Glenfields Care Home Limited

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Inspection report

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Date of inspection visit:
16 May 2016

Date of publication:
01 July 2016

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 inspection took place on 16 May 2016 and was unannounced. We previously visited the service in April 2014, when we found that the registered provider met the regulations we assessed.

The home is registered to provide accommodation and care for up to 28 older people, including people who are living with dementia. On the day of the inspection there were 23 people living at the home. The home is situated on the outskirts of Driffield, in the East Riding of Yorkshire. There are various communal areas where people can spend the day, a garden and an enclosed courtyard. The second floor of the home is accessed by a stair lift and there are ramps to the premises to enable wheelchair access.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at Glenfields Care Home.

People told us that they felt safe living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff told us that they were well supported by the registered provider and registered manager, and felt that they were valued. They confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

We checked medication systems and saw that medicines were stored, recorded and administered safely. Staff who had responsibility for the administration of medication had received appropriate training.

People who lived at the home and relatives told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff.

People told us that they were very happy with the food provided and people's nutritional needs had been assessed. We observed that people's individual food and drink requirements were met.

We saw that any complaints made to the home had been thoroughly investigated and that people had been provided with details of the investigation and outcome. There were also systems in place to seek feedback from people who lived at the home, relatives and staff.

Staff, people who lived at the home, relatives and health care professionals told us that the home was well managed. Quality audits undertaken by the registered provider and registered manager were designed to identify any areas of improvement to staff practice that would promote people's safety and well-being. Staff told us that, on occasions, feedback received at the home was used as a learning opportunity and to make improvements to the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse (including potential incidents) to the relevant people.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and people told us they liked the meals at the home. We saw that different meals were prepared to meet people's individual nutritional needs.

People told us they had access to health care professionals when required. We found that care professionals were asked for advice and that their advice was followed.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

People told us that their privacy and dignity was respected and we saw evidence of this on the day of the inspection.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests, their preferences and the people who were important to them.

People were encouraged to take part in meaningful activities and keep in touch with family and friends.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. People who lived at the home were also invited to comment on the care and support they received.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

Glenfields Care Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 16 May 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who uses / used this type of service. The Expert by Experience who assisted with this inspection had experience of accessing health and social care services.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was not asked to submit a provider information return (PIR) before this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We noted that Healthwatch had undertaken an 'Enter and View' visit to the home on 22 March 2016 and some information from their report is included in this report. Healthwatch is the independent consumer champion for health and social care in England.

On the day of the inspection we spoke with four people who lived at the home, three relatives, three members of staff, the deputy manager, the registered manager and the registered provider. Following the day of the inspection we spoke with a further three relatives and we received feedback from two health care professionals.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for three new members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Glenfields Care Home. Comments included, "The staff are always around and I have a mobile buzzer. I used to fall about, nasty falls, but since they gave me the buzzer I take it everywhere in the home and I haven't fallen since", "I can't walk so two carers go with me to make sure I'm safe" and "Definitely, it's secure, it's comfortable. Someone is always on duty to bathe you when you want one."

We asked staff how they kept people safe and their comments included, "We make sure there are no obstacles or hazards. We assess situations to make sure people are safe, and we have regular refresher training on topics such as using the hoist." Relatives told us they felt their family members were safe; this included the safety of the premises and safe practices being followed by staff. One relative said, "They take care lifting [my relative] in a hoist. There are always two people there and they make sure they are safe."

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse or a potential incident. Staff told us that they would report any concerns to the registered manager and that they were confident they would be listened to and that appropriate action would be taken. They told us they would use the whistle blowing procedure if they needed to, and were confident the registered manager would protect their confidentiality. We found that when safeguarding concerns had been identified, the safeguarding 'threshold' tool provided by the local authority had been used by the registered manager to identify whether the issue needed to be managed 'in house' or whether an alert needed to be submitted to the local authority safeguarding adult's team.

Risk assessments had been completed for any areas that were considered to be of concern. We saw that everyone had a risk assessment in respect of moving and handling, the risk of falls, use of the call bell, water temperatures and the risk of fire. Some people had more individual risk assessments in place for areas such as the use of a reclining chair and the use of a 'hospital' bed with bedrails and bumpers. We saw that risk assessments had been reviewed on a regular basis to ensure they remained relevant and up to date. We noted that mobility assessments recorded any equipment and the number of staff needed to help people to mobilise safely, and that care plans recorded the equipment people had in place to promote good pressure area care.

There were documents in place to record people's personal details and life history, such as previous addresses, to help the emergency services should the person go missing from the home. Some of these were fully completed but others were not. We discussed this with the registered manager and she told us that they were waiting for additional information from some families so they could fully complete the forms.

We saw that any accidents or incidents involving people who lived at the home were recorded. We noted that the accident book recorded the home's procedure for dealing with slips, trips and falls. It also included information about the local authority 'falls' service and we saw that there was a 'falls' chart in place to

record any falls that people had. These recorded the date, time and description of the fall, and had been signed and dated by staff. The forms were analysed every two months to identify the type of accident, whether any patterns were emerging and if any areas that required improvement had been identified.

Only senior staff had responsibility for the administration of medication and training records evidenced that these members of staff had completed appropriate training. Staff had signed a document to confirm that they had read the home's medication policy.

We observed that there were safe systems in place to manage medicines and that medication was appropriately ordered, received, recorded, administered and returned when not used. We observed that medicines were stored safely and securely; the medication trolley was fastened to the wall in the medication room and was locked when not in use. We saw that controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage and recording arrangements. There was a suitable cabinet in place for the storage of CDs and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced. We also saw that CDs were audited each week to ensure no recording or administration errors had been made.

The temperature of the medication fridge and room were checked and recorded each day to ensure medication that needed to be kept cool was stored at the correct temperature. The packaging of medication that was stored in boxes or bottles was dated when the medication started to be used, to ensure it was not used for longer than the recommended period of time.

We looked at medicines and medication administration records (MARs) and we spoke with senior staff about the safe management of medicines. We found that medication records were clear, complete and accurate, although we discussed that more care needed to be taken to ensure that hand written entries on MAR charts were signed by two people to reduce the risk of errors occurring. We also discussed how it would be helpful to record more information when medication was discontinued mid-cycle. These suggestions were actioned on the day of the inspection. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was supplied by the pharmacy in a 'biodose' system; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. There was a separate chart to record the administration of creams and a separate pain monitoring chart; this recorded when pain relief medication had been administered.

We suggested that it would be more dignified to assist people with eye drops after lunch rather than during the lunch time meal, and that staff could be more discreet when asking people if they required medication for pain relief. The registered manager told us that they would ensure this happened in future.

We checked the recruitment records for three members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at Glenfields Care Home.

Most people who lived at the home told us there were enough staff on duty; one person said, "I sometimes think staff work really hard. If I press my alarm there is someone there immediately." However, two people told us that they were not sure where 'buzzers' were when they were not in their room. We observed that

there were sufficient numbers of staff on duty to enable people's needs to be met. We noted that call bells were answered promptly and that people did not have to wait for attention. The registered manager told us that the standard staffing levels were four care workers each morning / afternoon shift and three care workers on the afternoon / evening shift. At night there were two care workers on duty. We checked the staff rotas and saw that these staffing levels were being consistently maintained. In addition to care staff, there was an activities coordinator, a cook, domestic assistants, kitchen assistants and a handyperson on duty, and the registered manager was supernumerary. This meant that care staff were able to concentrate on supporting people who lived at the home.

Most relatives told us that there appeared to be enough staff on duty. One relative told us, "There seems to be. They always have time to chat to mum." However, another relative told us that they felt there could be more staff on duty over the weekends, as there were no domestic staff on duty on Saturdays and Sundays. The Operations Director told us that agency staff were only used in very exceptional circumstances.

We saw the health and safety policy and the maintenance policy. We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, the stair lift, mobility hoists, bath hoists, portable appliances, the fire alarm system, emergency lighting and fire extinguishers. The home's maintenance person carried out a weekly fire test including checks on the fire alarm system, emergency lights, fire doors, fire extinguishers and exit routes. This helped to make sure the fire safety arrangements in place at the home were robust.

Staff recorded any faults or repairs that they identified in a specific book and this was signed when the work had been carried out. The maintenance person also carried out checks on window opening restrictors, lights, toilet seats, toilet roll holders, taps and radiator covers in each room and any repairs that were needed were recorded and actioned. This helped to ensure that the premises remained safe for the people who lived and worked at the home.

There was a business continuity plan in place that advised staff on the action to take in the event of emergency situations such as flood or utility failures. This included information about evacuating the premises and important telephone contact numbers. There were also personal emergency evacuation plans (PEEPs) in place which recorded the support each person would need to evacuate the premises in an emergency.

We walked around the building and saw that communal areas of the home, bedrooms, bathrooms and toilets were being maintained in a clean and hygienic condition. A relative told us, "There is always someone chasing around with a Hoover, with the windows open – there is no smell." People who lived at the home told us that their bedroom and communal areas of the home were clean. The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that she had submitted applications for authorisation for two people and that these had been authorised by the local authority. The training record evidenced that all care staff had completed training on DoLS and dementia awareness. This meant that staff had been provided with information to help them to understand the principles of the MCA, DoLS and decision making.

We saw in care records that staff had taken appropriate steps to ensure people's capacity was assessed and to record their ability to make complex decisions. Two people's care plans included information about a relative who acted as Power of Attorney (POA) for their family member. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf.
However, one care plan did not record whether the POA acted in respect of health and welfare and / or finances. We fed this back to the registered manager at the end of the inspection and they told us they would obtain this information and record it in the person's care plan.

We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans that people had signed to confirm their consent to staff administering their medication and to record their agreement to having a flu vaccination. Care plans also recorded when people were unable to consent to certain aspects of their care.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "I would prompt them, for example, show them a choice of clothes and a choice of meals. There is a list of choices for lunch time and tea time but I would offer something different if I needed to." A relative told us that their family member was "Getting worse" but could still make their own decisions.

People who lived at the home and relatives told us they felt staff had the skills they needed to carry out their role. We saw that the training record identified which training was considered to be essential by the home; this was induction, first aid awareness, basic food hygiene, health and safety, safeguarding adults from abuse, fire safety, manual handling and infection control. Senior staff who administered medication were

also required to undertake medication training. Non-essential training had also been provided for staff and we saw that most staff had completed it; this included dementia, falls awareness, pressure area care, whistle blowing, dealing with complaints, DoLS, MCA, end of life care, advanced decisions and health and safety / infection control. Training was in the process of being arranged for all staff on the topic of person centred care, specifically for people who were living with dementia. New staff were required to complete the Care Certificate; the Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

Records evidenced that new staff carried out induction training when they started in post. This included orientation to the home and information on the home's policies and procedures. Topics covered in induction training included moving and handling, first aid, health and safety, safeguarding vulnerable adults from abuse, fire safety and food hygiene; staff also shadowed experienced staff as part of their induction training. This was confirmed by the staff who we spoke with. One member of staff told us, "I had to wait for my DBS check and references to come through before I started work, and then I did some shadowing. Even though I brought some certificates with me, I still did orientation to the home and some competency tests." The registered manager confirmed that, when staff had recorded previous training on their application form, they were required to produce training certificates as evidence. If these were not available, they were required to undertake this training again.

Staff told us that they felt well supported and able to raise concerns. They said that they attended supervision meetings with a manager. We saw records of these meetings and noted that they also included discussions on reflective practice. Reflective practice is when people study their own experiences to improve the way they work. We noted that the home's policies and procedures were updated on a regular basis to ensure that they referred to the most recent good practice guidance and legislation. Staff were required to sign a document to record they had read the policies and procedures, as well as separate guidance documents that they had been given, such as advice on choking from NHS choices, information from the local authority on the safe use of hoists and slings and National Institute for Health and Care Excellence (NICE) guidance on pressure ulcer care. This helped staff to keep their knowledge and practice up to date.

People told us that their special diets were catered for. One person said, "I am diabetic and my diet is being controlled. They still give me good helpings." We spoke with the cook who described how they were made aware of people's special dietary requirements and likes / dislikes, and how these were met. They showed us a list of this information that was kept in the kitchen. The cook said that people were asked each day about their meal choices for the next day. However, some people forgot their choices or changed their minds, and enough food was prepared to allow for this. The registered manager told us that homemade soup was made for one person at lunchtime, as they preferred their main meal in the evening. They said that the same soup was liquidised so that anyone with swallowing difficulties had an alternative available to them.

