Leicestershire County Care Limited

Thurn Court

Inspection report

Thurncourt Road
Thurnby Lodge
Leicester
Leicestershire
LE5 2NG

Tel: 01162413126

Date of inspection visit:
27 November 2023
28 November 2023

Date of publication:
08 January 2024

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Thurn Court is a purpose built care home providing accommodation and personal care for up to 44 people with mental health, sensory impairment, physical disabilities, older people, and people living with dementia. This includes the assessment unit for up to six people discharged from hospital for short term placement for the purpose of rehabilitation and the assessment of ongoing care and support needs. At the time of our inspection 33 people were using the service.

People's experience of using this service and what we found
Potential risk related to people's care, health and welfare were assessed and kept under review. Records showed improvements were needed to ensure actions to mitigate risk when implemented were recorded in a timely manner. This was supported by the provider's analysis of records, which they had highlighted with staff as an area for improvement.

Systems and processes for the reporting of safeguarding concerns, were in place which were understood by staff. People's medicines were managed safely, supported by clear guidance and protocols. People were supported by sufficient and experienced staff who had undergone a robust recruitment process.

External contractors maintained systems and equipment. There were safe infection and preventions measures in place.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and relatives were positive about the quality of the care they received, and of the inclusive and friendly atmosphere of the service. Observations showed staff provided empathetic care and support, and put people at the heart of the service. A health care professional involved in decisions related to people's health, informed us that staff worked collaboratively with them to achieve good outcomes for people.

Monitoring of the service was carried out through a range of audits, and the seeking of feedback about the quality and the service provided from people and their relatives. Staff worked collaboratively with a range of health and social care professionals to support people's health and wellbeing. The outcome of internal audits and the analysis of events within the service were shared with staff to drive improvement.

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

Rating at last inspection
The last rating for this service was Good (published 17 August 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Thurn Court on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Thurn Court

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Thurn Court is a 'care home.' People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Thurn Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people using the service and 3 relatives. We spoke with the registered manager, the operations manager, a senior care assistant, 2 care assistants, the activity co-ordinator, a cook and the administrator. We reviewed a range of records. This included 5 people's care records and multiple medication records.

We looked at 2 staff files in relation to recruitment and a variety of records relating to the management of the service. Following our site visit the provider continued to provide information, which included data to support quality assurance and staff training.

Following the inspection
The provider submitted additional evidence to support how the registered manager monitored the service and staff, and included information as to how the outcome of audits, engagement with external organisations and learning from incidents were used to drive improvement.

Good

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- The provider had systems in place to safeguard people from abuse. Safeguarding referrals were made to the appropriate organisations in a timely manner, consistent with local safeguarding protocols.
- The registered manager kept a record of all safeguarding concerns. The information included the nature of the concern, who had raised the concern and its outcome.
- People told us they felt safe at Thurn Court, some stated this was because they wore a pendant and had access to call bells, which meant they could request staff assistance if needed. A person said, "Staff respond when I press the button, I have a call bell pendant around my neck."

Assessing risk, safety monitoring and management; Lessons learnt
- Potential risks to people were assessed, which included actions to be carried out by staff to reduce known risks. We found improvements were needed to evidence the actions taken to reduce risk were documented, consistent with people's assessed needs. For example, staff confirmed 2 hourly welfare checks were carried out as when required, however they would sometimes complete care records later in the day and did not always include the time the welfare check was undertaken.
- The provider's internal quality monitoring had highlighted most falls happened at night. As part of lessons learnt staff had been reminded of the importance of ensuring 2 hourly checks were carried out and recorded within the agreed time frame.
- Potential risks to people were assessed and kept under review to promote their safety. People's care records provided guidance for staff on how to reduce risks. For example, the use of sensor mats to help prevent falls. Sensor mats trigger an alarm when a person gets up from a chair or bed, enabling staff to respond and provide timely assistance.
- Staff were knowledgeable as to people's needs and provided a clear account of the support and care they provided. For example, by providing reassurance and using distraction techniques where people became anxious or distressed.
- Processes were in place for the reporting and following up of accidents or incidents. For example, in the event of a person having fallen, staff would increase the frequency in monitoring of the person to ensure in the event the person's health deteriorating action could be taken in a timely manner if required.
- People's safety was maintained by staff and external contractors who undertook scheduled checks of systems and equipment to ensure they were in good working order.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● Best interest decisions had been made where people were assessed as lacking capacity to make an informed decision. Best interest decisions involved professionals and family members, including people's legal representative where Lasting Power of Attorney (LPA's) had been granted for health and welfare and/or financial affairs.
● A relative who had an LPA in place for health and welfare for a family member confirmed staff liaised with them about decisions relating to their family members care, and told us they spoke directly with the GP.
● People told us they made day to day decisions, which included what time they got up or went to bed, the clothing they wore, and where they ate their meals.

