GGS Care Home Limited

# Thornton Lodge Care Home

## Inspection report

67 Broom Lane
Salford
Greater Manchester
M7 4FF

Tel: 01617922020

Date of inspection visit:
13 March 2017

Date of publication:
19 May 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Thornton Lodge Care Home provides 24 hour nursing and /or personal care for up to 34 older people, including care for people with dementia. It is close to local amenities with good access to public transport and motorway networks.

The inspection took place on 13 March 2017 and was unannounced. An inspection was carried out in December 2015 when the home was rating Requires Improvement in three areas and overall. There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to poor record keeping. A further focused inspection was undertaken in March 2016 when only the domain of responsive was looked at. At the focused inspection the service was found to have improved in regard to record keeping, but we were unable to evidence sustainability at this time. At this inspection records were seen to be complete and up to date.

There was 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 who used the service told us they felt safe. Staffing levels were sufficient to meet the needs of the people who used the service and were based on a dependency tool.

There was a safe system of recruitment in place. This helped ensure staff employed were suitable to work with people who were vulnerable.

Safeguarding policies and procedures were in place at the service. Medicines were managed safely and health and appropriate safety measures were in place.

The induction programme was robust and on-going training was comprehensive and included relevant areas of learning.

Most of the people who used the service were living with dementia. The environment required improvement so that people would be better able to orientate themselves around the premises, to their own rooms and communal spaces and to time, day and date.

Nutritional and hydration requirements were documented and addressed, special diets were catered for and a kosher diet could be sourced for those who wished to have this. The dining experience could have been improved with better presentation of tables and the addition of condiments and napkins.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People told us staff were kind and caring and we observed friendly and polite interactions throughout the day. Staff respected people's privacy and dignity.

Relevant information about the service was given to people who used the service and their families. Where people had expressed them, their wishes for when they were nearing the end of their lives had been documented. The service endeavoured to care for people in the home if that was their wish.

People's choices, wishes and preferences were documented within the care files. However, some preferences, such as times of rising and retiring were not always adhered to.

There were a number of activities on offer for people and special occasions were celebrated at the home.

Complaints were documented and responded to appropriately and we saw a number of compliments received by the service.

People told us the management at the home were very approachable and helpful.

We saw evidence of a number of audits and checks within the service. Monitoring and analysis of the audits helped identify themes and drive improvement.

The service was involved in a number of local initiatives to help improve the health and well-being of people in the home.

## 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 who used the service told us they felt safe. Staffing levels were sufficient to meet the needs of the people who used the service and were based on a dependency tool.

There was a safe system of recruitment in place. This helped ensure staff employed were suitable to work with people who were vulnerable.

Safeguarding policies and procedures were in place at the service. Medicines were managed safely and health and appropriate safety measures were in place.

### Is the service effective?

Requires Improvement

The service was not always effective.

The induction programme was robust and on-going training was comprehensive and included relevant areas of learning.

The environment required improvement so that people would be better able to orientate themselves around the premises, to their own rooms and communal spaces and to time, day and date. Nutritional and hydration requirements and special diets were catered for, but the dining experience could have been improved.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

### Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and we observed friendly and polite interactions throughout the day. Staff respected people's privacy and dignity.

Relevant information about the service was given to people who

used the service and their families.

Where people had expressed them, their wishes for when they were nearing the end of their lives had been documented. The service endeavoured to care for people in the home if that was their wish.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's choices, wishes and preferences were documented within the care files. However, some preferences were not always adhered to.

There were a number of activities on offer for people and special occasions were celebrated at the home.

Complaints were documented and responded to appropriately and we saw a number of compliments received by the service.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

People told us the management at the home were very approachable and helpful. However, some people's preferences, spiritual and cultural needs were not addressed appropriately.

We saw evidence of a number of audits and checks within the service. Monitoring and analysis of the audits helped identify themes and drive improvement.

The service was involved in a number of local initiatives to help improve the health and well-being of people in the home.

# Thornton Lodge Care 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.

The inspection took place on 13 March 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC).

Prior to the inspection we looked at information we held about the service such as notifications, safeguarding concerns and whistle blowing information. There had not been a recent provider information return (PIR) requested for this service.

During the inspection we spoke with two people who used the service and six relatives. We spoke with three members of care staff and the registered manager. We spoke with a visiting health professional. We also spoke with three members of care staff, the cook and the registered manager. We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed care during the day and reviewed records at the home including five care files, four staff personnel files, meeting minutes, training records, health and safety records and audits held by the service.

