Wellburn Care Homes Limited

Glenholme Residential Care Home

Inspection report

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Date of inspection visit:
30 August 2017

Date of publication:
06 October 2017

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?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection which took place on 30 August 2017.

At the last inspection in April 2016 the service was not meeting all of the legal requirements with regard to governance. At this inspection we found improvements had been made and the service was no longer in breach of these requirements.

Glenholme Residential Care Home is registered to provide accommodation for personal care to a maximum of 37 older people, some who may live with dementia. Nursing care is not provided. At the time of inspection 31 people were living at the home.

A manager was in place who was in the process of applying to become registered with the Care Quality Commission. 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.

People said they felt safe and they could speak to staff as they were approachable. We considered there were sufficient staff on duty to provide safe care and support to people.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support. However, we have made a recommendation that volunteers who spend time in the home should also be vetted.

People told us their privacy, dignity and confidentiality were maintained. Staff understood the needs of people and care plans and associated documentation were clear and person centred. Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way. People received a varied and balanced diet to meet their nutritional needs. People told us staff were kind and caring and they felt comfortable with all the staff who supported them

Appropriate training was provided and staff were supervised and supported. People were able to make choices about aspects of their daily lives. They were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People and staff spoke well of the manager and management team. There were effective systems to enable people to raise complaints, and to assess and monitor the quality of the service. People told us they would feel confident to speak to staff about any concerns if they needed to. The provider undertook a range of audits to check on the quality of care provided. These methods included feedback from people receiving care.

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.

Systems were in place to ensure people's safety and well-being. Staffing levels were sufficient to meet people's needs safely. Checks were carried out before staff began work with people. However, we have made a recommendation that volunteers who spend time in the home with people should be vetted.

People were protected from abuse as staff had received training with regard to safeguarding. Staff were able to identify any instances of possible abuse and would report it if it occurred.

Risk assessments were carried out to minimise risk to people. People received their medicines in a safe way.

Is the service effective?

Good

The service was effective.

Staff received supervision and training to support them to carry out their role effectively.

People's rights were protected. Best interests decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

A programme of refurbishment was taking place within the home, which should ultimately benefit the people who lived there. Additional living space and bedrooms were being created.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were kind and patient.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Good

The service was responsive.

People said the service was flexible and based on their personal wishes and preferences. Where changes in people's care needs were assessed, these were made quickly and without any difficulties to ensure people received care that met their needs.

Staff were knowledgeable about people's needs and wishes. There was a good standard of record keeping to help ensure people's needs were met.

There was a programme of activities and entertainment.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was well-led in most areas.

A limiter is put in place that restricts the domain being rated as good until the manager of the service is registered with the Care Quality Commission.

Staff and relatives told us the manager and management team were readily available to give advice and support. They were very complimentary about the changes that were being made in the home.

Improvements had been made by the manager and deputy manager and were being maintained by the staff team to promote the delivery of more person centred care for people.

The home had a robust quality assurance programme to check on the quality of care provided.

Glenholme Residential Care Home

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 August 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

During the inspection we spoke with 13 people who lived at Glenholme Residential Care Home, three relatives, two visitors, the manager, the deputy manager, the regional manager, four support workers, two team leaders and one member of catering staff. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for four people, recruitment, training and induction records for five staff, four

people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the manager had completed.

Good

Is the service safe?

Our findings

There were 31people living at the home at the time of inspection. A staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers.

Staffing rosters and observations showed two team leaders and five support workers were on duty until 2pm. This reduced to four support workers from 2pm until 10pm. We considered there were sufficient members of staff on duty to provide care to people who used the service. However, some people commented staff were busy. One person told us, "Nothing happens here, staff are always very busy." Another person commented, "I chose this home as I liked it but I'm a little disappointed as staff don't have enough time to spend with people." A third person said, "I'm bored, staff don't have enough time to spend with me." We discussed these comments with the manager who told us it would be addressed.

People told us that they felt safe living at Glenholme Residential Care Home and were well supported by staff. One person told us, "I feel safe here, no one bother us." Another person commented, "I feel safe here, I use my buzzer and someone comes, normally very quickly even if they just call in. They (staff) always call back when they say they will." A third person said, "I am safe here, the staff call in and out all the time." Other people's comments included, "I have nothing to worry about, people are nice here." One relative told us, "I'm very happy with the care [Name] receives. I think they're safe here and have no concerns about their safety." One visitor commented, "I have no worries about [Name]'s safety."