People's risk of malnutrition or weight gain was assessed and monitored. The registered manager described to us how one person was measured above their elbow to monitor their well-being, as they could not be weighed due to their ill health. A health care professional told us, "I have observed that staff took great care when assisting people to eat their meals and the diligent giving of fluids to residents having feeding problems or potential dehydration, and showing me good records on this." Care plans evidenced that referrals were made to the dietician or speech and language therapists (SALT) when there were concerns about a person's diet or eating / drinking difficulties. One person's care plan recorded, 'Assistance needed and slow pace required. The care worker assisting must be sitting down." We saw that any charts being used to monitor well-being such as food and fluid charts and weight records were up to date.

We observed the lunchtime experience in the main dining room and the small dining room. There was a

menu as well as condiments and serviettes on each table, although we noted that the print on the menu was not easy to read. After the inspection the registered manager told us that they had produced menus with larger / easier to read print. We saw that staff were busy during the serving of lunch in the main dining room and this did not give them much time to encourage conversation, although people had plenty of time to eat their meal, and staff encouraged people to eat. The operations director told us that staff used their judgement in respect of instigating conversation, as some people preferred to concentrate on eating their meal. They said that staff ate their meals along with people who lived at the home and engaged in conversation when this was appropriate. We saw that people were assisted appropriately to eat their meals; one person was visually impaired and we noted that staff described the meal to them and they were provided with a plate guard and spoon so they could eat their meal without assistance.

People told us they were happy with the meals provided and we saw that ample drinks were provided throughout the day. There was a choice of main meal and dessert. One person told us, "It is a very nice choice every day. They come and ask you what you want" and another said, "It's homemade. They ask you the night before and they record it, but you forget what you have chosen." Two people told us that the cook had made them a cake when it was their birthday, which they appreciated. However, one person said, "The food is lacking in imagination. I would like to see freshly cooked joints, mashed potatoes and seasonable vegetables." A relative told us that their family member had put on weight since moving into the home. They said, "The food is beyond belief. They mince up her meat and the chef takes the meals to her to check they are OK."

We mentioned to the registered manager that it would be good to see fresh fruit offered as well as biscuits with the morning and afternoon drink, and following the inspection they contacted us to say that this was now happening.

Staff told us that, if a person was unwell, they would either ring the GP themselves or speak to the registered manager, depending on the situation. People told us that they were able to see a GP if they needed one. One person said, "They [the staff] would get me a doctor if I needed one. Fortunately I am very healthy – I am one of the lucky ones." People told us they were also able to see other health care professionals such as the chiropodist and dentist. One person said, "The doctor has been to see me and I have a private chiropodist to come and cut my nails." A health care professional told us that people were able to speak with them freely when they visited the home.

A health care professional told us that staff were proactive in seeking medical advice from them, including in situations where the person seemed stable, but their relatives had expressed a health concern. They added, "I have no reason to believe the staff do not follow instructions from me about treatment." We saw that any contact with health care professionals was recorded, including the reason for the contact and the outcome. People's records evidenced that advice had been sought from health care professionals such as dentists, district nurses, physiotherapists, chiropodists and speech and language therapists (SALT) and that any advice received had been incorporated into care plans. A health care professional confirmed that staff took notes about their visit and transferred this information into the person's care plan.

A relative told us that they were always informed about their family member's GP visits and general well-being. One relative told us, "Very much so. The manager rang me when my relative had a tummy upset. They went for a few tests at the hospital" and another said, "I have no issues but I'm certain they would keep me up to date."

We saw that some people had a patient passport in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to

hospital staff.

People told us that they had no problems finding their way around the home. One person said, "I can find my way around the home. I have my buzzer if I need it." We noted that the home was accessible to people who used a wheelchair, and the Services Director told us there were plans in place to install a platform lift to replace the stair lift to make access easier for people who were accommodated on the first floor. Some carpets had become discoloured and the Service Director told us that these were due to be replaced with non-slip wood-effect flooring to enhance people's safety. The registered persons had obtained guidance from the Alzheimer's Society called 'Optimising treatment and care for people with behavioural and psychological symptoms of dementia', as well as information from Dementia UK and National Institute for Health and Care Excellence (NICE), and we saw there was suitable signage to help people find their way around the premises.

