Thornton Lodge Limited

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Inspection report

105 Brigstock Lane
Thornton Heath
Croydon
CR7 7JL

Tel: 02086841056

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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

We inspected Thornton Lodge on 3 May 2016 and the inspection was unannounced.

Thornton Lodge is a care home without nursing providing accommodation and personal care for up to 45 people with past or present mental health issues, older people and people with learning disabilities. On the day of our visit there were 42 people living in the home. The premises are in the form of a large residential home with ordinary domestic facilities.

There was a registered manager at the home. 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.

At the last inspection, carried out on 25 February 2015 we found that people were not adequately protected against the risks of acquiring infection because of unhygienic rooms. We also found that the registered provider needed to do more to ensure their quality assurance processes meet best practice standards and take account of the views of people and their relatives. We asked the provider to submit an action plan detailing the improvements to be made.

These actions have been completed and on this inspection we found that the relevant requirements were being met.

People's feedback about the safety of the service described it as good and that they felt safe. People were safe because the service had provided training to staff and had systems in place to protect them from bullying, harassment, avoidable harm and potential abuse.

Staff protected people's dignity and rights through their interaction with people and by following the policies and procedures of the service Feedback from people was that staff were caring in their attitude and responsive to people's needs. A caring attitude was observed during the inspection and personalised care, dignity and respect formed part of staff training.

There was a structure and system in place for regular staff supervision and each member of staff had a training record which was relevant to their role.

The service managed the control and prevention of infection well. Staff followed correct policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene. Medicines were well managed, with staff displaying a sound understanding of the medicines administration systems, recording and auditing systems.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by the manager and acted on appropriately.

People at risk of poor nutrition and dehydration were sufficiently monitored and encouraged to eat and drink. The quality of the food was good, with people getting the support they needed and the choice that they liked.

Care, treatment and support plans were seen as fundamental to providing good person centred care. Care planning was focussed upon the person's whole life, including their goals, skills, abilities and support needs.

The service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and companionship. The service enabled people to carry out person-centred activities within the service or in the community and encouraged them to maintain hobbies and interests. This was supported by policies and procedures which emphasised the rights of people and developments in care planning which included people's life histories written from their own perspective, which enabled staff to work in a person-centred way.

People described the responsiveness of the service as good. People received personalised care, treatment and support and were involved in identifying their needs, choices and preferences and how they are met. People's care, treatment and support was set out in a written plan that described what staff needed to do to make sure personalised care was provided.

Improvements had been made to quality assurance systems to ensure that people's views were sought and that quality audits take account of the experience of people living at the home. Records and personal information were kept in a secure and confidential manner.

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 were protected from bullying, harassment, avoidable harm and abuse that may breach their human rights. Staff had received appropriate training in safeguarding people and were knowledgeable about how to report any concerns.

Risks to individuals and the service were managed so that people were protected whilst maintaining their autonomy and freedom. They were reviewed to ensure people could lead meaningful lives whilst keeping them as safe as possible.

The service ensured that there were sufficient numbers of suitable staff to keep people safe and meet their needs, with planned staff rotas and clear descriptions of staff duties each day.

People's medicines were managed so that they received them safely. Staff were trained in the handling, management and administration of medicines.

Is the service effective?

Good

The service was effective. People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Staff received support and training which enabled them to care and support people effectively.

People's consent to care and treatment was always sought in line with legislation and guidance. Decisions made on behalf of people that did not have the capacity to consent were made in their best interests. Staff showed a good understanding of the Mental capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink enough and maintain a balanced diet. People's individual support needs were taken into account and their preferences were respected and menus planned in advance.

People were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support, which was provided by both community and specialist services, where required.

Is the service caring?

Good

The service was caring. People were supported by staff who had developed positive caring relationships with them and who supported them maintain their connections with families.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. This was achieved through the use of information contained in care plans and assessments and through staff using their knowledge of individual people's communication styles.

People's privacy and dignity were respected and promoted through staff ensuring that people had personal space, that their rooms were personalised and their belongings looked after securely.

Is the service responsive?

Good

The service was responsive. People received personalised care which was responsive to their needs. People were supported to have care plans that reflected how they would like to receive their care, treatment and support. These included their personal history and individual preferences.

People had control over their lives and were supported to follow a range of interests according to their preference. The service used a variety of approaches to listen and learn from people's experiences, concerns and complaints. These included making use of a keyworker system to develop personal and individual understanding of people, engaging with relatives, using feedback collected through external assessors and through information shared at staff handover sessions.

