Mr & Mrs R Bagoban

Thistledown Residential Care Home Hayling Island

Inspection report

33 Beach Road
Hayling Island
Portsmouth
Hampshire
PO11 0JB

Tel: 02392461282

Date of inspection visit:
16 November 2016

Date of publication:
26 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 16 November 2016 and was announced. The last inspection took place in September 2013 and the service was found to be compliant in the areas we inspected.

Thistledown Residential Care Home is a small service which provides accommodation for a maximum of 6 people living with a learning disability. At the time of our inspection there were four people living at the service.

People we spoke with told us they felt safe with the care and support they received at Thistledown. Staff who supported them knew how to recognise different types of abuse and what actions to take if they suspected someone was at risk of harm.

The service kept personalised risk assessments which were up to date and people had been consulted in writing these. There were environmental risk assessments in place and a business continuity plan in the event of a fire.

Staff recruitment was robust and staff received appropriate training to undertake their role. New staff received an induction period and all staff received regular supervision and annual appraisals.

The service did not not always follow the Mental Capacity Act as required by legislation. They had considered people's best interest in relation to making specific decisions. However they had not considered applying for a Deprivation of Liberty Safeguard in relation to a person whose movements they were now restricting.

Staff were seen to be kind and caring; they knew the people they were providing care and support for. People were able to attend and participate in as many activities as they wanted to. People chose what they wanted to eat, there was a good selection of meal choices and staff were aware of any restrictions with people's dietary requirements.

The service had a registered manager who had been in post since 2014. 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.

Quality assurance checks were being completed but did not always identify areas of concern. The service had policies and procedures in place which staff were following. There was a formal complaints procedure but no complaints had been received. The registered manager was aware of what actions they would need to take should they receive a complaint.

The service should notify CQC of incidents, we saw that on one occasion this had not happened, however

the service had followed appropriate procedures and informed the local authority as well as taking action to minimise the risk of the incident reoccurring.

During this inspection we found two breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014

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.

People did not have personal emergency plans in place to support them in the event of an emergency, but due to the size of the service staff were aware of each persons individual needs..

The service had detailed risk assessments in place and staff knew how to keep people safe.

Medicines were stored, administered and disposed of safely.

Is the service effective?

Requires Improvement

The service wasn't always effective.

The service had not considered applying for a DoLS for someone who was being restricted. Mental Capacity assessments had been completed in relation to people managing their finances.

Staff had received training in essential areas but had not received training in MCA and DoLS or dementia.

People were supported to access healthcare professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff knew how to protect people's privacy and dignity but this wasn't always put into practice. Staff showed people resect at all times.

Staff treated people in a kind and caring approach.

People were supported to be involved in the planning of their care and the reviewing of their care needs.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was responsive to their needs.

People were supported to attend activities of their choice and recognised when people's needs changed.

There was a formal complaints procedure in place and the registered manager knew what action to take if they received a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

Statutory notifications had not been sent to the Care Quality Commission as required to do so.

Quality assurance checks were being completed but did not always identify issues. Policies and procedures were being followed and up to date.

There was a registered manager in place who everyone knew and staff felt the service was well led.

Thistledown Residential Care Home Hayling Island

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.

This inspection took place on 16 November 2016 and was announced. This was because the service is a small residential home for people living with a learning disability and we wanted to make sure someone was at home. The inspection team consisted of one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with four people, the provider who is also registered manager and one member of care staff. We looked at records relating to the service. Including four care records, two staff recruitment files, daily record notes, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Thistledown Residential Care Home. Due to their learning disabilities they responded with "Yes" answers when the question was asked. Staff we spoke with explained how they kept people safe. A staff member said, "I ensure the building is safe and secure, I work within my remit and I ensure that those (who require to be) are accompanied when out."

We saw the service had a business continuity plan which described what actions needed to be taken and who to contact in the event of an incident such as a fire. We checked to see if each person had a personal emergency evacuation plan (PEEP) within their care file.These would provide staff with information about the person's individual needs and abilities in the event of an emergency. However, we found that none of the care files contained them. This meant that the service did not have a safe procedure in place for each individual, as there was no guidance for people such as the emergency services as to how a person may react, or what their needs were in the event of an emergency. The registered manager told us as only four people lived at the service the staff would be able to explain their needs to the emergency services if required. The told us they would implement PEEPs for each person as a matter of priority. We will check these are in place at our next inspection.

