Southampton City Council

Glen Lee

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 9 and 11 December 2014 and was unannounced. The planned inspection was brought forward in response to concerns we received about people not having their needs met.

The home provides accommodation and care for up to 34 older people, some of whom were living with dementia. There were 30 people living at the home when we visited. There are bedrooms over two floors and a passenger lift. There is a range of communal sitting areas as well as a dining room where people can eat together if they choose to.

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 and associated Regulations about how the home is run.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the

Summary of findings

home was currently subject to a DoLS, the registered manager was in the process of applying to the local authority for people who may need a standard (rather than urgent) application.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was not a robust system of audit in place to enable staff to know how medicines should be stored at the home and care plans were not in place for people prescribed medication as 'when needed'.

People were supported by sufficient numbers of suitable staff to keep people safe and meet their needs. However, staff said they sometimes felt rushed and did not feel this "was fair" on people living in the home.

We recommend that the provider reviews the way in which staffing levels are decided, to ensure people receive care which meets their needs.

Thorough recruitment checks were completed before new staff started work to ensure they were safe to work with people. Staff had received training in safeguarding and how to protect people and were aware of how to refer issues to the local authority safeguarding team.

Staff had the appropriate knowledge and skills to meet people's needs. Staff were aware of the importance of seeking consent from people before they supported them around the home. People were involved in how their needs were met. People enjoyed mealtimes and were supported to eat and drink in individual ways.

Staff were caring in their approach, which people responded to. Staff respected people's privacy and dignity when supporting them and respected their wishes.

People received care and support which met their individual needs. People's views of the home were sought and there was a complaints procedure in place.

The culture of the home encouraged people, their relatives and staff to give their views and the registered manager was approachable. There was a system of audit in place to ensure the quality of the care provided. The registered manager was supported in their management role.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the home were not safe.

Medicines were not always managed safely. There was no system of audit to show how much medicine should be stored at the home. There were no care plans for people prescribed medicine when required.

The registered manager and staff had received training in safeguarding adults and were aware of how to follow safeguarding procedures.

Staff had been recruited following pre-employment checks. There were enough staff to meet people's needs.

People had risk assessments in place to ensure risks were identified and minimised where possible.

Is the service effective?

Good

The service was effective. People received care and support from staff who had the appropriate knowledge and skills. Staff received the supervision and support they needed to do their job.

Staff sought consent from people, where possible, before they supported them around the home. The registered manager and staff understood the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005.

People were encouraged to enjoy their meals and staff ensured they had enough to eat and drink to meet their needs.

Is the service caring?

Good

The staff were caring.

People were supported by staff who were caring in their approach towards them.

We saw staff respected people's privacy and dignity when supporting them and respected their wishes.

Is the service responsive?

Good

The home was responsive. People's needs were assessed and personalised care plans were in place to enable staff to support them as individuals.

People enjoyed a range of activities, both in groups and one to one.

People received care and support which met their needs. People's views of the home were sought and there was a complaints procedure in place.

Summary of findings

Is the service well-led?

Good

The home was well led. The culture of the home was open and transparent.

There was a system of audit in place to ensure the quality of the care provided. The registered manager was supported in their management role by the provider.

Learning from incidents or investigations was used to train staff and to improve the quality of the service provided.

Glen Lee

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 home under the Care Act 2014.

We last inspected the home on 7 April 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

The inspection took place on 9 and 11 December 2014 and was unannounced. One inspector undertook the inspection. The planned inspection was brought forward following concerns raised about the home.

Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the home is required to send us by law and our previous inspection report.

During this inspection we looked around the premises, spent time talking with people, observed people having their lunch and socialising in the dining room. Not everyone was able to verbally share with us their experiences of life at the home because of their dementia or complex needs. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with two people, six visitors, three staff, a visiting healthcare professional and the registered manager. We looked at a range of records regarding the management of the service, three care plans, medication charts and audits.

