

Wellburn Care Homes Limited

Glenholme Residential Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place over two days, 5 and 6 April 2016 and was a result of concerns raised to the Commission regarding staffing levels and the cleanliness of the premises. The inspection was unannounced. This meant that the provider and staff were not made aware of our inspection ahead of our visit. The service was last inspected 4 August 2015. The service was rated as good and no breaches of regulation were identified.

The service provides residential care for up to 37 older people who may be living with a dementia. Glenholme Residential Care Home is a two storey converted townhouse with bedrooms located on both floors.

At the time of the inspection 31 people were living at the home, 19 of these people were living with a diagnosed dementia.

There was a registered manager in place.

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.

Medication Administration Records (MAR) were not consistent. The service were using two differing MARs which had different codes for staff to use to determine whether a medicine had been given, refused or destroyed. Due to this we found conflicts in the coding system, it was unclear what medication had been administered. Medicines were not always disposed of in an appropriate and safe way. Liquid medicines were flushed down the sink.

The use of the dependency assessment tool, to determine staffing levels, was not effective in ensuring there were sufficient staff on duty, to meet the assessed needs of people who used the service. People who used the service were protected against other risks associated to their care and welfare by appropriate assessment and risk management measures being put in place.

People who used the service felt safe in the home and with the staff who supported and cared for them. Staff knew how to report any concerns about the safety and welfare of people who used the service. Robust recruitment procedures were in place and appropriate checks were carried out before people started work.

People were protected against the risks associated with the premises through appropriate legislative safety checks, in house safety checks and maintenance, such as portable appliance testing (PAT) and fire safety checks.

The home had not been adapted to meet the needs of people who are living with a dementia. The provider recognised the need for refurbishment to address this, but at the time of the inspection no work had been undertaken.

The service ensured that people were supported to have sufficient to eat, drink and maintain a balanced diet. Where people were identified as being at risk of malnutrition or dehydration the home did not monitor these needs effectively.

People were supported and had access to a range of healthcare professionals. This included GP's, opticians, dentists and chiropodists. The home included these professionals in the on-going care and treatment of people who used the service when necessary.

Consent to care and treatment was sought in line with legislation and guidance.

Positive and caring relationships were developed with people who used the service. The service had a stable staff team who knew people well. Staff knew and understood how people preferred to be cared for and supported.

Observations demonstrated that people were treated with kindness and compassion. People's privacy and dignity was respected and promoted. Staff were proactive in their approach to offering care and support discreetly to people who used the service.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

People did not receive personalised care that was responsive to their needs. Planning and delivery of care and support was not person centred and did not always focus on assessed needs. People's needs were reviewed regularly to ensure care remained responsive to the needs and wishes of people who used the service.

The service had a complaints procedure in place that was accessible to people who used the service. The service listened and learnt from people's experiences, concerns and complaints but failed to record these investigations in line with their policy.

There were a lot of activities planned within the home to encourage stimulation and involvement from people who used the service. These activities not only met social needs but also captured cultural and religious needs.

The service promoted a positive culture that was open, inclusive and empowering. They ensured people who used the service and staff had opportunities to become involved and suggest ways in which the service could be improved.

The service could demonstrate that it had good management and leadership. The registered manager split her time between four days in the home and two half days in the adjoining day centre. In the weeks prior to the inspection we found that the registered manager had been heavily involved in offering support to another of the provider's service. From a review of documentation, discussions with staff and the management team it was identified that this had had a negative impact on the management of the service.

We saw the service had engaged with external stakeholders and worked in partnership with other agencies in the process of trying to deliver high quality care.

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.

Medication Administration Records were not consistent and as a result of conflicts in the coding system it was unclear what medication had been administered. Medicines were not always disposed of in an appropriate and safe way. Liquid medicines were flushed down the sink.

The use of a dependency assessment tool, to determine staffing levels, was not effective in ensuring that there was sufficient staff on duty, to meet the assessed needs of people who used the service. People who used the service were protected against other risks associated to their care and welfare by appropriate assessment and risk management measures being put in place.

People who used the service felt safe in the home and with the staff who supported and cared for them. Staff knew how to report any concerns about the safety and welfare of people who used the service. Robust recruitment procedures were in place and appropriate checks were carried out before people started work.

People were protected against the risks associated with the premises through appropriate legislative safety checks, in house safety checks and maintenance

Requires Improvement ●

Is the service effective?

The service was not always effective.

The home has not been adapted to meet the needs of people who are living with a dementia. The provider recognised the need for refurbishment to address this finding but at the time of this inspection no work had been undertaken.

The service ensured that people were supported to have sufficient to eat, drink and maintain a balanced diet. Where people were identified as at risk of malnutrition or dehydration the home did not monitor these needs effectively.

People were supported and had access to a range of healthcare

Requires Improvement ●

professionals. This included GP's, opticians, dentists and chiropodists. The home included these professionals in the on-going care and treatment of people who used the service when necessary.

Consent to care and treatment was sought in line with legislation and guidance.

Is the service caring?

Good ●

The service was caring.

Positive and caring relationships were developed with people who used the service. The service had a stable staff team who knew the people who used the service well. Staff knew and understood how people preferred to be cared for and supported.

Observations demonstrated that people were treated with kindness and compassion.

People's privacy and dignity was respected and promoted. Staff were proactive in their approach to offering care and support discreetly to people who used the service.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People did not always receive personalised care that was responsive to their needs. Planning and delivery of care and support was not person centred and did not always focus on assessed needs.

The service had a complaints procedure in place that was accessible to people who used the service. The service listened and learnt from people's experiences, concerns and complaints but failed to record these investigations in line with their policy.

There were a lot of activities planned within the home to encourage stimulation and involvement from people who used the service. These activities not only met social needs but also captured cultural and religious needs.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The service promoted a positive culture that was open, inclusive and empowering. They ensured people who used the service and staff had opportunities to become involved and suggest ways in which the service could be improved.

The registered manager split her time between the home and the adjoining day centre. Prior to the inspection we found that the registered manager had been heavily involved in offering support to another of the provider's services. From a review of documentation, discussions with staff and the management team it was identified that this had had a negative impact on the management of the service.

We saw that the service had engaged with external stakeholders and worked in partnership with other agencies in the process of trying to deliver high quality care.

Glenholme Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 April 2016 and was unannounced. This meant that the provider and staff were unaware of our visit prior to our arrival and announcement.

The inspection was carried out by two adult social care inspectors.

On this occasion we did not ask the provider to complete a 'provider information return' (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. Before the inspection we looked at information we held about the service. This included the previous inspection report and notifications of incidents concerning the service (notifications contain information that the provider is legally bound to tell us about). We spoke with the local authority commissioners and the local safeguarding authority to obtain their views on the service provided at the home.

During the inspection we spoke with ten people who lived at the home and three visiting relatives. We spoke with the registered manager, the deputy manager, one team leader and five care workers. We also spoke with the provider's managing director. We observed care and support in communal areas throughout the home and looked around the premises. We reviewed a range of records about people's care and how the home was managed. These included care records of seven people, recruitment and training records relating to all members of staff and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Is the service safe?

Our findings

We saw that staffing levels were stretched at the time of our inspection. On the first day of the inspection we found that actual staffing levels were down by 50% against the planned staffing levels. This meant only two care workers and the team leader were available to deliver care and support. We spoke with one care worker about this who said, "It is normally four care workers and one team leader, but I don't think the manager could get cover today." We found that management were able to get an additional staff member to offer cover later that morning and that the deputy manager offered care and support to supplement the care workers and achieve full staffing capacity. Staff we spoke with told us that staffing levels were normally consistent.

We spoke with the registered manager about how they determined staffing levels. They told us that they used an electronic dependency assessment tool. This meant the home had a tool that considered the needs of people who used the service as well as the number of people. In discussions about the use of the tool the registered manager told us that she ran the weekly update retrospectively each week. This meant that the tool was not an effective or current assessment of the staffing levels required to meet the needs of people who used the service. We looked at the dependency assessment tool for the eight weeks preceding the inspection and found that, despite the use of overtime, the home had failed to achieve the staffing levels that the assessment tool had calculated. In discussions with the registered manager we identified this was directly attributed to the number of care staff vacancies in the home. The home had recruited four new members of staff, whose recruitment checks were outstanding, and had four vacancies remaining. On the first day of the inspection we saw that the manager was holding interviews with prospective employees.

People we spoke with said staff were very accommodating and helpful. One person said, "They never say no when I ask for help" another person said, "Sometimes there is not enough people about when you need them." One relative we spoke with raised concerns about the staffing levels within the home over weekend and bank holidays. They said, "It always seems to be weekends or these bank holidays when there are not enough staff about, I don't know if it is sickness or poor planning but it always happens."

At the end of the first inspection day the registered manager had taken appropriate action to ensure that all shifts were covered with the appropriate staffing levels required. This included utilising care staff from the provider's adjoining care centre.

We recommend that the provider addresses the effectiveness of the dependency assessment tool that they use to determine staffing levels and make contingency plans to cover unexpected staff absence.

Prior to the inspection concerns were raised about the standard of cleanliness within the home. On the first day of the inspection we saw that the home had dedicated domestic staff and that they were visible throughout the home. We saw that domestic staff had stripped fabric seats and sofas in order to wash the covers. We found that the home were using inappropriate aides to act as waterproof protectors on these chairs and sofas. We spoke with the registered manager about this and saw that they placed an order for appropriate aides to be delivered to the home. We spoke with one of the domestic staff who described how

their responsibilities had been impacted as a result of staffing issues the home had faced. They said, "Because we are trained carers as well we have picked up some care work, I could not leave the girls to struggle. But it is getting better now and I am back to just doing my domestic jobs."

People we spoke with raised no concerns about the cleanliness of the home. People said, "They (staff) always wear their pinnies and gloves."

We looked at medication administration records (MAR). MAR charts were not standardised, with different MAR charts in use from different pharmacies. This resulted in staff errors with documented administration codes that were used as each MAR contained conflicting codes (codes are used to indicate things like administration and refusal of medicines). This meant that there was a heightened risk of medicine administration errors occurring as records did not clearly indicate what medicines had been administered or refused. On the second day of the inspection we found that the registered manager had taken action to ensure that all MAR charts were standardised. This meant that the risk of further errors occurring had been addressed.

When checking the stock of medicines we found that two medicines had reached their expiry date but were still being used. We spoke with the registered manager about this who took immediate action to ensure those medicines were disposed of and new stock replenished. This led us to find that medication was not always disposed of in an appropriate and safe way. We saw that liquid medicines were being flushed away in the sink. We spoke with staff and asked what the normal process was for the safe disposal of liquid medication. We were told, "We normally just flush it away."

We recommend that the provider seek the advice from the relevant pharmacies about the safe disposal of medicines.

Risks to people's health and safety were appropriately assessed, managed and reviewed. We found these risk assessments were present in each person's care records, in some instances where no risk was posed. Where risk assessments were appropriate we saw that they were relevant to the individual needs of people, such as use of moving and handling equipment. These assessments contained details about how to minimise any risks.

People we spoke with told us that they felt safe and well cared for. One person said, "I trust them (staff)." Another person told us that they felt reassured that staff "know what they are doing" and added, "I feel completely safe here."

All staff had access to the safeguarding policy and details of the local authority who they could raise concerns too. Staff told us, and training records confirmed that all staff had received training in safeguarding vulnerable adults. Staff we spoke with were knowledgeable about the risk of potential abuse and the forms of abuse that can occur. They told us how they would report any concerns of abuse and action they would take to make sure people were protected.

We looked at recruitment records which demonstrated that staff were subject to rigorous pre-employment checks before they commenced employment. These checks included checks with the Disclosure and Barring Service (DBS). DBS checks help to protect people from receiving care and support from individuals who may be barred from working with vulnerable people.

Records we looked at confirmed that checks of the building and equipment were carried out to ensure risks to the health and safety of people, staff and visitors were minimised. For example, relevant checks had been

carried out on the boiler, fire extinguishers and portable appliance testing (PAT).

Is the service effective?

Our findings

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that 27 people who lived at the home were subject to a DoLS at the time of this inspection. We reviewed the documentation relating to this and found they had all been authorised by the local supervising authority, and the home was acting within the legal authorisation of each of these safeguards. Four of these DoLS had expired and the registered manager had submitted applications to request new authorisations. The expiration of the DoLS had not been updated in the individual care records to reflect that there was no current, authorised safeguard in place for these people. From discussions with staff and from our observations we ascertained that although the DoLS had expired staff were not acting in such a way that unlawfully deprived people of their liberty. For example, people chose how they wanted to spend their day and were happy to be included in trips out of the home with supervision from staff.

The care records we looked at showed that the delivery of people's care was not always proactive. We saw that one person had been assessed as having continence problems and stated that they required support to use the toilet. We observed this person make a number of unsuccessful attempts to visit the bathroom independently over a three hour period. When we spoke with staff about proactive care plans, for example, regular prompting of people to encourage them to use facilities, they told us this was not something they did. One member of staff informed us that this person was using continence aids that were inappropriate as they had not been assessed by the appropriate healthcare professionals.

