Cornerstone Trust

Thicketford Place

Inspection report

132 Thicketford Road
Bolton
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 9 October 2018 and was unannounced. The previous inspection took place on 16 March 2016 when the service was rated good in all domains and good overall.

Thicketford Place is a small care home, providing support for up to six adults with learning and physical disabilities. The provider is a charity organisation, The Cornerstone Trust who set up the home in 1993. A group of trustees oversee its running, with the day to day management carried out by the registered manager. The home is on a main road, in a busy residential area in Bolton. There is good access to local buses and there are nearby shops and other local amenities.

Thicketford Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home can accommodate six people in one adapted building. At the time of the inspection there were four people living at the home. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Safeguarding and whistle blowing policies were in place and staff demonstrated a good understanding of safeguarding issues. They were confident to report any concerns or poor practice they may witness.

Staffing levels were sufficient to meet the needs of the people who used the service and staff recruitment was robust. There were general and individual risk assessments, which were reviewed and updated as required.

Health and safety measures were in place within the home. Accidents and incidents were recorded and addressed appropriately. Robust medicines systems were in place to help ensure safety in this area.

The assessment process for new people to the service was thorough and detailed to help ensure needs could be met. All care files were comprehensive and included relevant, up to date information.

There was a thorough induction for new staff and an on-going training programme. Staff had regular quarterly supervision meetings and appraisals were undertaken annually.

The kitchen was clean, tidy and well-ordered and food safety guidelines were followed. People's dietary requirements were adhered to. The premises were clean and tidy and the building was accessible for people with restricted mobility.

The service was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Communication between staff and people who used the service was friendly, respectful and compassionate. People's dignity and privacy were respected. Various methods were used to communicate effectively with people.

People were supported to express their preference for particular care staff and were supported to access advocates if required. Staff were aware of confidentiality and data protection issues.

Care plans were person-centred, and people were encouraged to make choices and pursue their preferred interests and pastimes. The service provided support for a number of activities and interests that the people who used the service wished to engage in.

Reviews of care were undertaken, and people were supported to be as involved as possible. The complaints policy was prominently displayed on the notice board but there had been no recent complaints.

The registered manager was supported by a finance and administration manager as well as a team of Trustees. There were monthly meetings held where the participants discussed the service and the needs of people who used the service and staff.

Policies and procedures were reviewed annually, and updates and changes made as required. The registered manager regularly checked staff competence and there were a number of audits and quality checks in place at the service.

The service had links to the wider community to help ensure people who lived in the home had a wider support network. There was evidence of excellent partnership working with other agencies and professionals.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safeguarding and whistle blowing policies were in place. Staff were confident to report any concerns or poor practice they may witness.

Staffing levels were sufficient to meet the needs of the people who used the service and staff recruitment was robust.

There were general and individual risk assessments and health and safety measures were in place. Accidents and incidents were recorded and addressed appropriately. Robust medicines systems were in place.

Is the service effective?

Good

The service was effective.

The assessment process was thorough. All care files were comprehensive and included relevant, up to date information.

There was a thorough induction for new staff and an on-going training programme. Staff had regular quarterly supervision meetings and appraisals were undertaken annually.

People's dietary requirements were adhered to. The premises were clean and tidy the building was accessible for people with restricted mobility.

The service was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

Communication between staff and people who used the service was friendly, respectful and compassionate. People's dignity and privacy were respected.

Various methods were used to communicate effectively with people.

People were supported to access advocates if required. Staff were aware of confidentiality and data protection issues.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred, and people were encouraged to make choices. The service provided support for a number of activities and interests that people wished to pursue.

Reviews of care were undertaken, and people were supported to be as involved as possible.

The complaints policy was prominently displayed on the notice but there had been no recent complaints.

Is the service well-led?

Good

The service was well-led.

The registered manager was supported by a team of Trustees. Policies and procedures were reviewed annually, and updates and changes made as required.

The registered manager regularly checked staff competence and there were a number of audits and checks in place at the service.

The service had links to the wider community to help ensure people who lived in the home had a wider support network. There was evidence of excellent partnership working with other agencies and professionals.

