Whytecliffe Limited

Glentworth House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Glentworth House provides accommodation and nursing care for up to 33 people who have nursing needs, and other conditions such as dementia, diabetes and strokes. Glentworth House is owned by Whytecliffe Limited and has another home nearby. Accommodation was provided over two floors with a passenger lift that provided access to all parts of the home. People spoke well of the home and visitors confirmed they felt confident leaving their loved ones in the care of Glentworth House.

The home had a registered manager. A registered manager is a person who has registered with the 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 home is run.

Medicines were not managed safely and in accordance with current regulations and guidance. Systems in place had not ensured that medicines were administered appropriately or by nurses who had completed an annual competency assessment. We have identified these issues as areas of practice that needs improvement.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The home was applying these safeguards appropriately and making the necessary applications for assessments when these were required.

People were supported in ways that were most appropriate for their needs and known wishes. A relative said, "There is a nice atmosphere here. The staff and management are nice and caring and concentrate on the residents. You can't fault the quality of care which is provided." There were sufficient numbers of staff available to meet people's needs.

People's healthcare needs were assessed and care was planned and delivered in a consistent way. Care plans gave information and guidance to staff about people's health and care needs that was clear. Any risks associated with people's care needs were assessed and plans were in place to minimise the risk as far as possible to help keep people safe.

Observations of interactions between staff and people, our conversations with people, their relatives and feedback from health and social care professionals found that people were cared for by staff who were kind and compassionate. Staff engaged and communicated with people in a way that respected their dignity. Social and daily activities provided met peoples individual needs. One visitor said, "The residents themselves always seem so peaceful and content and that is evidence of the fact that the staff and [registered manager] work so hard to pay attention to their needs as well as keeping them feeling happy and comfortable."

People, their relatives and staff told us they felt able to approach any member of the management team. They said there was clear communication between the staff team and the management of the service. A visitor said, "I find Glentworth House to be extremely well managed and with a high calibre of both nursing staff and carers." People were able to complain or raise concerns if they needed to. The provider regularly reviewed the performance of the home to ensure that standards were maintained and improvements were made. They sought the views from people using the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe. Medicines were not recorded appropriately by staff assessed as competent.

People said they felt safe and there were enough staff on duty to care for them.

Staff received safeguarding training and knew how to take action in response to any concern that may arise about possible abuse.

Risks to people were identified and acted upon and people were kept safe from the risk of infection.

Medicines were handled and administered safely.

Is the service effective?

Good

The home was effective. Staff received regular training and supervision to ensure they had the skills and knowledge to meet the needs of people.

Staff demonstrated that they had the necessary knowledge and awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards and took necessary action to assess people's capacity to make decisions and provide informed consent.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

Is the service caring?

Good

The home was caring. Interactions between staff and the people they were caring for were polite, warm and showed regard for what people needed and how to respond to those needs.

People who were able to speak with us felt that they were treated with dignity and respect.

Is the service responsive?

Good

The home was responsive. Care plans were updated at regular

intervals and were audited to ensure information remained accurate and reflected each person's current care and support needs.

There were structured and meaningful activities for people to take part in.

People who were able to speak with us felt able to raise any concerns or issues about the home.

Is the service well-led?

Good

The home was well led. People benefited from a well-led home, where the culture and the management style were positive.

The provider had a system for monitoring the quality of care. The registered manager reviewed the day to day operation of the home.

People's views were sought regularly at the home.

Glentworth 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.

The inspection took place on 12 & 13 July 2016 and was unannounced. It was carried out by an inspector and specialist advisor. The specialist adviser brought skills and experience in the administration of medicines. Their knowledge complemented the inspection.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the home must inform us about.

During the inspection we spent time with people who lived at the home. We spent time in the lounge and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted.

We spoke with ten people and five of their relatives or visitors. We gained the views of staff and spoke with the registered manager and six care workers, two nurses, the training manager and cook.

We contacted selected stakeholders, including four health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided. Those that responded were happy for us to quote them in our report.

We looked at six care plans and three staff files and staff training records. We looked at records that related to how the home was managed that included quality monitoring documentation, records of medicine administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 9 July 2014 and no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People and their relatives said they felt safe and staff made them feel comfortable. One person said, "Staff do everything they can to make me feel safe." Everybody we spoke with said that they had no concerns around safety. A relative we spoke with said they did not have any concerns about the safety of their relative and told us they felt their relative was well looked after. However, despite the positive feedback we received, we identified an area of practice that needs improvement.

We looked at the management of medicines. Medicines rounds were carried out by registered nurses. The policy was that all registered nurses should undertake medicines competencies. However, not all nurses had been assessed this year to date. All nurses should be assessed as competent to administer medicines on an annual basis as a minimum in line with best practice guidance. We brought this to the attention of the registered manager who gave an undertaking this issue would be addressed. We have therefore identified this as an area of practice that needs improvement.

Some medicines required closer regulation because of the harm that can be caused if they are not managed safely. These were being stored safely in a locked cabinet in a locked room. The recording book for these medicines was signed and dated with the correct quantities. The second member of staff that witnessed the administration of these medicines was often a member of care staff who had not been assessed as competent as recommended in the NICE guidelines. This was also not compliant with the homes own, 'Administration of Medication Policy ', which stated, 'only staff who are trained in such matters should administer medication.' We have therefore identified this as an area of practice that needs improvement. We brought these issues to the attention of the registered manager who gave an undertaking this issue would be addressed.

People we spoke with confirmed they were happy with the way medicines were administered. They told us that it was administered on time and that supplies didn't run out. We observed nursing staff administer medicines to people. Medicine was seen to be administered safely and in line with agreed good practice. We observed a member of staff administering medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Consent for treatment was observed to be obtained prior to administration. Medicines Administration Records (MAR) were up to date, with no gaps or errors, which meant people received the medicines as prescribed. Where people were prescribed when required (PRN) medicines there were protocols for their use.

Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks of the medicines fridge and these were found to be within regular limits. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed.

There were policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had

received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. A staff member said, "If I saw anyone at risk I would go to the nurse or [registered manager]. I went on a course not so long ago so I also know all the numbers to call of social services or CQC."

Care plans highlighted general health risks such as diabetes. Where risks were identified there were measures in place to reduce the risks as far as possible. Risk assessments were completed to manage and reduce risks to individuals as part of their care plan. These were followed to reduce the risk of an incident occurring. Care plans showed each person had been assessed before they moved into the home and any potential risks were identified. Risk assessments included risks associated with falls, skin damage, nutritional risks including swallowing problems, risk of choking and moving and handling. For example, specially adapted beds were in place for those that were at risk of falls. Risk assessments were reviewed at least once a month or more often if changes were noted.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Health and safety checks were undertaken to ensure safe management of, for example, food hygiene, hazardous substances, moving and handling equipment and staff safety. Regular fire alarm checks had been recorded, and staff told us they knew what action to take in the event of a fire. Plans were in place to instruct staff on the systems in place to evacuate people and deal with emergencies.

People we spoke with told us staff were always available to provide care and support. Staff were available to respond to people's requests and needs promptly. Individual bedrooms were fitted with call buttons and staff responded in good time to people's call bells. This meant that people did not have to wait for staff to provide assistance. Staff had time to speak with people and to check that people across all areas of the home were safe. Staff told us they checked in with people who preferred to spend more time in their bedroom and we saw that no one was left alone for long periods of time. This included discreet observation of staff supporting people who were nursed in bed. One person commented, "I have the call bell but staff come of their own volition and ask if I want anything so I'm not on my own." Staff told us that they were happy with the numbers on duty. Staffing levels were reassessed when the needs of people changed, to ensure people's safety.

The provider had effective systems in place for the safe recruitment of staff. Records showed that recruitment checks were in place to ensure staff were suitable to work at the home. Disclosure and Barring Service (DBS) checks were carried out for all the staff. The DBS is a national agency that keeps records of criminal convictions. They requested and checked the references provided for staff and their suitability to work with people.

Good

Is the service effective?

Our findings

People were positive about living at Glentworth House. People told us that they thought staff had the skills to support them. One person told us, "They're very thorough at their job, everything's done well." People or their relatives told us they felt well looked after and enjoyed aspects of the home such as the opportunities for social activities and mealtimes.

