Shaw Healthcare Limited

Glebe House

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

Summary of findings

Overall summary

The inspection took place on 21 January 2019 and was unannounced. Glebe House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Glebe House is situated in Southbourne, West Sussex and is one of a group of homes owned by a national provider, Shaw Healthcare Limited. Glebe House accommodates 40 people across separate units, each of which have separate bedrooms with ensuite shower facilities, a communal dining room and lounge. There were also gardens for people to use and a hairdressing room. The home provides accommodation for older people, a small number of whom are living with dementia. At the time of the inspection there were 39 people living at the home. The home had a registered manager. 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.

At the last inspection the home was rated as Good. At this inspection we found the home remained Good.

People continued to be safe. Risks to their safety had been identified and lessened. People were supported by sufficient staff who had the appropriate skills to meet their needs. One person told us, "If I call for help, normally they come quickly, but if it's an emergency they come running".

People were protected from abuse. Staff knew the signs that might indicate a person was experiencing harm and knew what to do if they had concerns about people's safety. One person told us, "I'm safe. It's a lovely place".

People's needs were assessed and met. Their health was promoted and people were encouraged and able to maintain their health and well-being. Timely responses and referrals had been made when people were unwell. People received their medicines to maintain their health and told us that they trusted staff to meet their needs when they were unwell. Staff worked in a coordinated way with external healthcare professionals.

The home was clean. Infection control measures ensured that people were protected from the spread of infection and cross contamination was minimised.

People were complimentary about the food and told us that staff respected their right to choose what they had to eat and drink. People had sufficient amounts to eat and drink. One person told us, "The meals are very good, reasonable choice".

People had access to an environment that met their needs. People had their own rooms if they preferred to

spend time alone. Communal areas such as lounges, dining rooms and gardens enabled people to spend time with others to meet their social needs.

People were actively involved in discussions and decisions about their care. Regular care plan reviews as well as residents' and relatives' meetings enabled people to voice their opinions and make suggestions. People could raise questions and concerns. These were respected, listened to and welcomed. One person told us, "I do feel party to discussions about my care".

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and procedures at the home supported this practice.

Care was person-centred and focused on people's needs and preferences. People told us that they were fond of the staff and that they were well-cared for. Positive and compassionate interactions were observed and people were treated with kindness. Staff were sensitive to people's needs and supported people in a way that maintained their dignity and privacy. People received dignified and appropriate care at the end of their lives.

Feedback about how the home was managed was positive. The registered manager worked in partnership with others. People, relatives and staff were complimentary about the leadership. They told us that it was well-organised and that they were involved in the running of the home. One person told us, "I know the manager and I feel I can approach her".

Quality assurance processes provided the registered manager and other external managers with a way of monitoring the systems and processes within the home to ensure that these were effective.

Further information is in the detailed findings below.

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 home remains Good.	**Good**
Is the service effective? The home remains Good.	**Good**
Is the service caring? The home remains Good.	**Good**
Is the service responsive? The home remains Good.	**Good**
Is the service well-led? The home remains Good.	**Good**

Glebe 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.

The inspection took place on 21 January 2019 and was unannounced. The inspection team consisted of two inspectors and one 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.

Before the inspection we looked at information we held, as well as feedback we had received. We used information the registered manager sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to make. We also looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. We communicated with the local authority for their feedback. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with ten people, two relatives, six members of staff, a visiting healthcare professional, the registered manager and the operations manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and electronic medicine administration records (MAR) for 12 people, three staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed people in the communal lounges, their experiences during lunchtime and the administration of medicines.

Good

Is the service safe?

Our findings

People told us that staff continued to make them feel safe. When they were asked why they felt safe and how staff achieved this, one person told us, "Oh yes for me I feel very safe here. It's because I have no worries and at home things were difficult for me".

The registered manager and provider ensured that staff were safe to work with people. Information about staff's suitability to work had been gathered before their employment began. This included obtaining references, employment history and information about their qualifications. Disclosure and Barring Service (DBS) checks had also been undertaken before staff were able to work unsupervised with people. The DBS helps prevent unsuitable people from working with vulnerable groups.

There was sufficient staff to meet people's needs. Staffing levels were aligned to people's assessed needs. People told us that staff were busy, however, were available when they called for assistance. Staff's skills and levels of experience were taken into consideration when planning the staffing rotas. Less experienced staff worked alongside the more-experienced to develop their skills and to enable them to receive support and guidance.

People were protected from abuse. Staff understood their responsibilities to safeguard people from harm. Appropriate referrals had been made to the local authority when incidents had occurred. Advice and guidance provided by the local authority had been listened to and complied with.

Potential risks to people's safety had been identified and were managed well. People could continue to take risks and consideration had been made as to how these would be lessened. For example, one person accessed the local community independently. Record showed that the person had their own mobile telephone so that they could contact staff if they needed assistance when they were out. The person's mobile telephone number was recorded in their care plan so that staff could contact them if they needed assurance that the person was safe.

When accidents and incidents had occurred, these were monitored to help identify patterns and trends. Lessons were learned when accidents and incidents had occurred and records showed that people's care plans and risk assessments had been updated and amended to reflect any changes in their needs.

Environmental and equipment checks were conducted to ensure that people were safe. Personal emergency evacuation plans (PEEPS) were in place to inform staff of how to support people to safely evacuate the building in the case of an emergency. The provider had a contingency plan in case of emergencies. This provided staff with information about alternative places for people to stay if the home needed to be evacuated.

People were provided with medicines to maintain their health. Medicines were administered by trained staff, who had their competence regularly assessed. An assessment of risk was conducted that identified if people were safely able to administer their own medicines. When appropriate people could continue to do this.

There were safe systems in place to store, dispense, administer and dispose of people's medicines. People told us that they were happy with the support provided and received their medicines on time. Information about people's health and the medicines that were prescribed was available so that this could be passed to external healthcare professionals if needed. For example, when people needed to attend hospital;

People were protected from infection. Staff responsible for handing food had received appropriate food handling training. The home was clean and staff were provided with appropriate personal protective equipment to minimise the spread of infection. Staff disposed of waste appropriately to minimise cross-contamination.

Good

Is the service effective?

Our findings

People continued to receive a service that effectively met their needs. Comments from people included, "It was a good move coming in here. Overall, I'm very pleased to be in this place".

People's needs were assessed prior to them moving into the home and on an on-going basis. Care plans were specific to people's assessed needs and provided staff with advice and guidance about how to support people appropriately. People's risk of malnutrition was assessed and appropriate action taken. For example, for people who were at risk of losing weight and becoming malnourished, they had access to fortified food and drinks. Their food and fluid intake had been monitored to ensure that they received sufficient amounts to eat and drink. Advice had been sought from external healthcare professionals when there were concerns.

People were complimentary about the food. They told us that they had choice and had access to snacks and drinks outside of mealtimes. One person told us, "The meals are very good, honestly. We get drinks all day and I can ask for a drink anytime". People who chose to eat their meals in the dining rooms enjoyed shared conversations with one another. People's right to choose where they ate their meals was respected. Some people preferred to eat in their rooms and had their meals provided to them there. Aids and adaptations were available to enable people to be independent. Records for one person advised staff that the person needed a plate guard so that food did not fall off their plate whilst they were loading their fork. The person was observed independently eating and did not require the support of staff. People's personal beliefs were respected and meals were adapted to meet these. For example, if people followed a vegetarian diet.

People spoke fondly of staff and told us that they had faith in their abilities and skills. One person told us, "The staff are well-trained. They just get on and do things". When staff first started work they undertook an induction. This enabled them to undertake training courses that the provider considered essential for their role. They were allocated to work alongside more experienced staff. This enabled them to orientate around the home and get to know people's needs as well as the provider's policies and procedures. Staff had access to on-going training to ensure their skills remained current. Links with the local authority and external healthcare professionals promoted the sharing of best practice.

People's healthcare needs were assessed and met. There was a coordinated approach to people's care. People were visited by an optician at the home and were provided with new spectacles. One person commented how much this improved their vision and how much easier it was for them to undertake their sewing. People had access to GPs and told us that staff could identify when they were not well. Records showed that staff had been responsive when people were unwell or if there had been changes in their needs. Timely referrals to external healthcare professionals had been made to ensure people received appropriate care and treatment. An innovative approach to monitor people who had complex, long-term health conditions had been used. This had been a joint initiative between the provider and the local GP surgery, the results of which were monitored by community nursing teams. A handheld device was used to monitor people's health. If people showed signs of their health deteriorating, intervention could be offered in a timely way before any conditions escalated. This reduced the risk of strokes or further disease. Records

showed that this had been effective for one person. An external healthcare professional who had been monitoring the results of the device remotely, had contacted the home. They had advised staff that there had been a decrease in the person's heart rate and advised that they had already contacted the person's consultant.

