The Brothers of Charity Services

Thingwall Hall Nursing Home

Inspection report

Thingwall Hall
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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

Thingwall Hall nursing home provides care and support for up to 44 people with learning disabilities and complex support needs. The accommodation is spread over four bungalows with a smaller number of people occupying them, and a larger home with twenty bedrooms and communal areas.

At the time of our inspection there was 23 people in total living at Thingwall Hall nursing home.

At the last comprehensive inspection the service was rated good. At this inspection we saw that the service remained good.

There were systems and processes in place to ensure that people who lived at the home were safeguarded from abuse. This included training for staff which highlighted the different types of abuse and how to raise concerns. Staff we spoke with confirmed they knew how to raise concerns. Risk assessments were detailed and specific, and contained a good descriptive account for staff to follow to enable them to minimise the risk of harm occurring to people who lived at the home. Our observations showed there was plenty of staff around the home to help people with their day to day needs. Medication was well managed and only administered by either registered nurses or staff who had the correct training to enable them to do this. There was a process for analysing incidents, accidents and general near misses to determine what could be improved within the service provision. There was personal protective equipment (PPE) available within the home, and staff wore appropriate protective clothing when competing personal care tasks or serving meals.

Staff were suitably trained, supervised and appraised to enable them to provide good care to people who lived at the home. Training was a mixture of e learning and face to face courses. The service was operating in accordance with the principles of the Mental Capacity Act 2005, and best interest processes were documented for people who required support with decision making. Consent was also sought and clearly documented in line with legislation and guidance. Menus were varied, people told us they had input into the menus. There was access to other medical professionals who often visited the home and were involved with people from a clinical point of view. The service was able to demonstrate good relationships with external healthcare professionals. The building had been recently refurbished to a high standard. All bedrooms were spacious and had en suite facilities. There was new floorings and directional signage around the home.

Staff treated people with kindness and respect. People were treated as individuals, and their choices and preferences were respected by staff. This was evident throughout our observations around the home, and the information recorded in people's care plans. Staff also described how they ensured they protected people's dignity when providing personal care. People were included in their care and support as much as possible, and there was evidence to suggest that person centred plans had been discussed with people and their relatives.

People's support plans were person centred and contained a high level of detail about the person, their likes, dislikes, how they want to be supported and what successful support looks like for them. There was a

process to listen to and respond to complaints which was clearly displayed for people in the home and any visitors if they wished to raise a formal complaint. Staff were trained to support people who were on an end of life pathway, and we saw that training was taking place for this.

The vision of the organisation was person centred and the staff we spoke with told us they liked working for the company. Quality assurance systems were robust and sampled a wide range of service provision. We saw that were issues had been identified they had been subject to an action plan which was reviewed regularly.

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

Thingwall Hall Nursing Home

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 was a comprehensive inspection.

This inspection took place on 27 November 2017 and was unannounced.

The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has expertise in a particular area.

Before our inspection visit, we reviewed the information we held about Thingwall Hall. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who used the service. We viewed the provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

We spoke with four people who used the service and six staff. We also spoke to the registered manager of the home, and the deputy manager. We spoke with a visiting healthcare professional. We looked at the care plans for four people and the recruitment files for three staff. We also looked at other documentation

associated to the running of the service.

Good

Is the service safe?

Our findings

We received the following comments about the home in relation to whether people felt safe. "It's a good home, yes I like this place, it's quiet,", "I get tablets at 8am, 4pm and 9pm", "No upsets with staff", "yes I do like it staff treat me ok" and one person said "Yes" when we asked them if they felt safe.

Staff were able to explain the course of action that they would take if they felt someone was being harmed or abused, this was reflected in the organisation's safeguarding policy. Staff we spoke with also said they would whistle blow to external organisations such as the Care Quality Commission (CQC) if they felt they needed to. We saw that the recruitment and selection of staff remained safe, and DBS checks continued to be completed on all staff who worked at the home. There were sufficient number of staff to support people in the home.