Good

# Is the service safe?

## Our findings

We were only able to speak with two people who used the service as many others were living with dementia. However, those we spoke with told us they felt safe. One person said, "The best thing about being here is being looked after and being safe". We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed the body language of other people who used the service when staff approached them and we watched interactions. People we observed were comfortable and calm when interacting with staff.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. Inspection of staff rotas, discussions with staff and relatives demonstrated there were sufficient suitably experienced and qualified staff available at all times to meet people's needs. A visiting health professional told us, "There are a good amount of staff around". Relatives we spoke with were happy with staffing levels. One told us, "There are always plenty staff around".

We saw the service used a dependency tool to assess each person's level of need in order to inform staffing. Evidence of this was kept in the care plans. Nurses' professional registration (PIN) numbers were noted and revalidation had been undertaken recently to ensure all PINs were valid and up to date.

We looked at four staff personnel files and saw a safe system of recruitment was in place. The system of recruitment was robust enough to help protect people from being cared for by unsuitable staff. The staff files contained proof of identity, application forms that documented a full employment history, terms of employment, interview questions and notes and two references. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with vulnerable people and informs the provider of any criminal convictions against the applicant.

There was an appropriate, up to date policy in place at the home with regard to protection from abuse, bullying and harassment. The policy also referenced the whistle blowing policy and procedures, via which staff could report any poor practice they may witness. The referral process to the independent safeguarding authority was outlined within the policy. We noted safeguarding issues were addressed appropriately and we saw notifications to Care Quality Commission (CQC) were made in a timely manner. The registered manager and the provider attended safeguarding provider forums and we saw the minutes of these meetings.

We saw the safeguarding procedures were outlined within the welcome pack given to new users of the service and these were presented in easy read format and included useful contact numbers.

We looked at the medicines management policy which was comprehensive and up to date. The policy included information on self-medication, controlled drugs (CDs) which are some prescription medicines that are controlled under the Misuse of Drugs legislation, and drugs errors and adverse reactions. There was reference within the policy to the Mental Capacity Act (2005) (MCA) with regard to covert medicines (given in food or drink) outlining the need to ensure this is done in a person's best interests if the individual does have

capacity to agree.

We looked to see how the medicines were managed. The service used the Well Pad trolleys. This is where medication is stored in individual plastic storage boxes so each person's medication is kept together in their own name, this helped minimise medication mistakes. We saw medication was checked before being offered to people and then recorded on the individual's medication administration record sheet (MARs). We saw that medicines were safely and securely stored.
Some people were receiving controlled drugs these were suitably stored and recorded as required in the controlled drugs register. Topical creams were administered by care staff and had been correctly recorded when applied.

The senior member in charge of the shift told us that there was a designated person who was responsible for the ordering, receiving and disposal of medication. The treatment room was clean and well organised and was maintained at the correct temperature. The temperature of the medicines fridge was recorded twice daily. There were weekly medicines audits and we saw that issues identified were addressed with appropriate actions.

There was CCTV in place in communal areas only and this had been discussed with people who used the service and their relatives. There was an appropriate policy in place with regard to the CCTV.

There were relevant and up to date policies with regard to health and safety. These included environmental health, Control of Substances Hazardous to Health (COSHH), waste management, emergency planning, accidents and incidents and fire safety. There was a fire safety policy and an up to date fire safety risk assessment. We saw up to date gas and electricity certificates, certificate of service of fire equipment and business continuity and emergency contingency planning.

The service employed a maintenance person to oversee all the everyday repairs within the home. They had a maintenance file, daily task sheet and schedule of agreed tasks. There was a water hygiene management programme, including weekly, monthly and quarterly testing and we saw an up to date legionella certificate. Equipment such as ladders, extractor fans and nurse call systems were regularly checked. We saw that wheelchair checks were in place, the lift was serviced regularly and we saw an invoice for repairs helping to ensure the lift remained in good working order.

Appropriate individual risk assessments were in place within care plans with regard to issues such as the use of bed rails. Personal emergency evacuation plans (PEEPs) for each individual were kept in a fire file and were reviewed as required to ensure the information remained current.

We noted accidents and incidents were recorded appropriately and monitoring and analysis was undertaken to look at where and when accidents had happened. This helped ensure any patterns or trends were addressed to help minimise further similar instances.

