Care Quality Commission

Glenhomes Care Home Limited

Glenhomes Care Home

Inspection report

9 Greenmount Lane
Bolton
BL1 5JF
Tel: 01204 841988

Date of inspection visit: 28 July 2015
Date of publication: 23/09/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

We undertook the unannounced inspection on 28 July 2015. The service had not been inspected before under the current registration. Glenhomes Care Home is a home providing personal care for up to 21 older people. It is situated close to the centre of Bolton, the motorway network and public transport. The home is a large converted, semi-detached building, in a residential area, with a passenger lift provided. There is a garden with both a lawned and patio area which is fenced off for safety.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service and their relatives told us they felt safe within the home. Safety equipment was in place and regularly maintained and serviced.

We saw that the service had appropriate risk assessments in place for people who used the service. The risk assessments determined the level of risk and the control measures required to manage that risk.

Summary of findings

Appropriate safeguarding policies were in place and staff we spoke with had an understanding of the issues and procedures. The service followed safeguarding procedures when required, although no safeguarding issues had been raised within the last 12 months.

Recruitment of staff was robust and the policy was followed appropriately. Potential staff were required to produce proof of identification and references and all were subject to satisfactory disclosure and barring service (DBS) checks, to help ensure they were suitable to work with vulnerable people. There were sufficient staff to attend to people's needs.

Medicines were administered, stored, ordered and disposed of safely. Medicines management policy and procedures, which were robust and comprehensive and included information on controlled drugs, medication errors, homely medicines and covert medication.

People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times. However, the meal time experience could be improved to ensure that people were supported into the dining room in a more organised way.

The service considered the requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, the records in respect of consent and capacity were inconsistent.

The induction process was thorough and included mandatory training and shadowing. Supervisions and appraisals took place regularly and were documented appropriately. Training for staff was on-going.

People who used the service and their relatives felt the staff were kind, respectful and polite. . One person who used the service told us, "The staff are lovely here, they really look after me". Throughout the day we observed staff interacting with people who used the service in a kind and considerate manner, ensuring people's dignity and privacy were respected.

Some staff had undertaken training in end of life care and others were booked on further training courses. The service endeavoured to support people at the end of life according to their wishes.

Care plans were not easy to follow and did not demonstrate person centred care planning. There was an inconsistent approach to how information was recorded. Five of the six care files contained information sheets that were loose and could easily have fallen out or been misplaced. The registered manager agreed to review and change the care plans to ensure they were more reflective of person centred care.

There was an activities coordinator and a number of activities were on offer to people on a regular basis. These included exercises, church services, pet therapy, visits from a local befrienders' group, crafts, trips out and entertainment. Seasonal festivities were also arranged.

An appropriate complaints policy was in place and people were aware of how to complain. The complaints process was outlined within the service user guide. No recent complaints had been received by the service.

People who used the service, relatives and professionals felt the management were approachable.

One professional told us, "Overall I feel Glenhomes is a lovely little independent care home always working towards improving the residents' quality of life".

Regular staff supervisions were undertaken, including themed supervisions, general supervisions and tailored sessions to address particular learning needs. Appraisals were undertaken annually and staff meetings took place regularly to help ensure good communication between staff and management.

Feedback was sought from people who used the service on a monthly basis and issues identified and addressed. A number of audits were regularly undertaken and the results analysed to help drive improvement of service delivery.

Summary of findings

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. People who used the service and their relatives told us they felt safe within the home.

Safety equipment was in place and regularly maintained and serviced. There were appropriate risk assessments in place for people who used the service.

Appropriate safeguarding policies were in place and staff had an understanding of the issues and procedures. Recruitment of staff was robust and there were sufficient staff to attend to people's needs.

Medicines were administered, stored, ordered and disposed of safely.

Is the service effective?

Requires improvement

The service was not consistently effective. People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times. However, the meal time experience could be improved.

The service considered the requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, the records in respect of consent and capacity were inconsistent.

The induction process was thorough and supervisions and appraisals took place regularly. Training for staff was on-going.

Is the service caring?

Good

The service was caring. People who used the service and their relatives felt the staff were kind, respectful and polite.

We observed staff interacting with people who used the service in a kind and considerate manner, ensuring people's dignity and privacy were respected.

The service endeavoured to support people at the end of life according to their wishes.

Is the service responsive?