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. Application forms included full employment histories and a copy of each worker's identity was also available. Relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. The manager told us one volunteer came to visit and have lunch one day a week in the home. We were told they had not been vetted as their relative previously lived at the home. We recommend the provider ensures that all volunteers involved in interacting with people and spending a length of time in the home, should be vetted.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. One staff member told us, "I wouldn't think twice, I'd go straight to the manager or senior to report any concern." They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. They informed us they had received relevant training.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This

was for if the building needed to be evacuated in an emergency.

People received their medicines safely. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed every six months. Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. They explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Medicines were stored securely within the medicines trollies and treatment rooms. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

We checked the arrangements in the home including in the area where work was being carried out, to ensure that people were kept safe. We observed and were told people were not left unsupervised in the lounge nearest to where the building work was taking place. This area of the home had been cordoned off and the door was kept closed and this part of the building was now not easily accessible. The regional manager told us building work should be completed at the end of October 2017.

Good

Is the service effective?

Our findings

People were supported by skilled, knowledgeable and suitably supported staff. One staff member told us, "My training is up to date." Another staff member said, "I've done level two in health and social care." Another member of staff commented, "There are opportunities for training, last month I did dementia and mental capacity training." Other comments included, "We do training on the premises", I've done equality and diversity and mental capacity training", "Staff can ask for extra training courses" and "I have a training day in October."

Staff members were able to describe their role and responsibilities and they told us there were opportunities for personal development. One staff member commented, "I'm training to be a team leader. Another staff member said, "I was promoted to a senior." Staff made positive comments about their team working approach. A number of staff members had worked at the home for some years. One staff member told us, "We're a longstanding staff team." Another member of staff commented, "We've had students on placement here and we all work well together."

Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff undertook the Skills for Care, Care Certificate to further increase their skills and knowledge in how to support people with their care needs. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.) A staff training matrix showed that a range of courses took place to ensure staff had the knowledge to meet peoples' care and support needs and provide safe care.

Staff told us they were supported by the management team. The management team held regular supervision sessions with each staff member. This meant staff could discuss their professional development and any issues relating to the care of the people who lived there. One staff member told us, "I've just had supervision with the deputy manager." Another staff member commented, "I have supervision every two months. A third staff member said, "I have supervision regularly." All staff members also had an annual appraisal of their performance with the manager.

Staff told us communication was effective to keep them up to date with people's changing needs. A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. One staff member commented, "Communication has improved. We have a handover every morning. You're updated from last time you were on duty." Another staff member said, "We get a handover from night staff in the mornings." A third member of staff commented, "If you've been off a while the night shift team leader will stay later and go through things with you." This was to ensure staff were made aware of the current state of health and wellbeing of each person.

Systems were in place to ensure people received varied meals at regular times. People received drinks of juice, water, tea and coffee throughout the day. One person told us, "The care workers are very attentive, they are always bringing me cups of tea." We spoke with the cook who was aware of people's different

nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately.

People were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Records were up to date and showed people were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Where people had been identified at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. One relative told us, "[Name]'s eating is better and their health has improved."

Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat. For example, '[Name] enjoys hearty foods such as shepherd's pie and mince and dumplings. They are very independent with eating and require no staff support.'

Food was well presented and looked and smelled appetising. People and relatives were positive about the food saying there was enough to eat and they received nice food. One person told us, "The food is good." Another person commented, "The food is quite fussy but it is quite nice." A third person told us, "The food is lovely, there's plenty to eat."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, GPs, community psychiatric nurse, dieticians and speech and language therapy teams (SALT). Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals. One visitor told us, "[Name] has made big improvements since they came to live here, including being able to walk again." Relatives told us communication was good and they were kept informed of their relative's well-being. One relative told us, "I'm kept well informed." Another relative commented, "I have had several discussions about [Name]'s on-going care, staff have kept me up to date."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. 29 DoLS applications had been authorised by the relevant local authority. There was evidence of mental capacity assessments and best interests decisions in people's care plans.

Building work was taking place in part of the home which was due for completion in October 2017. An annexe which used to provide day care was being converted and was to become part of the home and four bedrooms were being created. Other work was taking place in the home creating more communal areas including a larger dining room, café and office. Due to the alterations, two of the communal lounges were

cramped as one was included in the renovations but care was being taken by management and staff to ensure all people were kept safe as the refurbishment took place.

Good

Is the service caring?

