Thornwood Care Limited

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Inspection report

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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

This inspection took place on the 16 November 2018 and was unannounced.

Thornwood 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.

Thornwood is a care home providing accommodation for up to 16 people with a dementia type illness. There were 15 people living there at the time of our inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The service had a registered manager in place. 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.

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made. Care plans reflected people's assessed level of care needs and care delivery was person specific, holistic and based on people's preferences. Risk assessments included falls, skin damage, behaviours that distress, nutritional risks including swallowing problems and risk of choking, and moving and handling. Pressure relieving mattresses and cushions were in place for those who were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes. Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns. Staff had a clear understanding of making referrals to the local authority and CQC. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home. People said they felt comfortable and at ease with staff and relatives felt people were safe.

Staff had received training to ensure they provided safe and effective care and there were opportunities for additional training specific to the needs of the service. This included the care of people with specific health needs such as diabetes and dementia. Staff had formal personal development plans, including two monthly supervisions and annual appraisals. The provider assessed people's capacity to make their own decisions if there was a reason to question their capacity. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought

consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People were very complimentary about the caring nature of staff. People told us care staff were kind and compassionate.

A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. Activities were provided throughout the day and were developed in line with people's preferences and interests. Staff had received training in end of life care supported by the Local Hospice team. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. The service worked well with allied health professionals. People and their families knew how to raise any concerns they had and were confident these would be responded to

Staff spoke positively about the provider and registered manager and felt supported. There were systems to seek people's views about their care, and the management of the home. The provider had systems to monitor the quality and safety of the service provided. Staff said they were encouraged to suggest improvements to the service. Relatives told us they could visit at any time and, they were always made to feel welcome and involved in the care provided.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Thornwood remains Good.	**Good**
Is the service effective? Thornwood remains Good.	**Good**
Is the service caring? Thornwood remains Caring.	**Good**
Is the service responsive? Thornwood remains Good.	**Good**
Is the service well-led? Thornwood Remains Good.	**Good**

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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 checked 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.

This inspection took place on the 16 November 2018 and was unannounced. The inspection team consisted of an inspector 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.

Before the inspection we reviewed the information we already held about this service. This included details of its registration, previous inspection reports, action plans and any notifications they had sent us. Notifications are information about significant events the provider is legally obliged to send to the Care Quality Commission. We also reviewed the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority with responsibility for commissioning care from the service to seek their views. We spoke with and received correspondence from three visiting health and social care professionals, which included, speech and language therapists, dietician and a social worker.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore, we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with 13 people that used the service and seven members of staff: registered manager, deputy manager, cook/activity co-ordinator and five care staff. We reviewed four sets of records relating to people including care plans, medical appointments and risk assessments. We also 'pathway tracked' four people living at the home. This is when we followed the care and support a person has received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We looked at the staff recruitment and supervision

records of four staff and the training records for all staff. We looked at medicines records for all the people and minutes of various meetings. We checked some of the policies and procedures and examined the quality assurance systems at the service.

Good

Is the service safe?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

People told us they felt safe and secure living at the home. One person told us about feeling safe, "Absolutely yes, no reason to think otherwise." Another person said, "Oh yes I feel safe here."

The provider continued to protect people from avoidable harm, abuse and discrimination. Staff had received training in, and understood, how to recognise, respond to and report abuse. They told us they would immediately report any abuse concerns to the management team. Staff were also aware of whistle-blowing procedures and felt confident raising any concerns. The manager understood their responsibilities in reporting and dealing with concerns to ensure people remained safe.

Individual risk assessments had been implemented, reviewed and updated to provide sufficient guidance and support for staff to provide safe care. Risk assessments for health-related needs were in place, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw where necessary, people had the mobility equipment supplied to help them maintain their independence. Any accident and incidents were recorded and monitored so lessons could be learned and help prevent further occurrences.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

People told us there were enough staff to keep people safe and meet their needs. People were protected from infection through staff being knowledgeable about infection control measures. We saw staff wore personal protection equipment during the delivery of personal care and whilst serving people's meals. A relative told us, "The home is always clean, warm and smells nice." One person told us, "My room is lovely and clean."