Risk assessments were completed in a range of different areas and were all specifically tailored to meet the person's needs. For example, we saw that one person had a risk management process in place when they became verbally and physically aggressive. This process included links to the providers training programme which supported the staff to deescalate this behaviour safely and in accordance with best practice guidance. This ensured staff were operating a consistent approach, which was important to the person.

We saw from past safeguarding outcomes which had been investigated by the provider that recommendations from these investigations were implemented to improve the service provided to people. For example, we saw additional training had been identified for the staff team and arranged.

Medication was well managed. Medication was only administered by registered nurses or senior staff who had undergone specific training which included annual assessments of their competency. We spent time with the nurse in charge and checked the medication. We saw that the medication was stored in a temperature controlled room. The temperature of this room was not always being recorded, we raised this at the time with the nurse in charge. Storing medications at inappropriate temperatures could affect their ability to work. We received assurances that this recording of temperatures would be more consistent. We viewed some of the MAR (Medication Administration Records) charts for people and saw that they were filled out correctly. We spot checked the medications for two people and saw that the balances of the stock corresponded to what was recorded on the MAR chart.

We checked the procedure for controlled drugs, (CD's). These are medications with additional safeguards placed on them. We saw the procedure for administered controlled drugs was in line with the provider's policy and national guidance.

The home was clean and odour free and there were provisions for hand sanitizer on the walls. Sluice rooms were kept locked when not in use, and staff wore personal protective clothing (PPE) when supporting people with personal care. Personal Emergency Evacuation Plans (PEEPs) were in place for everyone at the home, which were personalised to each person's needs. There was also regularly maintenance undertaken on the hoists, slings, electric and gas. We spot checked these certificates and saw that they were in date.

Iincident and accidents were well documented and analysed for any emerging patterns or trends. We saw evidence that improvements had been made when things went wrong. For example, we saw that some mattresses in the home needed to be replaced, and this had been an on-going issue. The registered manager had tracked this through with maintenance and updated their quality assurance processes to ensure that a more robust check of mattresses was taking place.

Good

Is the service effective?

Our findings

People told us they liked the food and felt they had enough to eat. One person said, "I really like the food here." We saw that people who required specialised diets were catered for. In addition, people who required their food to be presented in a specific way, such as blended or fork mashed, had guidance from Speech and Language Teams (SALT). Menus were available in the dining room, and were presented in pictorial format.

Records showed that staff were up to date with the providers training programme. Staff were trained in a range of topics including safeguarding, first aid, moving and handling, Mental Capacity Act 2005 (MCA), and medication administration for senior staff and conflict resolution training, referred to as SPACE. Our discussions with staff indicated that they were regularly required to attend training refreshers. Staff told us, and records showed that supervisions took place regularly, and staff received an annual appraisal.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager demonstrated an understanding of the MCA and the associated DoLS. Discussion with the registered manager confirmed they understood the need for DoLS to be in place, when an application should be made and how to submit one. We saw that DoLs were applied for following a specific two-stage mental capacity assessment process which clearly documented the reasoning behind the DoLS. Consent was also gained in accordance with people's best interests, and we saw evidence of best interest meetings taking place regarding certain aspects of people's care. The person was involved as much as possible in these processes.

Each person's individual needs were assessed at the time they were admitted to the home. We saw one person had quite specific routines and anxieties, which they required support with. They had a separate plan of support with regards to this. Another person had a different cognitive ability which affected how they wanted their support to be provided, and we saw a plan in place to help support this person with this need. This shows that the service is providing diverse support to people whilst assuring that their choices and needs were identified.

We spoke to a medical professional who was positive about the staff in home and assured us there was a good working relationship between the service and the wider healthcare communities. Records and health action plans showed that people were supported to attend medical appointments and screening. Invasive procedures were discussed as part of best interests with the involvement of a wider multi-disciplinary team.

