Welmede Housing Association Limited

Glebe Cottage

Inspection report

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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

Overall summary

The inspection of Glebe Cottage took place on 8 April 2015 and was unannounced. 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 and to look at the overall quality of the service. The previous inspection was carried out on 23 September 2013 and found that the provider had met the standards required.

Glebe Cottage is a residential home which provides accommodation and personal care for up to six people, who are living with a learning disability and have complex needs. At the time of our inspection there were five people who lived there. Whilst people were unable to take part in full discussions, we were able to speak with and observe how they interacted with staff. The premises consisted of a detached house with accommodation arranged over two floors with a spacious and secure garden for people to use.

At the time of our visit, Glebe Cottage had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People were safe at Glebe Cottage, a relative told us, "My relative is very safe here." Staff had a good understanding

Summary of findings

about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

There was sufficient amount of staff deployed to meet people's needs. People were supported by staff that had the necessary skills and knowledge to meet their needs. Recruitment practices were safe and relevant checks had been completed before staff started work. Staff worked within best practice guidelines to ensure people's care, treatment and support promoted well-being and independence.

Medicines were managed safely. Any changes to people's medicines were prescribed by the person's GP.

Staff were up to date with current guidance to support people to make decisions. Information about the home was given to people and consent was obtained prior to any care given. Where people had restrictions placed on them these were done in their best interest using appropriate safeguards.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The home worked effectively with healthcare professionals and was pro-active in referring people for treatment.

Staff involved and treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. Relatives and friends were able to visit. People's privacy and dignity were respected and promoted for example when personal care tasks were performed.

The home was organised to meet people's changing needs. People's needs were assessed when they entered the home and on a continuous basis to reflect changings in their needs. People who wanted to move into the home would come on a trial period, so they could ascertain whether the home meet their needs.

People were encouraged to voice their concerns or complaints about the home and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the home.

People had access to activities that were important and relevant to them. People were protected from social isolation through systems the home had in place. We found there were a range of activities available within the home and community.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

People's care and welfare was monitored regularly to ensure their needs were met within a safe environment. The provider had systems in place to regularly assess and monitor the quality of the service provided. Management liaised with, obtained guidance and best practice techniques from external agencies and professional bodies.

People told us the staff were friendly and management were always approachable. Staff were encouraged to contribute to the improvement of the home. Staff told us they would report any concerns to their manager. Staff felt that management were very supportive.

Summary of findings

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 safe.

People were protected from abuse and avoidable harm by effective recruitment procedures and staff who were trained to work within current guidance.

People were cared for and supported by a consistent staff team that were suitably qualified, skilled and experienced to keep people safe and meet their needs.

People had risk assessments based on their individual care and support needs.

Medicines were administered and stored safely.

Good

Is the service effective?
The service was effective.

People's care, treatment and support promoted a good quality of life based on good practice guidance.

Staff understood and knew how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was completed in line with appropriate guidelines.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of their health. The home worked effectively with healthcare professionals and was pro-active in referring people for treatment.

Good

Is the service caring?
The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

Interactions between staff and people who lived at the home were kind and respectful. Staff were happy, cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

People's privacy and dignity were respected and promoted. Staff told us they respected people's privacy and dignity when providing personal care

Good

Is the service responsive?
The service was responsive.

The home was organised to meet people's changing needs.

Good

Summary of findings

People's needs were assessed when they entered the home and on a continuous basis. Information regarding people's treatment, care and support were reviewed regularly.

People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service.

Is the service well-led?

Good

The service was well led.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

People told us the staff were friendly, supportive and management were always visible and approachable.

Staff were encouraged to contribute to the improvement of the home and staff would report any concerns to their manager. Staff told us the management and leadership of the home were very good and very supportive.

The provider had systems in place to regularly assess and monitor the quality of the home provided.

Glebe Cottage

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 home, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 April 2015, was unannounced and conducted by two inspectors.

We reviewed records which included notifications, previous inspection reports, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. 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 home, what the home does well and improvements they plan to make.

We contacted the local authority and clinical commissioning group to get their feedback on what they thought about the home. We also contacted three health and social care professionals who visited the home regularly to get their views on the care that was provided.

