Mr & Mrs R Smart

Glendon House

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 21 and 24 March 2016 and was unannounced.

Glendon House provides accommodation and care for up to 36 people, many of whom would be living with dementia. At the time of our inspection 28 people were living in the home.

A registered manager was 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.

We found that there was a breach of regulations because the service didn't always act appropriately to mitigate identified risks to people's welfare. This had resulted in three people receiving unsafe care or being exposed to the risk of avoidable harm.

We identified a second breach of regulations because suitable systems were not in place to monitor the way that risks to people's welfare were being managed in the service. You can see what action we told the provider to take at the back of the full version of the report.

Improvements were required to effectively implement mental capacity assessments. This required a greater understanding of the Mental Capacity Act 2005 by service managers tasked with carrying out the assessments.

There were enough staff to meet people's needs, although on one of our inspection days the service was short of staff. Staff received the training and support they required to ensure they could provide effective care to people.

Staff had developed good relationships with people and their visitors. They adapted their approach to individuals to ensure people received the style of staff engagement they preferred.

People's care plans were personalised to their needs and preferences. There was a wide range of social activities that people could participate in. They were encouraged and supported to maintain their faiths and engage with their community.

Environmental risks were well managed in the service and the service managers had the support of people, their relatives and staff. There was a good atmosphere in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Whilst risks to people's welfare were identified, appropriate actions were not always taken to mitigate risks.

Medicines were managed appropriately, but records did not always show that prescribed creams were administered to people.

There were enough staff deployed and thorough recruitment processes were in place.

Staff understood their responsibilities in relation to safeguarding people and knew what actions they would need to take if they had any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments had not been carried out where necessary.

People enjoyed the food but the lunchtime period required better organisation to ensure people were not kept waiting.

Staff received a good standard of induction, training and support from service managers.

Is the service caring?

Good

The service was caring.

Positive and caring relationships had been fostered between staff and the people they looked after.

People's views were sought about their care and support arrangements.

There was a variety of communal areas, so people could decide where they wanted to spend their time in the home.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's current needs and gave the staff guidance on how these needs were to be met.

People attended clubs and participated in their local community and had a good range of activities available to them in the home.

People were confident to raise concerns with staff if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Whilst environmental risks to people were well managed, the standard of care provided to people was not adequately monitored.

The service managers had the support of staff, people living in the home and their relatives.

Glendon House

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 21 and 24 March 2016 and was unannounced. It was carried out by three inspectors 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.

During the inspection we spoke with 13 people living in the home and relatives of seven people. We made general observations of the care and support people received at the service throughout the day. We also spoke with the registered manager, one of the partners in the business, a community nurse, four members of care staff, kitchen staff and domestic staff members.

We reviewed four people's care records and medicines administration record (MAR) charts. We viewed two records relating to staff recruitment as well as training, induction and supervision records. We also reviewed a range of monitoring reports and audits undertaken by the service managers and the provider.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found that whilst risks to people's welfare were identified the necessary actions to mitigate these risks were not always taken. One person being looked after in bed had a pressure area on their heel and required regular repositioning to prevent skin breakdown. Their care plan stated that they were not to be positioned on their back to help allow the area time to heal. However, repositioning charts showed that the person was regularly being repositioned on to their back.

Another person's care plan showed them to be at risk of ingesting toiletries. When we looked in their ensuite bathroom we found that cleansing foams, mouthwash, shower gels and shampoo were accessible to them in their bathroom cabinet.

One person had been admitted to the home eight weeks prior to our inspection. After four weeks living in the home the person had lost over 6 kg. Their nutritional support had been reviewed and their care plan showed that they needed to be offered fortified food, little and often. The records also referred to 'requesting supplements and dietician involvement'. The person's GP had been contacted at this point and they advised that the person required encouragement to eat. The person was then weighed on a fortnightly basis and at the time of our inspection, the person had lost a total of 9 kg. No further professional support had been requested.

We reviewed the person's food charts for the previous two weeks. It was clear that the person was being offered three meals a day, including large lunch time meals. This was not in accordance with the assessed need to offer them small amounts of food on a frequent basis. On only one of 14 days was anything recorded as being offered to the person outside of normal meal times. The manager told us this was a staff recording issue. The cook told us that fortified snacks were always available but it was the responsibility of the care staff to ensure people were supported to eat when necessary. During lunchtime we observed the person ate one mouthful of their lunch before leaving the table. The manager told us that the person's relative often sat with them during lunch and encouraged them. However, the person's relative was not present for lunch on the day of our inspection and the person received no encouragement from staff to eat their meal. We spoke with the manager about the level of staff support this person required to help ensure they ate enough. The manager agreed that this needed to be increased.

