during our inspection and two further professionals on the telephone following our inspection. We reviewed the records relating to the maintenance of the home and the quality management systems.

Good

Is the service safe?

Our findings

Without exception, people told us they felt safe and secure living at Thorpe House and would not hesitate in speaking with the manager or one of the nurses if they felt upset or threatened in any way. One person said, "It has been a long journey to get this well and the staff have always kept me safe and protected from things that may harm me". Another person said, "The staff make me feel safe. They come in during the night to see if I'm alright and they are with me during the day."

All staff had been trained in safeguarding and were fully aware of their responsibilities to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. Staff were able to tell us what type of abuse they might find in the setting and they were able to confidently describe this to us. Staff also knew the principles of whistleblowing, the duty by a staff member to raise concerns about unsafe work practices or lack of care by other care staff and professionals. They assured us they knew the whistleblowing process and would not hesitate to report any concerns

Risks to people at the home were regularly assessed and reviewed. General environmental and specific risk assessments were completed. We found risk assessments in place in the care files we reviewed around suicide, choking, falls, moving and handling, neglect, fire, deliberate fire, infection control, oral health and other aspects of personal care. The service used evidence based standardised risk assessments such as the Malnutrition Universal Screening Tool (MUST) to assess people at risk of malnutrition. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. They also used the "Waterlow" score to determine risks around tissue viability.

Some of the risk assessments we reviewed were highly specific to people's individual needs. Many people at the home were at risk due to long standing mental health issues. Where risks had been identified specific staff requirements for action were recorded. For example, one person had a history of being verbally abusive to staff and other service users. When being abusive the person had been identified as being a risk to others and was also at risk of harm from other service users who may retaliate. A detailed plan existed to guide staff as to the most appropriate way of de-escalating the situation. Behaviour management and incident records suggested the risk management plan was successful.

Risks were managed at the service and there were systems and processes in place. The service balanced the necessary levels of protection without being overly risk averse in order to give people confidence to develop their levels of independence. The registered manager told us, "There are risks in everything we do. We don't tell people you can't do this because it's too risk, but we look at how we can introduce them to it in the least risky way. Such as when looking at improving people's abilities and independence."

We asked the registered manager how they determined staffing levels at the service to ensure they had the right amount of staff to meet the complex needs of the people living at Thorpe House. They told us they

regularly audited staffing levels but did not use a dependency tool as the nature of the service meant people's needs could alter rapidly. They worked on a minimum staff basis of one staff to four people but the two occupational therapists, and the two house supervisors were not included in the minimum staff numbers. They had developed an on-call system where a registered mental nurse was always on call to assist at these times. Additional staff were placed on the rota if people needed escorting to hospital and we observed during our inspection staff stayed with one person whilst in hospital to ensure this person's mental health did not deteriorate by being cared for by people who they did not know.

We completed a tour of the premises as part of our inspection. We inspected the bedrooms, bath and shower rooms, the laundry, kitchen and various communal living spaces. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions and all upstairs windows had tamper-proof opening restrictors in place. We found radiators were covered to protect people from injuring themselves on hot surfaces. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be current.

As part of our inspection process we looked to see how medicines were stored, administered and ordered. . We observed the morning medicine round and saw medicines were administered to people by the nursing staff . Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge temperatures were taken daily and recorded. However the room in which medicines were stored was hot and there was no record of room temperatures or a means of measuring the temperature. There was a portable air conditioning unit in the room but it was not in use at the time of our arrival at the home nor during the administration of medicines. This meant the provider could not guarantee medicines were always stored at the correct temperatures. On speaking with the registered manager, they told us the problem with the heat in the office where medicines were stored had been discussed at the previous two director meetings and the service had determined medicines would be stored in locked cabinets in people's rooms. These had been delivered and were waiting to be installed. They told us this would ensure a higher degree of privacy and dignity for people using the service ensuring medicine administration was undertaken in the privacy of people's rooms. We reviewed this information and saw that this had been discussed and plans put in place to resolve this issue with medicine storage at the service.

A nurse we spoke with showed us the medication administration records (MAR) sheet was complete and contained no gaps in signatures. We saw any known allergies were recorded. We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed.