Staffing and recruitment
● Staffing numbers were continually reviewed based on people's needs. This meant there were sufficient numbers of staff with the necessary training, skills and competence to support people's safety and meet their needs.
● People had a pendant, which they could use to request staff assistance. Care records instructed staff to check and record call bells were close to hand for people to use to request staff support when they were in bed.
● Staff were recruited safely. Staff records included all required information, to evidence their suitability to work with people, which included a Disclosure and Barring Service check (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer.

Using medicines safely
● Medicines were received, stored, administered and disposed of safely.
● Staff had undertaken training in medicine management, which included assessments of competence by health care professionals for specific styles of medicine administration. For example, the application of transdermal patches.
● People were supported with their medicines in a safe and timely way. People's records detailed the prescribed medicine, which included guidance as to the use of medicine to be given as and when required. For example, to reduce people's anxiety when they became anxious, to control pain and manage symptoms as part of end of life care and support.
● People were aware of the medication they took, which included medicine to help with pain. A person said, "I have a pain patch, its changed every Saturday, I take paracetamol as well."

Preventing and controlling infection
● People were protected from the risk of infection as staff were following safe infection prevention and control practices.
● People spoke positively of the cleanliness of the service. A person said, "Staff come and clean my room every day."
● Staff had undertaken training in infection prevention and control and provided care and support consistent with the provider's policy and procedure. For example, staff wore gloves and aprons, known as

personal protective equipment, when providing personal care.

Visiting in care homes

● People were supported to maintain contact with their family and friends. There were no visiting restrictions, and we noted staff welcomed visitors to Thurn Court throughout the inspection.

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.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives were positive about the atmosphere of the service and its impact on them. A person said, "I haven't a family, they [staff & others] are my family. They have made me family." A relative told us, "A very organised and friendly home, we never felt unwelcome, always offered us a cup of tea."
- Relatives spoke positively of the care provided. A relative told us how their family member had flourished since moving to Thurn Court. A second relative said when speaking of the service, "It couldn't have been in a better place."
- Our observations supported an inclusive environment, which encouraged individuals' independence and decision making. People were seen serving themselves vegetables from serving dishes at lunchtime, adding condiments to their meal, and making choices from the menu.
- Staff have a good rapport with people, and demonstrated empathy and care in their care interactions. Good outcomes for people were supported through a range of activities, led by an enthusiastic activities organiser. Upcoming events for the Christmas period included parties and a church service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager worked in an open and transparent way when incidents occurred at the service in line with their responsibilities under the duty of candour. This meant they were honest when things went wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes were in place which enabled the registered manager to have clear oversight of the quality and safety of the service.
- Audits were undertaken by the management team in a range of areas, which included medicine, infection prevention and control, people's dining experiences, and health and safety. The outcome of audits and reviews of incidents were shared with staff collectively and individually through e-mail, internal meetings, supervision and the provider's electronic monitoring system.
- Incidents and events were shared by the operations managers with the registered managers of all the providers' services.
- An external health care professional spoke of the dedication and diligence demonstrated by the registered

manager, and the support and encouragement they offered to staff.
● Staff were complimentary about the leadership and management of the service; with many staff saying the registered manager was supportive and approachable.
● Staff were supported through supervision, observed practice and training, which enabling them to provide good quality and safe care.
● The registered manager was aware of future changes in CQC's approach to regulation, and had attended webinars organised by CQC to gain insight and information.

Working in partnership with others
● The registered manager, management team and staff worked collaboratively with partnership organisations, which include the local authority, safeguarding teams and health care professionals to support the delivery of good quality care for people.
● People spoke of regular support from the GP and district nurse, which included support from occupational therapists for those who accessed Thurn Court for the purpose of rehabilitation. A person told us, "I have a care plan for discharge after having an assessment to assess care required when I return home."
● An external health care professionals informed us senior staff showed an excellent level of knowledge about people at Thurn Court, and any instructions given were followed by staff and documented.