We fed back these concerns to the manager on the first day of our inspection because they presented risks to people's welfare. When we returned three days later to complete our inspection we found that actions had been initiated to rectify these matters.

These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people were well managed. We saw that actions had been agreed with the GP in relation to how staff could temporarily reduce risks to people's welfare pending visits from healthcare professionals to whom referrals had been made. When people had sustained falls appropriate actions had been taken to

reduce the risk of subsequent falls. Accidents and incidents were monitored for patterns and changes to the way the service operated or how staff were deployed were made if necessary.

Medicines were stored securely. Controlled drugs were stored and administered appropriately. When necessary, such as with eye drops, the opening date for medicines was recorded on labels. This meant that staff could ensure that the medicines were used within specified timescales. During the medication administration round in the morning we saw that medication was only signed as having been administered after staff had observed the person had taken it.

However, charts that recorded when people had prescribed creams administered showed gaps where we would have expected to see a staff member's signature. Staff told us that they were administering people's creams, but were forgetting to record this. Whilst people's creams were administered in the privacy of their rooms, the recording charts were kept in the office. When we queried this with the manager they told us that they felt staff were more likely to complete the chart if it was in the office.

Environmental risks were regularly assessed and testing carried out as necessary. These included lifting equipment, health and safety and utility supplies. In February 2016 the kitchen had been inspected by the district council's environmental health department and had been awarded a five star rating, which is the highest rating that can be achieved. This meant that food was handled hygienically and that the kitchen facilities were suitable and safe.

All staff members we spoke with understood their responsibility to ensure people were protected against abuse. They described the types of abuse people could be exposed to and knew what signs to look out for. They had each undertaken training in safeguarding and knew what they would need to do if they had any concerns. There was a safeguarding protocol folder for staff to refer to if necessary in the senior's office which was centrally located in the home and accessible to staff at all times.

Twenty-seven people were living in the home on the first day of our inspection with one person due for admission later in the day. The usual staffing arrangement for the daytime was four care staff, a senior and the deputy manager who usually organised the shift and helped out. There was also one staff member responsible for activities with a second person due in to assist with this later on. One person had a staff member allocated to them for the whole day. Their care records showed that the person routinely received this level of support that they had been assessed as requiring. Two staff members were in the kitchen and two domestics were also on duty.

On the day of our inspection the service was short of two care staff members and the deputy manager. One staff member who usually did activities was helping care for people and the manager was also helping out when necessary throughout the day. Care staff told us that they relied on the deputy manager quite heavily and that their presence was missed, but were appreciative that the manager and the activities staff member were helping out. Despite this the service was calm and staff went about their duties efficiently. We reviewed staff rotas and found that the service was staffed appropriately in the preceding weeks and the shortage of staff on the day of our inspection wasn't typical.

However, one relative told us that there were staff shortages, "They can be short at weekends. Things don't always get done then." The manager told us that there had been a high staff turnover in recent months but this had now reduced and the staffing situation was more stable.

There were robust processes in place to minimise the risks of recruiting unsuitable staff. We reviewed the recruitment files for staff members employed recently and found that the provider had obtained

appropriate references, identity and Disclosure and Barring Service (DBS) checks. Staff had not commenced duties until all necessary checks had been satisfactorily completed.

Requires Improvement

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 checked whether the service was working within the principles of the MCA.

Staff we spoke with understood that some people required help to make or communicate their decisions. They also appreciated that some people's ability to make decisions could fluctuate and that they could make decisions about some things, but not others. Staff gave us examples of how they assisted people to make decisions, for example, by showing them plated up options for meals. When necessary staff made day to day decisions regarding people's care in the person's best interests.

The manager advised us that they had submitted DoLS applications for most people living in the home to the local authority for permission to restrict people's liberty in order to keep them safe. However, mental capacity assessments had not always been carried out to determine whether people could consent to the restrictions in place. The service had recently begun implementing mental capacity assessments, but managers were not clear which decisions would require an assessment. We reviewed two assessments, but one did not state what the decision was that needed to be made. The second one had been carried out in relation to a person who clearly had capacity.

People were complimentary about the food. One person told us, "The food is brilliant." Another person told us, "It's good quality food here you know." A relative told us that their family member required pureed food and needed their drinks thickened. They told us that they could rely on the staff to make sure their family member received food that was prepared in this way. We observed that different parts of meals were pureed separately so that the food remained as appetising as possible for people.

A glass drinks dispenser in the dining area didn't have any glasses nearby for most of the day. This meant that outside of mealtimes, when glasses had been available, people were unable to help themselves to a cold drink. The hatch to the kitchen was nearby and we observed people requesting hot drinks throughout the day outside of the times of the tea trolley. These and snacks were prepared upon request with goodwill by the kitchen staff. The cook told us that staff had full access to the kitchen overnight and could prepare snacks and hot drinks for people as necessary.