Concerns were followed up promptly and outcomes recorded.

Is the service well-led?

Good

The service was well-led. The registered provider and registered manager were visible on a daily basis at the home and were actively involved in ensuring that the home was led by example and regularly monitored.

The registered manager had developed a culture which

promoted openness and transparency for staff and a person-centred and inclusive environment for people who lived in the home.

The provider had improved on the use of quality audits, both internal and external, and through seeking regular feedback from people and relatives.
Records were held in a secure and confidential manner.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 3 May 2016 and was unannounced.

The inspection team consisted of one inspector and an expert by experience who was experienced in care for people with mental health needs. 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, 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 we held on the service including previous reports, notifications and feedback from the public. During the inspection we observed care practice and tracked the care provided through looking at records, care plans and speaking to a variety of people.

We spoke with 15 people and five care staff. We also spoke with the registered manager, administrative and domestic staff. We looked at five care records, five staff records and two medicines records. We also looked at the policies and procedures of the home.

Good

Our findings

At the previous inspection in February 2015 we had found that many of the rooms had a pervading smell of urine and were not clean. This presented a risk of infection and germs spreading to individuals and throughout the home by way of cross-infection. We had asked the provider to send us an action plan setting out the improvements that would be made.

The action plan outlined a programme of improvements with timescales. During the inspection of 3 May 2016 we saw evidence that this had been implemented and was working and that the standard was met. The registered provider had invested heavily in replacing old carpets and new flooring, which had removed offending odours. Laundry and domestic tasks were carried out to a good standard and bathrooms and wash areas contained hand washing liquid and dryers.

This had a positive impact on people, as the home was clean, more homely and with a reduced risk of cross infection.

People told us they felt safe in the home. One person said, "I trust the staff. Staff don't upset you. Staff are kind and don't shout. We have enough staff here. Yes, I feel safe here". Another said, "I can go for a walk if I feel worried. Staff never forget about me". Another person commented, "It is not difficult to get attention. I shout and they come straight away".

During our visit we saw that staff observed safe working practices with regard to moving and handling, ensuring there were no hazards in the home and in administering medicines. Staff told us, and training records confirmed that they had received safeguarding training. Staff were able to describe different types of abuse and how they would report any abuse/allegation/safeguarding concern to the manager. There were no current safeguarding matters relating to the home. There were policies and procedures in the home with regard to safeguarding. Safety was also a regular topic at residents' monthly meetings.

Risks to people's safety were managed well so that people were protected and their freedom supported and respected. Staff had received training on how to assess risks and we saw that people's care plans included risk assessments. These included risks associated with falls, nutrition, weight loss and behaviour. Other risk assessments included continence, social and psychological care.

Accidents and incidents were recorded and appropriately signed by the manager or senior staff on duty in accordance with the procedures. The Care Quality Commission (CQC) had received notifications of accidents in the home, in accordance with the requirements of regulations. There had been four notifications made in the previous 12 months.

People were cared for in a safe manner. When people behaved in a way that may challenge others, staff managed the situation in a positive way and protected people's dignity and rights. For example, people were supported to walk where they pleased or to withdraw from activities. Where people left their meals unfinished they were gently encouraged to eat some more. These approaches meant that they reduced the causes of behaviour that distressed people. Restraint
was not practised.

The premises were clean and homely. Separate domestic and maintenance staff were employed and worked hard at ensuring the home was well maintained. The home kept a record of maintenance checks and any small repairs to equipment.

The staffing levels in the home were sufficient to meet the needs of people and ensure their safety. There were seven care staff on duty at each shift, with the manager and domestic and catering staff as additional support.

Staff files all showed evidence of criminal checks through the Disclosure and Barring Service (DBS), photo ID, application form and previous employment history. References had been followed up. There were policies and procedures in place relating to staff and their work and conduct.

We checked the medicines trolleys and the medicines administration record (MAR) charts. All blister packs were aligned as per the MAR charts. All bottles of medicines were dated when opened. The controlled drugs (CD) corresponded to the tally in the CD book. The home medicines books and running totals were aligned. Staff had a good knowledge of the safety issues behind medicines and they were able to explain procedures confidently and expertly.

The service managed the control and prevention of infection appropriately. Staff followed policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene.