We saw assessments in place with regard to self-medication. We saw one person was able to self-medicate and had the appropriate storage facilitates to keep their medicines safe. Staff conducted regular checks to ensure compliance with prescribed medicines. Whilst no people were receiving their medicines covertly the nursing staff had a good understanding of the requirements to ensure a legal frame work existed before doing so. Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were

accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date. We saw evidence people were referred to their doctor when issues in relation to their medication arose. Staff were aware of the need to ensure people prescribed certain medicines had regular blood tests.

We asked a nurse about the safe handling of medicines to ensure people received the correct medication at the right time. Answers given along with our observations demonstrated medicines were not consistently administered correctly. For example, on three occasions we witnessed people being administered medicines when the label on the medicine gave clear instruction it had to be administered 30 to 60 minutes before food yet during the inspection it was administered after food. .

We looked at the provider's medicines policy. The policy demonstrated most elements of medicine administration had been addressed but regular reviews of the policy had not referred to current legislation and best practice. We spoke with a registered nurse and director about the need to review the policy against national guidance.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the service. This included Disclosure and Barring Services (DBS) checks, reviews of people's employment history and two references for each person. People using the service were involved in the interviewing process. The senior RMN told us they would listen to the comments of the person as "It's their home. It's their care. If they said, "I really don't like that person"; we would have to take it on board." The service fully appreciated the importance of getting the right staff for the people using the service.

Good

Is the service effective?

Our findings

People we spoke with were all complimentary about the staff. We were told they thought staff were very good and met their needs. One person said, "The staff know me very well and have been the main reason I have made such good progress to get better". We spoke with a district nurse who said, "The staff here are very effective in promoting good health and independence".

One community psychiatric nurse we spoke with following the inspection told us "I feel [person's] physical health is well monitored. We don't get the metabolic problems associated with medication at Thorpe House."

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. For example, when staff were administering medicines we observed people were asked if they would prefer their medicines at a particular time rather than medicines being administered at a time convenient for staff. People who were prescribed as required medicines were asked if they required the medicine.

The senior registered mental nurse (RMN) told us all new staff completed the Care Certificate a month after they started work. This is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that all workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Prior to starting the Care Certificate staff completed a two week induction, shadowed staff and had a settling in period under the close observation of a registered mental nurse. We saw detailed information of induction training received in the first two weeks of starting work including watching DVD's, reading policies and practical training. Staff told us they were supported to do additional training and attend conferences to ensure they kept up with best practice. For example, the occupational therapist told us they had requested to attend a conference and training session to keep up with their continued professional development (CPD) to ensure they remained fit to practice and the directors had agreed to fund this.

The registered manager told us the service had recently been accredited to take students on placement. They told us these new links with the university would open up further training opportunities for the staff at Thorpe House as they would be able to access training provided by the university.. One director had expressed an interest in qualifying in cognitive behavioural therapy. The home also utilised local authority training opportunities and had a full programme of training organised for the year. The registered manager told us they had a teaching qualification and provided some of the training to staff. They kept up to date with current practice by attending conferences, and professional practice events.

Staff told us they had regular supervision on a two monthly basis with their supervisor to discuss their role. Supervision was confidential and accessed only by the supervisor and supervisee but one member of staff agreed to show us their record which demonstrated the session had been used to reflect on practice and identify areas to develop. Staff told us they felt supported through formal systems such as appraisal and supervision, and informal discussions with the management team and the registered mental nurses on duty

if they required on the spot guidance. This demonstrated staff were supported to develop in their roles and that any gaps in knowledge and skills were identified through this process to ensure safe care delivery at Thorpe House.

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw four standard DoLS authorisations had been submitted to supervisory bodies for people living at the service. We saw conditions attached to authorisations had been translated into support plans and enacted or where the condition was unable to be delivered the supervisory body had been informed. Of the remaining people receiving care at Thorpe House we found no indications DoLS were required.

The registered manager and support staff we spoke with were able to demonstrate an understanding of the Mental Capacity Act 2005 (MCA) and of the Deprivation of Liberty Safeguards (DoLS). We saw reference in the latest team meeting in relation to one person whose DoLS had just been authorised, and what this meant for the person and the staff supporting the person. This demonstrated the home understood its responsibilities in this area and ensured staff were informed about individual situations to protect people at the service and ensure they were acting in accordance with the law.