We observed the lunchtime meal. People were assisted to tables, but were sat for between 15 to 20 minutes before the meal choice or a drink was offered. There were no menus or pictures of the meal options on

tables. A few people with memory problems were unsure why they were sat at the table. The menu for the week ahead was on the wall. This was on one sheet of paper and due to the amount of information contained it may not have been easy to read. One inspector joined a table with three people on it. However, 15 minutes had passed and no drinks had been served. One person at the table fetched themself a drink and served the other people on their table. This was accepted by staff in a good natured manner. People who received assistance to eat their meals were not rushed and staff were attentive to their wishes.

Staff told us that they received a good induction when commencing work at the service and that training was comprehensive and ongoing. A new staff member told us that they shadowed experienced staff until they felt competent to work alone. As well as the organisation's mandatory training staff were shortly due to receive training in catheter care and advanced dementia. Staff told us they were well supported by the service managers and as a consequence felt competent in carrying out their duties.

Staff confirmed they received supervisions which allowed them to discuss their work, training and future plans with their line manager. Staff said they found the supervision sessions useful. Records of staff supervision and annual appraisals of their work were maintained.

People had access to a wide range of health professionals who provided guidance and advice to staff so that they could be cared for effectively. We saw that the service sought guidance from health professionals in relation to specific queries. For example, they obtained professional advice about the amount of fluid that would be appropriate for one person to drink in a day.

The service worked closely with community nurses from the local GP surgery. A community nurse told us how they were working with the service to raise awareness of common health conditions and how to manage them on a day to day basis. For example, they had provided guidance to staff about how best to manage some chronic health conditions and what symptoms could be indicative of chest infections or urinary tract infections.

Good

Is the service caring?

Our findings

We received positive comments from people and their relatives about the way that staff supported them or their family member. One person told us, "They take time to talk to us here. It's so important." Another person said, "It's pretty good here actually." A relative told us that their family member didn't always sleep well at night and that they came downstairs where staff offered them a drink and sat and chatted with them. Another relative told us they had looked at several homes before deciding on Glendon House. They told us, "This was by far the best and is a notch above anything else I saw." The service had received a card of thanks which stated, "Just to say thank you for everything. [Family member] hasn't had a good year, but through it all you have shown unstinting care and kindness."

We observed that one person had gotten up from the dining table and was about to mobilise with the assistance of a walker rather than a walking frame which would have been safer for them. A staff member saw what was about to happen and intervened. They asked the person to sit down whilst they located the walking frame. When they returned they explained patiently and clearly why the person was safer using walking frame and demonstrated where they needed to hold on to it. The person smiled, nodded and went safely on their way.

Staff and people living in the home addressed each other by name, staff using people's preferred names when appropriate. Relatives we spoke with also knew the names of staff and told us that staff sought them out and engaged with them which helped them feel welcomed in the home at any time. Staff told us about people's individual personalities as well as the friendships and relationships between different people living in the home. They knew when it was appropriate to share a joke with people and when more discreet support and care was called for. They recognised that some people responded to a friendly and chatty approach, but that others preferred a more formal style of engagement from staff.

People were encouraged to express their views in relation to the care and support that they received. We saw from people's care records that, where possible, people's views had been taken into account in the way that their care was planned. One person told us, "Yes, they ask me how I want things done."

Some relatives came in and participated with monthly reviews of their family member's care and the service was looking to encourage more family members to do this. Relatives we spoke with told us they were involved in their family member's care, "If they have queries about [family member], they'll ask us. They always tell us if there's something going on." Resident and relative meetings were held quarterly. The last one had been held after tea time, so that relatives who were unable to come in during the day may have been able to attend.

The service understood that on occasions people would benefit from independent advocates to help them make some decisions about their care and their lives. We saw records showing that, when appropriate, people had been offered the support of an advocacy service.

People's dignity was respected. We went to visit one person who was being cared for in bed, but their door

was locked. A staff member replied to our knock and explained that they were assisting the person with personal care. They locked the door as it stopped people walking in.

People had access to their bedrooms at any time should they require some time alone. There were several communal areas of varying sizes in the home which meant that people had choice in where they wanted to spend their time. There was plenty of space to enable people to spend time with their visitors where their conversations wouldn't be overheard if they didn't wish to use to their room. Some areas were quieter than others, which some people preferred. One person liked to sit in a comfortable chair in an alcove by a window near the main entrance. They told us they liked to watch the comings and goings of people on their own in peace and quiet sometimes.

People's care records were kept confidentially in the office. However, some information regarding some individual's specific dietary needs was pinned up on a board in the main dining room. Whilst this served as a reminder for staff to ensure people were given suitable meals, it needed to be kept more discreetly.