Good

Our findings

The service was effective in its care for people. People were cared for by staff who knew and understood their needs.

The service had a relevant training programme in place which covered the Skills for Care Common Induction standards. Training topics included Safeguarding, Infection Control, Mental Capacity, Equality, Diversity and Human Rights. Refresher training was recorded and planned.

There had been a low turnover of staff in the past 12 months and most staff had worked in the home for three years or more, which provided them with a good understanding of people's needs and provided the people living in the home with a stable and consistent staff team.

Staff told us they felt supported. One staff member told us, "I can go to the manager with any issue and I know he will listen". Another staff member said, "We are a good team here and we all help each other". All staff said that they had received supervision meetings and records we looked at contained supervision and appraisal meetings with staff. Supervision was held every two months.

Consent to care and treatment was always sought in line with legislation and guidance. The manager and staff confirmed that they had an understanding of the Mental Capacity Act.

The Mental Capacity Act (MCA) 2005 sets out what must be done to ensure the human rights of people who lack capacity to make decisions are protected. Staff told us that they were aware of their responsibilities on a day to day basis when working with people who use the service to help them understand their care and treatment including gaining their consent. Records showed that staff in the home had received awareness training in the MCA and the manager was able to demonstrate that decisions about people's best interests were made in consultation with the person and their family.

Records confirmed that people's capacity to make decisions was assessed before they moved into the home and on a daily basis thereafter. Records confirmed that the home had been making requests for authorisation to restrict people's liberty in their best interests under the Deprivation of Liberty Safeguards (DoLS). DoLS requires providers to submit applications to a "Supervisory Body" if they consider a person should be deprived of their liberty in order to get the care and treatment they need. At the time of inspection one applications had been made to the supervisory body and was awaiting an outcome.

People were supported to eat and drink enough and maintain a balanced diet in accordance with personal and cultural preferences. Menus and variety of food were planned in consultation with people using the service. The chef spoke confidently and passionately about wanting to provide good and healthy meals for people. The chef described how people's preferences were incorporated into the 4-weekly menu and confirmed that religious and cultural preferences were taken into account.

People were positive in their comments about the meals and the support they were given with eating and drinking. One person told us, "At meal and tea times there is a buzz and you never go thirsty. You can get water, orange juice or make a cup of tea or coffee in the kitchenettes upstairs outside meal times." At lunchtime we observed a good atmosphere, with people eating their lunches, chatting to each other and to the care staff. Some people preferred to have lunch in their Rooms. We spoke with two people who preferred to stay in their room. They told us that they were making a choice and that they didn't feel excluded or neglected. Staff regularly checked on them and brought them food and liaised with other health care services about their welfare.

People were supported to maintain good health, had access to healthcare services and received on-going healthcare support. People had a health records file which contained details of medical appointments such as GP, mental health and dental appointments.

The service engaged proactively with health and social care agencies and acted on their recommendations and guidance in people's best interests. Appropriate referrals were made to other health and social care services, for example care managers and community mental health teams. One representative from a community mental health team spoke positively about the home and told us there was a good working relationship between the two services.

People's individual needs were met by the adaptation, design and decoration of the service. The home provided a safe environment whilst allowing people to move freely and to leave the home if they wished. Each person had their room personalised and adapted to their needs and bathrooms and furnishings were designed to ensure maximum independence and autonomy whilst providing support to people.

Good

Our findings

Everyone we spoke with felt that the staff were kind and caring and that they were treated with compassion, dignity and respect. One person told us, "I could not be happier here than I am the moment. This place is a fantastic place. It is a very nice place believe me, everyone treats me really well." Another person said, "Yes I like all the staff that support me. I can chat to the staff. They are very caring and it is okay to live here. I can have family or friends whenever I like."

Staff demonstrated a good understanding of people's preferences and personal histories and this was reflected in the individualised way each person was supported. For example, one person required support during a mealtime, while another preferred to remain alone in their room. People told us that they had their privacy respected, for example when they were allowed to remain in their room and the regular checks and attentiveness meant that they weren't overlooked or neglected for doing so. We observed staff speaking and supporting people in a caring and compassionate manner, and responding to people in a respectful way.

We saw that the staff had received training in person-centred care and that the home's policies and procedures placed importance on dignity and respect. Care plans and other records which referred to people used language that was clear, respectful and person centred. Information was confidential and stored in a safe manner.

