Gainford Care Homes Limited

Glenbrooke House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection carried out on 26 April 2017.

Glenbrooke House is registered to provide accommodation and personal care to a maximum of 10 people. Nursing care is not provided. Care is provided to younger people who have learning disabilities including some people who have a physical disability.

At the last inspection in March 2015 we had rated the service as 'Good'. At this inspection we found the service remained 'Good' and met each of the fundamental standards we inspected.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. There were enough staff to provide individual care and support to people. Staff received opportunities for training to meet peoples' care needs and in a safe way. A system was in place for staff to receive supervision and appraisal and there were robust recruitment processes being used when staff were employed.

The registered manager was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were provided with opportunities to follow their interests and hobbies and they were introduced to new activities. They were supported to contribute and to be part of the local community. Staff had developed good relationships with people, were caring in their approach and treated people with respect. Care plans were in place detailing how people wished to be supported and people were involved in making decisions about their care.

People had access to health care professionals to make sure they received care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed. People received their medicines in a safe and timely way. People who used the service received a varied diet and had food and drink to meet their needs.

There was regular consultation with people and/or family members. A complaints procedure was available and written in a way to help people understand if they did not read. People we spoke with said they knew how to complain but they hadn't needed to.

Staff and relatives felt there was an open, approachable and stable management team. The registered manager had worked at the home for several years. The provider continuously sought to make improvements to the service people received. The provider had effective quality assurance processes that

included checks of the quality and safety of the service.

The provider undertook a range of audits to check on the quality of care provided. We have made a recommendation that the quality assurance system used to collect people's views about service provision should be further developed.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Glenbrooke 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 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 12 April 2017 and was unannounced.

It was carried out by an inspector and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service for older people.

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 who contracted people's care. We spoke with the local safeguarding teams.

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 four people who lived at Glenbrooke House, one relative, the registered manager, the area manager, three support workers and a visiting professional. We looked around 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 four 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 registered manager had completed.

Good

Is the service safe?

Our findings

Some people who lived at the home had complex needs which meant they did not express their views about the service. During the time we spent with people we saw they appeared comfortable with staff. Other people who used the service said they felt safe. One person told us, "I'm alright, I'm safe here." A relative also confirmed people were safe. They commented "[Name] is well settled here and staff are very supportive."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. They told us, and records confirmed they had completed safeguarding training. They were able to tell us about different types of abuse and were aware of potential warning signs.

There were sufficient numbers of staff available to keep people safe and provide individual care. Staffing levels were determined by the number of people using the service and their needs. There were three staff on duty during the day and an additional staff member who provided one to one support to a person. These numbers did not include the registered manager. Overnight staffing levels included two waking night staff. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased or decreased as required.

Risk assessments were in place that were reviewed monthly and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for pressure area care, choking, distressed behaviours and moving and assisting. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring. A weekly risk monitoring report was completed by staff at the home to highlight any areas of risk. It included areas of care such as pressure areas, serious change in health status, weight loss and infection control.

There were personal evacuation plans for each person in the event of an emergency. Regular health and safety checks were carried out by the home staff. Staff meeting minutes showed health and safety issues were discussed. Certificates of maintenance for the premises were up to date such as for gas and fire safety to ensure the premises were safe and well-maintained.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to incidents of behaviour described as challenging. A weekly report was also submitted to head office that included information about any accidents or incidents that may have occurred.

Medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary

training and felt they were sufficiently skilled to help people safely with their medicines.

The home had a stable staff team and low staff turnover. There were no staff vacancies at the time of inspection. The provider had robust recruitment processes which included completed application forms, interviews and reference checks. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant the provider made sure only suitable staff were recruited.

At the previous inspection we had concerns that the registered provider was appointee for some people's monies. At this inspection the registered manager told us this had been addressed and arrangements had been made with the local authority for the relevant local authority to be responsible for people's monies, where relatives were not responsible for their monies. Within the home a system was in place to deal with people's personal allowances and any monies held on their behalf for safe keeping.

