Inspection Report

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

Thornton Hill

Church Road, Thornton In Craven, Skipton, BD23 3TR

Tel: 01282842023

Date of Inspection: 22 May 2013

Date of Publication: June 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✗ Action needed
Supporting workers	✗ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Anchor Trust
Registered Manager	Mrs. Jo Hickey
Overview of the service	Thornton Hill is registered to provide accommodation and personal care for people. It is owned and managed by Anchor Trust. The home is a large converted manor house with a purpose built extension known as the Manor Wing.Thornton Hill is set in its own grounds and overlooks the valley. It is in the village of Thornton-in-Craven, which is approximately 8 miles from Skipton.
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 22 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Some people were not able to tell us about their experiences. We therefore used a number of different methods to help us to understand the experiences of people. We spoke with thirteen people who used the service and seven visitors. Everyone we spoke with told us the care and support at the home was of a good standard.

People's care plans contained a level of information that ensured their needs were being met. We saw records that showed people were involved in developing their care plans and that relatives or their representatives had been involved, where necessary. However, not all information, in relation to night checks and monitoring records, for example food and fluid charts, were completed. This meant that peoples care needs could be overlooked and we could not be assured that proper care was being given.

We also looked at the way medication was being managed in the home. We found that some people were not protected against the risks associated with medicines because appropriate arrangements were not in place to manage the administration of medicines safely.

People were cared for by staff who were not always fully supported to deliver care and treatment safely and to an appropriate standard. Staff described moral as low and some training was not being updated or provided.

There was an effective complaints system in place.

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 22 June 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

People's preferences and experiences were taken into account in relation to how care and support was delivered.

Reasons for our judgement

Some people were not able to tell us about their experiences because of their complex needs. We therefore used a number of different methods to help us understand these experiences, including talking to people, observing the care being delivered and looking at records. We noted that before people received any care or treatment they were asked for their consent and staff acted in accordance with their wishes.

At the time of our visit staff were introducing a new format for keeping records relating to care delivery. They were part way through the process so we looked at the new and 'old' care plans as both were being used. We noted that care plans were created with input from the people who used the service and/or their relative as appropriate. Care plans were individual and reflected people's individual backgrounds, cultures and preferences. Information in the care plans showed the home had assessed people in relation to their capacity to make their own choices and decisions about the levels of care they needed. People and their families were involved in discussions about their care and the risk factors associated with this. Individual choices and decisions were well documented.

Four people using the service told us how they liked to be treated and that they had been involved in talking to staff, who knew about their preferences and they felt they had contributed to the care plan in use. One person told us, "I tell them and say my piece, and they take notice. All the staff are very caring and do what I want." Two visitors told us that the staff treated them with respect and dignity, and as a family they had been asked about their relative's care.

When we spoke to staff about the Mental Capacity Act and deprivation of liberty safeguards they had a good awareness of the principles of how this impacted on people living at Thornton Hill. Staff understood their obligations with respect to people's rights and choices when they appeared to lack the capacity to make informed and appropriate decisions. The manager told us that staff were due to receive training around the Mental Capacity Act and also dementia awareness. However, the staff we spoke with had a clear

understanding that where people had the mental capacity to make their own decisions, this would be respected. The manager told us that when necessary, a best interest meeting to discuss a person's care and treatment was organised. (A best interest meeting takes place when informed choice cannot be made by a person using the service, and considers the views of all those involved in the individual's care). We saw written evidence of these meetings having been held. One visitor we spoke with during the inspection told us, "I have been asked about my relatives care needs and past life. She can't remember a lot of things and I have helped fill in the gaps." Another person told us, "Staff contact me straight away when anything changes. I like that as I like to know what is happening."

During our visit we saw several examples of how staff respected people's privacy and dignity. We saw staff knocking on doors, and waiting for consent before entering bedrooms, bathrooms and toilets. We also saw staff supporting people in a calm, respectful and caring way.

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's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. However, we could not be assured that people always experienced care, treatment and support that met their needs and protected their rights.

We have judged that this has a minor 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 looked at nine care plans. We saw that an assessment had been completed before people had moved in. This meant that the service had sufficient information to be confident that they could meet a person's needs. The care plans were person centred and detailed individual care needs and contained information about the person's preferred daily routines, their past histories including important events and significant people in their lives.

