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Glenhurst Manor

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 22 and 25 January 2016 and was unannounced. Glenhurst Manor provides care and accommodation for up to 36 older people. On the day of the inspection 26 people lived at the home.

The service did not have 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 acting manager was in the process of applying to be the registered manager during the inspection.

People were encouraged and supported to make their own decisions and choices whenever possible in their day to day lives. People's privacy and dignity was maintained. We observed the staff supporting people with kindness and patience at all times.

People were protected by safe recruitment procedures. Staff were supported with an induction and ongoing training programme to develop their skills and staff competency was assessed. Most people we spoke with felt there were sufficient staff on duty.

People had access to healthcare professionals to make sure they received appropriate care and treatment to meet their health care needs, such as district nurses and doctors. Professionals said the staff followed the guidance they provided. This ensured people received the care they needed to remain safe and well, for example people had regular visits by district nurses to change dressings.

People's medicines were managed safely. Medicines were managed, stored and disposed of safely. Senior staff administered medicines had received medicines training and confirmed they understood the importance of safe administration and management of medicines.

The manager and staff had sought and acted upon advice when they thought people's freedom was being restricted. This helped to ensure people's rights were protected. Applications were made and advice sought to help safeguard people and respect their human rights. The provider was acting in accordance with the Mental Capacity Act 2005.

Staff had undertaken safeguarding training, they displayed a good knowledge of how to report concerns and were able to describe the action they would take to protect people against harm.

People were supported to maintain a healthy, balanced diet. People told us they enjoyed their meals and we observed mealtimes did not feel rushed.

People's care records were mostly comprehensive and detailed people's preferences. Records were

regularly updated to reflect people's changing needs. People and their families were involved in the planning of their care.

People's risks were considered, managed and reviewed to keep people safe. All the people we spoke with told us they felt safe at Glenhurst Manor. Where possible, people had choice and control over their lives and were supported to engage in activities within the home.

People and staff described the manager as being very supportive and approachable. Staff talked positively about their jobs and took pride in their work. Visiting professionals and staff confirmed the manager made themselves available and staff followed their instructions.

People's opinions were sought formally and informally. Audits were conducted to ensure any concerns with the quality of care or environmental issues were identified promptly. Accidents were investigated and, where there were areas for improvement, these were shared for learning.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were recruited safely.

Staff knew how to recognise and report abuse.

Medicines were safely stored and administered and there were clear protocols for each person and for staff to follow. Staff had training and knew how to respond to emergency situations.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and training to meet people's needs.

The provider was acting in accordance with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were involved in decisions about their care.

People's privacy and dignity was promoted by the staff.

Staff knew about the people they cared for, what people required and what was important to them.

People's end of life wishes were documented and respected.

Is the service responsive?

Good

The service was responsive.

People's care plans were reviewed regularly to enable members of staff to provide care and support that was responsive to people's needs.

People were supported to have their nutritional needs met. People's healthcare needs were assessed and people had good access to professionals.

People were able to take part in activities organised at the home.

A copy of the complaint's procedure was displayed in the home. No complaints had been received by the home in the past year.

Is the service well-led?

Good

The service was well led.

Members of staff, people and visitors told us the manager was approachable and supportive.

There were systems in place for assessing and monitoring the quality of the service provided.

Glenhurst Manor

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 checked whether the provider was 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 was a comprehensive inspection that took place on 22 and 25 January 2016. The inspection was carried out by one inspector and a specialist advisor. We spoke with and met ten people living in the home and two relatives.

We reviewed the notifications we had been sent from the service since we carried out our last inspection. A notification is information about important events which the service is required to send us by law.

We also liaised with the local social services department and received feedback about the service.

We looked at six people's care and support records, an additional four people's care monitoring records and medication administration records and documents about how the service was managed. This included staffing records, audits, meeting minutes, training records, maintenance records and quality assurance records.

We spoke with the manager, five members of the care staff team, one housekeeper and the chef.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service and relatives were confident their family member was safe. One person told us, "I feel very safe here; all the staff are kind and caring". A visitor told us, "I feel my sister is safe here, well looked after".