Requires improvement

The service was not consistently responsive. Care plans were not easy to follow and did not demonstrate person- centred care planning.

There was an activities coordinator and a number of activities were on offer to people on a regular basis.

An appropriate complaints policy was in place and people were aware of how to complain.

Is the service well-led?

Good

The service was well-led. There was a registered manager and people felt the management were approachable.

Summary of findings

Regular staff supervisions, appraisals and meetings took place to help ensure good communication between staff and management.

Feedback was sought from people who used the service and issues identified and addressed.

A number of audits were regularly undertaken and the results analysed to help drive improvement of service delivery.

Glenhomes Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 28 July 2015 and was unannounced. The inspection team consisted of two adult social care inspectors from the Care Quality Commission.

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 the service does well and improvements they plan to make. We also reviewed information we held about the home in the form of notifications received from the service, including safeguarding incidents, deaths and injuries.

Before our inspection we contacted Bolton local authority commissioning team to find out their experience of the service. We also contacted the local Healthwatch to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care.

We contacted four specialist health and social care professionals, who use the service regularly, to ascertain their views on the service and whether they had any concerns.

During the inspection we spoke with four people who used the service, three relatives and one professional visitor. We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed records at the home including six care files, five staff personnel files, meeting minutes and audits held by the service.

Good

Is the service safe?

Our findings

We spoke with four people who use the service and each one stated they felt safe as a result of the care they received. Each of the four people we spoke with were also able to tell us what they would do if they didn't feel safe. One person told us, "The staff are very caring here and I feel very safe, I have no worries". Another person told us, "I have never felt unsafe here, but if I did I would definitely speak to someone about it".

We spoke with three relatives. One relative said, "I feel [my relative] is safer here than at home due to having less falls".

We were taken on a tour of the building and saw that appropriate emergency equipment was in place and there were emergency signs in situ. We looked at health and safety information and saw that all the emergency equipment was regularly checked and maintained. Maintenance records were complete and up to date and the service employed a handyman to carry out minor repairs.

Staff were issued with an employee safety handbook on commencement of their employment. There was a health and safety risk assessment file in place which was signed by all staff to say that they had read the file. We saw guidance and information around the control of substances hazardous to health (COSHH) and how to report any concerns.

We saw environmental risk assessments and that the service's fire and evacuation procedures, which were up to date. Emergency equipment was regularly tested and the service had contingency plans in place to respond to any emergency. The service had recently responded to a situation where the area's water supply had been cut off for a significant length of time. The staff had reacted in a controlled and appropriate manner, ensuring that none of the people who used the service had been adversely affected by the incident.

We looked at a sample of six care files to understand how the service managed and recorded risk to people who used the service. Each file included a variety of risk assessments that included moving and handling, skin care and falls. The risk assessments determined the level of risk and the control measures required to manage that risk. For example, one risk assessment identified that a person was at risk of falls, appropriate control measures had been put in place and appropriate referrals had been made to other agencies.

Accident and incidents were recorded and forms kept in individuals' care files. All accidents and incidents were audited on a three monthly basis, the results analysed and the information used to help minimise the risk of further incidents. Falls were recorded, monitored and audited and actions put in place to minimise the risk of falls. These actions included making changes to the arrangement of furniture in an individual's room to help make mobilising safer, ensuring that a person was assisted to the toilet more often, to lessen the risk of them attempting to get up without assistance and risking a fall, and making appropriate referrals made to the falls team.

The service had an up to date safeguarding vulnerable adults policy which linked to the local authority policy and procedures. The policy included guidance on restraint, managing violence and aggression, whistle blowing and reporting poor practice. This policy had been reviewed and updated recently to help ensure it was fit for purpose. No safeguarding issues had been raised within the last 12 months.

We spoke with four members of care staff, all of whom had undertaken training and demonstrated an understanding of safeguarding issues and reporting procedures. Staff told us they were confident that if they reported any safeguarding concerns or witnessed any poor practice, this would be followed up immediately and appropriately by the management.

Recruitment at the service was robust and the policy was followed. Potential staff were required to produce proof of identification and references and all were subject to satisfactory disclosure and barring service (DBS) checks, to help ensure they were suitable to work with vulnerable people.

We saw there were enough staff to attend to the needs of the people who used the service. We looked at a number of recent rotas which confirmed this. Staff told us there were sufficient staff to enable them to lead and participate in activities with people who used the service.