Thicketford Place

Detailed findings

Background to this inspection

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

The inspection took place on 9 October 2018 and was unannounced. The inspection was undertaken by one adult social care inspector.

Prior to our inspection we contacted the local authority commissioning team and the safeguarding team. This helped us to gain a balanced view of what people experienced accessing the service. We received no negative comments or concerns.

We looked at notifications received by CQC. We had received a provider information return form (PIR). This form asks the provider to give us some key information about what the service does well and what improvements they plan to make.

During the inspection we spoke with the registered manager and two members of care staff. People who used the service were unable to speak with us, but we observed their body language and staff interactions with them. We spoke with two relatives of people using the service and contacted three health and social care professionals. All the feedback we received was extremely positive.

We looked at all four support plans, three staff personnel records, training records, health and safety records, audits and meeting minutes.

Good

Is the service safe?

Our findings

A professional visitor to the service, who we contacted, told us, "All aspects of safety are covered [at the service], no clutter on the floor for [person] to fall over, wires etc out of sight, kitchen door very hard to open for residents, hand rails in the bathroom, any hot drinks are placed out of [people's] reach. Carers are always on hand if [person] is moving around to make sure they remain safe and steady. No bad practice in the area of safety has ever been observed".

There were comprehensive policies in place for both safeguarding and whistle blowing. Staff we spoke with had undertaken safeguarding training and demonstrated a good understanding of safeguarding issues. They were confident to report any concerns or poor practice they may witness and told us there were flow charts to guide them through the reporting procedure. There had been no recent safeguarding concerns, but systems were in place to log any concerns raised.

The staffing levels were sufficient on the day of the inspection to ensure people's needs were fully met. Rotas demonstrated that enough staff were always on shift and the service used their own bank staff to cover for sickness or leave. When staff left the service, they endeavoured to recruit from the bank staff so that any new employees would already be familiar to the people who used the service. This helped ensure there was as little disruption as possible which was important to people living with autism. A professional visitor to the service told us, "The carers are regular and not bank staff, so this makes for excellent continuity because they all know each other so well".

The staff ratio was the same at weekends as during the week and there was always a 'waking' night staff on duty. The registered manager explained that a 'sleepover' staff member would be put in if any individual was unwell or required some extra input. Staffing numbers were increased during the day to help ensure there were staff to facilitate activities. The service employed a domestic staff member to come in twice weekly to undertake cleaning duties and the care staff undertook day to day cleaning tasks.

Staff recruitment was robust. Files included all required documentation such as interview notes, references and terms of employment. People's employment history was checked, and all staff were subject to Disclosure and Barring Service (DBS) checks to help ensure their suitability to work with vulnerable people.

There were general and individual risk assessments in place which were regularly reviewed and updated. Equipment, such as epilepsy sensors, profiling beds, wheelchairs and stair lift were maintained and serviced as required. Individual risks, such as choking, behaviour that challenges, travelling, finances, road safety, fire safety and hand hygiene, were assessed and measures to minimise the risks documented and put in place.

There was a general health and safety policy, fire policy and fire risk assessment in place. Fire alarms were tested weekly, extinguishers were checked regularly and there was a safe entry and exit system to the building. Fire drills were undertaken regularly. CCTV was in place outside to minimise the risk of intruders. We saw all relevant certificates relating to safety, such as gas and electrical safety.

There was an appropriate accident and falls policy in place and records were kept via body maps, accident books and incident and concern sheets. These were monitored and analysed individually to look at patterns and trends and enable the service to address these. Accident and incident reports fed into person-centred planning meetings, staff meetings, senior meetings, in house reviews and statutory reviews. An overview of all accidents and incidents would be useful to the service to see if any wider themes and patterns were in evidence.

Robust systems were in place around the ordering, storage, administration and disposal of medicines. We saw that medicines were kept in a locked cupboard inside a locked room. A medicines management policy was followed by staff. This included information about covert medicines, that is when medicines are given in food or drink without the person's knowledge, in their best interests, where capacity is an issue. The policy also had guidance around medicines given as and when required (PRN) and homely remedies. One senior member of staff took responsibility for ordering and disposal of medicines and administration was done by two staff, one to administer and one to check, to minimise the risk of errors. A pharmacy advice visit earlier in the year had been positive with regard to all aspects of medicines management.