The home had recently been fully refurbished throughout, and the bungalows were in the process of being refurbished. The building was modern, spacious and there was directional signage and easy read information displayed around the home to help people navigate where they wanted to go.

Good

Is the service caring?

Our findings

We received positive comments with regards to the caring nature of the staff. Some comments included, "They [staff] help me to go to the toilet in the night", "They are never not nice"and "The staff are nice." Other people just told us "Yes" when we asked if the staff were caring and treated them with respect.

Staff we spoke with demonstrated a good understanding of how to protect and promote people's dignity. We observed staff asking for consent before providing care to people. We spoke to staff members who provided examples of how they would ensure they respected people's privacy and how they promoted dignity, which included knocking on doors, and asking people's permission before offering support.

Visitors were free to come to the home and see their family member when they wanted, and there was space in the home for people to visit in comfort either in the person's room, or in the communal areas.

There was advocacy information available for people who wished to make use of this facility. This information was displayed in communal areas where it was easily accessible for people. We saw that there was a variety of information available in easy read formats. This ranged from polices to information people had displayed in their room, such as what they were going to do that day. This supported some people's understanding and allowed them to make choices independently.

Care plans were either signed by the person themselves, if they had the capacity to do so, or via a best interest process which involved their family members. Some people we spoke with could not remember whether they had been involved in reviewing their care plans, however, care plans had been signed and dated when they had been subject to review.

Good

Is the service responsive?

Our findings

People told us that they engaged in a variety of different activities which they enjoyed. One person told us the staff take them to the shop when they choose to buy magazines. Another person told us about a friendship they had been encouraged to make with another person who lived at the home. We saw that activities were arranged and took place on site, people particularly enjoyed the bingo.

Support plans provided detailed information about people's health, behaviours, communication and the way in which they wanted their support delivered. This information was personalised and an individual personal profile was available which contained information around people's life history, likes, dislikes and personal preferences. For example, one person had a specific plan around how they were required to be positioned in bed to support them with their breathing needs. The plan was detailed and there was step by step photographs as well as a detailed explanation for the staff to follow. We saw each person had a person centred plan in place, which detailed what successful support looked like for that person, and a one page profile, which was 'snapshot' of the person centred plan. This meant that new staff would be able to gage a good understanding of the person they were supporting.

Staff were trained in end of life care, and people could be supported to remain in the home if that was their preference.

There was a process in place to respond and deal with complaints. This was displayed in the communal areas of the home. People we spoke with told us the process they would follow if they wished to make a complaint. We saw that there had been no complaints raised since our last inspection. The complaints policy contained details of who people should contact if they wished to complain, including the Local Authority and the Local Government Ombudsman.

We saw that even though there had been no complaints raised, there was still evidence that the service was listening to feedback and making positive changes in service provision. We saw this was discussed at 'resident meetings' and entitled 'Ways we can improve.' For example, the décor of the home had changed because people had requested this.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. 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.

Everyone we spoke with was complimentary about the registered manager. All of the staff we spoke with said that the registered manager was approachable. Comments included, "Oh yes, [registered managers name] is really nice."

Quality assurance procedures were clear. We looked at the last quality assurance audit which took place at the home and saw that some improvements had been highlighted. This included some documentation in people's files which had missing information. We saw that an action plan had been formulated from this information and was checked regularly to ensure completion.

Team meetings took place every other month, the last team meeting took place in October. We were able to view minutes of these meetings.

There were audits for the safety of the building, finances, care plans, medication and more regular checks like the water temperatures. We saw any recommendations were being followed up with a plan of action by the registered manager.

There were policies and procedures in place for staff to follow, the staff were aware of these and their roles with regards to these polices.

The registered manager was aware of their roles and responsibilities and had reported all notifiable incidents to the Care Quality Commission as required. The ratings from the last inspection were clearly displayed in the main part of the building. The rating for the last comprehensive inspection was also displayed on the providers webpage.