The door to the home was wide open when we arrived to inspect. We were quickly informed the door was constantly monitored but most people at the service were free to come and go as they wished. For example, we saw people going for a walk in the grounds and to the shops. Those people subject to a Deprivation of Liberty Safeguard authorisation were supported to go out when they wanted to and therefore had no wish or were physically unable to leave the premises. This air of freedom added to the homely feel of the environment where people were happy to live.

We spoke with one member of care staff about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint. We saw detailed care plans for people who may for their own safety or the safety of others need to be physically restrained. We saw one care plan where known aggressive behaviour patterns were recorded. Against each manifestation of aggression was a detailed response requirement of staff. Where the possibility of physical assault on other people was envisaged a detailed step-by-step approach to care was described. This included the possibility of physically restraining the person. We saw staff guidance using acceptable physical interventions was described in both written and pictorial forms. Staff told us they had received the necessary training and they felt confident they were acting in accordance with the law. We saw where physical intervention was used the events of before, during and after the incident were recorded and reported to relevant individuals, such as the person's psychiatrist.

Care plans and daily records of care given demonstrated that known circumstances which triggered bouts of anxiety or behaviours that challenged the service were documented in great detail. Records in care plans we

looked at demonstrated that practical interventions were carried out by staff to ensure people were not distressed or subject to stressors which would have a detrimental effect on people's mental health. For example, one care plan described how situations could give rise to verbal aggression. The care plan described how staff should approach the person and discuss what had led to the upset and frustration and try and find solutions to avoid a repetition in the future.

We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by relevant clinicians. There was evidence of involving family members in the decision. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

People's dietary needs and preferences were assessed on admission, and this information was shared with the kitchen staff team. We spoke with the kitchen staff during our inspection and they were able to advise us of the special dietary requirements of four people living there varying from a diabetic diet to healthy eating diets. People living at Thorpe House told us how much they enjoyed the food. One person told us, "The food is fantastic. I never leave nothing. I eat every bit of what's in front of me. Fish, salad, new potatoes, meat and fishcakes." Another person said, "You can have cereal, toast or a cooked breakfast. I chose cereal and toast." Another person described the food as one of the good things about living at Thorpe House. The kitchen had recently been refurbished and had furnished with up to date kitchen appliances to ensure the dietary needs of people at the service were supported to the highest standards.

People at the service because of their mental health needs had their care coordinated under the Care Programme Approach (CPA). This approach ensures a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw written evidence that CPA meetings took place with all relevant health and social care professional in attendance. We saw outcomes of CPA meetings had been translated into current care planning records.

We saw evidence in written records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GPs, hospital consultants, community nurses, social workers, opticians and dentists. We were told the GP reviewed each person once a year and the consultant psychiatrist reviewed people once a year at the home or sooner if required.

Facilities at Thorpe House were to a high standard with well-maintained grounds which people were free to access. The home was situated on two floors access between floors provided by a passenger lift and a stairlift. We were told the stairlift would only be used in the event the lift broke down as a backup. People were offered the option to have their own key to their bedrooms if they wished. Thorpe House had a separate building providing four self-contained studio apartments where people recovering from long periods of mental ill-health could regain confidence and skills before returning to a fully independent life. The apartments were also used by people who found living with a mental illness in the community difficult but did not require fully supported care. We saw the facility received significant support from the service's own occupational therapy team (OT's). The physical environment, professional staff support and enactment of detailed care planning was demonstrably contributing to people's well-being. People living in the apartments confirmed the benefits they had experienced. These included the feeling of independence rather than living in a communal setting with other people. One person said, "This is as near as I remember what it felt like to live in my own home and it is preparing me to live alone again."

Outstanding ☆

Is the service caring?

Our findings

Without exception, people told us they were extremely happy with the caring approach and attitude of the staff team who they described as kind and friendly. One said, "The staff are more like friends". Another person said, "The staff are caring. I think they are good people and I have lots of friends here." One further person said, "Staff are very caring. They listen to me." Relatives described the service as "Brilliant", "Top class", and told us staff were very caring and very compassionate.
Other professionals we spoke with were highly complementary about the caring nature of the service. For example, a social care professional we spoke with over the telephone during our inspection told us, "I've not known an establishment that offers such a high level of care in 26 years. They are compassionate, understanding, find solutions to any problems. They have developed a good therapeutic relationship with [name]. They explained to us the positive impact the service had on the health of the person they supported, which they told us was down to the skills and approach of the staff.

