Mrs S Poordil and Mr M Poordil

Thornfield Care Home - Lymington

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

Thornfield Care Home is owned by Mr and Mrs Poordil who are throughout this report referred to as the provider. The home is located in a residential area, approximately one mile from the centre of Lymington. It can accommodate up to 17 people. The accommodation is arranged over two floors with a stair lift available to access the upper floor. On the ground floor there is an open plan living/ dining area from which there is access to the kitchen, laundry and the office. Four of the rooms were shared rooms. There is a large, mature garden with seating areas. The home does not provide nursing care. There were 16 people living in the home when we inspected, some of whom were living with dementia.

At the last inspection in April 2015, the service was rated good. At this inspection we found that the service remained good.

The service had a registered manager who was also the registered provider. 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 and associated Regulations about how the service is run.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

Safe recruitment practices were followed and there were sufficient numbers of experienced staff to meet people's needs.

People were supported by a staff team that received the training, supervision and support that they needed to provide people with care and support that met people's needs.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this in practice.

Improvements were planned to update aspects of the premises and make the design and layout of the home more suitable for people living with dementia.

People told us the food was tasty and that they were supported to have enough to eat and drink.

People told us they were supported by staff that were kind and caring and that they were treated with dignity and respect.

Care plans contained the information needed to support staff to provide people's care in a manner that was responsive to their individual needs.

People were supported to take part in activities which they told us they enjoyed.

People spoke positively about how well organised and managed the service was.

There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving appropriate support.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Thornfield Care Home - Lymington

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 the 29 June 2017 and was unannounced. The inspection team consisted of one 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 all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. We used this information to help us decide what areas to focus on during our inspection.

Some people were not able to speak with us and share their views about the care and support they received; however, we spent time observing interactions between people and the staff supporting them. We were able to speak with five people who used the service and three relatives. We also spoke with the registered manager, the provider, and three care workers. We reviewed the care records of three people in detail and the recruitment records for four staff. We also reviewed the medicines administration record (MAR) for all 16 people. Other records relating the management of the service such as audits, meeting minutes and policies and procedures were also viewed. Following the inspection we sought feedback from four health and social care professionals.

The last inspection of this service was in April 2015 when we found all of the essential standards of quality and safety were being met.

Good

Is the service safe?

Our findings

People told us they felt safe living at Thornfield Care Home and this was echoed by their relatives.

Suitable arrangements were in place for ordering medicines and relevant checks were made to ensure that these were supplied correctly. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. We observed staff undertaking a medicines round. They assisted people with their medicines in a person centred manner. Medicines were stored safely and the temperature records for both the trolley and the medicines refrigerator were being recorded on a daily basis. We carried out a stock check of Controlled drugs. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. The CD register tallied with the medicines being stored in the CD safe. Staff responsible for the administration of people's medicines had received training in how to do this safely and their competency to administer medicines was now being checked on an annual basis. During this inspection, we made some recommendations about how staff might more clearly record the administration of creams, food supplements and food thickener. The registered manager has confirmed since the inspection that these recommendations have been acted on.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. They had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff were confident the registered manager would take action to address any concerns about a person's safety or any allegation of abuse. Staff were aware of the provider's whistleblowing policy and were confident that they could raise concerns with the registered manager who would take action.

Assessments were undertaken to identify risks to people's wellbeing. For example, people had; moving and handling risk assessments, falls risk assessments and assessments which identified whether they might be at risk of poor nutrition or of experiencing skin damage. Where risks had been identified, measures were in place which helped to ensure that the risk was minimised. For example, where people were known to be at risk of poor nutrition, they had been referred to their doctor and placed on food and fluid charts so that their food intake could be monitored. Staff supported people to take positive risks. For example, one staff member told us, "Supporting a person to walk is positive risk taking. It would be easier to hoist the person and move them in a wheelchair but that is not in their best interests". A range of environmental risk assessments were also in place and helped to ensure that the home remained safe for people and staff.