Good

Is the service effective?

Our findings

There was an on-going training programme in place to make sure staff had the skills and knowledge to support people. The staff training records showed staff were kept up-to-date with safe working practices and they had opportunities for other training to understand people's care and support needs. Training courses included autism spectrum condition, diabetes, mental health awareness, palliative care, nutrition awareness, equality and diversity, mental capacity and team leadership. A number of staff had completed National Vocational Qualifications (NVQ) at levels two or three (now known as the diploma in health and social care.) A visiting training assessor told us "Staff are very enthusiastic about training." One staff member told us "I do on line and face to face training." Another staff member commented "I'm doing an NVQ at level 3."

New staff completed a comprehensive induction training programme which included all the essential training. They were then enrolled onto training towards a national care qualification. Records showed staff received regular supervision from the management team, to discuss their work performance and training needs. They also received an annual appraisal to review their work performance. One staff member told us "I have supervision every two months." We discussed the need for the registered manager to receive regular supervision as support was provided informally. The area manager and registered manager told us this had been identified and was currently being addressed.

People's nutritional needs were assessed and care planned, including support with weight management and advice from dieticians. Staff kept people's nutritional well-being under review and recorded their weight each month. People were involved in menu planning and preparing drinks and snacks. The kitchen was well stocked and we saw people enjoyed home baking. One person said, "Good, sausage and mash for tea, lovely."

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 Mental Capacity Act (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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. We found as a result, that nine people were currently subject to such restrictions.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Staff had received training in the MCA and the related Deprivation of Liberty safeguards (DoLS). Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care

professionals involved in their care made decisions for them in their 'best interests'. One person was subject to court of protection orders, as they did not have capacity to make decisions about the care and treatment they required.

People were supported to access community health services to have their healthcare needs met. Their care records showed that people had access to GPs, dieticians, opticians, dentists, nurses and other personnel. The relevant people were involved to provide specialist support and guidance. Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals.

Good

Is the service caring?

Our findings

During the inspection there was a happy, relaxed and pleasant atmosphere in the home. People moved around as they wanted. Staff interacted well with people, sitting with them and spending time with them. Camaraderie was observed amongst the people who used the service and they were supportive and caring of each other. One person told us "Staff are kind and caring." Another commented "The staff are good, I like living here." A relative told us "[Name] didn't want to leave when they came for a look around, as they liked the place."

Staff were given training in equality and diversity and person centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs.
Not all people were able to fully express their views verbally. Care plans provided information to inform staff how a person communicated. Examples in care plans included, '[Name] understands most words and what it means' and '[Name] will nod to show they understand.' This meant staff had information to inform them what the person was doing and communicating to them.

People were encouraged to make choices about their day to day lives. They told us they were able to decide for example when to get up and go to bed, what to eat, what to wear and what they might like to do. We saw one person had enjoyed a long lie.

Staff used pictures, signs and symbols to help people make choices and express their views. We saw information was available in this format to help the person make choices with regard to activities, outings and food. Care plans included details about peoples' choices. This encouraged the person to maintain some involvement and control in their care. Care plans contained details with regard to how people liked and needed their support from staff. For example, one care plan for sleep routine included, 'Leave a light on in the bathroom at night.'

Staff were kind, caring and respectful. Staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them.

People's privacy and dignity were respected. People looked clean and well presented. They were offered protective clothing if required at mealtimes to keep their clothing clean. We saw staff members asked people's permission and knocked before entering their bedrooms. Care plans also provided information for staff to promote people's privacy and dignity. Records were held securely and policies were available for staff to make them aware of the need to handle information confidentially.

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. A more formal advocacy arrangement was in place with a local advocacy group to assist people with some of their decisions and to promote their views. Advocates can represent the views of people who are not able to express their wishes. Information about the use of advocates was displayed in the home.

Good

Is the service responsive?