People's needs were met by the design, layout and adaptation of the home. People had their own rooms that they could use if they wanted to have their own space. People could choose to enjoy one of the activities or events, receive visitors and enjoy the communal gardens in warmer weather. People were supported to independently mobilise around the home and technology, such as call bells, were available for people to use if they required assistance from staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA. When required people's capacity had been assessed in relation to specific decisions about their care. The registered manager had involved relevant people in decisions that related to people's care to ensure that these were made in people's best interests. There were no authorised DoLS, however, when appropriate the registered manager had made DoLS applications to the local authority and taken appropriate measures, such as undertaking their own assessments of people's needs, whilst waiting for these to be reviewed.

Good

Is the service caring?

Our findings

Staff were kind and caring. Compassionate interactions between people and staff remained. People told us that they continued to feel well-cared for. Comments from people included, "Every one of the staff is so friendly. Anything you need, just press the bleeper and someone comes to help. The attitude of staff is excellent, they always have a laugh with me", "The staff are lovely, kind and considerate" and "Staff do ask how I am".

People were treated with respect. Staff had gathered information about people's lives before they moved into the home. This enabled staff to understand the person's life experiences and their preferences. Conversations between people and staff showed that staff knew people well and people enjoyed talking about their interests and families. People were observed to be smiling and happy.

The registered manager and staff were considerate of people's emotions and feelings. One person had experienced a recent bereavement. The registered manager had considered the impact this might have had on the person and had arranged for them to seek support to help them cope with the feelings that they might be experiencing.

People's diversity was acknowledged and respected. People were asked if they had any religious preferences when they first moved into the home. When people had expressed a wish to practise their faith, arrangements had been made for multi-faith church services and religious leaders to visit the home.

People were provided with privacy and were treated with dignity. Staff explained their actions and gained people's permission before offering support. People were actively involved in decisions that affected their day-to-day care. People had been asked about their preferences of male or female staff and told us that staff respected their wishes. Staff were tactful, sensitive and discreet when people needed support with their personal care needs. People told us that staff respected their privacy and that they were happy with the care they received. One person told us, "I definitely feel they give me my privacy, like drawing curtains and knocking on my door". Information that was held about people's needs was handled and stored to maintain confidentiality. Records were kept in locked cabinets and offices and conversations about people's care held in private rooms.

People were encouraged and able to be involved in decisions about their care and the running of the home. Regular conversations took place when people's care plans were reviewed. This enabled people to be involved in discussions about their needs and any changes related to them. Regular residents' and relatives' meetings took place and provided an opportunity for people and their relatives to comment on the care. Records of meetings showed that these had been reviewed by the registered manager to ensure any expressed wishes were considered. People were made aware of advocacy services when they required assistance to make their needs known. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

People's individuality was respected and people could continue to be independent. Some people accessed

the local community and enjoyed visiting local shops. When people required more support from staff, staff encouraged their independence as much as possible. Staff told us that they prompted people to continue to do as much as they could for themselves. People confirmed this and told us that staff were there to assist them if required.

People enjoyed visits from their relatives or friends. Relatives and visitors told us that they were made to feel welcome and that they could visit at any time. One relative commented that they found the home so welcoming that they had returned as a volunteer. People had access to telephones so that they could maintain contact with their family and friends. Greetings cards were displayed which enabled people to purchase cards so that they could continue to celebrate special events with their loved ones. Friendships had developed between people and they were observed to be enjoying conversations with one another.

Good

Is the service responsive?

Our findings

People continued to receive a personalised service that was responsive to their needs. They told us that there was enough to occupy their time. Comments from people included, "I do get what I need here. There is enough for me to do", and "They know what care I need and make sure I get what I need. The activities and entertainment is very good, like singers and musicians. Enough to keep me occupied".

Care was person-centred and based on people's needs and preferences. People could choose how they spent their time and how they were supported. One person had a health condition that required their medicine to be given at specific times. Staff took this into consideration and ensured that the person received their medicines at the prescribed times to enable them to manage their condition and maintain their health.

People's needs and preferences were documented in their care plans. These provided staff with guidance about how to support people in a way that they preferred. Records showed and people and relatives confirmed, that people had been involved in reviews of their care. These discussions and decisions were made in partnership.

Staff were responsive when there were changes in people's needs. Timely referrals had been made to external healthcare professionals when needed. Relatives told us that they took comfort in being kept informed about changes to their loved one's care.