We saw the service completed risk assessments on the environment for areas such as hot water checks, fire safety checks and fire drills as well as checks on the services minibus and gas and electric checks. We saw where concerns had been identified, action had been taken to minimise the risk to people living at Thistledown Residential Home. For example, the weekly water checks had identified an issue with the water temperature increasing. The service had recorded the issue and what actions they had taken to fix this.

Staff knew how to protect people from harm and abuse. Staff told us, "I'd talk it through with [name of registered manager] and/or I'd contact the local authorities safeguarding team." Staff confirmed they had received training in safeguarding adults and were able to describe different types of abuse such as financial, physical and neglect. We looked at the services accident and incident records along with their safeguarding incidents. We found very few incidents had occurred, but when they had the service had taken appropriate action.

Staff also described the individual risk assessments which were kept on file for each person. We viewed four people's care files and they all contained detailed risk assessments which were personalised. For example, one person liked to collect items such as newspapers and magazines and would rummage through waste bins for papers. The service had identified this risk and put an action plan in place to minimise the risk of this person and others living at Thistledown, from coming to harm.

As part of our inspection we looked at how medicines were administered, stored and disposed of. We found the service kept all their medicines within the same locked cabinet which was in the staff sleep in room. One person received controlled drugs. At the time of the inspection, these were being stored alongside all the other medicines within the locked cabinet. Controlled drugs require additional secured storage and extra checks prior to being administered. The registered manager moved them into a separate lockable section

within the lockable medicine cabinet. We saw the checks were being completed and stock was being frequently audited to ensure the correct amount had been administered. Where required, two staff members were checking in medicines and signing to say they had been given. We saw the service had policies and procedures in place for the administration of medicines. This showed the service had a robust procedure in place for the administration, storage and disposal of medicines.

At the time of our inspection, the service employed three care and support staff members, one bank staff member and the provider who was also the registered manager. As part of our inspection, we looked at whether the recruitment of staff members was safe and required checks had been completed. We looked at three staff recruitment files. They included the date a request was made to the disclosure and baring service (DBS) and the date it was received. The DBS helps providers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We saw each file contained two references however, one person's file did not have their full employment history. The registered manager immediately asked the staff member to complete this, which we saw before the end of the inspection. The registered manager explained they had known the staff member for a long time and knew their full employment history, they had also seen this staff members CV, but had not kept a copy on file. This showed the registered manager understood the importance of having a safe recruitment process in place and ensured immediate action was taken to rectify an oversight on their behalf. This showed the service had a safe recruitment process in place. We also looked staffing levels and found there to be sufficient staff to meet the needs of people living at Thistledown Residential Home at this time.

Requires Improvement

Is the service effective?

Our findings

People we observed appeared confident with the care and support they received from the care staff. People received effective care from staff members who knew them well.

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.

The service provided care and support for people who sometimes lacked the capacity to make certain decisions for themselves. We looked at what consideration the service gave to the MCA and whether the service was working within the principles of this.

We saw evidence in a person's care file where a best interest decision had been made in relation to managing their finances. We saw the service had assessed their understanding in relation to the value of money and had attempted different scenarios as to how monies could be used. They then recorded this within the persons file along with their MCA, explaining how they had come to the decision. This showed that the service had taken appropriate steps to consider all aspects of the situation and come up with a solution which was least restrictive and in the person's best interest. Staff we spoke with understood the importance or gaining a person's consent prior to carrying out any care and support

People can only be deprived of their liberty so they can receive care and treatment when it is the person's best interest and it has been legally authorised under the MCA. The application procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards. Within a community setting, the service would need to request that the local authority applied to the Court of Protection for authorisation of the Deprivation of Liberty Safeguards if they think the person's liberty must be deprived to keep them safe. We found staff had a limited understanding in relation to the MCA. The registered manager had not considered applying for a DoLS for one person who recently had an alarm fitted to their bedroom window to prevent them from leaving the service unattended. We discussed this with the registered manager who immediately stated they would apply for a DoLS assessment to be completed in relation to this. The service was not always working within the principles of the MCA. This was a breach of Regulation 11 (1), of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at staff training records and found all staff had completed essential training in areas such as safeguarding, first aid, moving and handling as well as the administration of medication. Staff told us they had undertaken a complete induction programme and they spent time shadowing more experienced workers until they felt confident to work independently. However they had not received training in MCA and DoLS which showed with their understanding in relation to this area. Staff had not received any training in relation to dementia, which would aid them to support people living at the service who had a diagnosis of this condition.