Our findings

People were supported to follow their interests and hobbies. They were positive about the opportunities for activities and outings. They all said they went out and spent time in the community. People had opportunities to go out in an evening and at weekends to social or sports activities such as bowling, karaoke, pub visits, picnics, walking, horse riding, swimming, discos, shopping, cinema or meals out. People's choices about whether to engage in these activities were respected. Comments from people included, "I love going to the library", "I go to the pub sometimes for a pint", "I'm going horse riding today," "I like going shopping" and "I'm going out for lunch."

Some people attended college or day placements. One person said "I go to the centre and meet my friends." People told us they had enjoyed Christmas and other seasonal parties that were arranged.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Records showed preadmission information had been provided by relatives and people who were to use the service. 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 provided instructions to staff to help support people to learn new skills and become more independent in aspects of daily living whatever their needs were. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication. Some people helped with their laundry and tidying their bedroom. A visiting professional told us "Staff try to encourage and motivate people."

People's care records were kept under review. Monthly evaluations were undertaken by care staff and care plans were updated following any change in a person's needs. However, the monthly evaluations did not contain sufficient detail about a person's progress or deterioration over the month. They stated 'No change.' We discussed this with the registered manager who told us it would be addressed to ensure it reflected the person's well-being over the month.

A daily record was available for each person. It was individual and in sufficient detail to record their daily routine and progress in order to monitor their health and well-being. This was necessary to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences.

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. Some people had been supported by staff from the service for several years. People were involved in discussions about their care and support needs.

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. A family member told us they were kept informed and were invited to any meetings to discuss their relative's care. One relative commented, "They(staff) keep me well-informed of how [Name] is doing."

The provider had a complaints procedure which was available to people, relatives and stakeholders. A copy of the complaints procedure was available for each person and written in a way to help them understand if they did not read. A record of complaints was maintained. People told us they could talk to staff if they were worried and raise any concerns. One person told us "I'd talk to the staff about it."

Good

Is the service well-led?

Our findings

A registered manager was in place who had registered with the Care Quality Commission in 2012. 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.

The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities and independent investigations were carried out. We saw that incidents had been investigated and resolved internally and information had been shared with other agencies for example safeguarding.

The provider had displayed the Care Quality Commission's (CQC) rating of the service, including on their website, as required, following the publication of the last inspection report.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and provider's representative, who attended at the end of the inspection, was 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 registered manager said they were well supported in their role by the provider and area manager. They informed us discussion about best practice and the sharing of ideas that took place at the home managers meetings attended by home managers.

The atmosphere in the home was relaxed and friendly. Staff and people we spoke with were positive about their management. Staff and relatives said they felt well-supported. Staff comments included, "[Name], manager is brilliant", "The registered manager is approachable" and "We're a team, staff support each other."

Staff told us staff meetings took place four weekly and minutes of meetings were available for staff who were unable to attend. Staff meeting minutes showed topics discussed included infection control, health and safety, resident well-being, safeguarding, lead responsibilities for staff, staff performance, complaints and incident reporting. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff meetings also discussed any incidents that may have taken place. The registered manager told us if an incident occurred it was discussed at a staff meeting. Reflective practice took place with staff to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a wide range of monthly, quarterly and annual checks. They included the environment, catering, health and safety, medicines, finances, falls, complaints, personnel documentation and care documentation. Audits identified actions that needed to be taken. Audits were

carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Three monthly visits were carried out by a representative from head office who would speak 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 registered manager to ensure they had acted upon the results of their audits. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned. They also audited a sample of records, such as care plans, staff files and the registered manager's audits to check follow up action had been taken by staff. These were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

Feedback was sought from people through meetings and surveys. The registered manager told us there had been a minimal response from the last provider survey sent out to all people, only three responses had been received. Comments received were positive and included '[Name] is more content and happy than I've seen them in years' and 'Overall I am extremely happy with the care given to [Name]. The management and staff are helpful and caring.' We discussed how further feedback could be obtained such as involving the local advocacy group to complete surveys with people to obtain more independent feedback. Visiting professionals could also be invited to give feedback about service provision.

We recommend the provider expands its quality assurance system in order to obtain feedback about service provision.