Numada Health Care Limited

Thalassa Nursing Home

Inspection report

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Date of inspection visit:
03 June 2019
06 June 2019

Date of publication:
20 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Thalassa Nursing home is a care home that can provide personal and nursing care to up to 47 people. At the time of the inspection they were providing support to 44 people, some of whom lived with dementia.

People's experience of using this service:
People were supported by staff who showed kindness, compassion and respect towards them. They told us they felt safe and listened to living at Thalassa Nursing Home.
Staff's knowledge of people's history, preferences and risk associated with the care and support needs was good. Staff respected and encouraged people to make their own decisions.
Recruitment practices remained safe and there were plenty of staff to meet people's needs. People were protected from avoidable harm, received their medicines as prescribed and infection control risks were managed appropriately.
The management team were open and transparent. They understood their regulatory responsibility. No one had any complaints and felt the management team were open, approachable and supportive. Everyone was confident the provider would take the necessary actions to address any concerns promptly. Feedback about the management team demonstrated they listened and took any feedback as an opportunity to make improvements for people.
Care records required further development to ensure they were person centred and gave accurate guidance to less familiar staff. Activity provision was limited, and we have made a recommendation about this.

Due to the need to make improvements to records the service met the characteristics of requires improvement in some areas; more information is in the full report
Rating at last inspection: Good (last report published 18 October 2016)

Why we inspected: This was a planned inspection to ensure the provider was meeting the requirements of the legislation.

Follow up: There is no required follow up to this inspection, but we will continue to monitor all information received about the service, to understand any risks that may arise and to ensure the next inspection is scheduled accordingly.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was well-led. Details are in our Well-Led findings below.	**Good**

Thalassa Nursing Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was conducted by two inspectors and an Expert by experience. An expert by experience is someone who has personal of professional experience of this type of service.

Service and service type:
The service is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we gathered information from: Six people who used the service, four relatives, the registered manager, head of care, the nominated individual and eight staff. We viewed the care records for

all five people, records for the management of medicines, records of accidents, incidents and complaints, together with audits and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe because records about risks for people were not always clear. This could increase the risk that people could be harmed.

Assessing risk, safety monitoring and management:
• Staff had good knowledge of the people they supported. They were aware of risks associated with their care, how to monitor for these and the action to take to reduce these risks.
• Records mostly reflected that risks were assessed, and plans developed to mitigate these. However, there were occasions when the records needed to be improved upon. For example, one person living with severe contractures of the limbs had no plan in place to reduce the risks of these deteriorating or causing further health implications.
• For a second person daily records did not always reflect that the care outlined in their plans was being delivered consistently. For example, one person's care plan highlighted that they required their position to be changed every two to three hours. However, the person's repositioning chart did not reflect that their position was being changed in line with their care plan. In addition, records for this person were inconsistent regarding their ability to consume food and drinks, placing them at risk of receiving incorrect and unsafe care by staff who may be unfamiliar to the person. We raised this with the registered manager who removed the inaccurate records from this person's file. However, this information had been present in the files since their dietary intake changed in March 2019.
• Other records provided more information and we saw these were followed and regular checks undertaken. For example, where people were at risk of skin damage, plans in place identified the need for pressure relieving equipment which we saw being used. Daily records reflected the equipment was being checked regular by staff who understood how to do this.
• Equipment was managed in a way that supported people to stay safe. Regular maintenance checks took place of equipment, such as hoists and lifts. Where it had been assessed that a person required the use of bed rails, staff ensured that protective bumpers were also in place to prevent any injuries. The bed rails were checked regularly by staff to ensure they were safe and working correctly.

Systems and processes to safeguard people from the risk of abuse:
• Appropriate systems were in place to protect people from the risk of abuse and people told us they felt safe. One person said, "Yes, it's the proximity of others and having a room to myself, that makes me feel safe". A relative said, "Yes. I couldn't ask for more. The manager and everyone are great. [The manager] sorts it all out. Everything is superb".
• Staff had the knowledge and confidence to identify safeguarding concerns and had attended training in safeguarding people at risk. Staff were aware of types and signs of possible abuse. The registered manager was aware of their responsibilities in safeguarding procedures.
• Where concerns that were of a potential safeguarding nature were identified, these had been investigated and reported to the appropriate external bodies.

Staffing and recruitment:
• There were sufficient staff to meet people's needs. People told us they felt there were enough staff to meet their needs and they didn't have to wait long for staff to respond to their requests. One person told us, "I've never had any problem with staff shortages. They're pretty good, they work hard". A second person said, "You could always do with more, but it's very good".
• The registered manager told us staffing levels and skill mix were arranged based on the needs of individuals. Our observations reflected staff responded promptly to people requests for support.
• People were protected against the employment of unsuitable staff as the provider followed safe recruitment practices.

Using medicines safely:
• Appropriate arrangements were in place for obtaining, storing, administering, recording and disposing of medicines safely and in accordance with best practice guidance. One person told us, "They bring it (their medicines) to me. I don't have to worry about it".
• Registered nurses administered medicines and had been assessed as competent to do so safely.
• Medicine administration records confirmed that people had received their medicines as prescribed. There was information about 'as required' medicines and when these should be offered to people.

Preventing and controlling infection:
• The service manages the control and prevention of infection well.
• Staff received infection control training.
• Staff had access to and used appropriate personal protective equipment.
• The home was clean, tidy and free from bad odours.

Learning lessons when things go wrong:
• When something goes wrong the service responds appropriately and uses any incidents as a learning opportunity.
• Incidents and accidents were monitored and reviewed regularly by the registered manager and head of care to identify any patterns or trends. They were analysed for any necessary action and learning was discussed with staff. Staff confirmed that learning from incidents and accidents was shared with them.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs:
• The home was not purpose built but did provide adequate space for people to enjoy time with one another or on their own.
• People had their own rooms that they had personalised and could choose to spend time in the small lounges or main activities rooms.
• Further work could be done to ensure that the environment would be supportive to those living with dementia. Direction signage helps to orientate people, but this was lacking. Some people might find it difficult to identify their bedrooms as there was no signage to show the room was a bedroom and only written text was used to aid people in recognising it was their room. People with dementia often find contrasting colours helpful in orientating them, however these had not been used.
• The provider was aware of the need to improve the environment for those people living with dementia and the head of care told us the provider used the Kings Fund audit tool to assess this but that this had not yet been completed for this service. They told us they intended to do this following the inspection.

Ensuring consent to care and treatment in line with law and guidance:
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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Staff had received training in the MCA and were able to talk to us about how they applied this to their day to day practices. They were aware of the need to gain consent and we observed them gaining this throughout our visit.
• Staff told us how they supported people to make their own decisions and where they were not able to they applied best interests decisions making processes.
• However, at times consent forms had been signed by people's relatives when this either wasn't required or they did not have the legal authority to do so. The registered manager told us they would address this.

• Whilst we saw best interests decisions had been made and relatives confirmed this, the assessment of people's capacity was not consistently recorded.
• Applications for DoLS had been submitted to the supervisory body responsible for assessing and approving these. At the time of our visit none had any conditions associated with their DoLS

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Prior to moving into the home, the registered manager undertook a pre-admission assessment involving the person and any other relevant people. This ensured they could meet the person's needs.
• The registered manager was clear that any specific training needs would be delivered prior to a person moving in if this was required and provided an example of when this had taken place.
• Once this information was gathered and the person moved in additional nationally recognised assessment tools were completed and the information helped to inform the development of people's care plans and risk assessments.

Staff support: induction, training, skills and experience:
• Staff completed an induction when they started working in the home. This involved four days training which covered the care certificate before a local home induction and the completion of a 12 week assessed skills for care workbook. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.
• Staff were encouraged and supported to undertake vocational qualifications.
• All staff were supported through supervisions and appraisals.
• Staff received training to enable them to have the skills and knowledge to support people effectively. Staff told us they found the training helpful in their role and were able to talk to us about what they had learned from this.
•The registered manager and head of care told us how the provider was developing a competency assessment framework for all staff which would enable them to be confident staff were competent in aspects of their work.