There were sufficient numbers of staff deployed to meet people's needs. In addition to the registered manager and provider, morning shifts were currently staffed by three care workers, one of whom was a senior care worker. There were two waking care staff on duty at night. We reviewed the staffing rotas for a four week period and found that the service had been staffed to these target levels. Rotas also showed that care was provided by a small and consistent staff team which helped to ensure that people were cared for by staff who knew them and their needs well. This was confirmed by a relative who told us, "It's always the same faces on duty". A number of ancillary staff were also employed including a chef, a maintenance person and housekeeping staff. The service did not employ staff specifically to oversee the laundry or to provide

activities or entertainment and this remained the responsibility of the care staff. People did not raise any concerns with us about staffing levels. They told us they could choose when to go to bed and when to get up and that the staffing levels supported this. We observed that staff were able to provide support to people in an attentive and timely manner and were able to carry out their role and responsibilities effectively. For example, when people with mobility problems stood to walk without assistance, staff were on hand quickly to assist them to avoid the risk of falls.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. These measures helped to ensure that only suitable staff were employed to support people in their homes.

Staff were provided with range of equipment to help ensure good infection control such as gloves and aprons and we observed that they were using this personal protective equipment effectively and following good infection control practices.

Good

Is the service effective?

Our findings

People told us they received effective care which met their needs. One person said, "The staff know what they are doing and the way I like things done". A visitor told us, "The home has a very good reputation and it is well founded, I always enjoy visiting". Another visitor said, "I'm really impressed, the staff are lovely, the owners are always there, its always clean and tidy, nothing is too much trouble, I wouldn't have any qualms about putting a relative of mine there". A relative told us how staff had "Brought out the best" in their family member. They said, "What they do is amazing…they could not do a better job". A social care professional told us that they felt staff managed people's needs well. This was echoed by a healthcare professional who told us, "I have had patients at Thornfield who have been extremely frail, at risk of all sorts of problems, looked after until the end of their lives....They also seem able to deal very well with behavioural problems associated with dementia".

Staff sought people's consent and acted in accordance with their wishes. For example, we heard staff asking people if they would like help to eat their cereal or whether they would like to come to the dining room for their lunch. People were asked how they would like to take their medicines, for example, we heard a care worker say "How would you like to take your tablets with juice or water?" One person told us, "The staff always ask me before they help me".

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. Policies and systems in the service supported this in practice. There was evidence that people's capacity to consent to their care and treatment was considered and, where required, mental capacity assessments had been undertaken to assess whether people could consent to the care and support being provided. The Mental Capacity Act 2005 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. Staff had a good understanding of the Mental Capacity Act 2005 and its main principles. One staff member told us how every person could make some decisions and that it was their responsibility to support them to do so. Where people had appointed an attorney to manage either their finances or to make decisions about their health and welfare, copies of these documents had been retained by the service. We did note that some of the care plan documentation incorrectly stated that relatives or advocates had consented on people's behalf to sharing information or to the care plan for example. The registered manager agreed to ensure this was updated to reflect the content and outcome of the mental capacity assessments which had been undertaken by the service.

People can only be deprived of their liberty to 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). Relevant applications for a DoLS had been submitted by the home and had either been authorised or were waiting to be assessed by the local authority.

Thornfield Care Home provided a comfortable and homely environment. It was clean and there were no

malodours. However, some aspects of the home's décor would benefit from being updated. The provider recognised that the environment needed to be upgraded and there were plans in place to extend and adapt the building. There were however no clear time scales for this to be completed due to difficulties planning how this would be achieved without impacting upon the people using the service. In the meantime, it was evident that the provider continued to invest in the service and had recently fitted new carpets and brought new lounge and dining room furniture. Where people required additional equipment to meet their needs, this had also been purchased. For example, a specialist bed had been bought for one person.

