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: 30 August 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ 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

We carried out this inspection to check whether Thornton Hill had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines
- Supporting workers

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 30 August 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 staff, reviewed information sent to us by local groups of people in the community or voluntary sector and talked with local groups of people in the community or voluntary sector. We used information from local Healthwatch to inform our inspection.

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.

What people told us and what we found

Our inspection of 16 May 2013 found that people did not always experience care, treatment and support that met their needs. 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. Another example of poor recording was in relation to repositioning charts and night time checks. We also found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to safely manage them and that staff were not being fully supported to deliver care and treatment safely and to an appropriate standard.

We found at this inspection improvements had been and that action had been taken to address the shortfalls identified.

One person who used the service told us, "I am quite happy here, staff are very good." Another person told us, "I can't fault them here, I am well looked after." We observed staff supporting people and offering assistance as needed. This was done in a professional, engaging and organised way.

Staff were described as 'friendly and approachable.' Without exception, people gave us the impression that they had good experiences at Thornton Hill.

Prior to this follow up visit we had received information of concern that staff were assisting people to get up at 5 am in order that people were up and dressed prior to the day time staff coming on duty. We therefore arrived at the home at 6:45am.

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

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 ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

This was a follow up visit to assess the improvements made following the last inspection and to check that the time people were getting up was in accordance with their wishes.

We used a number of different methods to help us understand the experiences of people who used the service, which included talking to people, relatives and visitors and reviewing records.

Some people living at the home had complex needs and were not able to verbally communicate their views and experiences to us. Due to this we used a formal way to observe people in this review, to help us understand how their needs were supported. We call this the 'Short Observational Framework for Inspection' (SOFI). Throughout our observations we saw staff treated people in a professional, patient, friendly and appropriate manner. Staff approached people in a sensitive and calm way.

We saw staff used a variety of ways to encourage people to be independent, make daily living choices and maintain their privacy.

We spoke with fifteen people who used the service. They said they were happy with the care and support they received. One person said, "I am really happy living here, I am amongst nice people." Another person said, "The staff are all very good."

Care and support was planned and delivered in a way that ensured people's safety and welfare. We looked at twelve people's care records. Care plans identified people's needs and their preferences, and specified how care should be delivered.

Since the last inspection procedures had been put in place to improve the standard of the recording around fluid and food intake, for those people identified at risk of dehydration or insufficient nutrition, and repositioning charts, for those people who were at risk of developing pressure ulcers. The records we checked were up to date and reflected the

care that people had received.

As part of this inspection we also checked the night records, as these had not previously been completed accurately. We had previously seen 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. On the whole, we found that these were now being completed correctly. We discussed with the care manager where there were anomalies and we were also contacted by the registered manager, who confirmed that action was being taken to address the matter with the individual staff who were not following the procedures.

Daily communication notes were found to contain good information that showed people had received appropriate care and support. There was evidence that other professionals had been involved in assessing and planning care when appropriate.

Staff we spoke with said they had been reminded by the manager about the expectations with regard to record keeping and the importance of keeping records up to date.

Prior to this follow up visit we had received information of concern that staff were assisting people to get up at 5 am in order that people were up and dressed prior to the day time staff coming on duty. We therefore arrived at the home at 6:45am. On arrival at the home there were two people up and dressed in the main house and three people up and dressed in The Manor. The Manor is a unit within Thornton Hill which is set up to specifically care for those who have a diagnosis of dementia.

We spoke to the two people in the main house to establish what time they had been assisted to get up and determine if this was as they wished. One person was clear about their time of getting up and told us, "I like to get up at 5.30 every morning." This person went on to explain that their previous employment had meant daily early rising and that that was what they still liked to do. The second person told us they had got up for the bathroom, had been assisted with this and had chosen to stay up. They were having a cup of tea and toast, 'to put them on' until breakfast was served. We gained the impression that both of these people were up and dressed through choice.

However, it was more difficult to assess whether the people who were up in The Manor had chosen to be, or had been given an option to go back to bed. We looked at the care records for the previous two weeks to identify who had been up before the night staff finished their shift at 7:15am. In the main house there were four people who had been up before 7:15am. However, we noted that a significant number of people had been up on three occasions over the two week period and either one or no people for the remaining days. On two days five people had been up before 7:15am and on one day six people. It tended to be the same people during those periods. We were concerned about this. We determined that if people were being assisted to wash, dress and groom for the day, this task can take in excess of 30 minutes. If 30 minutes was the time taken (which can vary significantly dependent on the individual), therefore for six people to be assisted, this could take up to three hours. Therefore, the first person would be woken to 4:15am. The provider may wish to note that early rising may not be in the person's best interests and that further exploration may be required to make sure routines are not rigid, that people are making choices about their daily living and that individual needs are being fully met.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage the administration of medicines safely.

Reasons for our judgement

This was a follow up visit to assess the improvements necessary following the last inspection.

Appropriate arrangements were in place in relation to the obtaining and storage of medicine. Medicines prescribed for people who used the service were delivered by the pharmacy every month.

Medicines were prescribed and given to people appropriately. The majority of staff had received training in the safe handling and administration of medicines. Some training had had to be rescheduled, due to the organiser cancelling this at short notice. However, there were sufficient staff on each shift who could administer medication, meaning people had access to their prescribed medication. Guidance was available on the administration of 'as required' medicines, for example, painkilling tablets, which were only to be taken when needed. We also found that staff were recording variable dose medications more accurately, meaning the auditing of medication was easier and medication could be accounted for.

The service uses a pre dispensed system for medication. This means medication is dispensed by the pharmacist in a sealed package, which holds each day's 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 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. Since our last inspection, staff had been reminded of the need to follow the procedure and we found that all handwritten MAR sheets were completed properly.

Medicines were being disposed of appropriately. We saw that unused medicines were recorded on the medicines administration chart and stored securely until they could be disposed of correctly.

We were not made aware of anyone who managed their own medication at the time of our visit.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were fully supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We spoke with four members of staff, and the care manager. We found that the majority of staff had received training and 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 been organised. She told us that the majority of care workers and team leaders had received supervision and that other sessions had been booked for those who had missed theirs due to sickness or other absence from work. 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, some of this training arranged had been cancelled by the training organisation at short notice. The manager confirmed that new training events had been scheduled and that attendance would be monitored.

At the last inspection staff told us that moral was low. We received varying views from staff about moral during this visit. Some staff reported some improvement, whilst others still felt that the moral was still low and that it would take time to improve.

We noted that staff meetings had not been well supported by staff and that the manager had rearranged dates and times to optimise staff attendances. We gained the view that senior managers were keen to discuss issues in the service with staff and that they were working towards achieving this.

Since our last inspection some bank staff had been recruited to avoid core staff having to work additional hours to cover the shortfall in staffing levels. This had been well received by staff and we were told that the use of agency staff had reduced over the previous six weeks. Staff told us that despite the difficulties they had experienced with staffing levels, they were still enthusiastic about delivering a good standard of care and that it mattered to them that peoples experiences in the home were positive.

People who used the service talked positively about the staff at Thornton Hill. One person told us, "They [the staff] do their best; they are run off their feet some days." Another

person told us, "The staff care about us, they make sure we are comfortable and well looked after."

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk