Review of compliance

Brothers of Charity

Thingwall Hall Nursing Home

Region:	North West
Location address:	Thingwall Hall Nursing home, Thingwall Hall, Broadgreen, Liverpool L14 7NY
Type of service:	Care home with nursing
Date the review was completed:	January 2012
Overview of the service:	Thingwall Hall nursing home provides care and support for people with learning disabilities and complex support needs. The accommodation is in discrete bungalows on a large site with some leisure areas, day support and work experience areas. The regulated activities registered for the location Thingwall Hall nursing home are:

	Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury The provider for Thingwall Hall nursing home is The Brothers of Charity Services. This is a charity with services in Lancashire and Merseyside specialising in the care of people with learning disabilities, in a variety of settings. They also have a separately managed service in Scotland.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Thingwall Hall Nursing Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

This review is part of a targeted inspection programme in hospitals and care homes that care for people with learning disabilities to assess how well they experience effective, safe and appropriate care treatment and support that meets their needs and protects their rights; and whether they are protected from abuse.

How we carried out this review

The inspection teams are led by Care Quality Commission (CQC) inspectors joined by two 'experts by experience', people who have experience of using services; either first hand or as a family carer and who can provide the patient perspective. A professional advisor is also a member of the team.

We reviewed all the information we hold about this provider, carried out a visit on 18 and 19 January 2012 observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

As part of our inspection, telephone discussions were held with relatives and other professionals who we were not able to meet with us during our visit, these comments are included within this report.

To help us to understand the experiences people have we used our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

What people told us

There were 32 people living at Thingwall Hall Nursing Home when we visited. We met 17 people. Some of the people we met had communication difficulties. Although they were unable to converse with us, we observed how staff supported them. Other people were able to tell us about their experiences. Some people have lived at Thingwall Hall for many years but others have moved there quite recently from other services as their needs had changed. People we spoke with were happy living at Thingwall Hall. One person told us "I like being here, it is better than my last place." Another person told us, "I have lived here a long time. It is good now."

We spoke with several relatives. Most were satisfied with the care provided and felt that staff were kind and supportive. One person said, "I feel confident that the staff make sure that [my family member] not only has the practical and correct support they need but also essentially the love and attention that they need". However some relatives felt that staffing was too low and that this affected activities. One person told us, "Staff are devoted but because there are not enough staff they are unable to provide the appropriate level of support based on the individual and each unit as a whole". Another person said, "My only staffing concern is that the staff need more support as the staffing level is too low."

Relatives said that the staff team were respectful towards people living there and listened if they had any concerns. One relative told us, "Staff are pleasant and communication is good". Another relative said "I feel comfortable when I visit and can see that [my family member] is fine".

What we found about the standards we reviewed and how well Thingwall Hall Nursing Home was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

The majority of staff were respectful and treated people in non judgemental way.

People's care and support needs were assessed and most care plans were detailed and up to date. However some had information missing or were not up to date and this reduced the effectiveness of planning and modifying care and support.

There were activities and experiences in place for most people but opportunities for accessing the community had recently been limited.

Information on people's health needs was usually detailed and well managed. There were occasions when there was not sufficient information on people's changing healthcare needs and this resulted in a lack of consistency in the care delivered. This meant that some people were not experiencing effective, safe and appropriate care, support and treatment that met their needs and protected their rights

- Overall, we found that improvements are needed for this essential standard.

Outcome 7: People should be protected from abuse and staff should respect their human rights

Procedures were in place to minimise and prevent abuse. Staff were appropriately trained to recognise the signs of abuse and how to respond and raise concerns. Where concerns were raised, they were dealt with appropriately.

Strategies for managing behaviour that challenged were safe and appropriate with records in place so that all involved had the information they needed to support the person effectively

Incident reports were detailed and were reviewed to see if alternative strategies could have been used and care plans modified accordingly.

People were receiving safe and appropriate care in order to keep them safe and their well-being promoted.

- Overall, we found that Thingwall Hall Nursing Home was meeting this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.
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What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are Moderate concerns with

Outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

There were 35 people living at Thingwall Hall Nursing Home when we visited residing in houses in and around the grounds of Thingwall Hall. There were houses, situated around the grounds, with from one to fourteen people living in each. The larger house was split into two smaller units, so that the people lived in smaller social groups.

We visited four houses and talked to people in the houses and around the grounds as well as observing care and how staff interacted with people who had limited verbal communication.

People spoken with said that they were happy at Thingwall Hall. One person told us, “I like living here. The staff are good”. Another person said, “It is nice here. I am going to the pictures now.” People told us that the staff supported them well. One person said, “I like the staff. They look after me.”

We also spoke with some relatives. They were pleased with the quality of the staff and felt that staff were helpful and supportive. One relative told us she felt that the staff took a comprehensive interest and role in ensuring her family member received the best support and care. Another person said, “There is a good mix of staff and

they motivate and engage people".

Most relatives said they were generally happy with the care and support their family member received. One person told us their family member had a great service and they were kept involved. However several relatives felt that staffing levels were too low. One person said, "Ultimately I am very satisfied with the staff themselves but have some worries about the level of staffing shortage or the lack of support available and provided in the houses". The relative added that they felt that the system that dictates how many staff were on the houses was failing the residents and the staff there. Another relative felt that their family members experience would be improved by more attention from staff and more support for things such as physiotherapy, activities and getting out, adding that higher management needed to listen and act on the feedback.

The people we spoke with were very keen to tell us about their activities which included on site activities and community based activities. Several people were out and about during the inspection visiting the cinema, going to town or going to a swimming. People in one house were having a film night, and one person had gone out with a staff member and bought a DVD and some popcorn. They told us they were going to enjoy themselves. Some people were involved in work experience on site. One person worked in the woodwork facility on site, making benches which they said they enjoyed doing. Another person told us about their planned holiday and showed us photographs of themselves on recent holidays. He said, "I enjoy going on holiday. We always have a good time."

Relatives had mixed views about activities. One relative felt that their family member had a reasonable social life. Other relatives felt that there were not always enough activities in some houses. One relative said, "The staff do a good job and I cannot fault them" but still [my family member] suffers from lack of activity, engagement and activity outside of the house and Thingwall Hall. Another relative told us that they felt the lack of transport since the fleet of mini buses had been cut, had an effect on activities.

People we spoke with told us they had care plans and were involved in them. One person showed us his care plan and said he looked at this with staff." Relatives said they were involved in decisions about care. One relative said she had provided staff with lots of information about her family member and this became part of the care plan. Adding "I am completely up to date with all records and meetings to do with [my family member]. Another relative told us that she has good communication with staff and was kept up to date. She was not sure she was familiar with the care plan but had information from her family member's reviews. Relatives said they felt communication was good. One relative said, "There is good communication with staff".

Other evidence

<u>Assessing people's needs</u>
People living at Thingwall Hall Nursing Home were mainly from the Cheshire and Merseyside areas. Many people have lived at Thingwall Hall Nursing Home for many years. Others have moved from other services and organisations, as their needs could no longer be met. Where people have moved into services recently

they have detailed pre admission assessments. Those who have lived at Thingwall Hall for many years have detailed care plans but we did not check pre admission assessments from so long ago.

Senior staff told us about the referral and admissions policies for the service. The policies were detailed and informative and gave staff clear instructions to follow when assessing a prospective admission at Thingwall Hall Nursing Home. There was comprehensive information about the services available to carers through brochures and the internet and throughout the site.

We looked at the assessment records to see if peoples' needs were identified. All the sets of notes we looked at included an assessment of needs. Staff told us that once a referral had been received, staff would look at whether they could meet the person's needs. They would request detailed information and senior staff visited the person in their current placement.

For a small number of the older people, who had lived at Thingwall Hall Nursing Home for many years, it was a home for life unless the person indicated otherwise, or their needs could no longer be met. For most people alternative options were looked at, in settings off site either with Brothers of Charity Services or other organisations and discharge plans were in place.

Care planning

We looked at the care records of five people. We did this to identify what their needs were, how they were to be met and if there was evidence they had been met. In most cases there were detailed and informative person centred care plans involving people as much as they were able to be and their families where appropriate. The majority of staff spoken with were able to discuss the care and support needs of people and their likes and dislikes in detail, showing that they were knowledgeable about their care. People had care plans suited to their communication needs. Some people had easy read style while others with limited ability to understand were involved in other ways, more suited to their needs and level of understanding. For example staff would spend time with people on a day to day basis.

One of the care plans seen in one house did not show information about a health issue that affected all aspects of the person's care and support needs. Although the care plan had been signed as reviewed, information had not been reviewed and updated to reflect the changes in the person's health and care even though the person had recently been acutely unwell. The information that was missing or out of date affected the care and support provided to the person. We did not see evidence of involvement of the person or their family, in the care plan but senior staff later told us that evidence of this was in place and the person and the family were involved in reviewing the file.

Risk assessments for other people were informative and included areas of care and support. There was also information about each person's daily routines and on behaviour described as challenging and how to manage it effectively. The plans outlined the person's strengths, goals and aspirations, likes and dislikes and preferred daily activities.

There was evidence that the needs, values and diversity of people were taken into account. There was an on site chapel and people were supported to attend places of worship if they wanted. Staff were aware of the need to provide culturally appropriate care. Staff spoken with said they made sure they were familiar with a person's religious and cultural beliefs.

Meeting people's health needs

People had either health action plans or relevant health plans in place. The majority were in depth and covered the health needs of the individual. However one person's health information as noted in care planning did not cover important health issues and had not been updated to reflect recent ill health and how to support the person through this. There was limited information about how to support the health needs of the person, but this was not enough to support them effectively. It did not inform staff of how the health issue affected the person, what strategies to use to help the person when they were acutely ill or when to give 'as needed' medication in order to reduce the effects of the illness.

Senior staff on site visited the home regularly to advise how to support the person. However staff spoken with regarding this person did not have the understanding of the person's condition and therefore were not supporting the person as well as they should have been. Health professionals had been involved in the person's care but there was no evidence that all staff were aware of how to support the person effectively and appropriately.

With the exception of the person above, the records showed that people were receiving physical health care in line with their plan and they were having annual health checks. Any health needs were regularly reviewed and appointments made with other health professionals as needed. This meant that their health needs were well met.

Several people with dementia in addition to their learning disability have been admitted to Thingwall Hall. Staff have received training to develop and improve their skills so that they effectively meet the additional needs of these individuals.

Delivery of care

We observed the care provided over the two days we visited in four different houses. The houses were adequately staffed while we were there but people expressed some concern over staffing numbers and how that affected activities, particularly those outside the site. Senior managers told us that a survey had been sent out shortly before the inspection to relatives of people living at Thingwall Hall. They told us that one of the questions asked if people were happy with the support provided. Almost all those who replied to the survey said that they were happy with the care and support of their family member. No-one who replied to the survey said they were unhappy with the service provided.

We observed staff interacting with the people in the houses and around the grounds. The care provided was mostly appropriate and well directed. We saw staff offering people choices at meal times and supporting people with their personal care, mobility and with their meals. Staff also encouraged people to get involved in

daily living skills and leisure activities. People seemed happy, comfortable and relaxed with the staff. Almost all staff were respectful of the needs of people and made it clear that people did not have regimented routines for meals or times to get up or go to bed. A member of the inspection team said, "Staff were very welcoming and were able to provide a significant amount of information about each person they were supporting. I felt this was very important as it showed how much detail the staff knew about each person as an individual and that they had a genuine interest".

Most care was provided in a respectful way with staff chatting to people while they supported them. However we were concerned that in one of the houses one member of staff was using outdated and judgemental language when describing one person's episodes of ill health. This showed a lack of respect for the person and a lack of understanding by the member of staff. They also spoke about another person in negative way discussing an incident that had occurred earlier in the day. Some of these comments were made in front of the person, while they were talking to the inspection team. This meant the person heard themselves described in a negative and ill informed way, which would have caused them distress (see outcome 7).

People were involved in individual activities based on each person's likes and dislikes including going out shopping, for meals out, and sports activities. We observed the reading group listening to and getting involved in poetry readings. We saw people going to the swimming pool in a local town, and other people going out to the cinema during our visit. Staff told us of work experiences that some people living at Thingwall Hall were involved in around the site and we talked with some people who were involved who told us they enjoyed their job.

Most people had a range of activities but some people, particularly in the nursing part of the service had fewer opportunities to access activities outside of the grounds. We were told by relatives and some staff that this was mainly because of their limited mobility, limited access to the services minibus and being unable to access public transport. We were told this was further compounded by staffing levels being low at times

People had access to two local citizen advocacy services. Senior staff said people have used these services and gave us an example of a person using an independent advocate when they didn't want to move houses and their family wanted them to. Visitors were welcomed at any time and encouraged to be involved in the life of their friend or family member. People also had good relationships with support staff. This meant that people had a number of ways open to them to express any concerns, including an independent advocate.

<u>Managing behaviour that challenges</u>
Risk assessments about behaviour described as challenging were present for the people whose records we looked at, with the exception of the one person discussed in care planning. There was clear evidence of the techniques or activities to use to distract or diffuse situations in the risk assessments.

There was evidence that other health and care professionals such as occupational therapists, psychiatrists and psychologists were involved with supporting people. This meant that the staff team were utilising the expertise available to them to

develop their skills and knowledge to assist with the complex needs of people in their care.

Senior staff discussed how incidents were recorded, reported, and monitored and how this information helped with amending care plans. This meant that staff had monitored the number of incidents, looked for patterns of behaviour or lessons to be learnt from incidents.

Our judgement

The majority of staff were respectful and treated people in non judgemental way.

People's care and support needs were assessed and most care plans were detailed and up to date. However some had information missing or were not up to date and this reduced the effectiveness of planning and modifying care and support.

There were activities and experiences in place for most people but opportunities for accessing the community had recently been limited.

Information on people's health needs was usually detailed and well managed. However, there were occasions when there was not sufficient information on people's changing healthcare needs and this resulted in a lack of consistency in the care delivered.

This meant that some people were not experiencing effective, safe and appropriate care, support and treatment that met their needs and protected their rights.

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is Compliant with

Outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We spoke with people about whether they felt safe and well supported at Thingwall Hall Nursing Home. We asked people what they would do if they were unhappy or scared. They told us they could tell staff or their families.

Relatives spoken with were confident that their family member was safe and well looked after at Thingwall Hall. A relative said that staff were open and accessible and willing to share any concerns. There had been one issue of concern relating to their family member. Staff had alerted them that there may have been an issue. They kept them up to date and involved and dealt with the issue appropriately. Another relative said they had experienced no issues with their family member's support.

Many people we spoke with had limited communication and were unable to answer specific questions. However we observed care and support in the houses and people were almost always treated in a respectful way. People we spoke with told us that they had been given information about abuse. They said they did not feel scared at Thingwall Hall Nursing Home and that staff kept them safe. One person told us, "I would tell the staff if people were unkind."

Other evidence

Preventing abuse

We spoke with nine members of staff, all were all aware of the safeguarding policy and procedures. We looked at these and they gave clear guidelines to staff. Staff told us they received regular training about protecting people from abuse. Senior staff told us they had appropriate systems in place to prevent and identify abuse and the risk of abuse. There was easy read prevention of abuse information sheet and staff said they discussed this with people.

Members of staff we spoke to were aware of whistle-blowing procedures. They were able to explain to us what they would do if they needed to use these to raise concerns. Staff spoken with were confident that they would be supported if they reported abuse. People had access to independent advocates when they wanted to use them, so they could speak to people outside of the organisation if they wanted to.

Staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards and felt this had increased their understanding. The staff we spoke to understood the provisions of the Mental Capacity Act (MCA) that relate to Deprivation of Liberty Safeguards (DoLS) applications. They told us that where applicable, they only use DoLS when it is in the best interests of the person who uses the service and in accordance with the MCA. Senior staff had been trained to recognise situations where an application may be required and were aware of the procedure.

Responding to allegations of abuse

Staff had all received safeguarding training and said they would follow the organisation's safeguarding policy. They were able to explain the correct procedures to follow if they suspected abuse or if abuse had been disclosed to them. Senior staff told us any safeguarding concerns were reported to the local authority. We reviewed safeguarding issues and these were managed appropriately and had been reported to CQC so that we were aware of any issues of concern.

Staff were aware of the steps to follow if a person made an allegation of abuse against another person or a member of staff. A member of staff told us, "If I saw anyone abusing someone I would report it straight away". Possible safeguarding alerts and concerns had been routinely reported to the Commission as required by the regulations.

At the end of the first day of our inspection, we informed senior staff about a member of staff who had shown a lack of respect, confidentiality and understanding of appropriate support to people in their care. The following day senior staff informed us the action they had taken in response to our information. After making sure the people living in this house who were affected by the person's behaviour were not distressed, they discussed this concern with the member of staff. They also looked at whether anyone else in this part of the service was behaving in a similar way. They met with staff in this part of the service and arranged additional training and supervision to ensure that the staff were fully aware of the expectations of how they must treat people they support with respect. Senior staff had also

informed the Local Authority through the safeguarding team of the issue and were awaiting further contact from them. These measures reduced the longer term impact of the member of staff's behaviour on the people affected by it.

Using restraint

Senior staff told us that physical intervention is not used unless in an emergency or if an individual needed a specific physical intervention. Staff received training on reducing potentially aggressive situations. If a situation occurred where a physical intervention was needed, this was evaluated and the care plan amended where needed. Staff then received training in physical intervention personalised to that individual. Senior staff gave an example of one person who had in the past had behaviour that challenged and needed some physical intervention to manage this. Staff received training in physical intervention to manage the immediate situation. They also realised that the person did not want to live with others, so arranged for the person to move into a small house on site supported by a small team. Very quickly the behaviour that challenged reduced and the person no longer needed any physical interventions.

The staff we spoke with said they avoided restraint as the preferred option is to use de-escalation techniques to prevent behaviour that challenges. We looked at the records of a small number of individuals that had behaviour that challenged and their records reflected this. Senior staff told us there had been no restraints in the previous twelve months and alternative ways of managing behaviour were used whenever possible.

Our Judgement

Procedures were in place to minimise and prevent abuse. Staff were appropriately trained to recognise the signs of abuse and how to respond and raise concerns. Where concerns were raised, they were dealt with appropriately.

Strategies for managing behaviour that challenged were safe and appropriate with records in place so that all involved had the information they needed to support the person effectively

Incident reports were detailed and were reviewed to see if alternative strategies could have been used and care plans modified accordingly.

People were receiving safe and appropriate care in order to keep them safe and their well-being promoted.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	9	4: Care and welfare of people who use services
	How the regulation is not being met: The majority of staff were respectful and treated people in non judgemental way. People's care and support needs were assessed and most care plans were detailed and up to date. However some had information missing or were not up to date and this reduced the effectiveness of planning and modifying care and support. There were activities and experiences in place for most people but opportunities for accessing the community had recently been limited. Information on people's health needs was usually detailed and well managed. However, there were occasions when there was not sufficient information on people's changing healthcare needs and this resulted in a lack of consistency in the care delivered. This meant that some people were not experiencing effective, safe and appropriate care, support and treatment that met their needs and protected their rights	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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