Due to peoples complex communication needs we were not able to speak directly to people who used the home. We observed how staff cared for people and worked together throughout the day to gain an understanding of the care provided. We spoke with five people, three staff, one relative and the registered manager. We observed care and support in communal areas. We looked at some of the bedrooms with people's agreement, reviewed three records about people's care, support and treatment and the provider's quality assurance and monitoring systems.

The home was last inspected in September 2013 and there were no concerns identified.

Good

Is the service safe?

Our findings

We observed that people were safe and were provided with guidance in a picture format about what to if they suspected abuse was taking place. A relative told us, "My relative is very safe, nothing has ever happened to them." A person wrote, "They keep me safe and clean." A healthcare professional told us, "I have always observed the service to be safe."

Staff knew what to do if they suspected any abuse. A member of staff told us, "People would let us know if there was something wrong, mostly through body language. That is why it is so important to get to know them. If I suspected anything, I would report it to the manager, she would contact social services, safeguarding, police and CQC." The home held the most recent local authority multi agency safeguarding policy as well as current company policies on safeguarding adults at risk. This provided staff with guidance about what to do in the event of suspected abuse. Staff confirmed that they had received safeguarding training within the last year. Information on identifying abuse and the action that should be taken was also freely available for people to look at through posters on display throughout the home.

We saw there were arrangements in place to safely store people's money. We saw each person had their financial income and expenditure recorded and verified. All monies were kept secure, in a locked room. This showed us that the provider had arrangements in place to reduce the risk of financial abuse.

Risk assessments and any healthcare issues that arose were discussed with the involvement of a relative, social or health care professionals such as psychiatrist, community psychiatric nurse, GP or speech and language therapist. Staff were knowledgeable about people's needs, and what techniques to use to when people were distressed or at risk of harm. Risk assessments clearly detailed the support needs, views, wishes, likes, dislikes and routines of people. Risk assessments and protocols identified the level of concern, risks and how to manage the risks. For example, where a person's complex mental health needs, required protection from eating things that were not food, staff put measures in place to ensure that access to things that would cause harm was stored safely or cleared away. The information provided enabled care and treatment to be planned in accordance to people's needs.

Also we saw information which identified where people were susceptible to injuries, or exhibited behaviour that challenged the home which could place people at risk of harm. Very detailed information and guidelines were given to staff on how to support the person and what things needed to be done to alleviate the situation or behaviour. Action plans were put in place in accordance to people's care and support needs.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used. This minimised the impact to people if emergencies took place.

We saw that entry to the home was through a bell system managed by staff. We saw a book that recorded all visitors to the home. The entrance to the back garden was secure through a locked back gate. This meant there were arrangements in place for the security of the home and people who lived there.

There was sufficient number of staff to keep people safe, the consistent staff team were able to build up a rapport with people who lived at the home. This also enabled staff to obtain an understanding of people's care and support needs. The staffing rotas were based on the individual needs of people. This included, supporting people to attend appointments and activities in the community. The registered manager told us they were in the process of increasing the staffing levels. We noted on the day of our visit, that people's needs were met promptly and they were given one to one support throughout the day.

There was a staff recruitment and selection policy in place. Staff confirmed they submitted an application form providing full employment history, information about previous training and qualifications, two referees and proof of identity. We saw that the provider had obtained and verified information provided and completed criminal record checks before staff started work. New staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

We checked the arrangements for the storage and recording of medicines. Medicines were stored securely

Good

Is the service safe?

and in appropriate conditions. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded.

Only staff who had attended training in the safe management of medicines were authorised to give medicines. We saw evidence that staff attended regular refresher training in this area. Once they had attended this training, managers observed staff administering medicines to assess their competency before they were authorised to do this without supervision. We saw staff administered medicines to one person, they explained the medicine and its function. Staff waited patiently until the person had taken the medicine.

We checked medicines records and found that a medicines profile had been completed for each person and any allergies to medicines recorded. The medicines administration records we checked were accurate and contained no gaps or errors. Any changes to people's medicines were prescribed by the person's GP.

Good

Is the service effective?

Our findings

A person wrote, “They support me with all my needs.” Staff told us, “We are here to care for and support the residents.” There were sufficient qualified, skilled and experienced staff to meet people's needs. The registered manager ensured staff had the skills and experience which were necessary to carry out their responsibilities. Staff confirmed that a staff induction programme was in place. The registered manager confirmed that they did not use agency staff, so additional duties were covered by existing staff within the home or other local homes managed by the provider that are knowledgeable about people and understood their individual needs.

Conversations with staff and further observations confirmed that staff had received training and that they had sufficient knowledge to enable them to carry out their role safely and effectively.

Staff provided us with guidelines of how to approach people during our visit to ensure we did not trigger issues that would cause them anxiety and not to leave anything unattended as this could cause harm to people living at the home.

A person wrote, “There is continuity of support that I know.” We saw that people were supported and staff knew what they were doing. The provider promoted good practice by developing the knowledge and skills staff required to meet people’s needs. All new staff had induction training relating to the ‘Learning Disability Award Framework’ that consists of maintaining safe working practices, maintaining a safe environment, confidentiality, consent, infection control, how to manage behaviour that is challenging, as well their roles and responsibilities.

All staff had been trained in areas relevant to their role such as: medicines, safeguarding, moving and handling, fire awareness, first aid, food hygiene, epilepsy awareness, health and safety, infection control, Autism and Asperger’s awareness, Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS), and Control of Substances Hazardous to Health (COSHH). This meant that people were supported by staff that had the necessary training to meet their needs.

Staff told us they had regular meetings with their line manager to discuss their work and performance. A member of staff said, “We talk about issues and training during supervision, I feel very supported.” The registered manager confirmed that monthly supervision and annual appraisals took place with staff to discuss issues and development needs. We reviewed the provider’s records which reflected what staff had told us. This meant that staff had received appropriate support that promoted their professional development.

We saw staff obtained consent before carrying out any tasks for the person. We heard staff ask people, if they would like to come with them so they could help them, or what would you like to do listen to some music or watch their favourite programme. Staff had a clear understanding for the need to obtain consent and the protection the MCA provides. The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. We saw assessments had been completed where people were unable to make decisions for themselves and who were able to make decisions on their behalf, made in their best interests.

The registered manager had made a number of DoLS applications in line with the latest judgment. We saw that people were able to move freely around the house. DoLS provide a legal framework to prevent unlawful deprivation and restrictions of liberty. They protect people who lack capacity to consent to care or treatment and need such restrictions to protect them from harm.

People had their needs assessed and specific care plans had been developed in relation to their individual needs. For example where people had specific dietary needs relating to their condition, guidelines were in place to monitor and review their needs, as well having safety measures in place to minimise the risk of harm to themselves. Staff monitored people during mealtimes to ensure that people’s mental health needs were supported and did not triggered behaviours in others.

People assisted staff with the preparation and cooking of meals. People were involved in the consultation about the choice of menu for breakfast, lunch and tea. There was a choice of nutritious food and drink available throughout the day; however an alternative option was available if people did not like what was on offer. The menu was in

Good

Is the service effective?

pictorial format so it was easier for people to understand and make informed choices. Staff confirmed that a dietician was involved with people who had special dietary requirements.

People were supported to have their nutrition and hydration needs met. Specialist plates are available for people to use, to promote independence. Detailed information about people's food likes and dislikes and preferences such as religious or cultural needs was available. Guidance was provided to staff about how to approach people about their food likes and dislikes as this could trigger people's anxiety levels.

People had access to healthcare professionals such as GP, district nurse, occupational therapist, dietician, behavioural therapist and speech and language therapist and other health and social care professionals. People has access to a learning disability nurse at a local hospital, who liaised with people to ensure they have a smooth transition whilst using the hospital's facilities. We saw from care records that any changes to people's needs, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People also have access to a specialist dentist who is experienced with people living with complex needs. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records. This meant staff was given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. The atmosphere in the home was calm and relaxed during our inspection. Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring. People were happy and laughing whilst enjoying being with staff. We saw from feedback given by people who lived at the home a person wrote, "They [staff] care and are motivated." Another person wrote, "They know me." A relative said, "My only contact with Glebe Cottage is on the phone, all staff are patient, upbeat and helpful." A healthcare professional told us, "The support workers that I have worked with have demonstrated a caring attitude towards people."