We saw the medicines management policy and procedures, which were robust and comprehensive and included information on controlled drugs, medication

Good

Is the service safe?

errors, homely medicines and covert medication. Covert medication is when medicines are given in food or drink. There was reference within the medicines policy to the Mental Capacity Act (2005) (MCA) to ensure that, where people did not have capacity to consent to taking their medicines, decisions were made in the person's best interests.

We spoke with a senior member of staff about how medicines were managed at the home. They were able to explain clearly how medicines were ordered, stored, administered and disposed of within the home. We saw that the medicines were sent from the pharmacy in dosette boxes and that each medication administration sheet (MAR) included a photograph of the person it referred to. Medicines were stored in a locked cupboard within a locked room and there was a separate controlled drugs cupboard with a record book, to be signed by two members of staff, for controlled drugs administration. In the case of medicines which were given as and when required (PRN) times of administration were noted to ensure these were given safely. Refusals of medicines were recorded and if medicines were refused on a regular basis, this was followed up with the person's GP to see if an alternative solution, such as liquid medicine, could be substituted for tablets. Only staff who had undertaken the appropriate training, and were deemed competent, administered medicines within the home.

We saw that fridges, where medicines were stored, were kept at the correct temperature and records were up to date of daily temperature checks.

We looked at the infection control policy which included information on outbreaks, minimising risk, training, managing clinical waste and the use of personal protective equipment (PPE).

Requires improvement

Is the service effective?

Our findings

We spoke with five professional visitors to the service. One person said, "I found the care staff very helpful and knowledgeable about the residents' physical and mental health". Another told us, "The staff are always helpful and the patients seem well cared for. I do not have any concerns". A third professional said, "The staff follow instructions and ring with any concerns".

We looked around the home and it was clean, bright and pleasant with no malodours. The service was part way through a refurbishment plan and the ground floor had been recently re-decorated to a good standard.

We saw, within the six care files we looked at, that the service ensured that appropriate referrals were made to other services and agencies as required. This helped people receive a good quality, joined up service.

We saw that do not attempt Cardiopulmonary Resuscitation (DNACPR) forms were only considered and added to the files if the person, or their family if appropriate, had specifically requested this. Whilst looking at the sample of six care files, we identified one person who had an active DNACPR order in place. The form was completed appropriately by the relevant healthcare professional and clear and appropriate reasons for the decision had been documented in line with current guidance. When questioned, the manager demonstrated a good understanding of the use of DNACPR orders and the correct process to be followed.

Policies and procedures regarding consent to care and treatment and capacity to consent were in place. We spoke with four staff who were all able to explain the principles of the MCA and best interests decision making. However, there was an inconsistent approach to assessing and documenting whether or not a person had capacity to make decisions for themselves and we found evidence of 'consent' documentation being signed by family members with no reference being made as to whether that family member had legal decision making powers.

Deprivation of Liberty Safeguards (DoLS) authorisations were sought appropriately. This is used when a person needs to be deprived of their liberty in their own best interests. This can be due to a lack of insight into their condition or the risks involved in the event of the individual leaving the home alone. Staff were aware of people who were subject to DoLS and could explain the reasons why.

We looked at personnel files for five staff members. These included notes of general supervisions, themed supervisions and specific targeted supervisions to address individual requirements. We saw that there were certain key documents, such as policies and procedures, that staff were required to read and sign on an annual basis in order to keep their knowledge current.

The induction process was individual, depending on previous experience and knowledge. If potential staff had not worked in care previously, they were sent on the local authority induction, which incorporated a range of mandatory training, before completing the in house induction. This consisted of orientation, reading policies, mandatory training and shadowing. Competence checks were carried out by senior staff to help ensure new staff were competent to commence work at the home.

Training was on-going at the service. Some training consisted of distance learning, with a booklet to fill in whilst other courses were face to face at the home. Staff we spoke with were able to tell us about the training and said they had gained skills and confidence from enhancing their knowledge.

Appraisals took place on an annual basis for all staff. This offered a forum to reflect on previous practice, training and knowledge and identify development needs for the future. Senior staff members took the lead in particular areas of interest, such as quality assurance, so that they could take responsibility for keeping knowledge and skills up to date in that area.

There was an appropriate policy regarding meeting nutritional needs. Nutritional risk assessments were in place and appropriate referrals were made to nutritionists or the speech and language team (SALT) to help ensure people's well- being with regard to nutrition.