The service had obtained a food hygiene rating of 5 from environmental health, which is very good. There was an appropriate infection control policy, signed as read by all staff. There was a policy on personal protective equipment (PPE), such as plastic aprons and gloves, to reduce the risk of cross infection. One senior staff member was responsible for ordering PPE. Staff used PPE appropriately and followed good infection control procedures, such as thorough hand washing to minimise any risks around cross infection.

Good

Is the service effective?

Our findings

The assessment process for new people to the service was thorough. One person had left the service since our last visit, due to a change in need. A new person had moved in, but their assessment with regard to the suitability of the service for them had been carried out over a long period of time. This had involved visits by staff to the individual's home and their day care facility, the person visiting the service for short, then longer periods of time, sometimes including a meal. This helped the service assess the compatibility of the person with those people already living in the home and the service's ability to meet the person's needs well. It also provided time for staff to undertake specific training to enable them to meet the person's needs fully. Due to the patience and time given to the process the transition had been very smooth, the person had settled well, and the other individuals had welcomed them. We spoke with a family member of the new person who told us, "[The process] went very well with a few visits. I am very happy with it and [person] has settled well."

All care files were comprehensive and included a photograph of the person, details of health appointments, support levels, information about medicines, routines, communication methods, other professionals involved and meeting details. All records were complete and up to date.

Staff we spoke with told us induction was thorough and this was evidenced within the records. Induction included mandatory training via the Care Certificate. This is a set of standards that care staff are expected to adhere to. The new employee was given a tour of the building, made aware of key policies and procedures, such as fire and health and safety, given the support plans to read and shown specific and general tasks. They then shadowed an experienced member of staff prior to commencing work.

Staff told us there was lots of training on offer and we saw certificates within the staff files. Refresher training for mandatory subjects was delivered regularly. Bespoke training relevant to people who used the service was delivered as required. For example, staff had been trained to deal with epilepsy and had recently undertaken Percutaneous Endoscopic Gastrostomy (PEG) feed training as this was now required. This is when a person is fed via a tube through the stomach.

Staff had regular quarterly supervision meetings where they could discuss issues such as teamwork, rotas, duties, health and safety, policies and procedures and, administration duties. Staff could also highlight any training needs and personal development required. Appraisals were undertaken annually, and these provided staff with the opportunity to reflect on the previous year and plan for the next year.

All the people who currently used the service were unable to communicate verbally, but were able to hear, and all had different methods of communication. We saw that a lot of the information produced was pictorial and easy read so that people who used the service were able to be fully involved with all aspects of their daily lives.

Daily records were completed by each shift with reference to any appointments in the diary, incidents or information to handover. If a person who used the service was admitted to hospital their information kept at the front of the medicines administration records (MAR) went with them to ensure the hospital had all the up

to date information. The registered manager told us that a member of staff always went to hospital with the person and staff stayed with them throughout their time there. This was over and above their duties, but was important to help ensure people's complex needs were understood and to make the experience less difficult for them.

The kitchen was clean, tidy and well-ordered and food safety guidelines, such as testing the temperatures of the cooked food and ensuring the fridge was at the correct temperature, were followed. There was a food safety policy and staff had undertaken food hygiene training. People who used the service were given a balanced diet and drinks were offered throughout the day. Some of the people who used the service had particular dietary needs, such as requiring gluten free food and following safe swallowing guidelines. There was evidence that these requirements were adhered to by all staff. Weights were recorded monthly and food and fluid intake recorded daily to help identify any loss of appetite or change to eating habits. Any concerns were raised with the person's GP.

The premises were clean and tidy the building was accessible for people with restricted mobility, with wide doorways. One doorway had been altered to become double so that it enabled better access. A stair lift had recently been installed to enable one person to access their upstairs bedroom safely and aid others in getting up and downstairs easily and safely. Since the last inspection a new light room had been added upstairs. This had been decorated in a way that was appropriate to people living with autism and had lots of sensory equipment for people to use. The room was set up so that furnishings and equipment could be changed to accommodate each person's needs and to reflect the changing seasons.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff we spoke with had undertaken training in MCA and DoLS and demonstrated a good understanding of the principles of the MCA and the issues relating to DoLS authorisations. Staff were able to give examples of where best interests decisions had been made for people who used the service.