The care records we looked at showed that people who used the service had their food and fluid intake monitored daily. The records demonstrated that people were having this element of their care monitored without any assessed need and without any care objective set. For example, people's input was monitored but there was no consideration of output and where people did not meet their target no follow up action was evident to show how risks associated with this were managed.

Care records demonstrated that where people were identified at risk of malnutrition, their weight was monitored using the Malnutrition Universal Screening Tool (MUST). Where people were not able to be weighed using scales, staff failed to adopt alternative measures for effective monitoring. For example, records relating to one person identified over nine months where the person was not weighed due to ill health. This person's height and ulna length (length of forearm) was available but staff had not measured the mid upper arm circumference (MUAC) to help calculate body mass index (BMI) and thus help to

effectively monitor this person's weight.

We saw that people were offered an array of snacks and drinks at intervals throughout the day. We saw when people asked staff for drinks staff responded quickly and offered people choice. We saw there was a choice of two hot meals at lunchtime. So that people understood what meals they were choosing a member of staff did a 'show and tell' of both meals. This meant that people could see what the meal looked like and could make an informed choice.

People were encouraged to eat independently. We observed two people who required support to eat their food. One member of staff provided support but this support was interrupted and not appropriate. For example, the member of staff crouched over the individuals and did not maintain eye contact. In one instance, a person was supported to have two mouthfuls of food before the member of staff left to engage with another person. The same member of staff then came back to support the person after four minutes had passed. This meant that people's mealtime experience did not always support their individual needs.

We saw that some people refused elements of their meals. For example, one person refused the dessert that was offered. A passing member of staff witnessed this and intervened. They offered a wide choice of alternatives to which the person then accepted and ate.

We spoke with people about the food, drink and snacks that were offered to them. One person said, "We are always getting fed," another said, "Sometimes I think we have too much choice (followed by laughter)." Another said, "It is lovely the food is always lovely."

People were supported to have access to other healthcare professionals. Records demonstrated that GP's, dentists, opticians and chiropodists were regular visitors to the home to respond to the needs of people who used the service. One person said, "They always help me and get my doctor if I need to see him." One relative we spoke with said, "They are a great help ensuring that we are involved with, and meet, healthcare professionals involved in Mum's care." During the inspection we saw that district nurses visited people at the home. We also observed staff respond appropriately, ensuring relevant healthcare professionals were called and involved in ensuring appropriate care and treatment, when a person fell ill unexpectedly.

The home has not been adapted to meet the needs of people who are living with a dementia. The home is very traditional and 'homely'. People who used the service told us that this is what they like about the home. One person said, "It is just like home from home, it is old and needs a splash of paint but it reminds me of my old house." A relative that we spoke with said, "(The) Home offers comfort as it is quite old fashioned but that works. I prefer the décor and feel, over that of the purpose built, clinical homes."

One relative we spoke with raised their concerns about a planned refurbishment of the home that had been postponed. We spoke with the registered manager and the managing director about these plans. They told us that these plans had been pushed back and that the refurbishment would be taking into account the need for them to adapt, design and decorate the service in a way which would help promote the individual needs of people who live with a dementia. At the time of the inspection the home was not 'dementia friendly'.

Is the service caring?

Our findings

People who used the service and two visiting relatives told us that they thought the home was 'lovely'. They said that staff were very caring and that, "Nothing is too much trouble for them." One person we spoke with said, "I like being here because I can do what I like. They (staff) let me sit where I want, if I want to go out they help me." When speaking with another person about a member of staff they said, "X is very amusing, X makes me laugh." Another person said, "They are a lovely set of girls here." Relatives we spoke with said, "(The) girls are very caring." Another relative said, "We have no concerns at all, really cannot fault it, we are very happy with our decision."

From our observations throughout the inspection we saw numerous interactions between staff and people who used the service. Staff treat people with kindness and compassion. We saw that people who used the service were comfortable with staff and that they were familiar with all members of staff on duty. We saw that where people required support or encouragement during care interventions staff displayed patience and compassion in ensuring that the interventions were as pleasant as could be.

When approaching people to offer care and support, we saw staff engaged individuals and explained what they were proposing to do. They asked people if that was okay and obtained verbal consent and acted in accordance with people's wishes. For example, before one person was transferred from a chair into their wheelchair. Staff informed them of what they were going to do and asked if that was okay. Throughout the transfer they spoke with the person and offered reassurance.