People living in the home were aware of their care plans. One person told us, "Yes, I do have a care plan. I meet my key worker every fortnight. I talk about everything and in particular if anything is going wrong I can tell her. My [name of relative] comes every night and they are happy that I am happy." Other people confirmed that visitors were not restricted and could come any time they wished.

People were supported to express their views and staff were skilled at giving people the information and explanations they needed and the time to make decisions. This meant that people felt listened to and could feel in control of their decisions.

Good

Our findings

Staff understood people's needs and how they preferred to be supported. People received personalised care, treatment and support and their care, treatment and support were set out in a written plan that described what staff needed to do to make sure personalised care was provided.

Care plans contained sufficient detail on individual needs which included details of physical and health care needs, social interests, spiritual and cultural preferences.

Staff were confident that they understood people's needs and could explain individual requirements and behaviour when asked. Staff were briefed verbally by the registered manager about people's needs and progress and information was shared between staff during handover sessions between shifts.

People were able to describe the various hobbies and activities they took part in and spoke positively about the activities and choices in the home. One person told us how their relatives came to visit once a month. Other people told us how they were able to go out independently or with staff. In order to be able to facilitate people's wishes, staff were flexible in their approach and also allocated times to go out with people to do shopping or enjoy a coffee or a meal. During our visit some people had gone to the park with a member of staff.

People were supported to live in the home as independently as possible, according to their preferences and their views were taken into account with regard to decision making and choices. This was achieved through involvement in assessment and care planning, monthly resident meetings, menu planning and involvement in day to day activities throughout the home.

Care was reviewed monthly, with a major review of the whole care package on an annual basis. People and their families were invited to participate as much as they felt able to.

The complaints procedure and policy was on prominent display on the notice board and was easy to read. People told us that they knew how to complain. However, no one felt they had any complaints. One person was able to tell us the cost of the home per month. They told us they had been living at the home for six years and if there was anything wrong they would "tell the manager and probably go somewhere else".

There were no complaints received about the home in the last 12 months.

Good

Our findings

At the previous inspection in February 2015 we found that the registered provider needed to do more to ensure their quality assurance processes meet best practice standards and take account of the views of people and their relatives. We asked the provider to submit an action plan detailing the improvements to be made.

We received an action plan which outlined a programme of improvements with timescales. During the inspection of 3 May 2016 we saw evidence that this had been implemented and was working and that the standard was met.

The registered provider had developed the quality assurance systems further by including external auditors to provide an objective view of the quality of service. The registered provider has also implemented surveys for visitors and stakeholders as well as a survey for the people living in the home, and these were included in management analyses of what was working well and what needed improvement in the home.

The surveys asked for people's views on their care, how safe they felt and their views on the range of activities and routines within the home. Although only one survey has been carried out since the previous inspection there was evidence that people's comments had been taken into account, for example with regard to being able to go out more or to have barbecues in the garden.

There have been two visits by people external to the management of the home who carried out a quality audit. Again, there was evidence that recommendations had been considered, for example with regard to renewing a carpeted area.

This had a positive impact on people, as the home was clean, more homely and with a reduced risk of cross infection.

People spoke positively about the person-centred and open culture in the home. Everyone we spoke with was positive about the atmosphere in the home and with the way it was managed. One person told us, "It is a very friendly place."

The management and quality assurance approach in the home was very much based on direct contact with the manager and clear lines of accountability within the staff team. Staff knew their roles and responsibilities within the structure. They also knew how to communicate concerns and had a good

understanding of the service's policies and procedures.

The registered manager had begun to attend local provider forums which offered an opportunity to learn about issues affecting the care industry in general and to receive information from the local authority.

The provider had developed an employee handbook which each staff member had. This contained summaries of the main policies and procedures, statements about staff conduct and the philosophy of the home.

The provider visited the home at least weekly and held monitoring and quality meetings with the manager. Health and safety checks were carried out, including fire safety equipment, water temperatures, and medicines.

The provider and manager had involved the staff team and encouraged them to be part of the overall quality assurance process by encouraging each member of staff to be a "Champion Of Responsibility" for specific areas of care or other tasks. Areas of responsibility included the quality of food, the maintenance of care plans and activities within the home.

The registered manager was able to demonstrate his awareness of his responsibilities including the responsibility to notify the Care Quality Commission of incidents and accidents and was meeting his conditions of registration.

We looked at records, including medicines, staff records, care plans, daily logs and quality checks and found that these were up to date and held securely.