Our findings

There was a lively and warm atmosphere in the home. Although the home was busy and building work was creating a cramped environment, people were complimentary about the care provided by staff. Staff were milling around checking if people were alright and assisting them as necessary. We saw several cards of appreciation from relatives commending staff for care provided to people. One person told us, "The staff are very good to me." Another person commented, "I am quite happy and contented." A third person said, "I am well looked after here, staff have done a lot for me." Other people's comments included, "The staff will do anything I want, I can't ask for anything more", "Nothing is a problem to the staff", "I have nothing but praise for the staff, they do a good job and "The staff are very good." One relative told us, "I have seen some very good care here." Another relative commented, "[Name] has very high standards and they seem quite happy here."

The environment was calm, friendly and welcoming. Staff promoted positive and caring relationships. People were spoken with considerately and staff were polite. Staff engaged with people in a calm and quiet way. People were supported by staff who were kind, caring and respectful. We observed staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. When they carried out tasks with the person they bent down as they talked to them so they were at eye level. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. For example, "Are you going to have a drink now?" and "Can I help you stand up?" Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well.

People's privacy and dignity were respected. We heard staff members discreetly offer people assistance with personal care. People told us staff were respectful. We observed that people looked clean, tidy and well presented. Some people wore jewellery and their clothes were colour co-ordinated. A relative commented "[Name] is always looking smart and clean." We observed staff offered to wash people's glasses where they thought they needed cleaning. Staff knocked on people's doors before entering their rooms, including those who had open doors. Staff received training to remind them about aspects of dignity in care and a poster was available to remind staff about principles of care including about promoting people's dignity.

We discussed with the regional manager the closed circuit television system (CCTV) that was to be installed in the new part of the building, we were informed that it was to be placed in people's bedrooms to monitor their safety. We advised the CCTV system as well as protecting people needed to be balanced with ensuring their right to privacy and maintaining their dignity as these were paramount in people's care. The regional manager told us they were very mindful of this and would keep the Care Quality Commission informed of progress and consult with us before people occupied the rooms.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for

example, if they were in pain.

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. One person told us, "I like a long lie in bed in the morning." Another person commented, "I can do what I want whenever I want." Care plans provided information about how people communicated their wishes. For example, one care plan documented, '[Name] can let staff know their wishes and express their likes and dislikes.' Another care plan for a person who did not communicate verbally recorded, '[Name] should be given a choice in what clothes they wish to wear each day.'

Care plans provided information about how people communicated. This information was available for staff to provide guidance about how a person should be supported. For example, one communication care plan stated, '[Name] is very softly spoken and quiet, so at times they can be hard to understand. Staff to give [Name] time to finish what they are saying.' Another stated, '[Name] communicates their needs well and does so verbally.'

We observed the lunch time meals in the two dining rooms. We saw the meal time was relaxed and unhurried. Menus were not available to remind people about the food available. We discussed this with the manager who said it would be addressed. People sat at tables that were set with tablecloths, napkins and condiments. Staff showed people two plates of food to help them make a choice of the meal they would prefer. People could help themselves to gravy as the gravy boat was on the table. Staff supported some people to eat. They talked to people as they helped them. Some other people were provided with prompts to encourage them to eat, staff did this in a quiet, gentle way. For example, "Would you like more gravy, there is plenty more" and "Can I help you to cut this?"

There was information displayed in the home about advocacy services and how to contact them. The manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told the service used advocates, such as an Independent Mental Health (IMHA) advocate as required in the process where people did not have a relative. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service responsive?

Our findings

People and relatives confirmed there was a choice of activities available and they had the opportunity to go out supported by staff. One person told us, "I am never in, I go out in the bus or for a walk with a member of staff." Another person commented, "I get on lots of trips." A third person said, "I can sit out and look at the lovely garden." Other comments included, "We have a quiz night with prizes every Monday night, there are nibbles and drinks", "When the weather is good we go to the park" and "We are going for a trip to another home." A relative told us, "I have seen some of the activities here, they are very good." We observed the home had cat which was enjoyed by some of the people. One person told us they had been able to bring the cat with them when they moved to the home.

Two activities organisers were employed and a programme advertised activities that were available and this included, pamper sessions, reminiscence, singing, newspapers, music therapy, movie afternoons, armchair exercises, quizzes, board games and crossword puzzles. Newspapers were available for people and the home subscribed to a 'Daily Chat' newsletter which contained puzzles and items of interest to keep people stimulated. Seasonal entertainment and concerts also took place. The hairdresser visited weekly and a new hairdressing salon was being created to assist with pamper sessions. The home had a minibus and people had the opportunity to go out on trips and these included to the coast, Durham and for luncheon outings. The deputy manager told us plans were being made for people at the home to go on an outing to Northumberland to visit and socialise at another of the organisation's homes.