When speaking with staff they demonstrated an understanding of the needs of people who used the service. The staff group were stable and it was clear from the discussions we had that this contributed to the caring relationships that had been developed. Staff we spoke with spoke confidently about the needs of people who used the service. They were able to describe people's preferences, likes and dislikes. They had an understanding of people's life histories and were familiar with families and other visitors to the home.

Is the service responsive?

Our findings

The care records we reviewed demonstrated that people's needs were assessed by staff but that care and support was not always planned and delivered in line with their individual care plans. For example, we found that for those people who were living with a dementia, care plans did not demonstrate how their dementia might impact on their care. They did not focus on how the dementia affected people's daily lives, what their concerns were or what actions staff should take to ensure care remained appropriate and met their needs.

Care plans were not person centred. Person centred planning is a way of helping someone to plan their care and support, with the focus on what is important to the person. For example, we saw that all people who used the service had care plan assessments for the same condition. In one instance we found that a person had a care plan for breathing problems, despite having no previous issues of health diagnosis that would prompt this assessment. We were told by the registered manager that care plans were under review across the whole provider but at the time of the inspection this had not commenced in the home.

Care records did not contain sufficient information relating to people's health and social care needs. The registered manager spoke with us about this and explained this was an area that was under review and development. At the time of the inspection the review of care records had not started.

Individual choices and decisions were documented within care records and we saw that they were subject to frequent review or as people's needs changed. These records demonstrated that changes in people's needs were identified and, where appropriate, referrals were not always made to external healthcare professionals to help ensure people's needs were met in a safe and effective way. For example, one person with incontinence needs did not have their care needs assessed by an appropriate healthcare professional. This meant that the assessment of people's needs, including the care delivery plans were not always responsive to the individual needs of people who used the service.

The service had a complaints procedure that was accessible to people who used the service, anyone who visited the service and also to staff. The process contained an assurance that any concerns or complaints raised would be investigated and responded to. We found that no complaints had been documented within the last twelve months. We were aware, as a result of intelligence gathered ahead of the inspection that this was not accurate. We spoke with the registered manager who was able to relay the complaints that she had handled and told us about discussions and resolutions that had been reached. She told us that they had failed to record these complaints in line with the provider's procedure. People we spoke with told us that they were aware of how they could complain.

We found that people who used the service had a variety of opportunities to get involved in activities on a daily basis. The home had its own mini bus which meant that people could be offered trips to local attractions. During our inspection we saw that people went on a bus trip along the coastal route and stopped for ice cream. We saw that planned activities also included Sunday mass and other church services to meet the religious and cultural needs of people who used the service. As well as trips outside of the home

we saw that the home arranged a host of internal activities included a visit from a petting zoo on the second day of our inspection. This was where animals were brought into the home and people could hold, stroke and touch the animals. Other activities planned included, film shows, musical afternoons, photo or reminiscence afternoons.

People we spoke with said, "We are always busy, there is always something going on." Another person said, "If you want to get involved you can and if you don't, well that is fine too."

Is the service well-led?

Our findings

The home had a registered manager in place. People we spoke with told us that they knew who the registered manager was and what their role was within the service. They told us that the registered manager was visible throughout the home and was "Always on the floor, definitely not locked away."

Staff we spoke with told us that the registered manager was very approachable. They told us that they had frequent dialogue with them about what was occurring within the home. We spoke with the registered manager about support that she received in her role. We talked about the role of the deputy manager. At this point the registered manager told us that the deputy manager had not completed all management training and supervision. They advised that they had "let her down" in respect of this as they had been required to utilise the deputy's skills and experience to cover staff vacancies within the home and ensure sufficient staff were available on shift.

We look at the quality assurance audits the registered manager completed each month. These audits covered a range of areas such as care planning, maintenance and hygiene. We found that the audits were designed to be a checklist and without a month on month evaluation we were unable to assess their effectiveness. We spoke with the registered manager about our findings from the inspection and identified through discussion, and along with the quality assurance process, that they were already aware of the areas and of where the home need to make improvements. Although no action had been taken to start addressing the issues and drive improvement across the home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the registered manager had been engaging with external stakeholders, such as the local authority in reference to the quality of care that was being delivered from the service. This included audits and investigations into specific incidents. This meant that the service was prepared to work in partnership with other agencies.

Regular staff meetings were held which captured all staff groups employed at the home. We saw that these meetings were used to relay information to staff but also provided staff with a platform to raise any issues that they might have.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The service did not have effective governance, including assurance and auditing systems. The assessment and monitoring processes did not drive improvement in the quality and safety of the service Regulation 17 (1)(2)(a).</p>