Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Thomas House (St Helens) Limited

Thomas House Care Home, 168 Prescot Road, St Helens, WA10 3TS

Tel: 01744608800

Date of Inspections: 12 June 2013
07 June 2013

Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Management of medicines	✖ Enforcement action taken
Safety and suitability of premises	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Thomas House (St Helens) Limited
Registered Manager	Mrs. Barbara Thornber
Overview of the service	Thomas House is a residential care home in St Helens. The service offers accommodation and support for up to 28 people. The building is arranged across two floors with lift access to the upper floor. Car parking is available at the front of the building.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 7 June 2013 and 12 June 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, were accompanied by a pharmacist and talked with commissioners of services.

What people told us and what we found

We had previously visited Thomas House in January 2013. At that time we raised concerns about the management and administration of medication and the effectiveness of the quality assurance systems in place. At this inspection we found those concerns had not been addressed. In addition, we found assessment and care planning documentation did not contain all the information staff required, which placed people at risk of unsafe or inappropriate care.

We spoke with four people who were able to tell us about their views and experiences of living at Thomas House. People told us they were satisfied with the care and support provided to them and that they were treated with dignity and respect. One person said, "The staff are great and very caring." People told us the food was enjoyable and that their food preferences were always taken into account.

We spent time with people in the dining room while lunch was being served. The atmosphere was calm and relaxed and people were given plenty of time to eat their meals. We observed positive interactions between people who lived in the home and members of staff. People told us they enjoyed the food and there were choices available. We found each of the three people on the table had chosen a different meal. One person said, "The food here is always good and you always get something you like."

We asked three people who lived in the home about what they would do if they had any concerns or wanted to make a complaint. All said they would speak to the manager. One person said, "If I have any concerns I would go and see the manager Barbara. She always makes sure everything is okay." We also spoke with a visitor who had come to see their relative. They told us about a concern they had raised and how it had been managed by the home. They were very satisfied that their concern was listened to and promptly addressed by the manager.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 05 September 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Thomas House (St Helens) Limited to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always receive care, treatment and support that met their needs. Assessment and care planning documentation did not contain all the information staff required, which placed people at risk of unsafe or inappropriate care.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with four people who were able to tell us about their views and experiences of living at Thomas House. People told us they were satisfied with the care and support provided to them and that they were treated with dignity and respect. One person said, "The staff are great and very caring." People told us the food was enjoyable and that their food preferences were always taken into account.

We spent time with people in the dining room while lunch was being served. The atmosphere was calm and relaxed and people were given plenty of time to eat their meals. We observed positive interactions between people who lived in the home and members of staff. People told us they enjoyed the food and there were choices available. We found each of the three people on the table had chosen a different meal. One person said, "The food here is always good and you always get something you like."

The director of the home told us that information about the home was provided to people before they move into the home. On admission to the home people received an information pack, which was kept within their rooms. We viewed an example information pack and found this was comprehensive. It included all the information people would need while using the service including: details of the facilities available; philosophy of care; and useful information on topics such as falls prevention.

We viewed the care records for three people. Each set of care records contained an assessment completed by the manager that aimed to identify the care needs of the person. The assessment and any other supporting information were used to develop the person's care plan and risk assessments. We saw evidence these were being reviewed monthly. The care records were lengthy and some relevant information was held separately. This meant it took time to find all the information required. The director of the

home showed us a blank copy of new care planning documentation that was about to be implemented within the home with the aim of making the care records clearer and more succinct.

We looked at one person's care records in detail and spoke with both the person concerned and the staff involved in their care. This person had recently moved into the home. We did this to evaluate whether all the person's care needs had been met effectively. We found the original assessment of their care undertaken by the home contained limited information and did not accurately reflect their care needs. For example, the assessment and corresponding care plan did not identify the person's mental health needs despite these being a primary reason for admission.

Throughout the initial assessment, risk assessments and care planning documentation evidenced there were inconsistencies and omissions. For example, the assessment and care plan both stated the person's medication was to be managed by the home. We found that the person was actually self medicating with three inhalers, which were kept in the person's room. This had not been risk assessed and staff did not have clear information about how to support the person with their medication. We found one inhaler had run out several days before and this had not been identified by staff. This meant the person was not receiving suitable care and support with their medication.