Requires improvement

Is the service safe?

Our findings

Medicines were stored securely and safely in locked cupboards and were refrigerated when necessary. Staff monitored and recorded the temperature of the fridge daily although records showed seven gaps since 18 September 2014. This meant medicines may not have been stored correctly on those days. Eye drops which needed refrigeration were stored in the fridge but three open bottles did not show the date they had been opened. Guidance for the use of eye drops states these should be discarded after 28 days of being opened. People may have had eye drops administered which were out of date.

Each person had a Medication Administration Record (MAR) chart to record the prescribed medicines people took. However, there was no process to record the amount of medicines received into the home. There were inaccuracies between the records and the tablets stored. For example, there was one box which originally contained 28 tablets and the records showed one and a half had been administered. There should have been 26 and a half tablets left but there were only 13 and a half left in the box. Staff could not account for how there were fewer tablets than there should have been. People may not have received their medicine as prescribed.

There were no care plans in place for staff to recognise when people needed as required medicine, for pain or agitation. Therefore, people may not get medicine when they need it. Trained staff said some people could ask for a tablet for a headache, for example, and they could recognise signs in people's body language, such as holding their head.

The above issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

However there were some aspects of medicines management that worked well. For example, care co-ordinators had completed training in the administration of medicines which enabled them to administer medicines safely. Staff explained the procedure they followed, which included checking they had the right person, the right medicines and the right dose. They signed the records after the person had taken their medicines so there was a correct record for what they had taken. If the GP had made changes to a person's prescribed medicines, the GP signed the records in the home. This practice ensured prescriptions were up to date and accurate.

One person told us they felt safe at the home. A visitor told us they did not worry about their relative, in terms of their safety. Another visitor said, "we can trust the staff".

Staff had received training in safeguarding adults and this was refreshed every six months to ensure staff were up to date with the training. Staff understood the safeguarding referral process and what could be referred under safeguarding. The registered manager had used safeguarding procedures appropriately to report incidents.

The entire staff team completed training called "Team Teach" which provided staff with strategies for supporting people with behaviour which challenges others. This trained all the staff in the use of recognised techniques ensured staff intervened to support people before incidents could escalate as well as responding in a consistent way.

The provider had a recruitment procedure in place which ensured people did not work at the home until pre-employment checks were completed, such as a Disclosure and Barring Service (DBS) checks and references. The registered manager told us DBS checks were renewed every three years. We were unable to see the records as they were held centrally at Southampton City Council who is the provider of the service.

There was a range of assessments in people's care plans which identified risks to their health and action to be taken. Moving and handling risk assessments identified people's mobility needs and whether they were to be supported with equipment such as a hoist. This information was used in the care plan so people could be moved safely. There were separate risk assessments for day and night, as people's needs could change. One person's assessment showed the hoist was used during the day but at night, using the hoist distressed the person and so was not used and other strategies were in place. Assessments were in place to ensure people were safe in their beds, for example, whether or not to use bed rails. A professionally developed "wellbeing" assessment tool was used to assess people's wellbeing who were living with dementia. This gave staff insight into the person's needs and was used to inform the care plan.

Requires improvement

Is the service safe?

The registered manager told us the staffing levels had been calculated about five years ago, when a certain amount of hours had been "allocated". In this time, people's needs, both for individual people and more generally in the community, had changed and become more complex but the allocated hours had remained the same. Therefore, there was not a system in place which calculated the number of staff needed based on current assessed needs.

We recommend that the provider reviews the way in which staffing levels are decided, to ensure people receive care which meets their needs.

Gaps in the rota could be filled by agency staff. The agency usually provided staff who had worked in the home regularly and so were known to people. However, agency staff could not be used to make up the numbers to six staff, which meant there was often five staff, which included agency workers. This was because the provider was not recruiting to vacant posts due to an internal re-organisation.

