Avery (Glenmoor) Limited

Glenmoor House

Inspection report

25 Rockingham Road
Corby
Northamptonshire
NN17 1AD

Date of inspection visit:
16 February 2017

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29 March 2017

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 unannounced inspection took place on the 16 February 2017. Glenmoor House provides accommodation for up to 59 people who require nursing or residential care for a range of personal care needs. There were 56 people in residence during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The registered manager and provider recognised there were areas that needed improvement in communication between staff and systems for reporting through the management structure.

People's needs were not always met in line with their individual care plans and assessed needs. Staff did not always provide enough detail in the monthly updates of care plans to reflect people's current needs.

People did not always receive their care from sufficient numbers of experienced staff which left some people living with dementia waiting for support to have their food and drink. People's nutritional risk assessments were not always accurate; staff did not always identify when people were at risk.

People were monitored closely following an accident. Staff monitored people's health and well-being and ensured people had access to healthcare professionals when required. People were protected from the risks associated with medicines management.

Recruitment procedures protected people from receiving unsafe care from care staff unsuited to the job. Staff received training in areas that enabled them to understand and meet the care needs of each person.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse. Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) and had applied that knowledge appropriately.

Staff understood the importance of obtaining people's consent when supporting them with their daily living needs. People experienced caring relationships with the staff that provided good interaction by taking the time to listen and understand what people needed. People had been involved in planning and reviewing their care when they wanted to.

The quality of the service was monitored by the audits regularly carried out by the manager and by the provider, their findings were analysed and acted upon.

There was a breach of one Regulation of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. We have asked the provider to provide an action plan which we will follow up.

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 always safe.

People did not always receive care from enough skilled and experience staff to meet their needs.

Risks were regularly reviewed and but care plans to mitigate the risks did not always reflect people's current risks.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse.

Staff had been appropriately recruited and had the skills and experience to provide safe care.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to have sufficient amounts to eat and drink to maintain their health and well-being.

People received care from care staff that had the training and supervision they needed to meet people's needs.

Care staff knew and acted upon their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

People had positive relationships with staff that knew them well.

People's care and support took into account their individuality and their diverse needs.

People's privacy and dignity were respected.

People were supported to make choices about their care and staff respected people's preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not always met in line with their individual care plans and assessed needs.

People's needs were assessed prior to admission and subsequently reviewed.

People knew how to complain and there were processes in place to deal with people's complaints or dissatisfaction with the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The management promoted a positive culture that was open and inclusive.

People's quality of care was monitored by the systems in place and timely action was taken to make improvements when necessary.

People were supported by staff that received the managerial guidance they needed to do their job.

There was a registered manager in place who understood their responsibilities in making notifications to the relevant authorities.

Glenmoor 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 unannounced inspection was carried out by an inspector and an inspection manager on 16 February 2017.

Before the inspection we contacted the local health and social care commissioners who place and monitor the care of people living at Glenmoor House. We also reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with nine people who used the service and four relatives. 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 nine members of staff including one nursing staff, one unit manager, five care staff, the kitchen manager and the registered manager and the area manager. We reviewed the care records of seven people who used the service and six staff recruitment files.

We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

People's assessed needs were not always met by sufficient numbers of experienced staff on duty. There was no formal calculation of staffing requirements to ensure that there were enough staff deployed to meet people's needs. The dependency on the nursing unit was extremely high; there was a reliance on one nurse on duty in the afternoons, evening and overnight. We observed that nursing staff were very busy and were responsive in providing care, however, this left little time to assess, plan and oversee the care that was delivered by care staff. The provider and the registered manager recognised that the dependency within the nursing unit was very high and was in the process of implementing a dependency tool to help calculate staffing requirements and take action to amend the staffing levels accordingly.

In the memory unit, people living with dementia did not always receive their meals or drinks regularly due to the lack of staff available to support people in a timely way. One member of staff told us "We need more staff on the dementia unit as we are having to put people to bed earlier than they want to because we don't have enough staff, I don't agree with it." We brought this to the attention of the registered manager who agreed that deployment of staff to the memory unit will be assessed and revised.

People were assessed for their potential risks such as their risk of acquiring pressure ulcers. However, care plans relating to people's pressure area care did not have clear instruction to staff in how often people required assistance to move to relieve their pressure areas.

Where people's mobility had deteriorated their risk assessment reflected their changing needs. People's care plans provided instruction to staff on how to mitigate people's risks to ensure people's continued safety. For example, the type of hoist and slings to use and ensuring that people wore the correct footwear to prevent trips and falls.

People were closely monitored for 24 hours following a fall or an accident. Staff were prompt in referring people for medical attention and kept their families informed. The registered manager monitored data from people's falls to detect areas where future accidents could be prevented.

Staff understood their responsibilities to safeguard people and knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. They had received training and were supported by up to date guidance and procedures. Relatives told us they felt their relatives were safe; one relative said "My [relative] is safe here." One member of staff told us "We have had safeguarding training that included scenarios which helped me to understand. I would report anything to the managers and they would report to the local authority." The manager maintained records of safeguarding referrals and any investigations; they raised safeguarding alerts where concerns had been brought to their attention.

People were assured that regular maintenance safety checks were made in all areas of the home including safety equipment, water supplies and the fire alarm. Staff were mindful of the need to ensure that the premises were kept appropriately maintained to keep people safe; we saw that staff reported any issues that could affect peoples' safety and these were dealt with promptly.

People could be assured that prior to commencing employment in the home, all staff applied for and were interviewed through a recruitment process; records confirmed that this included checks for criminal convictions and relevant references. Nursing staff were registered through their professional body and there were systems in place to ensure that their registrations had been maintained.

People's medicines were safely managed. Registered nurses managed the medicines for people who required nursing care. People who did not receive nursing care had their medicines administered by senior care staff who had received training in the safe administration, storage and disposal of medicines. We observed staff administering medicines to people and heard them explain what the medicines were for. Staff had arranged for people to receive liquid medicines where they found swallowing tablets difficult. Staff followed guidelines for medicines that were only given at times when they were needed for example Paracetamol for when people were in pain.

Requires Improvement

Is the service effective?

Our findings

People were not always identified as being at risk of not eating enough to maintain their health and well-being. Although staff assessed people's risks by using a Malnutrition Universal Screening Tool (MUST), staff had not calculated the MUST scores correctly. Staff had assessed some people as being at low risk of malnutrition even though they had lost more than 5% of their body weight in six months. As a result staff had not identified that these people were at risk and had not referred them to their GP or dietitian for nutritional advice; or updated people's care plans to reflect their current needs. The provider and the registered manager had identified that people's MUST scores were not accurate and had already arranged additional training and discussion with senior staff to update their skills and reassess people's nutritional risks.

Where people had been referred to the GP and dietitian for nutritional assessment, their advice had not always been followed. Although we saw that most people received food that was fortified with items such as cream, and people received soft or pureed foods to meet their needs, records showed that not everyone received their prescribed snacks or fortified drinks regularly. For example three people in the memory unit required additional milkshakes and snacks between meals, but records showed that they had not received them in the previous week. We observed that they did not receive their prescribed fortified milkshakes and snacks on the day of our inspection.

People living with dementia were not always provided with their food in a timely way. We observed that people in the Memory Unit had to wait for their meals which caused some people to lose interest and wander off without eating. Although most people ate their meals, others required assistance or prompting. We observed there was just one member of staff helping one person to eat whilst also supervising others in the dining room; people did not respond to the supervision and did not eat their meals. People with dementia did not always receive the supervision and assistance they required to eat their meals.

People did not always receive meals that met their preferences. We saw that people who were unable to make choices in advance of their meals were offered two plated meals so they could make an informed choice. However we observed that two people received meals that they did not like; their menu indicated that they had chosen these meals. One person told us "I don't like curry; I would never have ordered that." Records showed that staff completed menu choices on behalf of some people that could make these decisions themselves.

Staff recorded what people drank throughout the day; in the residential and memory units we saw people were not offered drinks regularly after 5pm; there was a marked fall in the amount of drink recorded in the evenings. We observed that there were no drinks available in the communal area in the dementia unit; instead people relied on regular tea rounds. People who were in their own rooms relied on staff to provide and support them with their drinks. We saw two people who chose to spend time together in their own area, had not been supported to have their drinks which had gone cold, they asked for more to drink. People did not always have access to or receive enough assistance to have regular drinks consistently throughout the day.