People were supported to make independent decisions about their care and support. For example, we heard staff ask people for their consent before they carried out any care, waited for a response before they started the task and respected their decision. One member of staff told us, "I always gain people's consent before providing care but if they refuse I accept their decision but consult the nurse or senior and go back later." Staff told us that although some people had difficulty in communicating their wishes verbally, they knew them well and were able to understand their preferred methods of communication. Methods of communication were documented in the care plans we looked at. For example, appropriate communication methods encouraged the use of short simple sentences and used gestures, demonstrations and objects to gain understanding. Staff used a calm, relaxed tone of voice, facial expressions and body language.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Consent to care and treatment was obtained. Some people were unable to provide informed consent for themselves but in those cases their next of kin or allocated health or social care professional were consulted. When MCA or DoLS considerations were being reviewed and specifically where people had no relative or friend that could advocate on their behalf outside professionals were consulted to gain an independent view. Staff understood their responsibilities under the Mental Capacity Act 2005. People were supported to make their own decisions about their care. If people were unable to make a decision because of a lack of capacity this was undertaken within their 'best interests' by other professionals involved in their care. Staff were aware of the Deprivation of Liberty Safeguards and records showed that this system was being used appropriately and new applications were made and updated as required.

Staff received regular training and supervision to ensure they had the skills and knowledge to meet the needs of people. Staff attended regular training which included mandatory courses in, for example, safeguarding, fire safety, manual handling, infection control and first aid. Uncompleted mandatory training was flagged up on the training database for the training manager to follow up. The staff we spoke with told us about the range of training they had. We spoke with a staff member who had been recently recruited. We heard about the induction at the home that included shadowing more experienced staff as a part of their

introduction to the home. They told us their induction had been suitable to equipment them with the knowledge and skills to carry out their job. The registered manager worked with the training and development manager and was aware of the Care Certificate, an identified set of standards that social care workers adhere to in their daily working life and one new staff member had begun working towards this as part of their induction.

All of the staff we spoke with told us they felt supported by the provider in relation to their training and development. They also told us they received supervision, averaging every two months, staff supervision records confirmed this. These sessions gave staff the chance to review their progress and to identify areas for development, any required training and concerns they had in relation to the people they supported. Team meetings took place and the records of the most recent meetings showed that areas discussed included individuals' care, day to day running of the home and updates on practices and policy.

There was a choice of menu and the staff were aware of individual preferences and ensured that each person received nutrition and fluid to meet their individual needs. It was evident that people's nutritional needs were being met. We saw that two people who were admitted to the home approaching end of life care had actually increased their weight since admission which had resulted also in an increase in well-being and independence. We asked people about the food and a person said, "The food is good and I'm fussy about my food." A relative said, "I would praise the food highly. [My relative] was a brilliant cook and still enjoys her food. The fact that the cook prepared a Portugese dish especially speaks volumes about how they care." We asked about the availability of food outside of meal times and were told that snacks were always available if requested. One person said, "They won't let me go without and do me toast or another snack if I say I'm peckish."

People were supported to use healthcare services when they required it. Each person had access to a GP who was a regular visitor to the home. Specialist healthcare professionals appointments were arranged to help people stay healthy. The home worked in close partnership with other agencies to meet people's needs. This was confirmed by a healthcare professional who told us, "I have found the staff to be engaging and open to my advice." Changes to people's health status were identified and referrals were made in a timely manner to appropriate agencies. Referrals were seen, for example, to the tissue viability nurse and speech and language therapist (SaLT). Each person's care plan contained a separate record of input from outside professionals and the outcome of their intervention. Care plan records showed that the home was able to take action to encourage and support healthy living as well as to respond to emerging healthcare needs.

We observed a staff handover between shifts. Staff arriving for the shift were provided with a clear overview of how people had spent their morning by the nurse on duty. It included an assessment of their demeanour and any specific health concerns. Staff used the hand over time constructively to brief themselves of developments and plan their shift together.

Good

Is the service caring?

Our findings

People were treated with respect. Staff demonstrated kindness and compassion when supporting people and were mindful of privacy and dignity. For example, staff ensured that people's dignity was protected when moving people from a wheelchair to an armchair. People were very complimentary about the friendliness and professionalism of the staff. One person said, "It's very nice here, they are all so caring and helpful." Some people were living with dementia and we observed one person talk with a member of staff about their deceased parents. The member of staff, in a kind and gentle manner, gave eye contact, engaged with them about their concern and reassuringly offered a guiding hand. The person immediately relaxed. They unfolded their arms and happily engaged with the member of staff. One member of staff told us, "I hope it shows that we really care and do the best we can for everyone". When we spoke to staff they were able to explain to us what people liked and how they liked to be cared for.

