Care Quality Commission

Solomon Care Limited

Tilsley House Care Home

Inspection report

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Avon
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Tel: 01934419300

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06 February 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Tilsley House Care Home is a residential care home that was providing personal care to 26 people aged 65 and over at the time of the inspection.

People's experience of using this service:

Governance systems were not always used effectively to identify gaps in records or areas that required further investigation.

People received personalised care that considered their individual needs. The registered manager was aware of the needs of people and knew them well.

Recruitment procedures were safe and staff members received training relevant to their roles.

The service worked effectively with healthcare professionals and were involved in pilot schemes and projects to help them improve the lives of people.

People and relatives spoke positively about the care provided by the service.

Safeguarding concerns were identified and appropriate actions were taken to protect people from potential abuse.
Rating at last inspection: The service was rated as 'good' at the last inspection. At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, and good governance. The service was rated requires improvement.

Why we inspected: This was a planned inspection based on the previous rating.

Follow up: We will review the report on actions the provider intends to take following the inspection. We will continue to monitor the service through the information we receive. We will inspect in line with our inspection programme or sooner if required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Care Quality Commission

Tilsley House Care Home

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

The team consisted of two adult social care inspectors, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was unannounced on the first day and announced on the second day.

Inspection site visit activity started on 5 February 2019 and ended on 6 February 2019.

What we did:

We reviewed various records including, the training matrix, recruitment files for three employees, four care plans, records of safeguarding incidents, programme of quality audits, compliments and complaints, questionnaires and staffing rotas. We spoke with eight people who were using the service, two relatives and five staff, including the registered manager, deputy manager and activities coordinator.

After the inspection, the service submitted additional information about the actions taken in response to our findings. This included a team meeting, reviewing documents and additional training for staff.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people were not consistently assessed or monitored. For example, one person had been recorded as drinking less than 100ml of fluid in 48 hrs and this had not been identified or actions taken. This indicated the person may be at risk from dehydration. The registered manager told us that this was a recording error and contacted us after the inspection informing us of plans to provide all staff with additional training about how to correctly record fluid intake.
- There were eight radiators in the home that did not have radiator covers to reduce the risk of burns to people. The service had been working to cover all radiators throughout the service since 2017. However, during our inspection six of the uncovered radiators that we touched were very hot. Risk assessments were in place although these did not consistently include actions that could be taken to minimise potential risks to people.
- Risk assessments were in place although these did not consistently include actions that could be taken to minimise potential risks to people. For example, one radiator did not have a radiator cover and the risk of the person being burned was assessed as 'low'. However, it did not include details of actions that should be taken to decrease the risk of a burn until the radiator was covered, such as ensuring the temperature of the radiator was turned down. This meant that people remained at potential risk from harm.
- The door to the laundry was unlocked and there were cleaning products and a trouser press that were accessible to people. This meant that some people were at risk of potential harm from chemicals or a burn.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection, we saw evidence that all radiators had been made safe.
- The registered manager contacted us after the inspection and told us senior staff were undertaking regular checks to ensure the door to the laundry was locked.

Preventing and controlling infection

- The home looked clean and was free from malodours. One relative said, "The staff work very hard to keep everywhere clean and tidy, just like a home should be." Comments from people included, "Everything is spic and span here, look around." and, "The home is clean and tidy. I make a mess in my room, but they come in and clean and tidy it up for me."
- We observed domestic staff undertaking cleaning duties and care staff changing their aprons and gloves. Comments from relatives included, "I have seen the staff wearing aprons and gloves when attending to the

residents."

● There was an area of flooring in a communal bathroom that had deteriorated, which posed an infection risk as it could not be cleaned effectively. We brought this to this attention of the registered manager and were contacted after the inspection and advised that the flooring would be replaced.

Systems and processes to safeguard people from the risk of abuse

● There were systems in place to protect people from the risk of abuse and actions were taken to keep people safe. The registered manager was aware of actions they should take if abuse was suspected or proven. This included alerting the police, making a referral to the disclosure and barring service (DBS) and working with the local safeguarding team. The DBS maintains a list of people who are unsuitable to work with vulnerable adults, when checks are made with DBS this information is available and should prevent unsuitable people from working with vulnerable adults in the future.

● Staff we spoke with told us confidently about the actions they would take if abuse was suspected or observed. Comments included, "I would report it" and, "[I] would report concerns."

● People told us they felt safe. Comments included, "I feel safe here they (pointing at the staff) keep me safe" and, "I feel safe here, I spend a lot of time in my room, but the staff come around and see me all of the time, when they are passing they often pop in to just to see that I am alright."

Staffing and recruitment

● The service managed to maintain safe levels of staffing according to their assessment of peoples' needs. The registered manager and deputy manager were involved with the delivery of care when the need arose.