People had been made aware of the complaints procedure and were supported by staff if they needed assistance to make their feelings known. Complaints that had been raised had been dealt with appropriately and in accordance with the provider's policy. People told us that they felt comfortable to raise questions or concerns about their care without the fear of repercussions.

People were not socially isolated. They told us that there were opportunities to be involved in activities or events and that staff respected their right to choose to be involved with these. People enjoyed taking part in the planned group activities. These included Bingo, scrabble and sewing. People used these as opportunities to enjoy shared conversation and reminisce. Records showed that people were provided with the opportunity to continue to pursue their interests. Records for one person, who was enjoying taking part in the sewing group, showed that this had been a lifelong interest of theirs. Some people preferred to spend time in their own rooms and staff respected this. Records showed that staff had taken time to visit people in their rooms to ensure that they were not lonely. People had access to televisions and music to help occupy their time. People were encouraged and able to maintain relationships and links with the local community. Records of a residents' meeting showed that discussions about visiting places of interest had taken place. People had planned to enjoy a Christmas meal at a local pub.

People's right to have information provided in an accessible manner was respected. The registered manager ensured people's communication needs had been identified and met. People's care plans contained information on the most appropriate way of communicating with people. One person's care plan advised

staff that the person was registered as Blind. It reminded staff to state their name and introduced themselves when entering and leaving the person's room. Staff had also been reminded to inform the person of what food they had on their plate so that they were kept informed and able to maintain their independence by eating and drinking without support. Information for people and their relatives, if required, could be created in such a way to meet their needs, for example, in accessible formats to help them understand the care available to them.

People had access to technology to summon assistance from staff. Call bells and sensor mats alerted staff to people's need for assistance.

People were provided with good end of life care. People and their relatives, if they wished, had been able to plan for the end of their lives. Records showed that people had been supported at the end of their life with appropriate care and compassion. There were links with local hospices and community matrons to ensure staff were provided with appropriate advice and guidance. The registered manager subscribed to the End of Life Care Hub (Echo). Echo is an NHS service that provides advice and support and access to specialists and equipment. Medicines were available in anticipation of people's health deteriorating.

Good

Is the service well-led?

Our findings

People and their relatives told us that the home continued to be well-led. People, relatives and staff were complimentary about the registered manager and about how the home was managed. Comments from people included, "The management is good", "The manager is nice and I can ask her questions" and "The place seems to run smoothly".

The management team consisted of the registered manager, a deputy manager and team leaders. An operations manager regularly visited the home to conduct quality assurance audits and to offer support to the management team. The provider had recognised and valued the registered manager's abilities and skills. They had asked the registered manager to provide management cover to another of their homes, as well as Glebe House. Despite this, the standards of the home and the care people had received, had remained good.

Quality assurance processes ensured that the systems and processes within the home were effective. These included audits of various aspects of care. A recent audit which had been conducted by the provider's quality assurance team, had scored the home as achieving 97% with only minor areas required to achieve 100%. Records showed that when issues that needed to improve had been identified, appropriate action had been taken in a timely manner. The local authority also undertook their own quality monitoring visits to ensure that the home was a safe and suitable place for people to live.

The provider's values of 'Happiness, Wellness and Kindness' were shared by the registered manager and staff. These values were demonstrated in practice and central to the care people received. Feedback from people and relatives demonstrated that they felt that they were treated in a way that incorporated these values. When asked what difference living at the home had made to their lives, two people told us, "The best thing for me is I am well looked after and have now worries" and "For me the best thing is I do believe I am getting the care I need and my daughter would agree".

Staff told us that they were involved in discussions about the home within regular staff meetings and that their input and suggestions were welcomed and respected. There was an emphasis on continuous improvement and learning. When care had not gone according to plan or concerns had been raised, these were shared with the staff team in meetings to provide encouragement and improve practice. Staff felt well-supported and records showed that they had access to regular supervisions and appraisals. These provided opportunities for staff to be given feedback about their practice and identify development needs.

People and relatives told us, and records showed, that there was a transparent and open culture. They told us that they were kept informed of any changes to people's needs or to the running of the home. Newsletters provided information about the home and the events that had taken place. Records of residents' and relatives' meetings showed that the registered manger had reviewed people's suggestions and discussions. They had commented on these and provided explanations about what was being done to meet people's needs and suggestions.

The provider and registered manager were aware of their responsibilities to comply with registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

There was good partnership working to ensure staff learned from other sources of expertise and people received coordinated care. There were links with the local authority and healthcare professionals. In addition, there were links with other registered managers from the provider's other homes. This enabled the sharing of good practice.