There was a consent to care policy in place and we saw that consent was sought from people who used the service whenever interventions were offered. People's body language or Staff understood people's individual communication methods which enabled them to be sure of the consent being given. We saw evidence of best interests decisions within the care files and DoLS authorisations were in place as required.

Good

Is the service caring?

Our findings

We were unable to speak with people who used the service due to communication difficulties. We spoke with two relatives who were very happy with their loved ones' placements. One told us, "[Relative] has come on so much, a lot happier and eating well. The staff are lovely. I visit and spend quality time with [relative] now". Another said, "I'm perfectly happy with the placement. The place is always clean and tidy and they [staff] communicate well with me". A professional we contacted told us, "The residents are calm, happy and looked after in all respects. The residents are always clean, well dressed and tidy. I have observed meal times when I have arrived early, and the residents are dealt with gently and lots of encouragement is used. Sympathy is given appropriately, when necessary, and I have never heard raised voices. I have never observed bad practice".

There was a relaxed and friendly atmosphere in the home and we observed staff interacting with people who used the service throughout the day. Communication was friendly, respectful and compassionate. We saw that staff reacted to people's moods, wishes and feelings. They did not stick rigidly to plans but were flexible in their approach, depending on the person's needs and wishes at any given time.

People's rooms were personalised with their own possessions and things they liked to have around them. If they needed to be alone or some quiet space, this was accommodated.

Staff we spoke with told us they loved their jobs. They were able to explain how dignity and privacy were maintained for people and we saw evidence of this. For example, people were gently encouraged and supported to return to their rooms and change their clothes if they had spilt food on their clothes.

The registered manager had a British Sign Language (BSL) level 6 qualification, which she used to good effect with people who used the service. We witnessed staff using various methods to communicate effectively with people. The methods included using sign language, pictures, gestures and facial expressions. Staff were very familiar with people's preferred methods and demonstrated patience and kindness in all interactions. The service had a board with photos of all staff and a recording of the person's voice. People who used the service could use this to refer to a particular member of staff if they wished to.

Staff used speech to accompany other methods of communication, as the people who used the service were able to hear and understand some verbal communication. They also used prompts, such as putting out table mats when a meal was about to be served or bringing a coat to indicate an intention to go out.

If a person had a planned admission to hospital they were prepared for this by visits to the hospital, communication with hospital staff and engaging with specialist hospital staff. Relatives and friends were able to visit at any time without making prior arrangements. Families we spoke with were always made welcome by staff and could go into the person's room, in communal areas or out in the garden. Families often took their relatives out for the day and were supported to do this.

There was a religion and beliefs policy and people were supported to follow their own belief systems if they

wanted to do so. People were supported to express their preference for particular care staff if they wished to and we saw evidence of their involvement in person-centred care planning. One person who used the service had an advocate to speak for them whenever they needed this, as their family did not live locally. We also saw evidence that the staff advocated strongly on behalf of people who used the service to help ensure they received all the support they required from all agencies.

The service user guide, with information about safety, services and premises, was produced in an easy read format. This, as with all other publications, could be produced in large print or other languages if required.

Staff were aware of confidentiality and data protection issues. They were all issued with a staff handbook which included information about these areas.

Good

Is the service responsive?

Our findings

Care plans were written in the first person, making them more individual, and included personal information, background history, things that were essential or important to the person and likes and interests. Information such as, '[Person] likes hair bobbles and scrunchies and can indicate which one they want', helped ensure people were treated as individuals. We saw evidence of input by family and friends into care plans to help ensure the information was person-centred.

Reviews of care were undertaken by the individual's social worker after six months at the home and subsequently on an annual basis. The service carried out their own reviews six months after social work reviews so that, effectively, the person's care needs were routinely reviewed on a six-monthly basis. Family members and/or advocates were invited to these reviews and encouraged to have input into the process. The service found that staff from day care facilities were unable to attend these reviews, due to time restrictions, so had ensured they requested a summary from them to help ensure their views were included and any issues or concerns highlighted.