This is a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

People received care and support from staff that had completed an induction that orientated staff to the service. One member of staff old us "I had three days training; it was a good refresher, as I have been in care for many years." Staff received training in areas that enabled them to understand and meet the care needs of each person they cared for and records showed that staff training was regularly updated and staff skills were refreshed. One member of staff told us "The training is quite good, it is face to face. The dementia training was particularly good."

People were cared for by staff that received supervision from their line managers. Staff in the nursing units told us they were well supported. Staff in the residential and memory units told us they did not always feel listened to as their concerns about the quality of care was not always acknowledged or acted upon. We brought this to the attention of the registered manager.

People and their representatives were involved in decisions about the way that care was delivered and staff understood the importance of obtaining people's consent when supporting them with their daily living needs. We observed staff communicating effectively with people using a variety of means to help them understand what people needed; for example where people could not communicate verbally, staff looked out for signs of agreement or disagreement with the care that was offered.

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).

People's care plans contained assessments of their capacity to make decisions for themselves and consent to their care. There was recorded evidence of how decisions had been reached through best interest meetings. Information about people's Lasting Power of Attorney (LPA) and advocates were recorded. Care staff had received the training and guidance they needed in caring for people that may lack capacity to make some decisions for themselves. The registered manager and care staff were aware of, and understood their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

People's healthcare needs were met. Staff maintained records of when healthcare appointments were due and carried out, such as GP review of medicines, eye tests, dentist and the chiropodist. Nursing staff monitored people's well-being by taking their clinical observations regularly, such as blood pressure.

Good

Is the service caring?

Our findings

People told us that they were happy living at Glenmoor House and said the staff were friendly. One person told us "I like it here, the staff are nice" and a relative told us they were "Really pleased with the home, the staff are extremely kind and thoughtful." Staff enjoyed working at the home staff told us "The atmosphere here is relaxed, friendly and everyone is really caring" And "I love the home; it's really nice, really friendly."

Staff took into account people's individuality and their diverse needs. Staff took time to find out what people enjoyed and provided for people's preferences. We observed staff talking with people about what interested them, and observed staff dancing with one person. Later in the day, their relative told us "Staff know her well, she loves dancing, staff dance with her." Another relative told us their relative enjoyed the individual attention they received; they told us "They [activities staff] massage her hands."

People were helped to settle into the home; one person told us "It's been very difficult, but the staff are very very kind, they have gotten to know me; they are nice to me." We saw that staff took time to be with them when their visitors left, one member of staff said "[name] doesn't like to be alone, we spend time talking with them about their family and their life." People received care from a regular group of staff, which helped form positive relationships. One person told us "All the staff are kind." One relative told us "Staff are great with her."

Staff were knowledgeable about the people they cared for; they were able to tell us about people's interests; their previous life history and family dynamics. "One member of staff told us "[name] does not like crowds, they prefer talking one to one and spends time listening to the radio." We saw that this person had their radio playing in their room whilst they were resting.

People's care was person centred. Relatives described how the care their relatives received met their individual needs. One relative told us "They know her well, her little ways; like that she wanders at night." People and their families were involved in their care planning. People had their individual routines and preferences recorded and carried out by staff.

Staff demonstrated their awareness of the need to maintain people's dignity; they were able to provide examples of how they supported people in a dignified manner, such as using positive language to encourage people to be independent. One person told us they felt independent, they said "I look after myself mostly, but staff know what I need, I feel well cared for."

There were arrangements in place to gather the views of people during their care reviews. People had provided positive feedback about the kindness of staff. People's relatives and friends were encouraged. One person told us "My family visit every day, they are made to feel welcome." Relatives were involved in activities; we observed that two visitors enjoyed singing songs from war time with people in a lounge. They told us "They [staff] sing songs with us too, they're really good." The provider had created large spaces in the home to encourage large family groups to hold their celebrations in the home.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to their admission to the home. Senior staff assessed people's needs and established whether Glenmoor House could meet their needs. Initial risk assessments and care plans were put in place and updated as their needs changed.