People's needs were met by a committed staff team. Visitors felt there were enough staff on duty although some noted how busy they appeared. One relative said there was a lot of staff on duty when they visited. However, staff felt there was not always enough staff on duty. One care worker said if there were six care staff on duty, there was enough, any less was not enough as many people needed the support of two staff together. They said, "personal care can be a bit of a rush, it's not fair on residents. We are here for them, not us." Another staff member felt five care staff was not enough as they struggled to do everything. They said the impact of this was that they were, "trying to rush them, I don't want to, we have to work at a faster pace".

Good

Is the service effective?

Our findings

One person told us, “The staff are very good, they do the right thing.” Visitors felt their relatives were getting the care and support they needed from staff who were knowledgeable and skilled. One visitor told us, “the staff seem very experienced.”

The provider organised induction training so staff would have the knowledge to support people. All new staff completed the “Skills for Care” induction course, which includes a range of topics to give staff an insight into the needs of people they were supporting.

Relevant training was available for staff. One staff member told us there was “lots of training” they could access. Another said the provider was, “really good with training” and that if they wanted to attend a specific training course, they asked their supervisor. Training was updated and refreshed regularly, for example, dementia training was updated every six months. Staff said the team “understood dementia”. We saw staff interacted with people in ways which suggested they did understand dementia, such as how they spoke with them and ensured they ate their meal. Training included training the provider considered mandatory such as moving and handling, as well as training for specific needs, such as stoma care.

All new staff, whether care staff, housekeeping or kitchen staff, undertook training in supporting people living with dementia. People were therefore cared for by the whole staff team who understood their needs.

Staff received regular supervision with newer staff receiving more when they started work, which meant they had extra support when they were new. Supervision could be a meeting sat with the supervisor or an observation whilst working. However, staff stated it was sometimes difficult to find the time for supervision. Supervision records showed staff were getting supervision every month or two months and a staff member confirmed they could ask for supervision sooner if they felt they needed it. This meant staff had the opportunity to discuss their work and how they supported people.

Where people lacked the mental capacity to make decisions staff were guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person’s best interests. The provider ensured all staff had received training in this. A staff member said, “some people can make some decisions” and that they always asked people to make choices, such as what to drink or wear. They identified some people’s abilities varied on a daily basis. Another staff member said some people needed support from their family, social worker or advocate to make important decisions.

Visitors told us they heard staff asking people for their consent before assisting them in some way, such as moving around the home. Through observation, we identified that people were asked for their consent before staff supported them in everyday tasks. Some people did not verbally express an opinion, but they were still asked. We saw a person returning from the hairdressing room with curlers in their hair. Staff asked them if they could take the curlers out but the person said no. The staff member asked again to persuade them but respected their decision and left it until later.

One care plan showed the person’s needs had increased and a move had to be considered. A ‘best interests’ meeting had been held and detailed notes had been taken. As a result, it was felt the person should be supported to stay at Glen Lee and extra staffing was put in place during the night. The person was therefore supported to stay in their home for longer.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, the registered manager was in the process of completing standard applications at a rate of three or four a week. This had been agreed with the local authority as it would not be possible to apply for everyone who needed to be considered at once.

One person said, “The food is very good, you only have to say can you get me a bit of so and so, it’s done”. Visitors confirmed their relatives got the food and drink they needed. One said staff had started to specifically prompt drinks for their relative as they had noticed they had not been drinking enough. The relative said they had told staff about the person’s likes and dislikes when they moved in. Staff were knowledgeable about people’s preferences and dietary needs, such as diabetes.

Food and fluid charts were in place where necessary. Staff recorded what people ate and drank, so their intake could be monitored. If people started to lose weight, staff would

Good

Is the service effective?

ask the GP to prescribe fortified drinks, which provide extra nutrients. Staff supported people to eat in ways which met their needs. This ranged from cutting food up for people to eat independently, to supporting people to eat pureed food. Staff confirmed food was pureed individually before being plated up, which meant it was presented more attractively. People could choose to eat in the dining room or somewhere else and this choice was supported by staff who took their food to them.