Failing to ensure appropriate training was being provided was a breach of Regulation 18(2)(a) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed they had regular supervisions. These were held every month and allowed the staff to discuss any concerns they may have as well as identify any learning needs or areas where they may require additional support. They had also received an annual appraisal.

We looked at how people were supported to have their nutritional needs met. We saw the service had a menu plan which both staff and the registered manager told us, was devised by those living at the service. Each person chose meals for one week and these were rotated. This was agreed by everyone living at the service and when asked if they had choice about what they ate they said, "Yes". We saw on the evening of our inspection, the plan was for everyone to go to the local pub for their evening meal. We were told by the registered manager, that this was something everyone enjoyed. We asked two people living at the service if they enjoyed going to the pub for their evening meal, they both agreed they did. No one at the service required a specialised diet, however one person struggled to eat salad and leafy vegetables and it was recorded that staff needed to be with the person when they ate. Both the person and staff knew they struggled to eat these so would ensure there was always another choice on offer. Staff also ensured the kitchen was kept locked overnight so as to minimise the risk of people coming to harm. This showed the service ensure people's nutritional needs were met but also made sure they were supported to choose how they were met.

People's care files contained records of when people had seen healthcare professionals. We saw records of medical appointments and when referrals had been made to other healthcare professionals such as audiology. This showed the service supported people to maintain good health and access healthcare support as required.

Requires Improvement

Is the service caring?

Our findings

We observed positive caring interactions between people and the staff. Staff were observed laughing and joking with people as well as speaking in a kind and caring manner.

We saw people being treated with respect and dignified support. However when we spoke with a staff member they told us that one person who required support when receiving personal care, would often have other people who lived at the service, entering the bathroom whilst they were in the bath. We asked why this was and how the person had felt about this intrusion of their privacy.The staff member reported they did not think he minded. However no one had actually asked this person if they minded people entering the bathroom whilst they were in the bath. Staff were seen always knocking on people's doors before entering their rooms and asking a person's permission before carrying out any task. Staff told us, "We always keep doors shut when providing personal care and try to keep them as covered as much as possible with towels. I encourage people to do as much as possible for themselves, so I prompt." Staff understood the importance of maintaining peoples dignity, but this wasn't always put into practice.

Staff knew the people they supported and this showed in the way in which they interacted with them. A number of people living at Thistledown had a learning disability which impacted on the way in which they communicated. The care files recorded how they communicated and what may impact on their behaviour. Staff knew how to interpret people's individual needs for example, they were aware of one person's specific behaviour which could put them at risk from harm. The service had devised a way of distracting this person so as to minimise their behaviour and the impact this may have on them and others.

People living at the service had been encouraged to be involved in the planning of their care and support. Each person had their own personalised care and support plan in their care files, which had been read to them and then signed to say this had been done. We saw these had been in picture format and the service planned to update them further to make them more person friendly.This was completed with the person, when appropriate or a family member. People were supported to make decisions about the care and support they received and this was recorded within their care plan. We saw the service had recorded information about the person's personal histories and what was important to them. This showed the service included people to be involved with the planning of their care and support. People's care files showed their care and support needs had been reviewed and that these had been discussed with the person.

No one at the service had an end of life care plan. We discussed this with the registered manager who had not considered it for the service. However, sought support from a counsellor for one person living at Thistledown when someone close to them died. The registered manager explained that this hadn't worked so they were looking at other ways in which they could support them to deal with their loss.

Good

Is the service responsive?

Our findings

People received care which was personalised to their needs. We saw people had been consulted in their care plans whenever possible and where this wasn't possible, the service had consulted with family members and other services, who knew the person well.

Staff understood what person-centred care meant and were able to say how they used it within the service and were able to describe each individual persons care and support needs. For example, one person had a tendency to become fixated on different things which may be a risk to them and others. The service looked at how they could support them with this whilst ensuring the risks were kept to a minimum.

We looked at the care files for four people who lived at the service. Each care plan was personalised to the individual and contained detailed information about the person and what mattered to them. There was information about the person's likes and dislikes and how they preferred to communicate. For example, one person we saw clear guidelines on how to deal with their emotions and behaviour. The service used a 'Red, amber, green (RAG) sheet to manage and record the person's behaviour. Red was for when they showed signs that the person was very unsettled, amber was signs they were becoming unsettled and green was signs that they were happy/settled. The service had guidance for staff on actions take depending on the RAG rating. This showed the service looked at ways in which to support and respond to people's change in needs.