People's dignity was promoted. People's preferences for personal care were recorded and followed. We looked at a sample of notes, which included documentation on when people received oral hygiene and showers. Documentation showed that people received personal care in the way they wished. People confirmed that they had regular showers and received care in a way that they wanted. One person said, "They know how I want my care given, I think they are good here." Care plans detailed how staff were to provide assistance with aspects of personal care throughout the day. We noted that people were discreetly supported to go to their rooms or bathroom whenever there was a need to address a matter of their personal care. One member of staff told us, "We maintain people's privacy and dignity. We always knock and only enter when invited as we respect their bedroom is their own space. We keep people as private as possible when providing personal care and we only discuss their personal issues in a private area and keep that information confidential."

Peoples' right to confidentiality was maintained. Staff undertook regular handover meetings to pass on information to other staff coming on shift, we were able to see that these were conducted in a private space to ensure that people couldn't overhear. People's care plans were stored in locked cabinets to ensure that confidentiality was maintained. One visitor told us, "Staff have really worked hard together to give people the care they need and in a way that demonstrates they care."

The staff were knowledgeable about the care people needed. When staff discussed people and their nursing and care needs they did so in a respectful and compassionate way. For those people living with dementia, those that knew them well were involved in the development of their care plan and these reflected that their differences were respected. Information about the person's life history was included and used to inform staff of people's interests and hobbies. For example, people were able to express their religious beliefs if this was what they wished. The care and nursing staff we spoke with knew people well. They were able to talk about their likes and dislikes, their histories, how they liked to spend their time and their preferences, for example in respect of food and drink.

Staff were patient and considerate in their approach. We saw that they interacted with people in a warm and friendly manner and staff were observed to have an excellent rapport with people by, for example, using

appropriate humour to create a social atmosphere. A health care professional told us, "The nursing staff have good clinical acumen and the carers are consistently in tune with the patient's needs, and treat them with respect and dignity." People appeared to enjoy the interaction with staff and it was apparent staff knew people well; they spent time with people talking about their day, asking how they were and what they were going to do that day. For example, for a person seated in a wheelchair, staff got down to their level to gain eye contact when they talked with them. Staff spent time explaining what was on offer, listened to them and responded to their queries. Staff encouraged people to make choices and people were offered choice, for example in respect of food, drink and where to spend their time.

People were encouraged to be as independent as possible. Staff demonstrated they had a good understanding of the people they were supporting and they were able to meet their various needs. One staff member told us, "We're like an extended family here and we know each person, their likes and dislikes." Staff were clear on their roles and responsibilities and the importance of promoting people to maintain their independence as long as possible. One person enjoyed the responsibility of folding napkins ready for use at meal times. A member of staff said, "We encourage people to do as much as they can for themselves. We encourage them so they won't lose their drive."

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. One relative said, "Carers are really nice and will do anything for you. We are made to feel so welcome and can visit at any time."

Good

Is the service responsive?

Our findings

People told us that the management and staff in the home responded to their needs and concerns. People who were able to give us their views said, "I have no difficulty in approaching staff, I can't complain.'' Another person said, 'I can't complain. I like everyone here, they are my friends I am happy a lot of the time, there are no problems."

Staff undertook care in an unhurried and patient manner. Care delivery was person specific and in line with people's preferences. The care plans detailed up to date preferences of people's wishes in respect of their care. For example, what they preferred to eat and drink, what time they got up and what time they returned to bed. For people unable to tell staff their preferences we saw that staff had spoken with families and friends. A member of staff told us, "People change and we adapt their nursing and care accordingly."

The provision of activities, one to one sessions and social events gave people the opportunity to take part in activities to help to maintain or improve health and mental wellbeing and was integral to the promotion of wellbeing for older people. There was good interaction seen from staff as they supported people with activities throughout the home. Staff, including the registered manager, were enthusiastic about providing individual meaningful activities for people and were receptive to new ideas. We received positive comments from staff and visitors about activities and the one to one sessions being undertaken for people who preferred or needed to remain on bed rest or in their room. A visitor said, "Staff heed their every need and pamper them with so much love, like how they remember to celebrate each one of their birthdays, give them facials and hand manicures, sing and dance with them." A monthly newsletter included details of events and activities people had attended and participated in and those upcoming.