A relative suggested that it would be helpful for people to have a large clock and calendar in the lounge to help them with orientation. The registered manager informed us following the inspection that these had been provided.

Good

Is the service caring?

Our findings

People who lived at the home told us that they felt staff really cared about them. One person said, "They ask you if you are all right and happy" and another told us, "People ask me what I want to do. They are very kind and caring." Staff told us that they felt staff who worked at the home really cared about people. One member of staff said, "Yes, you have to, to do this job." Comments from relatives included, "I have been very impressed with the staff – they are very caring. My family member told me that the staff 'like a joke' and she enjoys that", "Staff are lovely. One young care worker treats my family member as if she was her grandma" and "My mum is very well looked after."

We observed that staff referred to people by their preferred name. People told us that staff respected their privacy and dignity, and several females told us that they preferred a female care worker and that this was adhered to. One female said, "Yes, they always knock, and I have female carers to look after me." Another person told us, "If there was something private they would come to my bedroom. They ask me if I'm happy, or anything worrying you, but I'm able to do most things." Relatives told us that they had observed staff were very careful to respect a person's privacy and dignity. One relative said, "My relative definitely has dignity here – they respect that she is a human being." Health care professionals told us that they had witnessed people being treated with dignity and respect, and that treatment always took place in a private area of the home. One health care professional told us that staff always accompanied people who were having treatment to support them during the process. Staff described how they respected people's privacy and dignity. Comments included, "We close doors and we cover people to protect their modesty."

People told us that they were kept informed about what was happening in the home. On the day of the inspection we saw that staff were patient with people and took time to explain things to them clearly and in a way that they could understand. This varied from person to person to take account of their specific ways of communicating and level of understanding. The report completed by Healthwatch following their 'Enter and View' visit in March 2016 recorded, 'Positive and friendly interactions between carers and residents were seen'.

Relatives told us that they were happy with the level of communication between themselves and the home. Two relatives said, "Yes, they tell me the things I need to know." One relative added, "My family member is lucid. [Name] can tell me herself."

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Relatives told us that people were supported to be as independent as possible, for example, by encouraging people to continue to walk. One person who lived at the home told us, "I'm in charge – I'm quite

independent." However, one person told us, "When I'm asleep in bed I find I can't get up in bed and I need help, but they don't seem to understand that I can't and say 'Come on, you can do it'." Staff told us that they encouraged people to be as independent as possible. Comments included, "We would pass someone a flannel and encourage them to wash their face" and "We encourage people to do things for themselves, however small."

We saw that there was a frame containing photographs and names of staff who were employed at the home; this was waiting to be fixed to the wall. This served as a useful reminder for people who lived at the home and relatives, although we noted that larger print would have made the information easier to read.

The registered persons had obtained guidance documents on end of life care, 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) and 'Advanced decisions' from the NHS, and staff had attended training on these topics. Care plans included information about people's wishes at the end of their life in 'advanced end of life' care plans, and we noted that information on the principles of end of life care was included in care plans and available for staff. A health care professional told us that it would be helpful if staff could discuss end of life care (including DNACPR) when people were receptive and amenable to talk about these topics, as that this would enable them to talk to people and relatives about this topic when the time arose.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. Initial assessments included details of the person's medical history, the important people in their life and their daily routines, and included a 'one page profile' that recorded what was important to the person, the things that made their life better and how appropriate support should be provided. A relative told us that they had shared information about their family member when they were first admitted to the home, such as their family history, to help staff to develop an individual plan of care.

We saw that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included personal support, food and drink, mobility, continence, mental health / challenging behaviour, MCA / decision making / DoLS, social activities and pressure area care. Assessment tools had been used to identify if there was any level of risk, such as the waterlow assessment tool in respect of pressure area care and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information, and more formal reviews had been organised by care managers to review the person's care package. Most care plans we saw were up to date, although there were minor concerns such as some key worker records being out of date and one person had two different versions of a patient passport. The registered manager contacted us following the inspection to tell us that care plans were in the process of being updated.