We observed staff supporting people at lunchtime, we saw staff take two plates of lunch containing a different main meal, to people and asking them which they would like. This offered people with dementia a real choice as they could see the meal and eat it straight away. People were offered a range of drinks. Staff were aware of the importance of ensuring people ate something and tried different approaches, such as offering other food, or a dessert. People left the table before finishing their meal and were supported to return. We saw a staff member using a different strategy to ensure a person ate their meal by dancing into the dining room with a person so they would return to the table and eat their dessert. Staff were aware of who was not in the dining room and we heard them checking whether people had been given their dessert so that people did not miss out.

People and visitors confirmed staff contacted the GP if people were unwell. Through our conversations with staff we found staff involved healthcare professionals when needed. We spoke with a healthcare professional who said they were regularly called in to check people's skin integrity. They also said their team did not have any concerns with the home. Staff knew people well enough to see when a person was not feeling well which meant they received medical support as soon as possible.

Good

Is the service caring?

Our findings

A person told us the staff were “kind”. A visitor told us they were “struck by how caring” the staff were and that staff were, “lovely” and “smile a lot”. Another visitor said staff were, “not just doing a job…I feel they care about the family and carers as well. They know people as individuals...and are very observant.” We saw a letter from a relative which was clear that although they were making a complaint, they thought the staff “were wonderful, caring to the residents, all have patience and understanding”.

Staff interacted with people in a caring and compassionate way. At lunchtime, we saw a person was holding on to a staff member and walking around with them, instead of sitting at the table to wait for their lunch. The staff member was patient and responded warmly to the person. This meant their emotional needs were being met and the interaction kept the person interested in lunch, instead of walking away. Staff often touched people, kindly, when supporting them which people appeared to respond well to. Staff spoke about people in ways which demonstrated they cared about them and valued them. Staff were patient with people and understood their individual needs and preferences.

Staff spoke to people whilst they were supporting them, asking them what they would like to do, or explaining what was going to happen when necessary. People were offered choices throughout the day, from where to sit to what they would like to eat. Care plans were created and reviewed with input from relatives if they were unable to directly express a view.

Visitors told us staff respected people’s privacy and dignity. One said people were “dressed upstairs in their bedrooms”. We heard staff asking a visiting dentist if they could take them to the person’s bedroom. This showed people saw healthcare professionals in private.

Staff explained how they supported people with their personal care in ways which ensured their privacy and dignity. This included shutting the door and curtains and covering people up with a towel whilst undertaking personal care. Staff were aware there was a privacy screen which they said they would use if someone’s dignity was compromised but they declined to move to somewhere more private. People saw visiting healthcare professionals in their own bedrooms, so their dignity was maintained and privacy respected. People’s information was treated confidentially because their files were stored in a locked office.

Good

Is the service responsive?

Our findings

A visitor felt their relative received personalised care which was responsive to their needs. They said staff "try to coax" their relative to accept care and support and said "they are patient". They said the person had been declining personal care but care staff had "been persuasive", which had benefitted their relative. Staff were seen as flexible and knew what was "going on" with their relative.

People's needs were assessed before they moved into the home. The assessment process gathered information from the person, their family and professionals involved in people's care, such as nurses. A visitor confirmed their relative had visited the home for a day and stayed overnight so staff could get to know them and assess their needs.

People's assessed needs were used to create a personalised care plan which was reviewed monthly or sooner if necessary. Care plans included information about peoples' physical and mental health needs and how they should be met by staff. Care plans showed people or their relatives had been asked about their likes and dislikes and care preferences. Through talking with staff we found they were aware of how people liked to be supported and were consistent in their approach to people.