People were supported by a staff team that received the training, supervision and support that they needed to provide effective care. Existing staff had completed an induction in line with the common induction standards and new staff were now being supported to complete the Care Certificate. This was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. Staff completed training in a range of topics which included moving and handling, safeguarding people from harm, infection control, health and safety, fire safety, first aid and food hygiene. Some staff had additional training relevant to the needs of people using the service such as caring for people living with dementia or diabetes. Staff were soon to undertake training in managing behaviours that might be challenging to others. Staff were encouraged to access a range of nationally recognised qualifications in health and social care to further enhance their knowledge. Supervision took place on a regular basis and provided staff with an opportunity to discuss any concerns they might have regarding their role or the people they cared for.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks. We observed breakfast which was a variety of cereals or porridge and toast. One person was enjoying a boiled egg and another asked for a specific cereal which the cook said she would try and get. People were given a choice between two main meals at lunchtime, or could also ask for an alternative such as an omelette if they wished. Supper was either soup or a light meal such as macaroni cheese. A selection of hot and colds drinks were available throughout the day and people were supported to maintain good hydration. The food looked and smelled appetising and those people we spoke with told us they enjoyed the food provided. One person said, "The food is very good and cook will always do something if I don't like what is on offer". People's weight was monitored regularly to assist in identifying whether they were at risk of malnutrition. Where people had lost weight this information was shared with the GP so that remedial actions could be taken.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's support to ensure this was delivered effectively. People had regular visits from their GP and from other healthcare professionals such as community nurses, chiropodists and opticians. Staff were vigilant of changes in people's health and we were able to see from people's records that GP's were consulted in a timely manner.

Good

Is the service caring?

Our findings

People told us they were cared for by staff who were kind and caring. One person said, "The staff are caring and lovely, it is like one big family". Another person said, "They [the staff] are great, they always go the extra mile". The caring nature of staff was also commented on by relatives, with one saying, "I would like to be cared for the way my mum is cared for here". Another relative told us the staff were, "Very happy, smiley and caring people". A healthcare professional told us, "The staff are always kind and caring to the people they look after".

Our observations indicated that staff showed people kindness, patience and respect and offered people lots of praise and gentle encouragement. We saw a considerable number of warm and friendly exchanges between staff and people, for example, we saw one person thanking their care worker for the kindness they showed them. We saw another staff member give a person a kiss, when they said good morning to them. Throughout our visit, the atmosphere in the communal areas was good natured and people looked relaxed and happy in the company of the staff who when needed provided comfort and reassurance to people by, for example, holding their hands and stroking their arms.

Staff spoke fondly about the people they supported and it was clear they had developed a meaningful relationship with each person and supported them in a kind and caring manner. One staff member told us, "We are all a family here and that is how we treat each other". Another said, "Working here is like a family". A number of people and their relatives spoke to us of the homely nature of the home. One person said, "I like it here, this is a real home".

People told us their choices were respected and this was confirmed by the staff we spoke with. One staff member told us, "People get up when they want to, some ask to be woken up at a certain time. We will ask people what time they would like to get up, but if they decide they wish to stay in bed we leave them. We encourage people to retire at a reasonable time, but if they wish to stay up watching TV, we can't make them go to bed. We respect their choices".

Staff encouraged people to remain independent. During the inspection we observed a staff member supporting a person to stand and walk to the toilet. The staff member assisting did this in a patient and person centred manner, encouraging the person at every step of the process. The intervention took some time, but the staff member did not rush the person and instead waited for the person to complete the task in their own time. The person told us, "The staff are so patient, they never rush me". We observed at lunch that although staff were supporting a person to eat, they still ensured they had their own cutlery as every so often, they were able to feed themselves a small amount of food.

Staff spoke to us about how important it was to protect people's privacy and dignity. For example, staff told us how they used the screens in the shared rooms for privacy and always knocked on people's doors before entering. We also saw staff giving people privacy when using the bathroom and discreetly asking people who were sat in communal areas whether they would like to visit the toilet.

People were supported to maintain their faith. There were regular church services in the home which people were supported to attend if they wished to. End of life care plans were in place which described people's wishes in relation to how they wanted their care to be managed in their final days.

Good

Is the service responsive?

Our findings

People had detailed individual plans of care in place to provide guidance to staff in providing personalised care and support. For example, care plans contained information about the person's life before they came to live at the home and the things that were important to them. Care plans included specific, individual information about the impact on the person of living with specific health conditions such as dementia or diabetes. Staff were provided with guidance about how they should respond to one person's verbal and physical aggression. For example, they were advised to avoid excessive stimulation and feigned cheerfulness and instead 'listen attentively and respectfully'. A social care professional told us, "The care plans are great, they tell me what I need to know". Staff showed they had a good understanding of the people they were supporting. For example, we saw that staff were aware of the behaviours people with limited verbal communication might display when they wanted the toilet. Their knowledge of each person's preferences helped to ensure people received care and support which suited their needs. For example, we heard a member of staff say to one person, "Would you like some honey with your porridge, you like honey don't you". This enabled staff to be responsive to people's needs.