We spoke with a community psychiatric nurse who supported one person living at Thorpe House. They said not only had the service helped the person achieve mental stability within the home "but had extended it to activities in the community which had increased their quality of life and helped them resume their relationship with their family."

During our inspection tour of the property we observed staff knocked on doors before entering people's rooms, demonstrating staff actively respected people's need for privacy. Some staff were 'dignity champions' and their photographs were on a board at the entrance. These dignity champions ranging from registered nurses, nursing assistants and domestic staff met on a monthly basis with people at the service to discuss ways that dignity could be improved within the home and when people are outside of the home. Going forwards to drive improvements in this area, the home was encouraging people using the service to become dignity champions with equal access to relevant information and resources. We were told the dignity champions had effected change by raising awareness at the service and through practical problem solving. For example, following the intervention of one dignity champion, the bathroom doors were rehanged to ensure when staff were supporting a person and leaving the room, there was no opportunity for other people walking past to see into the bathroom. Another example the registered manager shared in relation to the positive outcomes from the work of the dignity champion was the improvements made to the group stroll. Staff and people using the service had historically separately grouped during the stroll into the community. Following discussions with staff and people using the service, this was changed so everyone mixed together which made the experience more sociable and made people more aware of opportunities available to them in the community. This had encouraged more people to actively seek this opportunity.

The registered manager told us "we have a wealth of material to support cultural needs." They told us they had compiled this information to ensure all staff were provided with information to support people from diverse backgrounds. Although they did not currently support people from an Islamic faith, they supported staff who were Muslim to practice their faith whilst at work. They had connections with Jehovah's Witnesses and one person was supported to practice their spiritual faith.

People living at the home were at various stages in their recovery from a period of mental ill-health, sometimes of a relapsing and remitting nature. The atmosphere was calm, relaxed, and settled which had a positive effect on people who had identified problems with anxiety which could result in behaviours that challenged the service. Staff skilfully contributed to the atmosphere as they spoke quietly and gave encouragement for people to participate in conversations and staff had time to sit and talk with people. For example, we saw staff sitting informally with people whilst they (the person)were having a cigarette. At other times during our inspection we found people happily interacting with staff or other people living at the service or enjoying time spent on their own in their rooms or apartments.

We were shown a letter from a relative of a person who lived there which said, "We are delighted to have [relative] in such a lovely, secure and caring environment. The real bonus for us is that for the first time in nearly sixteen months we no longer worry about their wellbeing. I attribute this entirely to the dedication of the staff. Some might infer that they are only doing their job but I would aver that doing the job empathetically has made all the difference." We received feedback prior to our inspection from a university lecturer who had visited the service. They said, "The 'feel' of the home was of inclusiveness with the emphasis on supporting people to reach their individual potential. The home director, manager, staff nurses and care workers appeared to work very closely together and valued each other's role."

We observed a particularly good rapport between staff and people in the home, with friendly interactions. We found all the staff we spoke with were passionate about improving the quality of life for people living at the service. We observed people were fully encouraged and supported to be as independent as possible. Care plans described how the nursing and occupational therapy staff worked proactively with people over a defined period of time. Goals were set by the person and the occupational therapist together, with the overall aim of maximising the person's independence, choice and quality of life, and reducing their need for support in future. This therapeutic environment encouraged and enhanced people's participation in specific programmes of care such as the re-ablement programme . We saw care plans where the long term outcome was for the person to return to their own home and specific goals had been set to work towards this outcome. One person told us,, "I am planning to leave here by Christmas and return to my own home" and "I need to re- learn how to care for myself and regain some confidence and the staff are helping me with that. . The staff have been really good at helping me cope with things I have not faced for so long – even crossing the road or going on a bus was frightening at first".

The home employed domestic cleaning, catering and laundry staff but these tasks were also undertaken by people as part of their rehabilitation programme. A person we spoke with thoroughly enjoyed keeping their own living area clean and tidy and commented it was helping them regain past skills to help them to live independently again. The home had recently installed a domestic style kitchen to enable people to regain skills in this area and whilst currently it was used with the occupational therapist supervision we were told each person at the service would be risk assessed to determine the level of support required with this activity with the intention some of the people at the service would be able to use this facility independently.