We saw each person attended regular activities with the support from the staff at Thistledown Residential care home. During the week, people were supported to attend a day service which supported them to work. We spoke with people about this. When asked if they enjoy going, they said "Yes." We saw there was a list of daily activities kept on the notice board beside the front door. We could see from this list, that everyone undertook different activities each day. Everyone living at the service enjoyed training for the special Olympics. We also saw that the service had identified that attending the day service Monday to Friday, was becoming too much for them due to a change in the health and support needs. The service had arranged so that this person attended three times a week instead, thus allowing them a day to rest in between. This showed the service understood the importance of attending the day service but recognised the change in a person's needs and supported them to ensure their needs were still met.

The service had a formal complaints procedure in place. We saw they had devised a pictorial version of the complaints procedure, so that people using the service were able to communicate their views. Whilst no one had needed to complain, the registered manager knew how to respond appropriately if they were to receive a complaint and would ensure they spoke with the person the complaint involved. This showed the service addressed complaints appropriately; ensuring the person's voice was heard.

Every month, people in the supported living home, attended a 'house' meeting. This meeting was to discuss any plans, complaints or concerns as well as to decide on any activities, meals or ideas for the service. People were supported to contribute to these meetings as best they could. We saw minutes taken from the meetings and there had been a recent discussion about everyone at the service wanting to do drama at

college again. This showed the service listened to the people they supported and took action to make changes when required.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been in post since 2014. Staff we spoke with felt supported by the registered manager and felt able to speak to them about any concerns they may have. Staff told us, "[Name of registered] is supportive." The registered manager told us that they felt supported by their team. At present the registered manager did not receive any formal supervision. However it was something they were planning to look into further now that their staff team was increasing.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the Care Quality Commission (CQC). We checked the records at the service and we found that all incidents had been recorded, investigated but had not always been reported correctly. We found on one occasion the service had reported the incident to the local authority and taken appropriate action but had failed to notify us (CQC).This was discussed with the registered manager who had not realised he had needed to notify us of this incident but will ensure incidents of this nature are reported in future.

Staff worked well with the registered manager; we saw them communicating with each other in a respectful and calm manner. There was an open and transparent culture which was promoted amongst the staff team. A staff member told us there were staff meetings held, these had recently been introduced. We discussed this with a staff member who said, because it was such a small team and service they often discussed things outside of a formal team meeting. We saw minutes had been taken at these meetings and discussions had been held about the service plans for the future as well as additional training needs which could support staff in their roles. For example, we saw that following a recent team meeting, additional checks were now being completed on peoples medicines and additional training was being sought in relation to be able to support a person living at Thistledown with their change in needs.This showed the service listened to the views of those working for Thistledown residential care home and supported staff to help develop the service.

We saw there had been no formal opportunity for people and staff, to feedback on the experienced of the service since 2015. When the lastsurvey we saw had been completed . We discussed this with the registered manager who agreed that this was something he needed to reintroduce, but explained that people and staff fed back to him all the time though this was informal and not recorded. We saw communications were made through the use of a daily diary, so if anything was needed to be discussed it was recorded in there along with actions taken. This shows that the management were listening to people and staff and taking action to make the changes requested.

We saw audits were regularly being completed on areas such as medicines, care plans, accidents and incidents as well as safeguarding. However we found these audits had not picked up the issues we have identified as breaches previouslty in this report. We saw that if any errors or areas requiring improvement were found then there was clear action plans implemented to prevent a reoccurrence. This showed the service completed checks to ensure the safety of those people using the service but these were not always robust. When concerns had been identified there were clear records detailing actions which had been taken. We also looked at the services policies and procedures and saw they were current and were being followed

by staff.

We spoke with the registered manager about what the greatest achievement had been since they came into post. We were told that it was related to securing additional staff. The registered manager explained how the change in one person's needs had meant they needed additional staff at times in order to be able to facilitate different activities and ensure everyone's care and support needs were being met. By providing additional support it meant people had an even greater choice with what activities they undertook and this would enable people to live a full, active lifestyle whilst remaining safe and well cared for.

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 11 HSCA RA Regulations 2014 Need for consent The service had not applied for a DOLS for a person who was no longer able to leave the service without the support of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate training in areas which they require in order to be able to support people effectively.