Supporting people to eat and drink enough to maintain a balanced diet:
• People were protected from risks of poor nutrition, dehydration and swallowing problems. Where people required their food to be prepared differently because of medical need or problems with swallowing this was catered for.
• People's nutritional status was monitored, and action taken where a person was losing weight. For example, we saw the dietician had been contacted for one person and the GP for another.
• Staff were knowledgeable about people's differing dietary requirements. Kitchen staff told us they were kept informed by nursing staff of people's needs, like and dislikes. They used this information to ensure people received meals that would provide them with good nutrition and that they would find appetising.
• People told us they were given a choice of meals and if they did not want what was on the menu, alternatives were available. One person's culture was considered and accommodated by kitchen staff.
• People received appropriate support during meals.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care:
• People told us if they needed to see a doctor they were supported to do so. One person said, "Yes, they do that. I see my own doctor if possible or a nurse. I'm going to hospital tomorrow. Someone is coming with me to the hospital. You don't go alone. My [relative] is coming, but they want someone else to come as well".
• Handovers between staff took place to ensure they were kept up to date about everyone's needs.
• Where people required support from external healthcare professionals this was organised, and staff

followed guidance provided.
• Records confirmed regular access to GP's, district nurses and other professionals.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
• People and their relatives told us they felt staff were caring and that they were listened to. Comments included; "I've never had a problem. I've always got along alright with the staff. I do whatever they ask me and vice versa"; "Certainly by the manager. With her it's what it says on the label. She says, 'Come anytime'. She's marvellous. I would be very sorry if she moved off anywhere else". Relatives told us staff were "Very, very understanding" and "They're wonderful. They're an absolute wonder".
• The atmosphere in the service was warm and friendly with staff observed to give individual attention to people when needed.
• Our observations of staff interactions with people showed that people were treated with kindness, compassion, dignity and respect; People were clearly relaxed and comfortable in the company of staff.

Supporting people to express their views and be involved in making decisions about their care:
• Although most people could not recall being involved in their care plans, they all said they felt listened to and able to express their views. Staff supported people to make decisions about their care, for example, when they wanted to get up, what they wanted to wear, how they wanted to spend their time.
• Staff understood peoples' communication needs and the registered manager assured us that information would be provided in a format that people needed to help them understand.
• People said were confident to talk to any staff about any concerns they might have.

Respecting and promoting people's privacy, dignity and independence:
• Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments before they moved to the home. Staff recognised people's diverse needs and there were policies in place that highlighted the importance of treating people as individuals; The provider ensured staff received training in dignity and respect; person centred care and equality and diversity to aid their understanding.
• The registered manager and staff were clear that discrimination would not be tolerated and were confident any human rights or equality needs people had would be met.
• Staff described how they protected people's privacy when supporting them with personal care. This included listening to people, respecting their choices and closing doors and curtains.
• On the first day of our visit some records were not stored securely but the registered manager took action, and this was rectified by the second day. Peoples' right to privacy and confidentiality was respected. Where needed conversations in public areas were discreet.
• People were supported to maintain as much independence as possible. Equipment aids were used in order that people could continue to eat meals independently. One person was enthusiastic about a member of

staff and the assistance she received to exercise in order to improve their mobility.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Although people's needs were met and changing needs responded to, further work was needed to ensure meaningful stimulation for people and accurate records.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• We observed very little in terms of activity provision that people wanted to engage in throughout the inspection. Although staff interacted with people kindly, this was often when they were providing direct care.
• People told us activities took place, but they often chose not to engage in these. One person said, "There's lots. I don't do it. I'm not ready to play ball. They have keep fit and they sing for them (other people). Yesterday a girl brought her owl and a dog comes once a week". A second person said, "I'm a guilty one, I don't go into the lounge, but from what I've seen it's excellent. A woman comes several times a week".
• Activity staff confirmed people were not formally involved in planning activities that took place. They said that games, quizzes and entertainments were provided but craft activities were more difficult to organise because people required help to take part and there were not enough staff to support this. They told us carers visited people in their rooms, massaging their hands or polishing their nails.
• The registered manager told us that they wanted to develop the activity provision in the home but were finding that most people did not want to engage.