We saw infection prevention and control policies and procedures were in place, regular infection audits were undertaken and infection prevention control and training was an essential part of the training programme for staff. The latest infection control audit rated the home at 92%. There were some recommendations and dates for these to be actioned. These were being addressed by the registered manager. People we spoke with told us they had no concerns about hygiene and cleanliness within the home. One relative told us, "There is no smell, no hygiene problems". Another said, "The home is clean and always smells nice".

Requires Improvement

# Is the service effective?

## Our findings

One relative we spoke with told us "My [relative] was here seven years prior to my [other relative]. There have been incredible changes for the better since the new owner took over. We have recommended the home to lots of people". A visiting health professional who was delivering some training around health issues, said, "Staff are quite knowledgeable and are open to learning".

The registered manager told us that most of the people who used the service were living with a dementia related illness. There were some dementia friendly signs to assist with orientation around the home, however these could be improved on. Some people had their names on their bedroom doors; however other bedrooms were lacking any signs or recognition to assist people to help identify their bedroom.

The décor in some parts of the home was tired and a plan of refurbishment was required. Bathrooms needed updated fixtures and fittings to make them more domestic to create a relaxed and pleasant bathing experience. One bathroom on the upper floor was being used for storage with three wheelchairs, a commode chair and hoist slings blocking access for people who used the service. The quiet lounge was cluttered with large cardboard boxes and a rack of unclaimed clothes. Random chairs were being stored in this room. This was also the cut through to the hairdressing salon; and a door leading out into the garden from the lounge was the designated smoking area therefore the lounge was not quiet and relaxing.

There were no large faced clocks to help people recognise what time it was or details of the day and date displayed. People could walk freely around the home and there were a number of communal areas for people to sit in. There was sensor lighting in the home in the toilets and bathrooms and lounges and this meant the lights were going off and on all day. This was very distracting and staff told us at times this was frightening for people as they could be in the toilet and the lights would go off, leaving people in the dark. This could present a risk of people falling or having accidents as they may not be able to reach the light. People living with dementia benefit from plenty natural light and where necessary bright electric lighting. We discussed this on the day with the registered manager and the provider.

We recommend the home addresses the issue with the lighting to ensure people's continued safety and well-being and consults the latest guidance around dementia friendly environments.

The home used daily 'Comfort' sheets for each person who used the service. These included information about washing (am and pm) eye care, oral care, hair care, nails, and hearing aids. Hourly rounds were undertaken during the day and night to note whether people were awake, in pain, whether the call bell was in reach, mattress and cushions were appropriate. Diet and fluids were checked and equipment, such as bed rails, checked within the hourly rounds. This helped ensure people were comfortable and well at all times.

We spoke with staff and asked about their induction. One staff member explained that they had been paired with a senior staff member at first until they felt confident. Their mandatory training had all been undertaken prior to starting work. We looked at staff files which confirmed this. We saw the training matrix which evidenced a high level of on-going training for staff.

Records showed that systems were in place to ensure that staff received regular supervisions and appraisal. Supervision meetings help staff to discuss their progress at work and to discuss any learning and development needs they may have.

Care records included risk assessments associated with food and drink, such as risk of choking, risk of malnutrition or dehydration. These were completed appropriately and the issues addressed with diet and fluids and referrals to specialist services, such as dieticians or speech and language therapy team (SALT) where relevant.

On arrival at the home people were still having breakfast, which consisted of cereals, toast, juice, and hot drinks. We were shown evidence that people were able to have a cooked option for breakfast if this was their preference. Menus were organised over a four weekly cycle and there were choices of meat or vegetarian options for each meal.

We saw that some special dietary requirements such as soft or pureed foods, thickened fluids (with the correct consistency noted), diabetic and gluten free were noted and addressed by the service. Some people were fed via percutaneous endoscopic gastrostomy (PEG) feeding. This is when a person is unable to eat their food orally and receive it through a tube into their stomach.

The home had been awarded a four star rating by the food hygiene standards, which is good.
We saw a nutritional action plan in one of the care plans we looked at. This was to ensure the person received a fortified diet (high calorie) to help build them up. All the information within this plan was complete and up to date.

Meal preference sheets were taken round daily and these were marked to indicate whether there was a special diet.

Approximately half of the people who used the service were Jewish, but the home did not have a kosher kitchen. However kosher food could be provided twice daily, sourced from a local Jewish store. Some of the people who used the service preferred to have a vegetarian diet and one person we spoke with said they preferred kosher food, which was brought in by family.