People who wanted it were actively engaged with items, including games and puzzles. People interacted positively with staff when engaged with an activity. People's individual care plans reflected their wishes, they showed people's specific need for social interaction, and these were being acted on. A member of staff said "We see people change, they can become brighter the more they interact. It's lovely, very rewarding."

Where more than one health care professional was involved in a person's care, the staff ensured the information was coordinated and the person received the care and support they required. Each person had access, as and when required, to the professionals involved in supporting their health and social care need. Staff told us, and care plans confirmed, people had contact with a range of community health services. People's care records included information on signs and symptoms that a person's health may be deteriorating and how people were to be supported to ensure they got the care and treatment they required.

A complaints procedure was in place and displayed. The provider operated a complaints system which allowed for local resolution of a complaint and then for review if the person raising a concern was not satisfied with the action taken locally. Information was made available to people about making a complaint and this was provided to people living in the home and others. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint."

Another said, "I would tell one of the staff and I know it would be taken seriously."

Regular staff meetings were held for the full team as well as separate meetings for nurses and senior carers. Biannual resident/family meetings were held and we saw that discussion points were recorded and actioned. A person told us, "We had a review meeting with [the registered manager] and carer just two weeks ago. I involved my family and friends and had it in my room as I receive bed care. I gave my point of view over. [The registered manager] listened and gave me my say."

Good

Is the service well-led?

Our findings

People, their relatives and staff told us they felt able to approach any member of the management team. They said there was clear communication between the staff team and the management of the home. A visitor said, "I find Glentworth House to be extremely well managed and with a high calibre of both nursing staff and carers." Staff were regularly communicating with each other and talking about people's care and support needs. There were regular team meetings with the opportunity to discuss specific topics and the day to day operation of the home. Minutes of these meetings showed that the subjects discussed were relevant to the operation of the home.

People and their relatives were complimentary about the home and everyone we spoke with said it was a friendly and welcoming home, where visitors could call in at any time. People, their relatives and staff commented on the leadership the registered manager provided. All staff we spoke with told us that Glentworth House was a good place to work. One staff member said, "I think management are open and fair." A person said, "I don't know the managers name but I recognise them and they are always about. I have most to do with the carers and they are very kind." A healthcare professional said, "The manager has a good relationship with her staff and the patients and has a very sensible, pragmatic approach."

The provider's culture and values were embedded through the staff probationary period and ongoing training in the everyday nursing and care practice in the home. All staff; nursing, care and ancillary we spoke with understood the purpose and values of the home and were continuously striving to improve. Staff spoke positively of how they worked together as a team. They said they had regular staff handover meetings and the provider listened to any suggestions for improvement they made. For example, a member of staff commented on the team and said, "We work very well together as a team and everyone communicates well". A relative said, "There is a nice atmosphere here. The staff and management are nice and caring and concentrate on the residents. You can't fault the quality of care which is provided."

Quality assurance systems were in place. The provider had systems and processes in place to monitor the quality of the service. Audits were undertaken internally by the registered manager and staff. Audits were robust and focused on standards. They showed how the provider monitored the quality of the service and picked up areas that needed improvement. Care plan audits identified that people's specific health needs were accurately reflected in care documentation. For example, improvements had been made to updating people's care plans. The registered manager used the audits to identify issues and worked through them to further improve the care and treatment people received.

The registered manager was aware of their reporting responsibilities to the Care Quality Commission about incidents such as safeguarding issues and had sent in notification to CQC as appropriate. The registered manager explained how they met their CQC registration requirements. They explained the process for submitting statutory notifications to the CQC to ensure that they were sent in a timely manner. This meant we had the most up to date information available about incidents that had occurred. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when

untoward events occurred. The registered manager was able to describe unintentional and unexpected scenarios that may lead to a person experiencing harm and was confident about the steps to be taken, including producing a written notification. They were able to demonstrate the steps they would take including providing support, truthful information and an apology if things had gone wrong.

The provider had a system for monitoring the quality of care. Some people living at the home found completing written surveys difficult but the provider had also looked at other ways of seeking feedback. The provider used biannual resident and relative meetings to gain feedback about care and took away from them areas for improvement. The last survey was 2015 and the registered manager told us about plans for the next to include people, relatives and key stakeholders. We saw that staff were involved in decisions and kept updated of changes in the home. They were able to feedback their views and opinions.