We asked staff how they got to know about people's individual needs. They told us that they would read care plans, speak to the person concerned, and to their GP or social worker. They confirmed that new staff were required to read the care plan for each person who lived at the home. One member of staff said, "[The registered manager] goes out to do an assessment and then she shares the information with staff." A health care professional told us that, at quarterly reviews, the staff are well informed about people and mindful of their wishes, and those of their relatives. We observed that staff appeared to know and understand people's likes and dislikes.

People told us they were appropriately involved in their care. One person said, "They [the staff] help me get washed. I have a shower once or twice a week, depending on how busy they are. Otherwise it's a strip wash and they help me with that." Other people told us, "I am looking forward to living a full life. I like my days to be organised to help me progress. I like to read a quality daily paper and somebody has arranged for it to be delivered" and "I prefer a bath and it's with a hoist. It's big and deep – I've told them I can swim!"

The registered manager described how they were able to communicate with one person who had no verbal communication. They told us they understood the person's non-verbal communication such as the shape of their mouth, their eyes and certain sounds they made. Another person was visually impaired and the registered manager told us how the person's objects were place in a set order to make them easy for the

person to locate. We noted that this information was recorded in each person's care plan.

People told us that there were various activities they could take part in and mentioned the special activities that took place at Christmas and a Strawberry tea. One person told us, "I watch the TV and I am going to do some water colour painting, which is a hobby of mine. I do read and I might choose a book" and another person said, "I go to the garden centre with my friend. I do the puzzle books and I do the crossword with my friend. I'm not interested in dominoes or bingo, but sometimes go to the entertainment." Other people told us they enjoyed the dominoes and bingo and some people told us about visits from various churches. One person told us, "I would like to go out but can only go if it's done by relatives." A relative also mentioned that people were not able to go out unless taken by relatives, as there was no mini-bus or other transport made available by the home. We discussed this with the registered manager, who told us that they were in discussions with a local voluntary organisation about providing transport.

There was an activities coordinator employed at the home and there was a weekly activity planner on display; we noted that it included pictures as well as words to assist understanding for people with cognitive difficulties. One relative told us that they helped with activities (crafts) at the home; they had a DBS check to evidence they were safe to be working with vulnerable people.

Although we did not see many activities taking part on the day of the inspection, a member of staff told us that they had provided nail care and manicures to six people, and that this was something people enjoyed. A health care professional told us that they had observed people taking part in activities such as dominoes, music sessions and entertainment when they visited the home. The Operations Director explained the plans they had in place to improve the provision of meaningful activities for people who were living with dementia and we noted that lots of information had been obtained to help them with this.

Staff 'handover' meetings were held to pass information from one shift to the next. This ensured that staff had up to date information to enable them to provide person-centred care. We noted that staff 'handover' records were audited. The audit for March 2016 recorded 'handover meetings done three times a day by the senior in charge of the shift. Records are neat, legible and accurate. They are filed in the manager's office'.

People told us that their relatives could visit at any time and relatives confirmed that they could visit at any time and that they were made welcome. One person said, "[My family] are made to feel very welcome. My friend visits and takes me out." Staff told us that the registered manager contacted some relatives who 'lived away' to keep them up to date with their family member's well-being, and gave us an example of how relationships had improved within one family as a result of this contact.

We saw that the complaints procedure was displayed in the home. We checked the complaints log and saw that any complaints received had been recorded, including details of the investigation and the outcome. For example, two people had complained about the choice at mealtimes and the cook had met with these people and asked them to make suggestions for different meals they would enjoy. We noted that complaints were included in the programme of audits so that there was an overview of complaints made over a period of time. Three relatives told us that they had not needed to complain but added, "I'm positive that [the registered manager] would sort out any problems if she could."

Staff told us that they would deal with minor complaints and concerns themselves if they could. They said they would inform the registered manager of more serious concerns. Staff were confident that people's complaints would be listened to and dealt with. Staff told us that there were 'residents meetings' for people who lived at the home so that gave them another opportunity to express any concerns.

We noted that 'resident' meetings were held each month and 'resident and/ relative' meetings were held quarterly. We reviewed the minutes of the meeting held in March 2016. Topics discussed included Easter food and treats, laundry, cleaning, furniture / equipment and the standard of care. Feedback from the meeting included, 'Excellent care / standard' and 'Staff are very approachable'.