● People told us there were enough staff to meet their needs. Comments from people included, "There is plenty of staff around here to keep me safe, they keep an eye on me day and night, nothing to worry about here" and one relative said, "My [relative] is very safe here, they have Dementia and their memory is very poor and they forget everything, there is always plenty of staff around here to keep her safe, when I am at home I never need to worry."

Using medicines safely

● The service managed medicines safely. There was a prescribe as needed protocol (PRN) in place and staff we spoke with described how they would ask people if they needed their PRN medicines. If people could not communicate they needed their medicines a pain tool was used to assess if the person was in pain and medicines administered appropriately.

● The service used body maps to record where on a person's body a certain cream should be applied, and creams were dated by staff when opened.

● People told us their medicines were managed safely. Comments from people included, They [staff] bring me my tablets every day and my eye drops" and, "I am brought a week's supply of my tablets every week, I put them into this box and then I take them myself when they are due."

Learning lessons when things go wrong

● The service reviewed accidents and incidents for themes and learned lessons when things went wrong. For example, staff had administered medicines that had been discontinued by the GP. The service worked to review and implement a new procedure for managing medicines that had been discontinued, including removing discontinued medicines from the medicines trolley so that they were not accessible to staff.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found that the service had applied for a DoLS where appropriate and had sent updates as required.

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed and the assessments we viewed were comprehensive. The assessments included details about illnesses that a person was living with and how these may affect them. For example, one person had been diagnosed with dementia and was experiencing hallucinations that may cause the person to, "Reach out for objects that are not even there."
- Assessments included details about preferable outcomes and how these outcomes could be achieved.
- Care plans required staff to support the development of romantic relationships between people if both people had the capacity to make this decision.

Staff support: induction, training, skills and experience

- Staff received the correct training and experience to be able to meet the needs of people. Training that staff received included, moving and handling, first aid and safeguarding training. We observed staff receiving manual handling training during our inspection and comments from people included, "The staff appear to know what they are doing, they must get some training I think."
- Staff we spoke with told us they were well-supported and could ask questions if they were not sure. Comments from staff included, "I'm really happy here. If I don't know, I ask, you've got to ask questions" and, "Residents are well looked after, I would report concerns 100%."
- Staff received regular appraisal and supervision sessions, these sessions were used to identify areas for development and to offer staff support.

Supporting people to eat and drink enough to maintain a balanced diet

● People spoke positively about the food. Comments from people included, "I am a non-meat eater, I still get a good choice as to what I would like to eat, at night if I am peckish I can ask for a sandwich." and, "The food here is very nice, I get plenty to eat all of the time, we get biscuits in the morning and cake in the afternoon as well, nice."
● Most people ate their lunch in the dining room and the tables each had a table cloth, flower arrangement and the menu. Some people were unable to attend the dining room and staff visited these people in their rooms to assist them with eating their food.

Staff working with other agencies to provide consistent, effective, timely care

● The service worked with healthcare organisations and professionals to achieve good outcomes for people. One healthcare professional said, "If there is a problem, they're on the phone" and, the service "Recognise when their residents' health needs are changing and are able to act accordingly."

Adapting service, design, decoration to meet people's needs

● The service had a lift and there were specially adapted baths for people with reduced mobility.
● The garden was accessible to all people as there was a ramp that made it wheelchair accessible.
● People were able to personalise their rooms and had their own pictures, ornaments and flowers on display. Comments from people included, "The home is very homely and clean and tidy all of the time" and, "The staff work very hard to keep everywhere clean and tidy, just like a home should be."

Supporting people to live healthier lives, access healthcare services and support

● During our inspection we observed healthcare professionals visiting people, including a psychiatrist and district nurse.
● The service made referrals to healthcare organisations and professionals when required. For example, the service had made a referral to the falls team when a person had an increase in the number of falls they were having.

Ensuring consent to care and treatment in line with law and guidance

● People told us staff always asked for their consent. Comments from people included, "The staff always ask if it is okay to do anything, they always ask and I always agree" and, "The [staff] are very free and easy, you can do what you like, but if you need help they will come running as soon as you ask."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People told us they were well cared for. Comments from people included, "The staff here have a very good caring attitude, they take time to sit and listen to you" and one relative said, "The staff here are wonderful, caring people, they are kind towards everyone."
- Relatives and people told us everyone was treated equally. One relative said, "The staff are very kind and caring towards everybody, they make everyone feel welcome, sometimes I bring my elderly parent in to see my [relative's name] they make them feel welcome as well. With a cheery hello and an offer of a cup of tea" and comments from people included, "The staff are kind towards me and everyone else, even the difficult moaning ones, we are very relaxed here, we laugh a lot, a big happy family."