Whilst there was no designated activities staff, the care staff spent time leading the activities and a small number of outside entertainers also visited the home. Exercise classes were also held on a monthly basis. We saw staff leading two activities. In the morning people enjoyed a word game using a large whiteboard. One person told us, "I like the word quiz and the banter that goes with it". In the afternoon, staff facilitated a bowling game; they made every effort to ensure each person was involved if this is what they wished. We were advised that people were supported to take trips to the local shops and garden centres and were on occasion invited to a local school for afternoon tea. One of the social care professionals we spoke with felt more could be done to enhance the activities programme provided, but the majority of people, relatives and professionals we spoke with told us they felt the activities provided were adequate. For example, a relative said, "There is a lovely chap who comes in and sings," and a social professional told us, "There is always plenty going on".

Surveys were intermittently undertaken with people, their relatives, staff and visiting health and social care professionals to ascertain their views about the service. However, there was no planned timescale for how often the surveys should be repeated. The registered manager told us that action plans or improvements plans would be developed if any of the feedback received was negative or indicated improvements were needed. Relatives were also encouraged to use websites such as NHS Choices to review the service. The feedback we viewed was largely positive. One relative had described how staff were 'Always attentive and responsive to [family members] complex needs, it is true to say that nothing is too much trouble'. Another said, 'They showed a deep understanding of [family member] care needs and personality enabling him to feel happy, safe and secure'. A formal resident and relatives meeting was currently only held on an annual basis. The minutes of the last meeting were brief but showed that people were encouraged to raise any concerns they might have. The registered manager told us that their, and the provider's, presence in the service most days meant that issues or concerns could be raised informally and addressed at the time. One relative told us, "The manager has a can-do attitude; they are always willing to listen".

People knew who to speak with if they needed to make a complaint or raise a concern, but those we spoke to said they had not needed to. Information about how to make a complaint was available within the service and within the service user guide.

Good

Is the service well-led?

Our findings

Thornfield Care Home was managed by a registered manager who was also the registered provider. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and its associated Regulations about how the service is run.

Throughout the inspection, the registered manager demonstrated a good knowledge of all aspects of the home including the needs of people living there, the staff team and her responsibilities as manager. They took an active role within the home, delivering care and serving as a role model to the staff team through their hands on approach. The registered manager clearly knew people well and had developed good relationships with each person. They spent a lot of time chatting with people and their visitors in a natural and relaxed manner. People responded well to the registered manager and seemed completely at ease with them. One person told us, "The home could not be managed better; they [the registered manager] are lovely and very approachable". This was echoed by a healthcare professional who told us, "The home is extremely well led".

Staff were very positive about the registered manager. One staff member said, "The management are always on hand to offer help and support and if I have an issue they listen to me and deal with it appropriately". Staff meetings were held intermittently and were an opportunity to discuss issues affecting people's care, training, recruitment and good record keeping.

There were systems in place to assess and monitor the quality and safety of the service. The registered manager monitored and analysed accidents and incidents, falls and complaints and where issues were identified, actions were agreed and taken. Checks were made to ensure people's care plans were accurate and intermittent audits were undertaken of the safety of medicines management and the effectiveness of infection control measures within the service. A health and safety audit was also undertaken. During the inspection, we discussed with the registered manager and provider the potential benefits of increasing the frequency with which audits are undertaken to ensure these continue to be effective tool at assessing the quality and safety of the service.

Weekly and monthly checks were undertaken of the environment. This included the fire safety arrangements, water temperatures and checks on equipment, such as the hoists, boilers and the stair lift. A legionella risk assessment was not in place, although samples of the water were tested each year and had been undertaken and had found no legionella present. Since the inspection, the registered manager has arranged for a legionella risk assessment to take place. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies or challenges.