Legionella are water-borne bacteria that can cause serious illness. Health and safety regulations require persons responsible for premises to identify, assess, manage and prevent and control risks, and to keep the correct records. The provider had a Legionella risk assessment that had been completed in October 2015 which identified a number of actions that required completing, which included the training of staff, monitoring and work on the premises to reduce risk. However, we found that this had not been completed. We discussed this with the manager who told us that they would ensure the actions identified from the risk assessment were completed. This was an area for improvement.

Fire testing and drills had been carried out; however these had not been conducted weekly in accordance with the provider's policy. This was an area for improvement. Other maintenance and servicing records were kept up to date for the premises and utilities, gas and electricity. Maintenance records showed us equipment, such as fire alarms, extinguishers, mobile hoists, the passenger lift, call bells, and emergency lighting were regularly checked and serviced in accordance with the manufacturer's guidelines.

People benefited from a safe service where staff understood their safeguarding responsibilities. Staff had received training in safeguarding adults to provide them with information about what constituted abuse or poor practice. They were able to explain about how to recognise the signs of abuse and they knew how to keep people safe. They also understood their responsibilities to raise any concerns if they suspected someone was at risk of abuse or if they witnessed any poor practice. One member of staff told us they would report to the most senior person or the provider in the first instance and they also had a handbook to refer to if there was anything they were not sure about. There was information in the entrance of the home which contained information about safeguarding and how concerns could be escalated to the local safeguarding team.

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. For example people had movement and handling risk assessments which provided staff with instructions about how people were to be supported. People also had risk assessments in place to reduce and manage the risks to their health such as pressure damage to the skin and falls. When required people had appropriate equipment supplied to reduce the risks of falls and maintain their skin integrity. Individual plans of care contained personal emergency evacuation plans for use in an emergency situation. People's care plans and risk assessments were regularly reviewed and updated as people's needs changed.

Systems were in place to monitor and review accidents and incidents. We saw that this information was completed with an assessment of the incident. Accident and incident forms were made available to the provider so that they could assess the action taken by the manager. This ensured that accidents were

reviewed to reduce the risk of reoccurrences of a similar nature.

Staff recruitment records contained an application form detailing employment history, interview notes, two references, proof of identity and a Disclosure and Barring Service (DBS) check. All of the staff spoken with confirmed they had provided references, attended an interview and had a DBS check completed prior to employment. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the service. This information helps employers make safer recruitment decisions.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. The manager explained the staffing arrangements in the home and how these were dependent on the numbers of people and their dependency requirements to safely live in the home. They told us that they were in the process of appointing a deputy manager. Most people told us that they felt staffing levels in the home were sufficient. One person did comment that during the night, sometimes there was a short delay when they used their call bell to request assistance.

People told us they received their prescribed medicines on time. One person said, "The staff deal with my medicines, as far as I am aware I take it at the right time." We saw all medicines were kept securely. Medicine records showed that each person had an individualised medicine administration record (MAR), which included a photograph of the person with a list of their known allergies. We looked at a selection of MAR. All of the records we looked at had been completed accurately. People who were prescribed PRN (as required) medicine had a clear care plan as to what the medicine was used for, how it was taken and the maximum dose. We discussed the use of PRN pain relief for those people who may not be able to tell staff that they were experiencing pain. The manager told us that pain assessment tools were available and used by staff before administering medicines, however there were currently no people in the home who were not able to tell staff if they were in pain.

Good

Is the service effective?

Our findings

Considering people's consent was part of the care planning process. We looked at a number of care plans and saw that people had consented to their care.

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.

The manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body; however they had recognised that more applications may be required. We noted that there were no mental capacity assessments or best interest decisions in care plans, where there was a reason to believe that people may lack the capacity to make certain decisions. This was an area for improvement. We discussed this with the manager who told us that they would implement this immediately. Following our inspection the provider wrote to us evidencing copies of mental capacity assessments and best interest decisions that had been completed.

Staff involved people in decisions about their care, such as which meal choice they would like, or which game they wanted to join in. We observed that a member of staff visited one person to tell them that an activity was taking place. After the staff member left, the person said the staff member was, "Absolutely wonderful, they all are". They told us the staff were always asking them if they needed anything.