We carried out a Short Observational Framework Inspection (SOFI) during the lunchtime meal. A SOFI is a timed observation to help us observe how people, who were unable to speak with us were assisted and supported with their meal.

The dining experience required some improvement to ensure that mealtimes were relaxing, unhurried and a pleasant experience. People did not know what they were having for their meal. Plates were placed in front of them. The tablecloths were creased and needed ironing; there were no napkins or condiments on the table. Food was brought from the kitchen without asking people if they wanted relish on their meal and several people left this.

The dining room was noisy with the chef having very loud music on in the kitchen and there was a radio on a conflicting station playing in the dining room. We observed a member of staff sitting down and assisting a person with their meal. This was done in a discreet and sensitive manner.
The lunchtime was task orientated, was hurried and two courses and drinks were over in 30 minutes.

A person who used the service told us, "The food is quite good". Another said, "I like cheese and jam on toast or bananas on toast. They [staff] give this to me every morning for breakfast" Relatives' comments included;

"Our [relative] requires blended vegetarian food and the home comply with this"; "My [relative] had lost some weight. The home had picked up on this and were looking for underlying causes"; "Food and drink is monitored and cups of tea are available any time".

Some care plans included Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms and we saw that these had been completed appropriately. Consent forms for care and treatment and the use of photographs and the use of CCTV were kept within the records. We saw that these had been signed, where appropriate, by the person who used the service.

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 so that they can 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).

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 were being met. There was sufficient information within care files to indicate an understanding of MCA and best interests, but explanations were needed to add to consent forms signed by a representative rather than the person who used the service. Staff had undertaken training in both DoLS and MCA and demonstrated an understanding of the principles. DoLS had been applied for appropriately and were in place for those who required them.

Good

# Is the service caring?

## Our findings

We spoke with two people who used the service. One person said, "The majority of the staff are excellent. They are kind enough and polite. Very accommodating and very nice". Another said, "Staff are very nice, carers are lovely. I'm very happy living here. I have a friend [living at the home] and we get on very well".

One relative told us, "[Relative] has settled in nicely. The staff are very caring and I find it homely. I am welcomed and know the staff well and they are all very nice". Another said, "Staff are very good and cooperative. [Relative] is quite content". Other comments included, "I am very happy about [relative] being here. I'm always made welcome and offered a cup of tea. Staff always respond kindly"; "Staff are very caring, they listen".

We observed care throughout the day and saw that staff interacted in a friendly and polite manner with people who used the service. Care was given kindly and dignity and privacy were respected by staff explaining what they were doing, keeping people covered and dignified and knocking on doors and waiting to be invited in if people were spending time in their rooms. Visitors to the service were made welcome and we saw them chatting with staff.

People who used the service were well presented. Their clothes were clean, ladies wore jewellery and make up and gentlemen were clean shaven. Visitors told us their relatives were always well presented. One relative said, "[Relative] is always shaved and well turned out".

There was a welcome pack given to people who used the service and their relatives. This included the ethos of the home, statement of purpose, complaints policy and safeguarding and whistle blowing information. This information was presented in easy read format. The welcome pack was also available in braille, large print, audio and a range of languages to make it as accessible as possible to people.

Where these had been expressed, people's wishes for their care when nearing the end of their lives were recorded within their care records. Staff at the home had undertaken Six Steps training. Six Steps' is the North West End of Life Programme for Care Homes. This means that for people who are nearing the end of their life they can remain at the home to be cared for in familiar surroundings by people they know and can trust.

We saw evidence of meetings around end of life care and saw that people had been reviewed to ensure they were being cared for appropriately. The relative of a person who had spent the last days of their life at the home told us, "Staff were incredible when [relative] was dying. End of life care was done well and the communication was good".

Requires Improvement

# Is the service responsive?

## Our findings

People's rooms had been personalised with their own furniture and possessions where this was what they wanted. One person said, "I have a very nice room, I brought my own furniture and they [staff] keep the room clean". Another said, "They [staff] respond promptly when I need them".

We looked at five care plans and saw that they included a range of health and personal information, which was complete and up to date. People's preferences, likes and dislikes were recorded. One relative said they had been asked about their loved one's past life to help inform the care plan. A person who used the service told us they had requested to change rooms and this had been actioned very promptly.