The person whose care we reviewed in detail had diabetes. The information within the assessment and care planning documentation was inconsistent and did not adequately identify the person's needs relating to their diabetes. For example, the person told us that before moving into the home they had a chiropodist who came out to see them once a month. Foot care is particularly important for people with diabetes. The assessment documentation, including a separate foot care assessment stated the person had no foot care needs. However, the care plan did identify the person had their own chiropodist because they had diabetes. We asked the manager about this and found that visits from a chiropodist had not been arranged and the person had not received any foot care whilst resident at the home. This meant their healthcare needs associated with their diabetes were not being appropriately managed.

Throughout the course of the inspection, we found examples of people's health needs not being appropriately supported. For example, following a health appointment in early May 2013, one person required diagnostic tests. This had not been recorded appropriately within the care plan or the communications book. We found that at the time of the inspection, one month later this had not been followed up by the home and the person had not yet received these tests. This meant the arrangements in place for communicating information about people's health needs were not sufficient.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 13.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We inspected this outcome as at the last inspection in January 2013, we had concerns about the management of medicines in the home and, as a result of our findings we issued a compliance action. This inspection was carried out to check whether appropriate arrangements were now in place for the safe management of medicines.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as looking at a sample of Medication Administration Records (MARs), stock and other records for ten people who lived in the home. We found errors, discrepancies and/or concerns in nine of the 10 people's records we looked at.

Medicines were kept in locked cupboards and care workers kept the keys for these safely. A fridge was available for those medicines that needed cold storage and the temperature of this was monitored daily. However, care workers were unaware of how to correctly read and record the maximum and minimum temperatures of the fridge. Although the temperature recordings showed the temperature stayed within the recommended range of 2-8C, there was a risk that any increases in temperature between readings being taken, for example if the door was left open, would be missed as the minimum and maximum temperatures were not being reviewed or recorded. Medicines may spoil and/or not work properly if they are not kept at the correct temperature.

It was not possible to account for all medicines, as care workers had not always accurately recorded the quantity of medicines received into or leaving the home, or how much had been carried forward from the previous month. If medicines cannot be accounted for, it is impossible to tell whether or not they had been given correctly. Some MARs were incomplete whilst others were inaccurate. We saw that records for the administration of Controlled Drugs (powerful medicines that need special storage precautions and extra

records to be kept) were also incomplete and had often been signed by a second staff member who had not actually witnessed the medicines being given and/or checked. We saw two people had been given their morning medicines on the day of our visit however the care worker had not signed the MARs for these. We saw the dose instructions for an inhaler had been recorded incorrectly on one MAR; the inhaler was labelled to be used once daily, but the handwritten entry on the MAR stated to use it three times a day. It was a serious concern that this error had not been spotted and that we had to intervene during a medicines round in order to prevent the person from being given too much medicine. The health of people living in the home was placed at unnecessary risk of harm as the medicines records were inaccurate.

We found that medicines were not always given as prescribed. We found that some tablets had been signed for as having been given, even though they were still present in the packets, whilst other medicines were missing and could not be accounted for. We found care workers did not always follow the instructions on the medicine labels. We saw one person had only been given their inhaler once a day, instead of twice daily, another had not been given their injections as prescribed and we found four different medicines, including creams and an inhaler used to prevent breathing difficulties that were not listed on the current MARs. People living in the home were at serious risk of harm when they were not given their medicines as prescribed.

Many people living in the home were prescribed medicines to be taken only 'when required' e.g. painkillers and medicines for anxiety. There was little or no information for care workers to follow in order to ensure that these medicines were given correctly and consistently with regard to the individual needs and preferences of each person. Some people chose to look after their own medicines, but risk assessments had not been completed in some cases and not reviewed in others. This meant that care workers did not have the information they needed to support people to take their medicines safely. Failing to administer or support people to take their medicines safely placed the health and wellbeing of people living in the home at serious risk of harm.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

We were shown round the building by a care assistant. We found the building to be in a good state of repair and adequately furnished and decorated. We were told there was an ongoing programme of refurbishment. People's rooms were personalised with their own belongings.

During lunch time we sat in the dining room and spoke with people. We observed the people sat near the window in the dining room were getting very hot as it was a sunny day and there were no blinds. One person told us that it did sometimes get very hot and that sometimes the curtains were closed but that then makes the room dark. The director of the home told us they had taken measurements for new blinds to be fitted in the dining room and lounge areas, which would resolve this.

The car park and building was accessible to people who used a wheelchair. Ramps were in place and doors were wide enough for wheelchair access. A lift was in place so people could access both floors of the building. The lift was under a maintenance contract and was fully working at the time of the inspection. There was access to suitable adapted bathing facilities and toilets to meet people's additional mobility needs.