People are able to make choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them. We noted that people had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations. For example when people refused to attend dental treatment, staff discussed the reasons behind the refusal and involved and obtained guidance from a specialist dentist who is experienced with people living with complex needs to ease the transition from refusal to having treatment.

During our observations, we saw a member of staff gently assist a person who was not fully clothed and need their modesty and dignity upheld. The process was carried out sensitively and skilfully to promote the person's dignity and respect. During the process the person was constantly reassured and told what was happening.

Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed. We saw detailed information in care records that highlighted people's personal preferences, so that staff would know what people needed from them. "We have residents who have challenging behaviour, so we make sure that we use the right techniques to calm them down such as making them a drink, talking to them or take them out to places they like." Information was record in people's plan about the way they would like to be spoken to and how they would react to questions or situations. For example if I am laughing, I am happy; if I am rocking that means I am anxious. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them. We noted that care records were reviewed on a regular basis or when care needs changed.

We noted that information about people's care and support was also provided if a person requires hospitalisation. This enabled hospital staff to know important things about people's medicines, allergies, medical history, mental and physical needs and how to keep them safe.

Staff approached people with kindness and compassion. We saw that staff treated people with dignity and respect. Staff called people by their preferred names, and personal care tasks were conducted in private. Staff interacted with people throughout the day, for example when preparing dinner, helping someone to get dressed, listening to music and watching television, at each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

People were involved in making decisions about their care. We observed that when staff asked people questions, they were given time to respond. For example, when being offered drinks, or going out to the shops. Staff did not rush people for a response, nor did they make the choice for the person. Relatives and health and social care professionals were involved in individual's care planning, and there was detailed information recorded including decisions made for those who lacked capacity. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care.

People were supported to express their views about their care, support, treatment or the home in different ways such as: day to day conversations, at service user meetings and social activities.

Relatives and friends were encouraged to visit and maintain relationships with people. People were able to attend various activities outside in the community in addition to their regular ones, for example attending the theatre, pantomime, bowling and Friday Friendship club.

People could be confident that their personal details were protected by staff. There was a confidentiality policy in place. Care records and other confidential information

Good

Is the service caring?

about people were kept in a secured office. This ensured that people such as visitors and other people who were involved in people's care could not gain access to their private information without staff being present.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example information related to a change in medication, healthcare appointments and messages to staff. Daily records were also completed to record each person's daily activities, personal care given, what went well and what didn't and any action taken. This showed us that the staff had up to date information relating to people care needs.

Good

Is the service responsive?

Our findings

We saw positive examples of how staff knew and responded to people's needs. For example a person was increasingly getting anxious due to our presence, so staff took them out for a long drive and something to eat to alleviate their anxiety, as they knew this would help. Another example was that a person stood next a chair and instantly a member of staff asked them if they would like to watch the TV, which they did.

There were detailed care records which outlined individual's care and support. Any changes to people's care was updated in their care record; this ensured that staff had up to date information.

People who wanted to move into the home were offered a trial period first, so they could meet others who lived at the home, get involved with activities and stay the night, to ascertain if the home met their needs and if they liked it. Information about the home was provided in pictorial format for those people who were unable to communicate verbally.

Care given was based on individual's needs, care and treatment. Pre and admission assessment provided information about people's needs and support. Where people displayed behaviour that was challenging, guidelines were provided to staff to minimise risk, whilst ensuring the person was safe. Staff were quick to respond to people's needs. The registered manager told us they do not use agency staff, existing staff from the home or other local homes managed by the provider covered any annual and sick leave. She told us by having a consistent staff team they were able to build up a rapport with people. This meant that staff knew people and understood their needs.

Pre and admission assessments recorded individual's personal details and whether they had capacity to make decisions for themselves was reviewed on a regular basis. Details of healthcare professionals such as doctor, dentist, care manager, information about any medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were documented. This information was reviewed before a care plan was developed and care and support given. This enabled staff to build a picture of the person's support needs based on the information provided.

