Glenthorne Care Services Limited

Glenthorne 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

About the service: Glenthorne House provides accommodation and personal care for a maximum of 27 older people. On the first day of our inspection there were 23 people staying at the home, with one of these staying at the local hospital. Some people were living with dementia. The service had a new provider who registered with the Care Quality Commission (CQC) in May 2018. This was this provider's first inspection at the service.

People's experience of using this service:

People at Glenthorne House were valued as individuals and treated with kindness and compassion. Staff knew each person well and engaged positively with people throughout the day. Staff knew how to communicate with people, so people understood the options available to them.

People lived in a service that kept them safe. Staff had been recruited safely and had received training on how to recognise and report abuse. People were supported to take their medicines safely. Audits and checks were carried out, so any problem could be identified and rectified.

Staff promoted people's dignity and privacy. Staff understood their responsibilities to protect people from abuse and discrimination. They knew to report any concerns and ensure action was taken.

People's and relatives' views were sought, and opportunities taken to improve the service. Staff were supervised, supported and clear about what was expected of them. People's care was provided in line with best practice. People were cared for by staff who received regular training that was tailored to meet the needs of the people living in the service.

People's needs and preferences regarding food and drink were known and respected. People were supported to have access to healthcare services. Staff recognised deterioration in people's health and sought professional advice appropriately and followed it.

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.

The provider had identified improvements were needed in the social activities at the home. They had employed an activity person to put in place meaningful activities for people to aid both their physical and emotional well-being.

People knew how to make a complaint if necessary. They said if they had a concern or complaint they would feel happy to raise it.

There was nobody receiving end of life care at the home during our inspection. Procedures were in place for

people to identify their wishes for their end-of-life care. This included any wishes they had for receiving future treatment or being resuscitated.

A system of audits and monitoring had been carried out. The provider and the interim manager had identified gaps in practice or required improvements and were implementing an improvement plan.

Rating at last inspection: This is the first inspection of the service since it was registered to the current provider in May 2018.

Why we inspected: This was a scheduled/planned comprehensive inspection based on the date of registration.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

The service met the characteristics for a rating of "good" in all the key questions we inspected. Therefore, our overall rating for the service after this inspection was "good".

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 was safe Details are in our Safe findings below.	Good
Is the service effective? The service was effective Details are in our Effective findings below	Good
Is the service caring? The service was caring Details are in our Caring findings below.	Good
Is the service responsive? The service was responsive Details are in our Responsive findings below.	Good
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	Good

Glenthorne House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The first day of the inspection was carried out by an adult social care inspector and an expert by experience whose expertise included older people and dementia care. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. The second day of our visit was carried out by the adult social care inspector.

Service and service type:
Glenthorne House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission (CQC). The registered manager was not working at the service at the time of the inspection and had applied to CQC to deregister which during the inspection was actioned. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. In the absence of a registered manager the provider had recruited an experienced interim manager to ensure the safe running of the service. On the first day of the inspection the provider was interviewing potential new managers.

Notice of inspection:
The inspection was unannounced on the first day and announced for the second day.

What we did:
Before the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the

service does well and improvements they plan to make. We also reviewed notifications. Notifications are specific events registered people must tell us about by law.

We used the Short Observational Framework for Inspection (SOFI) in two different areas of the home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with:

Six people
Two relatives
The provider, interim manager, three team leaders, three care staff, an administrator, the cook, new activity co-ordinator, housekeeper and the new maintenance person.
We also spoke with a visiting community nurse at the home.
We contacted health and social care professionals to ask them for their views about the service and received a response from none of them.
The local authority Quality Assurance Improvement Team (QAIT) to obtain their views as they had been working with the provider.

We also reviewed
Two people's care records on the provider's computerised care system.
Three personnel records
Training records for all staff
Medicines admiration records on the computerised system
Staff rota's
Statement of purpose
Audits and quality assurance reports
Minutes of meetings
Policies and procedures.
Records of accidents and incidents
Complaints
Environmental risk assessment
Emergency evacuation plans
Deprivation of liberties applications and best interest decisions.
Maintenance records and checks.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm
Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• People and relatives said they felt the service was safe. Comments included, "I think so."
• Staff undertook training in how to recognise and report abuse. They said they would have no hesitation in reporting any concerns to the management team and were confident that action would be taken to protect people.