In addition to the reviews there were three monthly person-centred planning (PCP) meetings. The service looked at people's plans and goals, food and exercise, activities, family and friends and physical health. Reviews were produced in easy read format to make them as accessible as possible. The service was responsive to any changes between meetings and happy to hold meetings at any time to accommodate changes.

The service provided support for a number of activities and interests that the people who used the service wished to pursue. We saw that these were individual to each person and included activities such as bowling, bike rides, trampolining, swimming, TV, games, light room, music, day care and trips to garden centres and cafes. Activities were flexible, depending on people's mood and wishes on any particular day and we saw that people were asked what they wanted to do and given alternatives. One relative we spoke with told us, "Care and activities are good. There is no problem if we want to take [relative] home. [Relative] is always nicely dressed and well presented". Another relative said, "My [relative] is perfectly happy and always happy to go back [to the home from an outing]".

The service kept records of activities but were working on a monthly activity plan. This was to help ensure fair access to attention and activities for all people who used the service. One to one time and quiet time was recognised as being just as important as outings and activities and the new light room was being utilised as one way to facilitate this need.

The complaints policy was prominently displayed on the notice board and people we spoke with were aware of how to raise a concern. One relative said, "I have no reason to complain". Another told us, "I would start with the manager if I had a complaint. She is always there, and I can always phone, not a problem". There had been no recent complaints, and an annual satisfaction survey sent out to relatives had reminded people of the procedure. Results of the survey had been positive.

We saw that some training had been undertaken with regard to end of life care, so that people could be supported to stay at the home, if this was their wish, when nearing the end of their life. The local district nursing team would provide support with this as required. The service had an easy read booklet entitled 'When someone dies'. They had used this when one of the people living at the home had suffered a loss, to help support them through this.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A professional we contacted told us, "[The registered manager] loves and cares for residents and staff alike and is very able to meet the differing wide range of needs that the residents have. [Manager] is very knowledgeable about their needs and is able to pass this information and advice on to me and to the carers".

The registered manager was supported by a finance and administration manager as well as a team of Trustees. There were monthly meetings held where the participants discussed the service and the needs of people who used the service and staff and the registered manager told us they were well supported.

The service was a Christian home, though this did not exclude people of any or no faith from using the service. The statement of purpose outlined the service's vision and values of delivering personalisation, inclusion, independence, choice, human dignity and spirituality.

There were regular staff meetings and supervisions, which provided a forum for issues, concerns and suggestions to be raised. An annual survey gave staff and relatives the opportunity to comment on the service delivered and the leadership of the service.

Policies and procedures were reviewed annually, and updates and changes made as required. Similarly, the staff handbook was reviewed and updated annually. The service ensured they kept up to date with good practice via alerts from health and safety, the local council and reading various publications. The registered manager attended provider and partnership meetings which also provided an opportunity to share ideas and good practice examples.

We saw evidence that the registered manager was prepared to challenge other services involved with people who lived in the home, if they felt they were not providing appropriate support. We saw an example of the registered manager having been extremely proactive with regard to another agency. The registered manager had also requested additional funding from the local authority to meet extra needs when a person's day care attendance was reduced. This helped ensure the individual's support to participate in activities would remain consistent.

The service had links to the wider community via two local churches, one of which ran a lunch club attended by some people who used the service. They also linked with the local shops and medical centre to help ensure people who lived in the home had a wider support network.

There were a number of audits and checks in place, including weekly fire alarm tests, medicines checks, care

file audits and premises checks. Staff competence was assessed regularly via observed practice, staff quizzes and within supervision meetings. The registered manager regularly checked staff competence and there was a senior monthly report submitted, regarding tasks and responsibilities completed.

There was evidence within care files of good partnership working with other agencies and professionals. For example, we saw documentation around the involvement of the Speech and Language Therapy (SALT) team, communication with various day care facilities and the community learning disabilities team. The service had recently had reason to work with the NHS district nursing team who were visiting a person who used the service on a weekly basis. This relationship had proved to be very positive. A professional visitor to the service commented, "It is safe to say that I love working with the people at Thicketford Place. Everything I have observed has been positive and engaging for them. This is the best residential care I have seen in the last 12 years".