Staff told us they had recent training in MCA and DoLS. We asked staff about their understanding of the MCA and DoLS and found it was good. A staff member told us, "Mental capacity is a client's mental ability to make decisions which affect their lives, everyone has capacity until proven otherwise and we all respect this, some people do not always make decisions that are in their best interests but when they have capacity, they have the right to choose".

People had their assessed needs and preferences met by staff with the necessary skills and knowledge. A relative told us "They have a good staff team here and the turnover is low". Staff received training in areas such as fire safety, mental capacity, diversity, food hygiene, safeguarding, infection control, management of hazardous substances, moving and handling and medication. They had also completed training in other specialist areas such as catheter care and the prevention of pressure sores to ensure they understood people's needs and knew how best to support them. One member of staff told us that they felt they would benefit from additional training to help them support people living with dementia.

People had access to healthcare professionals to make sure they received appropriate care and treatment to meet their health care needs, such as district nurses and doctors. We spoke with a visiting GP during the inspection who told us that they felt the home was responsive to people's needs. They told us that they received appropriate referrals and that staff followed their guidance.

People could choose what they would like to eat and drink and this information was recorded into care records. There was a menu on display to the entrance of the dining room. One person said, "The food is very good and staff will always offer something different if you don't like it." People had their specific dietary needs catered for, for example if they needed a diabetic diet. The malnutrition universal screening tool (MUST) was used when needed, to identify if a person was at risk of malnutrition. People identified as at risk of malnutrition had their weight monitored and food and fluid charts were completed. The chef confirmed they had information on people's dietary requirements. Care records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy balanced diet.

People made positive comments about the food provided. One person wrote in the comments book, 'Excellent food, beautifully prepared and presented cannot be surpassed'.

Staff wore special tabards and in the dining room we saw that tables were laid as if in a restaurant. People had a choice of wine and a range of soft drinks before and during lunch. The atmosphere in the dining room was very sociable. There was a great deal of friendly discussion and laughter. The experience of the lunchtime meal was a happy and social event.

Staff were competent, attentive and kind and were clearly well trained in the most effective and dignified ways to support people to eat their meals. We observed three people who were being supported to eat their lunch in their bedrooms. They were sitting up at an angle appropriate to assist them to eat their food safely. The staff sat appropriately close to the person and assisted the person to eat at the person's pace. There were bottles of water, glasses and fresh fruit available for people to help themselves to throughout the day.

Staff received regular supervision. We saw that supervisions also included a formal observation. These processes gave staff formal support from a senior colleague who reviewed their performance and identified training needs and areas for development. Other opportunities for support were through staff meetings, handover meetings between staff at shift changes and informal discussions with colleagues. Staff told us they felt well-supported. They said there was a good sense of teamwork and staff cooperated with each other for the benefit of the people who lived at the home. The manager had identified that there were shortfalls in the appraisal process. They told us that they would ensure that annual appraisals took place.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. We spoke with one person who was staying at the home short term. They told us, "This place is 10 out of 10. I could not fault it. The staff are so kind and do the very best they can at all times. Sometimes in the evening and at night they take a bit longer to answer but that is to be expected. This is a wonderfully, warm home with warm and caring staff, I am very happy here and do not want to go home". Another person told us, "It's absolutely fantastic, the patience and care the staff show to people is excellent. You can tell they really care. I was unwell before Christmas and the amount of times that staff popped into see me and make sure I was okay was really lovely."

Staff interacted with people in a kind and compassionate manner. We saw that they responded promptly to people who were requesting assistance and they did so in an attentive manner and friendly way. There were also a considerable amount of warm and friendly exchanges between staff and people which were, when people were able, reciprocated in the same way.

People's privacy and dignity was respected, staff supported people to maintain their personal hygiene during their activities of daily living. Personal care was provided in the privacy of people's own rooms. Staff knocked on people's doors before entering their bedrooms and bedroom doors had keys, should people wish to use them. Visiting times were flexible and people were able to choose whether to receive their visitors in the communal areas or in their own rooms. During the inspection we saw visitors were able to come and go freely.