Supporting people to express their views and be involved in making decisions about their care

- The service had identified that care plan reviews had not consistently included the person or their relatives. A new schedule had been introduced and the service was working to undertake reviews of care plans with all the people using the service and their relatives.
- Staff members respected the choices that people made and talked confidently about how they would encourage people to make decisions. For example, one staff member told us that even though people may be living with dementia, "[They] can still make choices."

Respecting and promoting people's privacy, dignity and independence

- We observed people being supported in a dignified way that respected their privacy. For example, when people were being supported with equipment a blanket was placed over the person's legs, this meant that when a person was wearing a skirt, they were not exposed to others.
- Staff knocked on people's doors before entering their rooms and asked for permission to enter.

Good

Is the service responsive?

Our findings

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People told us they had control of their lives. Comments from people included, "I can choose what I want to do, when I want to do it and what I want to eat…" and, "I like to have a smoke, so I have to go outside, I don't have to ask can I go, I just have to tell them I am going, choices of the food I eat are very wide, never given anything I don't like."
- Care plans included details about people's preferences, likes and dislikes. For example, one care plan said, "I often sit during the day with a lady called [person's name], we sit at the table for our meals together and sit in the lounge together. I enjoy her company and we seek each other out but if anybody asked me who she was I would not be able to tell you. " This information meant that staff could help the friends to find each other, even if the person was unable to tell staff who they were looking for.

Improving care quality in response to complaints or concerns

- Complaints and concerns were responded to honestly and where appropriate a written apology was provided. Comments from people included, "I know how to complain and raise issues, I have seen and fully understand the complaints policy, but I cannot think I would never need to use it." One relative said, "The manager's name is xxx they are very open and friendly, you can talk to them at any time, I have been asked to provide my comments on the home, all good I have to say, I often speak to the manager when I come in, and in the past I have rung them up on the phone."
- All complaints and concerns were logged on a 'complaints log' and this was used to record the timescales for response, actions taken and outcomes. This meant the management team could analyse complaints for trends.

End of life care and support

- The service worked to help people have a dignified and peaceful death. End of life care plans recorded people's wishes and details of relatives who should be contacted and when. For example, one person's care plan included information that the person's son could be contacted 24 hours a day if the person was nearing the end of their life.
- When a person was receiving end of life care the service would increase the staffing levels to meet the person's needs. One member of staff said they had recently, "Sat with [person's name] while [they] passed on".

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Governance systems were not always used effectively to identify gaps in records or areas that required further investigation. For example, records that were used to detail how much fluid people had consumed had indicated that people were not receiving or being offered adequate amounts of fluid. This had not been identified and no actions had been taken. This meant that people may be at risk of dehydration.

We recommend the service reviews governance systems in line with published guidance so that they are more closely aligned with the electronic care planning system.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● Care was planned to be personalised to people's needs and reflect their preferences. For example, one care plan recorded that a person wished, "To be as independent as possible with all washing and dressing [and] to verbally request clothing and shoes from staff." This meant that the person was able to retain some control of their life.
● The management team spoke honestly with us and were receptive to feedback that we provided, this included telling us about actions that would be taken in response to our findings.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The service held meetings with relatives and people to hear their views and actions were taken because of these. For example, in one meeting people had discussed having a piano at the service. During our inspection we observed a person playing the piano and singing songs to people.
● People, staff and healthcare professionals were given questionnaires, and these focussed on areas such as safety, resources available and if the service was caring. The completed questionnaires were reviewed to identify if actions needed to be taken because of the feedback submitted.
● The service was proud to have been involved with the filming of a T.V documentary that aimed to, "Improve the image of social care, encourage young people into care and change the stigma of care work to help promote best practice within the care industry.

Continuous learning and improving care

- The service had been involved in initiatives that focussed on improving outcomes for people who were receiving care. For example, the service had assisted people to enter a competition to personalise their walking frames with decoration. A person using the service won the competition and the initiative had resulted in a decrease in the number of falls being experienced. One healthcare professional said, "The [registered manager and deputy manager] demonstrate good leadership and are keen to develop the care home. They regularly attend our care managers meeting and are actively involved with all the audit / national awareness weeks and pilots that we implement."
- The service was proud to work with a local college helping to provide young people with work experience. In 2018, Tilsley House Care Home was shortlisted for the, 'work experience provider of the year award.

Working in partnership with others

- The service was working with healthcare professionals and organisations to improve the lives of people. For example, the service had been involved with healthcare professionals who were undertaking an audit that identified people with undiagnosed atrial fibrillation, a condition that can affect the rate of a person's heartbeat. The audit had helped the service to identify people who had this condition and who were undiagnosed, prompting a referral to the GP. This meant that people could receive a formal diagnosis and the correct treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not consistently assessed or monitored.