People were assessed before they moved into the home to ensure their care and support needs could be met. One relative told us, "The deputy manager visited the hospital before [Name] came here. He went through all the procedures and discussed [Name]'s care in considerable depth, he spent a lot of time with the family. We feel informed of what to expect."

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of people's needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. One person told us, "When I came here I didn't want to do anything, I couldn't walk but now I can get around quite well." One visitor commented, "[Name] has made big improvements since they came to live here." Reviews of people's care and support needs took place with relevant people. One relative told us, "The family feel included and involved in [Name]'s care.

Care plans provided information for staff about how people liked to be supported. For example, one care plan for personal hygiene stated, '[Name] requires support from one support worker for personal hygiene while also being encouraged to be as independent as possible.' Another care plan for personal hygiene recorded, '[Name] requires the support worker to ensure they have all of the things they need when bathing, their flannels, soap and their clothes.'

Other information was available in people's care records to help staff provide care and support. For example, a person who was supported to telephone their family had a care plan that detailed the guidance, '[Name] to be supported to use the telephone to call their family at any time…' Another person's mobility care plan stated, '[Name] requires the support of two staff members to transfer.' Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure people's daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People's care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes, dislikes and preferred routines. Examples included, 'Enjoys listening to classical music', '[Name] likes vintage cars', '[Name] likes a warm bedroom and for it to be in complete darkness when going to sleep', 'Doesn't like spicy foods' and '[Name] loves going out on day trips with other people on the bus.'

Relatives told us meetings used to be held with people who used the service and their relatives. The new manager told us they planned to hold a meeting with relatives to make them aware of their plans for the running of the home and to give more information about the improvements taking place.

People knew how to complain. People we spoke with said they had no complaints. One person told us, "I have no complaints." A relative told us, "I know who to speak to if I had any complaints." Another told us "I have no concerns, I'm kept well informed." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated.

Requires Improvement

Is the service well-led?

Our findings

A manager had been appointed to run the home in July 2017 and they were in the process of registering with the Care Quality Commission. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

There was a new management team in the home as a deputy manager had been appointed in October 2016 and they had been running the home until the new manager was appointed. Relatives told us there was consistency of care as there was a stable staff team as most of the staff had worked at the home for several years.

The management team were enthusiastic and had introduced many ideas to promote the well-being of people who used the service. People and relatives were all positive about the home and the changes that had taken place or were planned. Staff were positive about the management of the home and had respect for them. One staff member commented, "The manager is really nice, they are approachable." Another staff member said, "It's exciting there are lots of improvements being made in the home." One relative told us, "The new manager is approachable, we're kept informed." Another relative commented, "The staff and managers are very approachable, very helpful."

The atmosphere in the home was lively and friendly. People and relatives told us they were listened to by the manager and provider. One member of staff told us, "We're listened to." Another staff member commented, "They will consider the request and give you what you ask for."

The manager assisted us with the inspection, together with the deputy home manager. Records we requested were produced promptly and we were able to access the care records we required. The management team were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The manager said they were well supported in their role by the provider and regional manager. They told us they subscribed to a range of care industry and related publications and kept up to date with best practice and initiatives. The regional manager, was enthusiastic and told us about a visit they had taken to Somerset to research some best practice initiatives with regard to the environment and care. They explained how they would be incorporating some of their findings within Glenholme Residential Care Home to improve the environment in the refurbished annexe.

The manager was supported by a staff team that was experienced, knowledgeable and familiar with the needs of the people they supported. They told us they were well supported by the provider's management team. They had regular contact with head office, ensuring there was on-going communication about the running of the home. Regular meetings were held where the management were appraised of and discussed the operation and development of the home.

Staff told us daily 'flash' meetings took place with heads of department and weekly and monthly meetings

took place to improve communication in the home. Minutes of meetings were available for staff who were unable to attend. Staff meetings kept staff updated with any changes in the service and to discuss any issues.

At the last inspection we made a breach with regard to the governance of the service and considered improvements were required. At this inspection we found the auditing and governance processes had become more robust within the service to check the quality of care provided and to keep people safe.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. Monthly audits included checks on medicines management, safeguarding, care documentation, training, dining experience, kitchen audits, accidents and incidents and nutrition. Other audits were carried out for infection control, falls and health and safety. Regular monthly analysis of incidents and accidents took place. The manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re- occurrence.

Monthly visits were carried out by a representative from head office who observed and spoke to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the manager. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

The manager told us the provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and staff. The management team did not have access to the comments from the 2016 survey but they told us a survey was planned for later in 2017.