Assessing risk, safety monitoring and management
• Risks were identified, and staff had guidance to help them support people to reduce the risk of avoidable harm. Risk assessments undertaken included manual handling, falls, nutrition and hydration and skin integrity. The provider information return (PIR) told us, "We have recently introduced the quality compliance systems to support the service with policy, procedures, risk assessments and audits", which we saw.
• The provider had checks and audits in place to protect people from the risks of unsafe and unsuitable premises. For example, water temperature, testing of portable electrical appliances and window restrictor checks and an environmental risk assessment. Staff recorded maintenance issues they identified in a maintenance book. The provider was aware where maintenance issues required addressing and these were being actioned with the new maintenance person.
• External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment and lift maintenance.
• Legionella risk assessment had been completed and a certificate dated January 2019 was on display in the main entrance.
• Fire checks and drills were carried out in accordance with fire regulations. Fire procedures were clearly on display and a fire marshal on duty on each shift.
• People had personal emergency evacuation procedures in place (PEEPs) which detailed how staff needed to support individuals in the event of an emergency to keep them safe. These were held on the computerised system and a paper copy near the fire panel. This meant emergency services would be able to access people's information in the event of an emergency evacuation.
• In June 2018 the service was inspected by an environmental health officer to assess food hygiene and safety. The service scored the highest rating of five, which confirmed good standards and record keeping in relation to food hygiene had been maintained.

Staffing and recruitment
• Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character.
• Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults

•□Staff were busy during our inspection and acted quickly to support people when requests were made.
•□People, relatives and staff said on the whole there were enough staff to meet their needs and their call bells were responded to within a reasonable time. Comments included, "I think there are enough staff, I pop in every day."
•□The provider used a dependency tool to assess people's needs and ensure there were sufficient staff to meet people's needs. They had recorded an example of making staff changes in the provider information return (PIR), which stated, "Staff shared that they started to struggle to meet the needs in the morning of the individual who wanted to get up earlier with the change of season, from this we were able to immediately implement a further seven am staff start to support the night staff with responding to requests of getting up."

Using medicines safely
•□Medicines were safely managed. People told us they were happy with the way the staff supported them with their medicines.
•□Medicines were recorded on the provider's new computerised care system. These contained the information staff needed to administer medicines safely, including photographs of people so they knew they were administering them to the correct person. The system highlighted when medicines were required to be administered and if medicines had been missed.
•□Staff had clear guidance regarding the use of when required medicines.
•□The pharmacist providing medicines to the home had completed a review in March 2019 and hadn't raised any significant concerns.
•□Medicines were audited regularly with action taken to follow up any areas for improvement.
•□There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security.
•□Staff who administered medicines did so at the prescribed time and had received the necessary training to support their responsibilities in dispensing medicines.

Preventing and controlling infection
•□People lived in a home which was clean. Cleaning schedules were in place to help ensure these standards were maintained. One person said, "It's very clean here."
•□Where there were odours these were being managed by the provider with deep cleans taking place and carpets being replaced.
•□Staff used the correct protective equipment, such as gloves and aprons when providing personal care. This helped to protect people from the spread of infections.
•□Staff had received infection control training.
•□The provider's infection control policy had been reviewed and was in line with current best practice.

Learning lessons when things go wrong
•□Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns.
•□The provider and interim manager were putting in place a system to monitor accidents and incidents at the home to look for patterns and trends.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good:People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•People's individual health needs were assessed before they went to live at the service. Assessments were comprehensive, and people's individual care and support needs were regularly reviewed and updated.
•People had their care needs reviewed on a regular basis using 'Resident of the day' model. Staff involved family members appropriately to help ensure the care received was appropriate. Families said they were kept informed about their relatives and involved in decision making.
•Staff updated care records when changes occurred on the provider's computerised care system. This meant people's support was up to date to ensure they received the right care and support that was required.

Staff support: induction, training, skills and experience
•People received effective care and treatment from competent, knowledgeable and skilled staff who had the relevant qualifications and skills to meet their needs.
•Staff completed the provider's induction when they started working at the home and worked alongside experienced staff to get to know people.
•The provider was undertaking supervisions with all staff to ask their views about developing the service and to ascertain their development needs.
•Staff said it had been a difficult time with the change of manager but said they felt well supported.

Supporting people to eat and drink enough to maintain a balanced diet
•People were supported to eat a nutritious diet and were encouraged to drink enough to keep them hydrated. There was a hydration station which people could help themselves to drinks and snacks. The provider and interim manager were working with staff to ensure people always had jugs of water in their rooms as this had lapsed on some days.
•There was a four-week seasonal menu with two main meal and desert choices. Meals look appetising and well presented. We discussed with the provider and interim manager that people were having to wait for their desserts and the use of plastic plates and that the delivery of lunches was very routine orientated. They said this had been identified by an external assessor and action was being taken. We received an email after the inspection confirming china crockery was being used unless people were assessed as requiring plastic crockery.
•People said they liked the food and could make choices about what they had to eat. Comments included, "It's hot and you get a pudding…there are a couple of choices." A relative said, "The meals look nice, they encourage (person) to be healthy…eats fruit now she never used to."
•People's dietary needs and preferences were documented and known by the cooks and staff.
•People were regularly weighed and in the event of weight loss action was taken to implement nutritious

supplements and regular snacks of the persons choosing.