We recommend the registered person seek guidance and advice from a reputable source about the planning and provision of meaningful activities for people.

• The registered manager was aware of the need to further develop care plans to ensure that they contained person centred detail including people's needs, likes, dislikes and preferences. Staff had recently undertaken training in care planning as the registered manager wanted to ensure care staff's knowledge of people was incorporated into the plans.
• Staff's knowledge of people was really good. They understood people's history, likes, dislikes as well as their support needs.
• Where a change in people's needs was identified this was quickly responded to. For example, when people had lost weight, prompt contact was made with either the GP or dietician as appropriate and changes to people's support were implemented.

End of life care and support:
• No one was receiving end of life care at the time of our inspection.
• The registered manager was aware that care plans could be further developed to ensure people's preferences for end of life care were reflected.
• Some staff had received training to support them to understand end of life care and further training was either in the process of completion or booked. Staff were aware of good practice and guidance in end of life care, and respected people's religious beliefs and preferences.

Improving care quality in response to complaints or concerns:
• A complaints procedure was available, and people knew how to access this. People were confident that if they raised concerns these would be addressed, and appropriate action taken as a result. One person told us, "We just meet up and talk over small issues. You discuss it and it's sorted". A relative said, "I tell [manager] if I'm not happy with a person. I tell her and she'll listen"
• Records confirmed that any concerns or complaints reported had been investigated, responded to and action taken to prevent reoccurrence.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
• People spoke positively about the management of the service and told us they would recommend the home to others. One person said, "Everything about it is comfortable. You're well looked after. I've liked it since the beginning". A relative told us when asked if the home was well led, "It appears to be. Everyone seems to know where they're going and what they're doing and they keep up to date with training".
•The registered manager demonstrated an open and transparent approach to their role. There were processes in place to help ensure that if people came to harm, relevant people would be informed, in line with the duty of candour requirements. CQC were notified of all significant events.
• People, relatives and staff were confident about raising any issues or concerns with the registered manager and said their door was always open. One member of staff told us, "(The manager) is absolutely amazing". They described the registered manager as easy to talk to, very organised and very supportive. A person told us, "(The registered manager's) very open, very friendly. You can see her anytime".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• There was a clear staff structure throughout the service. All staff were clear about their roles and responsibilities towards people living at the home. Champions roles were being introduced into the service and staff were receiving additional training to support them in these roles
• The provider had a range of quality assurance process in place, including multiple audits of the service. Most of these had been effective and led to contact with other professionals or improvements being made. Although they had recognised the need for more person-centred care records, care plan audits had not always identified when there was a lack of clear information about risks.
• The registered manager had developed an action plan to develop the service and make improvements where needed. This included, ensuring care plans aligned with risk assessments. We discussed with the registered manager how the action plan may be more effective with clear timescales and with people being formally allocated responsibility. The registered manager told us they would develop this plan further.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff told us they felt listened to and supported. They confirmed regular meetings took place and that they were actively encouraged to provide feedback and make suggestions which would improve things for people.
• Although regular formal meetings with people and their relatives did not take place, everyone knew the

registered manager and spoke positively about how they were engaged with and asked their views.
• Feedback surveys were given out twice a year to people, relatives and health and social care professionals. Following this feedback action plans were developed and carried out. For example, we saw one action carried out had been to allocate consistent care staff to certain areas of the home to help build relationships.

Working in partnership with others
• Staff had developed links to other resources in the community to support people's needs and preferences. For example, the salvation army visited one person who could no longer go to them. Local churches provided religious support to those who wanted this.
• Staff worked closely with other health professionals to ensure people received the support they needed.