Some people told us that the Jewish religion and way of life was important to them and they felt this was facilitated. There were regular visits from the local Rabbi and some people had recently attended the Jewish festival Purim which was significant celebration in the Jewish calendar. The local Rabbi came to the home every Friday night to light the candles and say prayers for all the Jewish people who wished to take part. Kosher food was not supplied directly by the service, but was out sourced for those who wanted this. Some relatives told us that the preferred kosher diet was not imperative and they were happy with the vegetarian food provided. However this decision had been made for some people who could not make decisions for themselves.

Staff spoken with told us they thought people's preferences with regard to times of rising and retiring were not discussed and adhered with. One member of staff told us there was an expectation from day staff that as many people as possible were up and dressed before the night staff went off duty and the same occurred at night, that most people were either in bed or in their bedroom by 08.00pm. However, people we spoke with who used the service told us they had choice in this area. One person who used the service said, "I used to get up early, but then had to wait for breakfast for a while. I now get up between 08.00 am and 08.30". They told us they were happy with that arrangement. Another said, "I get up at 06.30 am – my choice. I go to bed at 10.00 pm and watch my TV for a while, that is what I want". These were people who were able to express their choices clearly and others may not have been able to do this.

We recommend people's preferences with regard to rising and retiring are clearly communicated to staff and addressed by the service.

We looked to see what was provided for people to do during the day. The home employed an activity coordinator to undertake specific activities within the home. We saw a plan of activities displayed in the notice board, which included bingo, dominoes, arts and crafts, puzzles and board games. There were no identified activities for people living with dementia such as reminiscence or for those people who were cared for in bed, though we did see some records of one to one chats between staff and people who used the service. There was a document called 'My Journal' in which activities people had taken part in were documented. One person who used the service said, "I join in everything. I particularly like the games and entertainment".

There was a regular newsletter which provided people with information about up and coming events in the home and special celebration days.

The complaints procedure was displayed and we saw the provider had a clear procedure in place with regard to responding to any complaints and concerns. We saw the complaints log which showed two recent complaints. Both had been responded to appropriately and complaints were analysed and monitored to ensure continual improvement. People we spoke with told us they would feel able to raise concerns with the provider the registered manager or with any of the staff. One relative said they had made a complaint which was dealt with promptly and appropriately.

We saw a number of compliments received by the service. Comments included; 'Thank you for the care and attention you gave to our very dear friend'; 'I would just like to say thank you all for not only looking after [person] but also for the friendship which gave her a great deal of pleasure'.

Requires Improvement

# Is the service well-led?

## Our findings

There was 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 we spoke with told us staff and management were extremely approachable. One person said, "[The registered manager] is a very nice person. A lovely lady." One relative said, "The manager is always around and I feel she would sort out any issues". Another said, "You can always find staff to talk to. They get [relative] ready when I take her out". Other relatives told us they had the mobile telephone numbers of the registered manager and the provider and if they called the call would always be answered promptly.

Although people we spoke with were happy with the support received, some staff members felt that people's preferences with regard to times of rising and retiring were not always addressed appropriately. These issues needed to be addressed by the service to help ensure care and support was suitable for all the people who used the service.

We spoke with staff about whether they were supported. A new staff member told us they had been made to feel welcome right from the start. They said the registered manager was very supportive and was a 'hands on' manager. They felt the teamwork was excellent and told us staff would work across the units and would help at any time if needed.

We asked the registered manager to tell us how they monitored and reviewed the service to ensure that people received safe and effective care. We were told that regular audit checks were undertaken on all aspects of the running of the home. We saw evidence of checks that had been undertaken, for example medication audits, care plans and infection control, nurse call systems, falls and pressure care. We saw that monitoring of falls with harm took place via data collection, analysis and actions, helping drive improvement to delivery of care. Other accidents and incidents were similarly monitored and analysed. People's finances were regularly audited to ensure there were no discrepancies.

We saw maintenance checks for the service including fire equipment, gas and electrical, lift and hosts and small portable appliances had been undertaken and certificates were valid and in date

We were told that formal team meetings and residents meetings were held. Minutes of the meetings were available. The registered manager operated an 'open door' policy at the home so that people could approach them at any time.

The service was involved with a local project called 'Haelo' which was a joint venture between the local Clinical Commissioning Group, the local NHS Foundation Trust and the local city council. The primary purpose was to improve population health and healthcare for local residents. The home also had links with another project in the local area, which promoted good oral health and hygiene.