People who used the service and their relatives were involved in their yearly reviews and initial care planning. Senior staff carried out monthly updates to care plans however, these did not always provide the updated details that care staff required to meet people's needs. This had caused some confusion amongst staff about people's current needs. For example staff did not have the correct information about whether people could eat and drink and frequency of position changes to alleviate pressure areas. We brought this to the attention of the registered manager who arranged for people's care plans to be updated in detail to reflect people's current needs.

People who required pressure area care in the memory unit did not always receive their care in line with their care plans and assessed needs. Where people had been assessed at risk of pressure ulcers, care plans instructed staff to ensure that people were helped to move to relieve their pressure areas on a regular basis; each person had a timescale in which they had to receive care, for example four hourly. Staff we spoke with did not know the regularity required for each person they provided cared for. Records showed that people did not receive their pressure area care as planned, for example one person who required two hourly care received their care every three or more hours. Records showed that people did not always receive their planned pressure area care in the evenings, leaving some people four or more hours between their planned care to assist them to reposition.

People had opportunities to take part in activities. Activities staff were deployed to assist people to carry out activities of their choice. One person told us "A lady comes to my room to do reading, puzzles, nails and skin I love the attention." We observed that activities staff spent time with people in small groups or one to one in the residential unit. However, there were long periods in the day when people in the memory unit were sitting in the lounge area in silence.

People maintained links with the local community through regular events. Children from the local school visited at Christmas and Easter and the local church choir performed in the home once a month. Some people were supported to attend an over 60's group. The home supported local charities such as a local youth football team.

People had their comments and complaints listened to and acted on. People's verbal complaints were dealt with by the unit managers. People had the option to complain in person at care reviews or at residents meetings, or in writing. A complaints procedure was available for people who used the service explaining how they could make a complaint; people said they were provided with the information they needed.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who had managed the home for many years; they understood their responsibilities in making notifications to the relevant authorities.

Staff were not always clear about the ethos of the organisation and did not feel empowered to approach the registered manager. The culture of the home was that of a rigid hierarchy as each member of staff were expected to pass everything through their line manager. This had proved to be a barrier between staff and the registered manager as not all feedback was relayed. Some staff told us they were disappointed that some of the issues they raised at supervision had not been resolved, for example the quality of the food. We found that not all the feedback from staff reached the manager as these were kept at the supervisor's level who were the line managers for care staff and not shared with the registered manager. The registered manager had not always been made aware of the issues that staff had raised with their direct line managers so appropriate and timely action was not always taken.

The registered manager did not have a complete oversight of the issues identified in this report as the communication between staff, unit managers and the registered manager was not always effective. Although the heads of each department met at least three times a week to discuss all aspects of the home, not all information which affected the quality of people's care reached the registered manager. For example people's verbal complaints had been dealt with at unit level, they had not all been recorded and they had not been shared with the registered manager. This meant that the registered manager did not always have an accurate oversight of the issues raised by staff and people who used the service.

The registered manager recognised that systems for communication had not been effective. They told us "We have been on a journey, we have had a change of ownership and implemented the new policies and ways of working and we have improved the environment. Now we need to work on building the teams and ensure that staff are fully involved." The registered manager and the provider had already identified the need to discuss the issues regarding MUST risk assessments, communication, staffing and staff development and had meetings planned.

People were asked for their feedback about the service in formal surveys and at residents meetings. The registered manager responded to people's requests; people had asked for a book to be available to provide feedback; the registered manager had provided a book in reception for people to complete which we saw was being used. People also had feedback books in the dining areas to pass their thoughts about the food to the catering staff.

People's entitlement to a quality service was monitored by the audits regularly carried out by staff, the manager and by the provider. The manager used the audits to improve the service and feedback to unit managers where improvements were required. For example the registered manager had implemented an effective way of monitoring people closely after a fall.

Policies and procedures to guide staff were in place and had been updated when required. We spoke with

staff that were able to demonstrate a good understanding of policies which underpinned their job role such as safeguarding people, health and safety and confidentiality.

People were able to rely upon timely repairs being made to the premises and scheduled servicing of equipment. Records were kept of maintenance issues and the action taken to rectify faults or effect repairs. Records relating to staff recruitment and training were fit for purpose. Records were securely stored to ensure confidentiality of information.

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	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always met. Regulation 14 (1)