Staff confirmed employment checks were carried out on their suitability to work at the home before they commenced their employment. Records showed that Disclosure and Barring checks (DBS) were completed before staff started work, so people were protected by the provider's recruitment arrangements. This check helps employers make safer recruitment decisions and prevents unsuitable people from being employed. We saw the provider had also obtained employment and personal references to further check the staff's suitability to work at the service.

People told us they always received their medicines and were happy for staff to support them with these. One person told us, "Yes. I get my medicines regularly." We checked the provider's system of recording and administering medication. Medicine records were up to date and we saw medicines were stored securely. People's medication administration records (MAR) showed the medicines they had been prescribed and recorded whether they had been administered or the reasons for non-administration. The provider had up to date medicine policies, procedures and protocols which included 'as required' medicines (PRN) and covert medicines. The protocols for PRN pain management medicines gave clear guidelines as to when they be required. Records were up to date with no omissions.

Good

Is the service effective?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. People told us that they felt that staff had appropriate and relevant skills to meet their needs. One person said, "I think they are well trained, seem to know what they are doing." Staff had completed most essential training and this was updated regularly. In addition they had undertaken training that was specific to the needs of people they supported. For example, dementia awareness. Staff's competency was also assessed through direct observations following training.

Staff received regular supervision. Supervision included an opportunity to discuss training, development opportunities, and review practice. Staff told us they felt supported by the management team and they felt confident to approach them to discuss concerns.

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 whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. People that could, commented they felt able to make their own decisions and those decisions were respected by staff. People told us, "They ask me first and then help me, if I need it" and "Always knock on my door before coming in." Staff had received training and understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice.

Mental capacity assessments and best interest decisions had been completed for care and treatment, for example, bed rails and life changing choices about medical treatment and intervention or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted.

People's needs were assessed and care, treatment and support was delivered in line with current legislation and evidence-based guidance that achieved effective outcomes. People's skin integrity and their risk of developing pressure wounds had been assessed to identify which people were at risk of developing pressure wounds and action taken included sourcing appropriate equipment to relieve pressure to their skin, such as specialist cushions and air mattresses.

People told us their health was monitored and when required external health care professionals were involved to make sure they remained as healthy as possible. People's health needs were supported by a local GP surgery. Where required, people were referred to external healthcare professionals; this included the dietician, tissue viability team and the diabetic team. People were regularly asked about their health and services such as the chiropodist, optician and dentist were offered.

People were supported to have a nutritious diet and sufficient drinks to meet their needs. People told us the food was good. Comments included "Lovely Food" and "Plenty of choice always nice.". People told us their favourite foods were always available, "I like all the food here." People were offered varied and nutritious meals which were freshly prepared at the home. Menus were displayed throughout the home and on tables which meant that people knew what was on offer each day.

People's individual needs were met as the premises was purpose built. All communal areas of the service were accessible via a lift. Communal areas were large and comfortable. There were adapted bathrooms and toilets and hand rails to support people. Visual aids in communal areas helped to support orientation of people with dementia to move around the home and increase their awareness of their environment. Signs were available to help people or visitors navigate around the home and find essential rooms such as WC's. People had unrestricted access to a courtyard garden which was safe, fully enclosed and provided level access and various seating options.

Good

Is the service caring?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

People told us that staff were kind and caring. One person said, "Really like the staff, they are very kind and patient, they are like my family." Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Always welcoming and make time to talk with us. All the staff are kind, friendly and easy to talk to." One staff member said, "We all work hard to make it their home, caring is what we do really well, there a lot of laughter here."

People were treated with kindness and respect and as individuals. It was clear from our observations staff knew people well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying, "Good morning, would you like some help," and "Would you like to come with me to your bedroom and I can help you."

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. This showed staff understood the importance of privacy and dignity when providing support and care.

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. One person said, "They treat me as an individual, I can be myself."

Staff promoted people's independence and encouraged them to make choices. We saw those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. Comments from staff included, "We let people to make their own decisions if they can, if someone doesn't want to do something then we go back later."

People's rights to a family life were respected. Visitors were made welcome at any time. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the days of our visits. One relative told us, "We are always welcomed and feel at home, tea, coffee and cake is always offered."