Risk assessments had been completed which included areas such as mobility, manual handling, falls, skin integrity and nutrition. The risk assessments detailed the actions required to reduce any identified risk. This meant that staff had clear guidance on how to ensure the safety and wellbeing for each person. However, despite the care plans detailing, very clearly how staff were to meet peoples needs, it was of concern that associated records were not being completed in a consistent way. For example, some people needed their fluid and food intake monitoring due to an identified risk of dehydration or insufficient nutrition. These records were not being completed accurately, there were gaps in recording, in some examples days had passed without an entry being made. Therefore it was not possible for staff to demonstrate if the person had had sufficient fluids or food. Another example of poor recording was in relation to repositioning charts. These were completed to show when a person had had their position altered in bed or if they were moved from their bed or chair. We noted that there were significant gaps in the recording of these also. This was of importance to people who were at risk of pressure area damage, for example. According to the records seen, some people had remained in one position for several hours. We were told that the care had been given but that staff were not maintaining the records properly.

At the time of our visit there were 31 people in residence. We checked the night records and we were concerned to find that the record did not accurately reflect the times care was being delivered. Some people were being checked 'hourly' and others were checked less frequently, depending on their wishes and care needs. The check could involve a simple look round the door or the delivery of care, for example repositioning someone who was

unable to move around their bed or to help someone to use the toilet. However, it was clear if the night record was being completed at the time the night staff were carrying out the checks or delivery of care. We saw that people were recorded as being checked at the same moment, by the same member of staff, in a different part of the building. Some checks were recorded one minute apart and other checks were recorded as on the hour every hour. It was therefore not possible to know, from the records, the time people had actually received care, how long the care intervention had taken or indeed if any night checks had been made.

Within the care plan was a daily record, this is where staff made comments about the health and welfare of someone. The manager told us it was expected that there would be at least one entry, per day. It was of concern to see that some daily records had not been completed as described. In some examples we saw, gaps of up to seven days were evident. Therefore, we could not see how the person had been during that time and if there care needs had been met or had altered in any way. Staff told us they were too busy at times to be able to complete all the records needed and that record keeping had become very 'hit and miss.'

Some people we met with had complex needs and were not able to verbally communicate their views and experiences. We therefore observed how staff interacted with people, including observations of care delivery. This helped us to understand how people's needs were being met by the care workers on duty. We met people in their own rooms and observed breakfast, and later lunch, being served in two communal areas. People were supported to eat their meal in an appropriate way.

Despite our concerns about the record keeping, it was evident that people were comfortable in their surroundings and people were supported in an attentive way by staff. Overall, people looked well cared for and visitors told us they thought people were treated well. One person told us, that sometimes when they were unwell and could not go to the dining room, staff came up to their room to sit and chat and make sure they were alright. They went on to say, "If I needed any help I get it very quickly." Other comments included, "I have not had any reasons to worry about my care or welfare." Staff were described as 'always polite and helpful, and they treated people with dignity and respect'. And on the occasions they needed to raise a concern they 'feel confident I can raise issues without worry'. One person told us, "All the staff care for you, including the cleaners, who are super." People also told us that staff talked to them and this lifted their mood.

Throughout our observation we saw the staff treated people with kindness and were courteous. Staff approached people in a way which showed they knew the person well. Staff spoke to people at a pace which was appropriate. There were arrangements in place to deal with foreseeable incidents, for example, medical emergencies.

Management of medicines ✖ Action needed

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 safely manage them.

We have judged that this has a minor 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 looked at records about medication. This included how medication was ordered, managed and disposed of.

A pre dispensed system for medication was in use. This means medication is dispensed by the pharmacist in a sealed package, which holds each days medication in a single container. The medication was delivered to the home, from the pharmacist with a printed medication administration record (MAR) which details who the medication is for, what the medication is and how often it should be given. However, some medication, although prescribed, did not have a printed MAR and staff had handwritten the instructions. This, we were told, was because the medication might have 'fallen' outside the monthly cycle and therefore had been dispensed separately or was a temporary treatment, for example a course of antibiotics and therefore was dispensed without a MAR. The homes policy for medication stated that all handwritten MAR sheets should be signed by the person completing it and countersigned. The reason for this was to make sure the information was correct and had been checked by two members of staff, therefore minimising the risk of an error being made. We saw that not all of the handwritten MAR had been signed or countersigned. We also found that a significant number of the handwritten MAR sheets did not include the amounts of medication received. Therefore it was not possible to see an audit trail of the amount of medication coming into and out of the home, meaning medication could not be accounted for.

Some medication was prescribed "as required" or prescribed as a variable dose. However, staff did not always have access to information which told them how they should determine when and how much medication should be given. This is important to ensure people were given their medicines safely and consistently. Also medication detailed as 'one or two tablets to be given' staff were not always recording whether the person had received one or two tablets. Again making it difficult to account for the mediation in stock.