Social activities were offered to people, based on their assessed needs. A specialised activities assessment tool was completed by staff which related to what type of activity would best suit people, for example, a sensory activity. Staff knew people's preferences regarding what they liked to do. Staff explained how one person would not enjoy sitting in the dining room for a group activity, but did like to listen to soft music and poetry in their bedroom. Other people liked hand and foot massage, talking to staff, having their nails manicured. Some people liked to join in group activities included music and movement, seasonal parties, art and making cakes in the kitchenette.

One person told us they would feel able to complain, "to anybody really". A relative said if they needed to complain they would speak to someone at the reception desk and that they would listen. Another said they could complain, they thought staff were, "approachable and open to how you feel". Two relatives for different people said they had not been given a copy of the complaints procedure but did not have cause for complaint. There was a complaints procedure in place and records showed complaints had been investigated within the timescales set by the provider. Records showed that following complaints, improvements in practice were made where necessary. Staff were aware of a person's right to complain, saying the usual route was for relatives to talk to the care co-ordinators who ensured the complaint was recorded.

The registered manager held meetings for people living in the home and their families and there had been three in 2014. Minutes had been taken and they showed positive feedback from people attending. The meetings were used to seek feedback, discuss new ideas and implement new procedures which had been put in place as a result of learning from incidents. The registered manager had recently completed a quality assurance questionnaire exercise but had yet to analyse the results.

Good

Is the service well-led?

Our findings

A visitor told us, "I like it here, the atmosphere, walking around, it is comfortable. There is a family atmosphere, welcoming". Two other visitors confirmed they were happy with the leadership of the home, saying it was "well run". Another visitor said they were "very impressed" with how the home was run.

Staff felt the culture of the home was "person centred". One said "We are here for the residents, we work as a team." Another staff member described the home as "happy, friendly", adding that "We all want to do the best we can…we all get on well together, support each other." Staff felt able and confident to raise any concerns with management.

Staff said they found the registered manager to be approachable. One said, "I can say everything, (the manager) is always helpful, if she can do something, she will do. I can give feedback and my views". The leadership team structure included care co-ordinators who were responsible for certain tasks. Staff were aware of their role within the team and good communication ensured people received a good service with consistent care.

The registered manager said they met people's needs around dementia, "really well". They knew this through verbal communication, the way staff spoke to people and feedback from family. They thought the home had a "lovely atmosphere" and staff were patient. Their view, which they promoted with staff, was that staff should think about their habits, likes and dislikes and how they would like to be spoken to. This view was reflected in our conversations with staff.

The provider had a management structure throughout the organisation. The registered manager was supported in their leadership and management role through supervision and training. Certain aspects of the running of the home were managed by separate departments, such as recruitment.

The registered manager had a programme of audits and risk assessments in place to monitor the quality of the service. One audit, about safeguarding, was completed to show staff had been trained, leaflets were available, all staff had up to date checks in place. Other areas of audit included medication, dignity in care and infection control. Audits were up to date and areas for action had been identified and actioned. There was learning from incidents such as safeguarding investigations by the local authority. The registered manager had created a new protocol to ensure a number of actions were taken appropriately after people fell in the home. The registered manager had also developed a night care plan for staff to record their hourly checks so that patterns in people's night time habits could be more easily noted.

The registered manager ensured the home met registration requirements. This included sending notifications of any reportable incidents and when necessary to the Care Quality Commission.

Staff meetings were held for care co-ordinators and care workers. The content of these meetings was tailored to the staff attending and were used to consider any issues which had been raised, such as safeguarding. Incidents resulted in the issues being investigated and explored at these meetings, meaning that staff could learn from the incidents.

The registered manager told us the home had a 'sensory' room which was being refurbished at the time of our inspection. They said the room was used for people to relax in, with staff if they wished, to listen to music or look at moving lights. The room was upstairs and staff found it was too far away from the communal areas so the room was to be moved downstairs, in the hopes that more people would use it.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The registered provider did not have systems in place to ensure they could account for all medicines within the home. People did not have care plans for medicines prescribed as 'when needed'. This equates to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12 (g).