People could express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw ideas and suggestions were taken forward and acted on. For example, menus, activities, trips out and laundry services.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

Good

Is the service responsive?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

People were involved in developing their care, support and treatment plans as much as they wished to. A senior staff member said, "We try to involve people all the time in how they want their care delivered, sometimes we have to rely on families." One person said that staff did discuss their care with them regularly.

People's needs had been assessed before they moved into the home, to ensure they could provide the support and care needed to meet their needs. Records confirmed people and their families or representative had agreed with the information recorded, as well as consent for photographs, sharing the information with external professionals and for reviews of their care plan.

Staff undertook care that was suited to people's individual needs and preferences. The care delivery was person specific and in line with people's preferences. For example, what they preferred to eat and drink, what time they got up and what time they returned to bed. For people unable to tell staff their preferences we saw staff had spoken with families and friends. Staff told us, "Care plans change with the persons' needs. From the records reviewed care plans had been reviewed regularly and updated when people's needs changed. Staff were kept up to date with changes in people's needs and the services provided through the handovers at the beginning of each shift. In addition, any significant information was recorded in a log that was passed on to the next staff team.

The staff team had a good understanding of the Accessible Information Standard and discussed ways that they provided information to people at Thornwood. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Staff told us of pictorial methods used for some people and of how this enabled people to make choices. For those who had a visual impairment staff used large print and said they could provide information on tape so people listen to the information.

Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. We looked at the care plan for one person who was approaching end of life care. The documentation had reflected care had been adjusted for this stage of their life. It emphasised the need for constant monitoring of pain and of ensuring food and fluids should be offered regularly in small amounts.

Activities at Thornwood were planned and tailored to meet peoples' preferences and interests as much as possible. We were told that the format of activities may change on the day depending on who chose to attend and how many. A programme of events was displayed in the communal areas of the home. These included one to one sessions, exercises, quizzes, craft sessions and musical and film sessions. During our inspection we saw a number of activities taking place and enjoyed by people. One person said they liked

helping the staff by doing hovering and laying tables. This made them feel useful. They also said they went out shopping locally and to visit their family.

Regular staff and resident/family meetings are now being held, times of meetings were displayed and details of suggestions and discussion points were recorded and actioned. For example, meal choices.

The provider had established an accessible effective system for identifying, receiving, recording, handling and responding to complaints. A complaints procedure was displayed in the reception area of the home and in other communal areas. A complaints log is kept and monitored by the registered manager. There was evidence complaints were fully investigated, responded to, apologies given if there was a need to with actions they were going to take.

Satisfaction surveys had been sent out regularly in respect of getting feedback on the service. These were collated and the survey outcomes shared with people families and staff. The actions to be taken were also shared. One visitor said, "I give feedback all the time."

Good

Is the service well-led?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

Effective management and leadership was demonstrated in the home. The ethos of the home was embedded into how care was delivered and the commitment of staff to provide good quality care and person specific care. The registered manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was apparent staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Care was personal to each person and staff clearly focused on the individual and their qualities.

The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open and friendly, by people and staff. Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns. Comments from staff included, "Vey open management style I feel that I can approach any of the management team about anything," and "The management team work with us and I know that if I was worried or saw something not right I could talk to any of them."

Quality monitoring systems had continued to be developed and embedded since the last inspection. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so quality of care was not compromised. Areas for improvement were on-going such as care documentation. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned, such as laundry service and menu choices. Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. As discussed there were areas of audits that would benefit from further evaluation as to whether actions taken to address an identified issue were beneficial and had worked.

Systems for communication for management purposes were established and included a daily meeting with staff. These were used to update senior staff on all care issues and management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The manager is open to suggestions, staff meetings give us the opportunity to raise issues and solve problems."

Relatives felt they were able to talk to the manager and staff at any time and the relatives meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it."

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked

with them and this ensured advice and guidance was acted on by all staff. Comments received included, "The staff are knowledgeable about the people they care for and want to get it right" and, "They listen, take advice and act on the advice."

The service had notified us of all significant events which had occurred in line with their legal obligations.