There were four bedsit type apartments in a purpose built coach house which each contained an area with a work surface, kettle, toaster and microwave to promote independent living for those people with the skills and with the desire to live more independently at the service or with the intention of returning to live in the community.
Staff respected the need to keep information about people confidential and we observed whenever staff needed to discuss an aspect of care about a person they ensured the doors and window of the office were shut to avoid people overhearing the conversation. We saw all personal information about people receiving care was only accessible to staff involved in care.

Where people had chosen to do so we saw end of life care or advanced care plans were in place. People with potentially diminishing mental capacity had recorded their wishes whilst they were able to do so. Care plans considered physical, psychological, social and spiritual needs to maximise the quality of life of people and their family. The person's preferred place of care at the end of their life was recorded and we found evidence which supported this was reviewed and if people's preferences changed, this was recorded accordingly. This ensured the service continued to respect people's wishes by appropriately reviewing and recording information in this respect.

We saw the service appropriately ensured DNACPR records accompanied the people to hospital and back to ensure people had an accurate and up to date record of this decision. There were procedure and protocols in place to support people at the end of their lives. They were supporting one person who was end of their life and we saw evidence the service liaised with the relevant people, accessed anticipatory and pain management treatments appropriately, as well as ensuring that they had the resources and equipment to keep the person comfortable. They were managing this person's pain via use of assessment, interacting with the person in a manner that they understood and by learning their verbalisation of pain and non-verbal communication. They had recognised well where the current pain management was not effective, as well as treatment for other symptoms, and liaised well with others to organise review of this. The service had developed good relationships with other services and specialists in devising care plans to support the person, and the staff when required. They told us they had been proactive in ensuring their out of hour care plan was kept up to date and their DNACPR appropriately evaluated. When a person reached the end of their life a staff member stayed with the person unless they had directed otherwise. Families were made welcome anytime and for as long as they wished and the service had provided sleeping arrangements for relatives. The registered manager told us if a person died whilst at the home a memorial plaque was commissioned with staff and people at the service involved in determining the words on the plaque. This was often a phrase or something that was particular about the person and gave people and staff somewhere to pay their respects and reminisce.

Good

Is the service responsive?

Our findings

People told us the staff were very responsive to their needs and involved them in the care planning process. Relatives told us they were always kept informed and were invited to contribute to their relations' reviews. One relative told us, "They are excellent. I cannot speak highly enough of the service".

We spoke with one professional over the telephone during our inspection. They told us about the person they were involved with who had severe mental health problems with long standing physical presentations. They described how the staff worked tirelessly to explore the issue, working collaboratively with others. They said within four or five months this long standing problem had resolved. They afforded the person time away from the service every day with support and had encouraged the person to make choices with guidance and support. They confirmed that the service was extremely responsive to people's needs and told us the service had developed therapeutic relationships with people which were utilised to ensure the person living there was supported to live a fulfilled a life as possible.

People told us they were involved in the compilation, and the reviewing of their care plans and risk assessments with regular meetings with their key worker to go through these. We saw some care plans were designed to help people recommence living an independent life in their own home. A large part of the care plan was dedicated to equipping people with daily living and social skills. The plan included, building relationships, household skills, self-medication, health awareness, cooking, laundry, leisure pursuits, shopping and road safety. Care plans were reviewed and updated as frequently as circumstances and progress dictated. We saw care plans related in some instances to the known difficulties people had with daily living tasks and in relating to other people. Some had cognitive impairments that made it hard for people to plan ahead whilst other were vulnerable to exploitation. Care plans demonstrated how to address the challenges whilst recognising the person's own wishes and ambitions.

We found a one page profile in each case file titled "Care Heart" which provided a quick reference and care profile for each person using the service. In addition, we were told each person was offered the opportunity to complete a "Portrait of their life" to assist further in personalising the care the service offered, and to "help them understand the person better as an individual person with unique life experience and events".

Some people had spent many years living with constant support from care staff. These people's care plans identified risks that they would come across as they spent more time in a community setting such as road safety or potential financial exploitation. Detailed care plans existed to help people mitigate these risks. We saw outcomes of escorted visits shopping or to social events where staff recorded how people coped with the challenges they came across.