People's needs were assessed with them to ensure the home could meet their needs. The provider also obtained information from relatives, health and social care professionals involved in their care. This enabled the provider to have sufficient information to assess people's care and support needs before they received care, support and treatment.

We noted that people attended a lot of activities throughout the week in the home and outside in the community. This information was displayed under each person's photograph with a photograph or picture of the activity. This enabled people to identify what activities they would be attending. Activities range from attending a day centre, reflexology, swimming, going for walks, going out with staff for a coffee and music therapy. They also were able to attend a Friday Friendship club held every week in the community. We also saw photographs of outings people had attended. The home had their own form of transportation to drive people to their activities and places of interests.

People were provided with the necessary equipment, care and treatment to assist with their care and support needs. We saw that people had access to healthcare professionals who has specialist experience with people who had specific needs. Information regarding people's individual needs and treatment was recorded in their care records; and staff was knowledgeable about their needs.

People and relatives confirmed that they were aware of the complaints system. Peoples' feedback was obtained in a variety of ways such as residents meetings, survey, discussions with people and their relatives. We looked at the provider's complaints policy and procedure. The staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with had a clear understanding of what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously. The registered manager maintained a complaints log. We were informed by the manager that there were no complaints about the home in the last twelve months.

Good

Is the service well-led?

Our findings

People were involved in how the home was run in a number of ways. We noted that there was 'residents' meetings for people to provide feedback about the home. We saw minutes of the meeting that relayed information about each person who attended the meeting, a summary of their activities and any issues during that month. We noted that the provider had conducted a family questionnaire in 2014, people's feedback was positive and stated that they were well looked after and encouraged to form positive relationships between healthcare professionals, staff and people. People were able to have access to specialists with specific knowledge to meet their needs and ease their anxieties. People were encouraged to be as independent as possible and participate in activities that were of interest.

Staff had the opportunity to help the home improve and to ensure they were meeting people's needs. For example fences were strategically placed so that people were safe whilst in the garden. This was done by a variety of methods through staff meetings, supervisions and team briefings, which was information that was cascaded from their head office. Staff told us that they were able to discuss the home and quality of care provided, best practices and people's care needs.

A relative told us about a situation that involved people living at the home, "I was very pleased and impressed about how they handled the situation." The provider had a system to manage and report incidents, and safeguarding. Members of staff told us they would report concerns to the registered manager. We saw incidents and safeguarding had been raised and dealt with and notifications had been received by the Care Quality Commission. Incidents were reviewed which enabled staff to take immediate action to minimise or prevent further incidents. For example people became aggressive when changes occurred such as end of term from the day centre, new visitors or staff coming to the home. Staff planned ahead to alleviate the stresses and introduced change slowly to avoid reoccurrence or to minimise the impact.

People's care and welfare was monitored regularly to make sure their needs were met within a safe environment. There were a number of systems in place to make sure the home assessed and monitored its delivery of care. We saw there were various audits carried out such as health and safety, room maintenance, housekeeping, care plans, and an external medicines audit conducted in September 2014, where no concerns were identified.

Staff told us they conducted a weekly spot check on rooms to check on the condition of the room in relation to health and safety needs. We saw accident records were kept, however no accidents had taken place. Management observed staff in practice and any observations were discussed with staff, this was to review the quality of care delivered. We noted that fire, electrical, and safety equipment was inspected on a regular basis. We also noted that equipment such as wheelchairs, baths and the home's transportation was also checked on a weekly or monthly basis.

We saw that the registered manager had an open door policy, and actively encouraged people to voice any concerns. They engaged with people and had a vast amount of knowledge about the people living at the home. They were polite, caring towards them and encouraging them. People felt she was approachable and would discuss issues with them. Some people interacted and stayed with us and staff for the majority of the inspection, at no point did staff tell them to go away or that they were busy.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing.

The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated that they were knowledgeable about aspects of this guidance. This ensured that people continued to receive care, treatment and support safely.