Staff working with other agencies to provide consistent, effective, timely care
•□Where people required support from healthcare professionals this was arranged, and staff followed the guidance provided. A visiting community nurse said, "Staff are pretty good they follow our guidance."
•□Referrals were made promptly to external professionals and people's care plans were updated as required. People's comments included, "The doctor comes if I need him" and "I see the doctor if I need and the chiropodist comes in."

Adapting service, design, decoration to meet people's needs
•□The provider had made ongoing improvements since owning the home. This included, new flooring in communal areas, new kitchen equipment, new bedroom doors, additional CCTV and new mattresses and commodes. They had a program of further improvements planned and were working with the new maintenance person to prioritise these to ensure the continued safety and security of the environment
•□People's rooms were personalised with soft toys, pictures and ornaments. On the ground floor bedroom doors had been personalised with name plaques and appeared like front doors. There were plans for all doors in the home to be changed. Memory boxes were also being put into place.
•□There was a suitable range of equipment and adaptations to support the needs of people using the service.
•□The provider said they had additional signage they intended to place around the home to help guide people.

Supporting people to live healthier lives, access healthcare services and support
•□Where people required support from external healthcare services this was arranged, and staff followed guidance provided by those professionals. Staff worked closely with health professionals, including the community nurses and speech and language therapists (SALT) and ensured people were referred promptly.
•□People's changing needs were monitored to make sure their health needs were responded to promptly. Records confirmed people had access to a GP, dentist, an optician and chiropodist when required.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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.

•□Mental capacity assessments were completed appropriately. Where restrictions, such as bedrails had been used, a mental capacity assessment, best interest meetings and applications for a deprivation of liberty safeguard (DoLS) had been used.
•□The interim manager had a clear understanding of their responsibilities in relation to DoLS. Appropriate DoLS application had been put in place for people having their liberties restricted.
•□Staff ensured that people were involved in decisions about their care; and knew what they needed to do to make sure decisions were taken in people's best interests.
•□Where people did not have the capacity to make decisions, they were supported to have maximum

choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

• People were asked for their consent before any care was delivered. Staff were observed asking people's permission before providing them with support. This was carried out in a gentle and unrushed manner and care was taken to ensure people understood as much as they were able to.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good:People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
•Staff engaged with people with kindness and compassion.
•People and relatives said staff were kind to them. Comments included, "They are kind, I like them" and "Yes and very patient with her."
•Staff used people's preferred names and greeted them with bright smiles.
•Staff showed respect and regard for people's wellbeing and comfort. Throughout our visit they were asking people if they required anything. One person was becoming distressed a staff member reassured them and they started to complete a jigsaw puzzle.
•People's relatives and friends were able to visit when they chose. The provider had been working with health professionals regarding protecting mealtimes to ensure people were not disturbed unnecessarily. Relatives said they were made very welcome in the home.
•Staff ensured people's rights were upheld and that they were not discriminated against in any way.

Supporting people to express their views and be involved in making decisions about their care
•People were encouraged to make decisions about their day to day care and routines where possible. Those with close family, friends or those with the legal authority to make decisions on behalf of people if required were consulted. A relative said, "We get a letter when an assessment is due, so we can choose to be here if we want to be."
•Staff knew people's individual likes and dislikes.