People's records included information about their personal circumstances and how they wished to be supported. For example, after lunch the staff knew which people liked to go to their room for a rest and supported them to do so. In addition, staff ensured people's privacy was protected by providing all aspects of personal care in their own bedrooms. Throughout the day we saw that people were spoken to by staff with their preferred names. This demonstrated that staff were aware of the contents of care plans and as a consequence they had knowledge of people's individual choices.

People and their relatives were given support when making decisions about their preferences for end of life care. The home held an accreditation of 'beacon' status for the National Gold Standards Framework Centre in End of Life Care. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling staff to provide a high standard of care for people nearing the end of life. The manager explained that people's advanced wishes were documented if people wished.

Good

Is the service responsive?

Our findings

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. For example, one person had a visual impairment; they had a care plan in place which stated the distance away from the television the person would need to be to ensure they had a good picture. For another person who was diabetic, there was a diabetic care plan in place which outlined how staff should manage the condition. We did note that this person's care plan stated that they should have their blood sugar levels monitored once a week, however this was not happening. Diabetes UK and NICE guidance state that monitoring of blood is an essential part of providing care that helps people to manage their diabetes safely. We discussed this with the manager who told us that this had been stopped some time ago and they would contact the diabetes nurse for further guidance. This was an area for improvement.

Regular handover meetings between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. There was an 'Events Calendar' available to people in the home. We saw that activities included quizzes, crafts, tai chi and reminiscence group. There was also live entertainment, such as singers and a pianist each afternoon for people to enjoy. People told us that they enjoyed the activities however they would like more activities that took place outside of the home. They explained that the provider had a minibus but due to some staff issues trips out were not currently taking place. We discussed this with the manager who acknowledged this and told us that they were actively looking to address this.

People's bedrooms reflected their personality, preference and taste. For example, some bedrooms contained articles of furniture, pictures and ornaments from their previous home. People were offered choices and options. They had choice about when to get up and go to bed, when to have breakfast, what to eat, what to wear, and what to do.

The provider had a policy and procedure in place for dealing with any concerns or complaints. This was made available to people and all visitors to the service. The policy was clearly displayed for people to access. A complaints file showed any complaints made, the action and outcome of the complaint and the response sent to the person concerned. We noted that no complaints had been received by the service in the past year.

Good

Is the service well-led?

Our findings

The home did not have a registered manager 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. However the acting manager was in the process of registering with the Care Quality Commission.

The manager had been in post for seven weeks and they told us, "There has been a lot to achieve during this time; I know there are still some things that need to be done and the records are at the top of my list". They continued, "The staff here are good but they need good leadership to help them be the best they can be, which is my role. I am very excited to be here and know this is a wonderful home with wonderful staff. I feel very lucky to be here". They explained that they were in the process of appointing a deputy manager to strengthen the management of the home.

All of the people who lived at the home and the relatives we spoke with told us they thought the home was well run. One person said, "It was quite a shock when the old management left the home suddenly and quite unsettling. But I think the new manager is really good, [manager] is in the process of appointing a deputy which will really help". Another person told us that the manager was, "Enthusiastic, positive and knowledgeable". Staff told us, "The manager is often on the floor, meeting people and speaking with them, she knows about everyone living at the home and is getting to really know the staff well, she has done well in a short space of time".

Quality assurance audits were completed by the manager. Medication audits were completed on a monthly basis. In addition we saw records of other audits that took place, such as monthly care plan audits, health and safety audits and infection control audits. Whilst these were in place to identify shortfalls in the service provided and seek improvement they had not identified all the issues identified during our inspection in relation to some of the records we looked at. This was an area for improvement.

People told us they were encouraged to share their opinions in how the service was run. Resident meetings were held and relatives were also invited to attend. We looked at the minutes from the last resident meeting which was held in July 2015.

Regular staff meetings were held so that staff could discuss issues relevant to their role. We saw that the last staff meeting took place in January 2016 and included topics such as communication, teamwork, training and recruitment.