Fire records were in place, which confirmed all required fire safety and emergency lighting checks had been undertaken. A call bell system was in place for people who lived in the home and the call points were checked on a rolling programme, with a different point being tested each time. The provider may wish to note evidence of gas safety checks could not be found at the time of the inspection. The director of the home told us these had been undertaken and they would send evidence of these checks when the home's administrator was back from annual leave.

Thermostatic valves were in place in all water outlets that could be accessed by people living in the home to reduce the risk of scalding. We saw evidence water temperatures were being routinely checked. A risk assessment had been undertaken to assess and manage the risks associated with Legionella. All radiators had covers to reduce the risk of burns.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider had a system in place to regularly assess and monitor the quality of service that people receive. However, this system remained ineffective in ensuring that all issues were identified and acted upon in appropriate timescales.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We inspected this outcome as at the last inspection in January 2013, we had concerns about the effectiveness of audit arrangements in place within the home. As a result of what we found we issued a compliance action. This inspection was carried out to check whether suitable quality assurance systems were now in place.

We looked at the systems and processes the home had in place to continuously monitor the quality of service provided. We found all risks associated to health and safety within the service had been reviewed in December 2012. These included areas such as fire, electrics, smoking and first aid. The home had a health and safety policy in place. Accidents and incidents were recorded and reviewed by the manager to look for trends and to ensure people's safety and welfare.

Audits were in place for both medication and care plans. These audits consisted of the manager checking each person's documentation and their medication administration records (MARs) and signing next to the relevant section to highlight that it was satisfactory. We found this system was inadequate as it did not highlight or address issues of concern, including those we found at the time of the inspection. There was no recording system to capture any issues that required action and to follow these through to ensure they had been appropriately completed.

Whilst the manager carried out regular checks on the stock of medication within the home and MARs, these checks had failed to spot many of the concerns and discrepancies that we found during our visit. This meant the system of audit in place to identify concerns and make the improvements necessary to ensure medicines are handled safely within the home was not robust.

People who used the service and their relatives were routinely asked to give feedback about the home. We looked at a summary of ten questionnaires returned in February 2013

and found these were positive. One relative said, "Mum feels safe and knows help is available at all times if needed. She enjoys the food at meal times."

Residents' meetings were not being held. The manager told us they had taken the decision to instead speak to people on a 1:1 basis to ensure people had the opportunity to express themselves. At the time of the inspection, four of these discussions had taken place and all were very positive. We were told an open door policy for relatives to speak with the manager was in place.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

The service had a complaints policy in place. This had recently been reviewed and clearly detailed the response the service would take if a complaint was received, including timescales. There was a three stage resolution process in place, which meant that if a person raising a complaint was not satisfied with the response they could escalate this through the complaints process. Minor amendments were required to reflect the role of the Care Quality Commission and the Local Government Ombudsman.

We viewed the complaints and compliments file and found no formal complaints had been made in the last 12 months. We saw a number of compliments about the home and thank you cards about the care delivered by the staff had been received.

Minor concerns that were raised verbally by people living in the home or their relatives were not being formally recorded at the time of the inspection. The manager was considering implementing a system to track verbal concerns to help them to identify trends. The manager was confident that any such concerns were being actioned appropriately and told us information was often communicated at staff meetings to ensure the home learnt from any concerns raised.

We asked the manager how they ensured people and their relatives had information about how to make a complaint. We were shown the information pack that people receive when they come to live at the home. This contained information about how to make a complaint. In addition, we saw copies of the form used to make complaints were available in the foyer of the home and on the first floor landing.

We asked three people who lived in the home about what they would do if they had any concerns or wanted to make a complaint. All said they would speak to the manager. One person said, "If I have any concerns I would go and see the manager Barbara. She always makes sure everything is okay." We also spoke with a visitor who had come to see their relative. They told us about a concern they had raised and how it was managed by the home. They were very satisfied that their concern was listened to and promptly addressed by the manager.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Assessment and care planning documentation did not contain all the information staff required, which placed people at risk of unsafe or inappropriate care. Regulation 9 (1) (a) (b) (i) (ii).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider had a system in place to regularly assess and monitor the quality of service that people receive. However, this system had been ineffective in ensuring that issues were identified and acted upon in appropriate timescales. Regulation 10 (1) (a) (b).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 05 September 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 17 July 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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