We were told by the manager that only those people who had received training were able to give out mediation. However, it was of concern that some training had lapsed, meaning

staff carrying out this task had not had up to date training or their competency checked.

A small number of people looked after their own creams or inhalers, however all prescribed tablets were dealt with by staff. People we spoke with did not raise any concerns about the management of their medication. Their comments included that staff dealt with them, they did not received medication or that as far as they knew staff handed medication out correctly.

Despite the shortfalls found, appropriate arrangements had been made in relation to the ordering, disposal of medication and the storage of medication.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not fully supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a minor 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 six members of staff, and the manager. We found that not all staff had received recent training or supervision to develop their skills and competency in meeting the needs of the people they supported. The manager confirmed to us that both the mandatory training and staff supervisions had lapsed for the care workers and team leaders. Staff were due to be trained in topics which were relevant to their roles including first aid, safeguarding, fire safety, food hygiene, infection control, health and safety, handling medication and pressure ulcer care. However, this had not been arranged and had fallen behind. New staff had completed an induction programme, but we were told that this was at a basic level and new staff still needed specialist training in subjects such as dementia awareness.

Some staff told us that they did not always feel supported in their role and that staff moral had declined to a 'low' level. They confirmed they were in need of some training in core subjects and that they had not received any formal supervision for 'some time.' Supervision is where staff can talk through any issues about their role or about the people they provide care, treatment and support to with their line manager.

Staff told us that they had attended staff meetings but that these were usually a forum to receive information and that they felt unable to contribute to the agenda or the discussion. This meant that staff were not able to discuss practice issues and for some staff they told us they were not confident in their work, due to the lack of leadership and direction. Some staff also felt that they were criticised for minor things but not praised when they had dealt with their work well. This, they told us, had caused staff to feel unappreciated by the management team.

We noted that there were a number of staff vacancies and that to avoid the use of agency workers, existing staff were working additional hours to cover shifts. Staff told us they preferred to do this as it meant there was a consistency for people using the service, however they did not feel that this could be sustained for long periods of time. Staff were keen to tell us that they enjoyed their work and that had they not 'worked as a team' then

the situation could be much worse. They told us they thought they delivered good care and that people were well looked after, it was a lack of time which meant this was not reflected in the care records.

When asked about the staff employed at Thornton Hill, one person told us, "They [the staff] are all very caring. I wouldn't say even one isn't." They also said, "The manager pops in regularly for a chat, and if I raise an issue it gets dealt with." Another person told us, "The staff I can't fault them. I feel confident and they are approachable." One person told us, "Occasionally the odd one is slightly rude because they have so much to do, and there were not as many staff now as before." They went on to say, "One manager is good, comes into my room to talk and listen to my troubles and tries to deal with it as best she can."

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

People we spoke with were very positive about the home and did not have any complaints. One person told us that if they had a complaint they would, "Just go and tell them [the staff]. I'm not frightened to tell them. They would put it right." However, one person did feel that the communication between staff could be better. They told us that information was not always passed on between staff.

The service has a company complaints procedure and we were told that this was provided to everyone when they arrive at Thornton Hill. People we spoke with could not recall the complaints procedure but everyone told us they were confident in being able to raise concerns and felt this would be dealt with properly by the managers. We looked at the record of complaints for the last twelve months. The complaints received had been dealt with in house and staff had followed the company complaints procedure. There appeared to be an 'open door' atmosphere around complaints and suggestions. At the time of our visit there were no outstanding complaints. The most recent complaint, received in March 2013, had been part resolved and the manager was in contact with the person who had raised it.

The policy, which was displayed, set out clearly what people could expect if they wished to complain about the services provided.

Staff told us what they would do if the received a complaint, they confirmed that senior staff were available during each shift and that they were confident that any complaints would be investigated thoroughly and dealt with properly.

People who raised 'minor niggles' with staff were resolved in house and staff told us these were not formalised as it could involve a minor issue. Staff told us they were keen to engage in a positive way with people they supported and that this made it easier for people to talk to them if they had any concerns or needed information.

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: People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. However, we could not be assured that people always experienced care, treatment and support that met their needs and protected their rights.
Regulated activity	Regulation
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 safely manage them.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**

This section is primarily information for the provider

care	**How the regulation was not being met:** People were cared for by staff who were not fully supported to deliver care and treatment safely and to an appropriate standard.

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 22 June 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.

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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