Good

Is the service responsive?

Our findings

The people we spoke with told us that staff provided the care they needed. One person commented, "They know how to look after us and see that we're okay." Staff told us that because they knew people well they noticed when people acted in untypical ways and recognised that this could mean they were unwell.

A community nurse told us about one person who had become poorly and would normally have been admitted to hospital. However, the person had been able to remain at the home due to the detailed support staff had received from the community nurse to ensure the person could be cared for appropriately. The community nurse told us they were impressed with the way the staff had acted to ensure the person received a good standard of care in the comfort of familiar surroundings.

One relative told us that their family member had suffered a spate of falls. The service had contacted the GP who had reviewed the person's medicines and made some changes. This had resulted in the person experiencing significantly fewer falls. They told us, "The staff knew what to do and they got things sorted. It's made such a difference to [family member]."

We looked at the care records of four people who lived in the home. We found that people's care plans were well maintained and reviewed monthly. They were individualised as they recorded people's preferences, choices and reflected aspects of their current care requirements and associated risks. Care plans we reviewed included details of people's life histories. This helped staff to understand people and what was important to them. They could then utilise this information to initiate meaningful conversations with people and better plan their care.

There was a good range of things for people to do in the home. One person said, "You can do what you want here." Another person told us, "We have animals in and entertainment, singing most days, games and quizzes." Two people told us they weren't keen on group events but they enjoyed painting, music and IT in their rooms. A potting shed was being built as one person had expressed an interest in doing some gardening.

On the inspection days people were making and decorating sweet boxes for Easter and Easter bonnets. We saw from the March schedule that activities people could have enjoyed included knitting, visiting entertainers, visiting animals and various crafts.

People were able to maintain and build links with their local community. Some people were enabled to attend a social club in the village. People with faith were able to attend local church services and some people received holy communion in the home. Once a month the home held a 'Butterfly Café'. This was a support group open to people living in the home, their families and the wider community. It provided support for the carers of people with dementia and an opportunity for their family member and people living in the home to do activities, for example making memory boxes.

People told us they knew what to do if they were unhappy or needed to raise a concern and gave us the

names of staff they would speak with. None of the people we spoke with had any complaints about the support they received and we had not received any complaints about the service in the 12 months prior to this inspection.

Requires Improvement

Is the service well-led?

Our findings

The food intake of people at risk of not eating enough was recorded on food charts. We reviewed the food charts for two people. One person's food charts showed that they did not receive meals in accordance with their care plan. Both people's charts contained significant gaps over several meals so we could not determine what food they had been offered. The repositioning chart for one person showed that they were not being repositioned in accordance with their care plan. There were also gaps in charts recording the administration of topical creams.

There were no systems in place to ensure that recording charts were properly completed. This meant that the service was not monitoring risks to people's health and could not be sure that prescribed creams were applied when necessary.

The manager gave us a blank care plan audit form, but when queried said that they were not auditing care plans at the present time. The service was also behind with auditing people's medicines. The management and administration of some people's medicines had not been audited for four months.

The manager told us they thought that the deputy manager checked that charts were completed appropriately and that they carried out medicines audits. The deputy manager was not at work during our inspection. However, the manager was not checking that the deputy manager was doing the required checks. Senior care staff knew that charts weren't being completed fully or checked, but did not view they had any responsibilities in this in regard.

The provider carried out regular unannounced visits to the service and provided us with the reports from their last four visits. These covered areas such as the environment, staffing, the activities programme and care plans. Whilst a sample of care plans were reviewed during two of these visits, the provider had not ensured that the manager was adequately auditing the delivery of care in the home.

These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust systems were in place to identify and mitigate environmental risks. A quarterly infection control audit had recently been carried out. We saw cleaning schedules were in place and the kitchen was being regularly checked to ensure hygienic and safe working practices were being used. The home was clean.

Accident and incident analysis was taking place and an un-notified visit had been carried out at night to determine the standard of care provision people received overnight.

Staff told us that there was a good culture in the home and that they felt supported by the home's managers. They told us that managers were open to ideas or suggestions for improvement. People and their relatives told us that if they had had reason to contact or speak with the service managers, their experience had been positive. People considered the home was well managed. One person told us, "When you want

anything, all you have to do is ask [the manager]." A relative told us, "I love this place. I sit and watch what goes on. And if I ever needed a care home I'd come here."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided to people in a safe way because actions to mitigate known risks were not always taken. Regulation 12(1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Suitable systems were not in place to monitor and mitigate risks to the welfare of service users or to evaluate practice in this area. Records were not complete. Regulation 17(1)(2)(b)(c)(f)