We looked at a care plan which had been developed specifically for that person. Care plans were built on a firm foundation gained from a detailed assessment before admission. This ensured the home had the facilities and staff skills to meet people's needs. The plan was person centred, with individual information on people's wishes in relation to how their care was provided. The care plan showed how the person liked to spend their time and how they liked to be supported. Where appropriate the care plan was targeted towards

enabling the person to live an independent life in the community supported, where necessary, by 'Assertive Outreach Teams' (AOTs) or the 'Community Mental Health Teams' (CMHTs). The care plan recognised the need to work collaboratively building long term relationships with health care professionals such as the CMHT to minimise the need for in-patient mental health care.

We saw evidence of active involvement in care planning by visiting health care professionals such as district and community psychiatric nurses, podiatrist and social care professionals including social workers. Professional involvement was recorded in people's care plans and information was shared on a daily basis in the daily diary to alert staff of any issues. This evidenced the service was working in partnership with others to ensure improved outcomes for people using the service.

We also saw a care plan in relation to a person at risk of pressure sores due to repetitive shearing movements when their mood was elated. This identified the issue and the risk presented, the goals from the person's perspective and detailed interventions required from all staff to ensure tissue viability was maximised. Although the care plan was reviewed at least every four weeks by the key worker and occupational therapist, the person had requested they only be involved in their care plan review every eight weeks as they felt a four weekly review was "too frequent and had little effect on their care". They were happy for staff to continue to review their care needs every four weeks and discuss these with them. This demonstrated the staff at the service were acknowledging and acting on the views of the person and how involved they wished to be in the review of their care plan.

People who used the service said they had individual choice at the home and their choices were respected. This included choice about how they liked to spend their day and what activities they wanted to undertake. Once person said, "We do different activities every week. We play games, we dance, movement to music and indoor games in winter." Another person told us, "I'm still tired from last night. I went out to a pub with [name]. I like to go bowling and to the pictures." A further person told us, "I go for a walk each day. Just go round the local shops with [name]."

People told us they met with their key worker each week to plan the following week's diary which was recorded on a diary planner. Staff recorded whether the person had undertaken the activity independently, whether they had been offered and accepted or declined and how much time was spent undertaking the activity. We spoke with one person whose occupational therapist had been working with to facilitate voluntary work at a charity shop. They told us they had "just been ringing [name of charity] and they are going to ring me back later." This person was actively engaged in securing this occupation and was excited about the prospects of this type of occupation. We noted in the resident questionnaire analysis from June 2016 people using the service gave positive feedback about the diary planners stating they were good as "They were reminded by staff to write what they wanted to do rather than what was available in activities that day, and this made them much more centred around them personally." We also noted "All residents agreed they had ample opportunities to visit the shops with or without staff support, and on a daily basis they were offered opportunity to go out with staff. The mix of recreational and therapeutic activities on offer at the service meant that people using the service felt they had meaning to their lives and added to the happy and relaxed atmosphere at Thorpe House and demonstrated the service was proactive in personalising this aspect of care.

The registered manager told us they successfully supported people whose needs challenged other services as "We can manage the behaviours. We approach issues positively. We look at why behaviour is happening and involve other professionals. We refer where we think another service, a different professional would help. We think outside the box."

The registered manager told us there were occasions when the service had to respond immediately which meant not following the care plan. The registered manager told us they made it clear to staff, that as long as there was recorded decision making detailing a balancing approach to managing the situation, staff could deviate from the care plan if it meant the needs of the person supported were met appropriately and responsively.

The service had a complaints policy which was structured and encouraged lessons to be learnt. There had been no recent complaints at the service. People told us they knew how to make a complaint if they needed to but they told us they had no recent complaints. One person said, "I'd go to staff if I wasn't happy." They told us they had made a complaint in the past and they were happy with how this had been handled. Our observations confirmed the home had a complaint system in place and people felt confident to approach staff if they were not happy with the service provided and that there concerns would be acted upon.

Good

Is the service well-led?

Our findings

One person who lived at Thorpe House told us "I think the home is well-led. It's a lovely surrounding." Another person who had lived at the home for several years said, "The service has changed for the better over the years." All the relatives we spoke with and professionals told us the service was well-led and well managed. The service had a registered manager who had been registered since 2011. The registered manager was supported by a team of dedicated registered mental nurses who were fully aware of their responsibilities under the legislation. They ensured that all significant incidents were notified promptly to the Care Quality Commission.