People told us that they had not been asked to give feedback about the care and support they received at the home. However, we saw that satisfaction surveys had been distributed to people who lived at the home in July 2015 and January / February 2016, and we saw the collated analysis. People reported that their needs were dealt with in a professional manner, that they were satisfied with the activities on offer and that they were treated with dignity and respect.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

People who lived at the home and visitors told us that they found it easy to talk to the registered manager. Staff told us, "[Registered manager] is brilliant. And the providers make sure they thank us, which is nice", "The manager has an open door policy" and "[Registered manager] is very good – she is supportive. She 'helps on the floor' when we need it." A health care professional told us that they had received positive feedback about the care provided at the home.

There was evidence that advice received was acted on. For example, Healthwatch had carried out an Enter and View inspection at the home in March 2016. The feedback received following their visit was very positive. They recorded, 'Staff observed speaking to residents in a friendly and respectful manner. Two choices for lunch. The home is well maintained.' They had advised that there should be a push-button entry system on the laundry room door and we saw that this had been actioned.

We saw the weekly management report that the registered manager was required to produce and submit to the head office. The report included the name of each person who lived at the home and whether there were any concerns, such as falls or newly identified medical problems. The report also recorded any maintenance that had been identified and / or carried out during the week, the outcome of medication spot checks, the details of any falls, safeguarding issues or DoLS applications, any complaints received, any notifications submitted to CQC and staffing issues. This provided an effective form of communication between the registered manager and other managers within the organisation, and assisted with the on-going auditing of the service.

There was a quality assurance checklist in place that recorded details of daily, weekly, monthly, eight-weekly, quarterly, six-monthly and annual checks or audits. Six-monthly quality and compliance care plan audits were being carried out and we saw that there was a record of any areas of non-compliance; we discussed with the registered provider that it would be useful to record when these had been achieved, and they told us this would be recorded in future. Other audits included those for cleanliness (including the kitchen), water temperatures, medication, weights and monitoring charts, infection control and employee

personnel files. The outcome of the audit on personnel files recorded 'all supervisions up to date – done eight-weekly. All appraisals done July 2015'.

We saw that satisfaction surveys had been distributed to relatives in January 2016. The responses had been collated and we noted that they were mainly positive; everyone reported that they were made to feel welcome at the home and that staff were willing to assist. Most people felt that people were happy and well cared for and reported that they were aware of the complaints procedure.

Satisfaction surveys had been distributed to people who lived at the home in July 2015 and February 2016, and we saw the collated analysis. People reported that their needs were dealt with in a professional manner, that they were satisfied with the activities on offer and that they were treated with dignity and respect.

There had also been a staff survey in July 2015 and a professional visitor survey in October 2015 but we did not check the analysis of these surveys.

Staff told us that they attended staff meetings and that these were a 'two way' process. They said that they were encouraged to raise concerns and make suggestions. One member of staff said, "We can mention niggles so that they don't build up into something bigger." We saw the minutes of the meetings in March, April and May 2016 and noted that the topics discussed included people who lived at the home, relative's views, medication and housekeeping.

One relative told us they had attended relatives meetings, but that these were not well advertised and they did not receive feedback about issues raised. Another relative told us that they had attended a meeting, but not for a while. They added, "It depends on the owners though. Suggestions can be made but they make the decisions."
The operations director assured us that these meetings were advertised well in advance and that they reminded relatives when the quarterly meetings would be taking place.

Staff described the culture of the home as "Homely – we provide one to one care to make them feel better" and "Home from home – one big family." Relatives described the home as, "Home from Home", "Friendly, not too big, very caring" and "Comfortable, not too big and food very good." One relative told us, "Another of my relatives was in another care home in the area. I feel the care at Glenfields is much better" and another said, "[My family member] has settled really well – I can't think of anywhere better."

We asked staff if any improvements had been made to the service as a result of learning from incidents or complaints. One member of staff told us they could not recall any such incidents, but that they would have a meeting to discuss any problems and how they could improve. Another member of staff told us about a person who did not like certain foods and that a separate menu had been prepared for them.