Respecting and promoting people's privacy, dignity and independence
•People's wishes to spend time in their rooms was respected by staff. People were moving freely around all areas of the ground floor. People who chose to remain in their rooms were regularly checked.
•People were treated with dignity and respect and their privacy was supported by staff.
•Staff offered people assistance in a discreet and dignified manner. People said staff respected their needs and wishes and they felt that their privacy and dignity were respected. Staff knocked on people's doors before entering their rooms. A relative said, "They knock before they come in to her room."
•To maintain people's dignity the provider had purchased tubs to store people's continence pads. This was so they were not on display.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good:People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•People's needs were assessed before they began to use the service and reviewed regularly thereafter. Their support was planned in partnership with them and their families in a way that suited them.
•People said they were included in decision making. One person said, "I do what I want to do…you can lie in, get up late, but they come around about half seven every morning to check on you anyway".
•Staff understood the importance of getting to know people, so they could provide their care and support in their preferred way.
•Care records on the provider's computerised system contained people's personal history details, risk assessments, likes and dislikes, medical history and medicine details.
•The provider had identified improvements were needed in the social activities at the home. They had employed an activity person to put in place meaningful activities for people to aid both their physical and emotional well-being.
•There was a notice board in the main lounge showing weekly activities with three activities a day. These included a visiting hairdresser, sharing moments, an outing and watch television. The new activity person had been compiling comprehensive plans to guide staff about how to undertake specific activities.
•Outside there was an area called 'memory lane'. This had a bus stop with a shelter, sheds which were themed into a laundry area, café and hardware shop and a post box. There was also a beach themed area. During the inspection this area was cleared so people could use it in the nice weather and further garden furniture brought. The provider said there were plans to make a market stall area.
•People had the opportunity to attend events and activities in the local community. People were regularly supported to visit the local amenities. One person regularly visited the learning disability hub. On the day of the inspection a staff member came in on their day off to support two people to go shopping. There was a cat living at the home which people who lived in the home loved.
•The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard (AIS). People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. For example, one person who had difficulty communicating had picture aids. The provider information return (PIR) also recorded, "Staff identify communication mannerisms by observing body language…previously the service adapted signage around the home to support communication with an individual whereby English was not her first language."

Improving care quality in response to complaints or concerns
•People and relatives knew how to make complaints should they need to. The provider had a complaints policy which was available to people and visitors.

•□Where there were niggles, the team addressed these promptly to prevent the concern becoming a complaint. People and relatives said they were happy they could make a complaint if they needed to. One relative said, "If I had any worries/concerns, I would approach the staff."
•□There had been three complaints raised with the new provider. They had followed the complaints procedure and in one case had met with the complainant and health care professionals to find a resolution to resolve the concern.

End of life care and support
•□At the time of the inspection nobody was receiving end of life care at the home. The provider information return recorded, "The service has provided support for a number of individuals through their last stages of life working alongside other health professionals to ensure that people have a dignified and pain free death; ensuring protected characteristics such as their religious beliefs are followed through."
•□Procedures were in place for people to identify their wishes for their end-of-life care. This included any wishes they had for receiving future treatment or being resuscitated.
•□When required staff ensured appropriate medicines were available for people nearing the end of their life, to manage their pain and promote their dignity.
•□The service had received positive feedback from people's relatives about the end of life care they had provided. Relatives had sent cards with messages of thanks for staff. Comments included, "We couldn't wish for better care or better staff" and "We would like to thank you for looking after our mum and appreciate everything you did for her."

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Good:The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider and interim manager had a clear vision about what they needed to do to further improve the service. They were producing an implementation plan to identify areas and to prioritise. Staff said there had been an unsettling period with the registered manager leaving but had been kept informed and were looking forward to working with the new manager. They said they would be happy for a relative of theirs to be cared for at the home.
- Staff and health care professionals spoke positively about the new provider and the changes they had made. One commented, "We can massively see the improvements at the home since the new provider came."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider knew people and their relatives well. They did not pass anyone in the home without talking to them and asking how they were. This caring approach reflected the relationships staff built with people and relatives.
- The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were a variety of ways people could influence the service provided; including informal conversations with staff and the provider and surveys. There were plans to hold resident and family meetings. The activity person was designing a newsletter to keep people and families informed. The provider had sent out surveys to people, relatives and staff and a few had been returned. They said they would be collating the information when more had been returned. They would then share the findings and actions with people and staff.
- Staff views were sought regarding the running of the home, through supervisions and meetings. The provider and interim manager were undertaking supervisions with staff to ask for their views about the future development of eth service. Staff said they felt involved and their views were listened to.

Continuous learning and improving care; Working in partnership with others

•□A system of audits and monitoring helped ensure any gaps in practice or required improvements were identified. Audits were used to continually review and improve the service. The providers had a planned schedule of audits to ensure all areas were covered. This included, infection control, care records and medicines.
•□The provider was working with other organisations to achieve better outcomes for people and improve quality and safety. This included the local quality assurance officer.
•□Staff worked with local services such as GP's and district nurses to ensure people's health and well-being was promoted.
•□The provider had links with other providers to share learning, best practice ideas and to discuss challenges. They were also members of National Activity Provider's association (NAPA)(whose aim is that every care and support setting to be full of life, love and laughter), the local care association and the Black Country Partnership for Care (BCPC) whose aim is to enhance the provision of health and social care services across the four local authority areas within the Black Country and gain maximum benefit from working in collaboration with other partners at a sub-regional and regional level.
•□The provider had used a consultant to undertake a mini inspection at the home and was acting to put in place their recommendations.