We found a culture of openness and transparency, combined with a desire to provide the best possible care to people living at Thorpe House. Staff at all levels were approachable and knowledgeable, and were committed to the on-going development of the service and for their service to be recognised for providing outstanding support to people with specialised mental health requirements. For example, they were working with the local university to facilitate student placements so the students could experience and develop skills in problem solving in relation to complex mental health issues; an opportunity the student might not otherwise have. As the service had difficult in recruiting qualified registered mental nurses, this was also a way of introducing this type of service to potential recruits who might want to specialise in this area.

People were at the heart of the service. The registered provider's philosophy, vision and values were understood and shared across the staff team. They and their staff team were passionate about providing high quality care tailored around people's individual needs and preferences. The registered manager said "I am incredibly conscientious; if there is something I don't know I will go and find out about it. The wealth of knowledge in this service is second to none. We want to make the service to be the best. To meet the needs of the people living here, ensuring independence and proving care in a dignified manner, the best care we can."

The staff we spoke with told us the management team were all supportive. The registered manager told us they valued the feelings of staff and their contribution to the service and they undertook a monthly staff file and morale audit. We were shown the audit from June 2016. We could see the registered manager had acted on the concerns raised by staff. Staff had stated supervision was supportive and they were happy with their supervisors. They also felt supported and guided by the RMN's on shift. The negative comments were relation to long shifts and the difficulty recruiting new staff. These issues were being addressed and the service was actively recruiting.

The registered provider and directors lived on site adjoining the home. The directors were all heavily involved at the service with specific roles in the management of the home. They had either registered nursing qualifications or had worked in the caring field and kept their registration and training up to date so in the event of an emergency they were able to step in. They invested both in the facilities at the service and in staff. To improve the living environment for people and there had been a rolling programme of renovations, most recently in replacing the windows and a full kitchen refurbishment in April 2016. The

registered manager told us, "If we need something to provide care, they [the Registered Provider] will provide it and they will ensure they get the best." The registered manager told us they held monthly meetings with the directors and the views of all were considered before decisions were made. They gave the example of the change in hours to 12 hour shifts and the pros and cons of lengthy shifts for staff. Arrangements were put in place for those staff who could not manage long shifts and the feedback from people using the service had been positive as there was more consistency with staff support during the day.

The views of the people living at the service had been sought in the running of the home and we were shown the results of the resident questionnaires from May/June 2016. This recorded that the general feeling about nursing care at Thorpe House remained positive. People using the service were asked questions about independence, choice and dignity, meals and drinks, social time comfort safety and security. Comments included "I spend time with my keyworker once a month to discuss my care"; "I am supported to plan my week." and "I am offered daily exercise of a walk." There was evidence to support that any comments requiring further enquiry had been actioned with an outcome recorded. This demonstrated the service was seeking and acting on the views of people at the service to inform improvements.

We saw maintenance schedules and environmental and care audits were a regular feature of the service. For example we saw records of regular flushing of taps and outlets to ensure the quality of water. The records of minor environmental faults demonstrated issues identified were quickly dealt with. For example faults identified during fire drills and testing, such as defective emergency exit lights, were attended to in a timely fashion. We saw evidence of effective auditing of mattresses, fire alarms, and fire doors. This demonstrated the service was effectively assessing and monitoring the quality of this aspect of service provision to ensure the environment was safe for the people living at the service. Although we found issues with medicines which should have been picked up by audit, the registered provider advised us it had not been picked up as they had not considered it to be an issue, although they would act on our concerns with medicines to ensure they are performing to the highest standards in this area.

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. We were shown the minutes of the latest meeting held on 17 August 2016 which staff had signed to show they had read. These minutes confirmed staff were fully involved in the meeting and their views were sought in relation to the service provided by Thorpe House. They were invited to chair the meeting although they chose not to. We were also shown the minutes of the residents meeting held on 4 and 19 July 2016. These demonstrated the views of people using the service were regularly sought and feedback given to any suggestions to improve their living experience.

The registered provider completed an audit at the service. We were shown the audit completed 22 May and 19 July 2016. The registered provider had checked three staff files to ensure staff recruitment checks had been completed, staff meetings were held every two months, recorded and available to others to read, policies were in place and staff knew where to access them. Staff had received supervision and appraisal, and their views had been sought and considered. They undertook an inspection of the premises, and an audit of specific access to service user care. From the information seen it was clear they were seeking feedback which they were monitoring and analysing for issues which may require further action.