During lunch time we completed the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We observed the atmosphere in the dining room to be relaxed and some people who used the service were

Requires improvement

Is the service effective?

happily chatting with each other. People who required additional help to get into the dining room were supported appropriately. At the start of the lunch time, there were periods of time where people were left unsupervised in the dining room, because all of the care staff were supporting other people to the dining room. One person appeared confused and attempted to get up out of their chair whilst no staff were present. This person was encouraged by other people who use the service to "sit back down". The length of time between the first person being brought into the dining room and the last person was 22 minutes and during this period three people complained they were thirsty and two others complained about the length of time they had to sit and wait. Once the last person was brought into the dining room there was then a sudden rush of activity with drinks and meals being served.

A choice of drinks was offered and those people who required thickened fluids were supported appropriately. The hot food came up to the dining area via a food service lift from the kitchen and was already plated, care staff then distributed the meals to people. We observed that people who required help with eating and drinking were supported appropriately and the support given was unhurried.

Menu options were discussed with people who used the service in advance of meal times but we observed two people being offered an alternative choice as they had changed their minds about what they wanted to eat. The food was well presented and looked appetising. One person told us "The food is really nice here and always hot", another person told us, "I would like to have more choice as you know what you're going to get each week".

The menu was put together with the involvement of the people who used the service and there were regular reviews of the menus to ensure people were happy with the food. Special dietary needs and requirements were adhered to by the service.

We spoke with the registered manager about this issue and he reassured us he would look to have one member of staff present in the dining room at the start of meal times who could take responsibility for serving drinks and supervising people who use the service.

Good

Is the service caring?

Our findings

People who use the service and visiting relatives told us the staff were caring and kind. One person who used the service told us, "The staff are lovely here, they really look after me". We spoke with three relatives. One of the relatives said, "Staff are wonderful, you just walk in any time and it is always the same". Another said, "Staff are polite, friendly and respectful with [my relative]".

We spoke with four professionals who visited the home regularly. One said, "I have found the care staff very endearing and empathetic towards the residents and they in turn feel very much at home". Another told us, "Overall I feel Glenhomes is a lovely little independent care home always working towards improving the residents' quality of life". A third commented, "Residents are well looked after, clean and well presented. Staff are respectful, helpful and polite. I think they do a good job".

Throughout the day we observed staff treating people with respect and dignity. We saw staff supporting people in a sensitive and respectful manner, smiling and encouraging people when undertaking routine tasks such as support with transfers from a wheelchair to armchair and support when going to the toilet. During the inspection we were able to view four rooms of people who used the service. Each room was single occupancy and looked visibly clean and well maintained. Each room was personalised with the person's own items, such as photos and furniture and this created a more homely feel to the room.

We saw that appropriate information was given to people who may wish to be admitted to the home, or their families. This consisted of a service user guide, which included information about the services, statement of purpose, complaints procedure, sample contract, summary of the last inspection and information about confidentiality. This guide was also produced in braille and large print so that it was accessible to as many people as possible. One relative told us there loved one's admission was "a very easy process" and said they had settled well at the home, with the support of the staff.

There was an appropriate policy on confidentiality. Records were stored in a cupboard which was located in a public area of the care home and although the cupboard had a padlock, there was a slight risk that if this cupboard was left unlocked and unattended, unauthorised access to confidential information could be obtained. The registered manager agreed to ensure this cupboard was always locked.

Relatives we spoke with felt their loved ones were always presented well and that staff ensured they were supported to dress appropriately. We asked if the home kept them informed about their relatives. They told us they were contacted immediately if there was any concern or any incident, for example a fall, had occurred. Relatives said that the appropriate professionals, such as GPs were called when required.

Care files were reviewed on a three monthly basis. Some relatives told us they had been invited to care plan reviews and had seen their relative's care plan. However, throughout all of the six care files we looked at there was little evidence to demonstrate how the service involved people who used the service in agreeing how their care was planned and delivered.

People's wishes for their end of life care were recorded if they had expressed these wishes and approximately half the staff at the home had already undertaken end of life training. Others were booked onto the course in the near future. One staff member told us they felt the training had really helped them deliver good end of life care to someone who used the service. There was recorded evidence at the home that a person had recently been cared for appropriately and according to their wishes at the end of their life.

Requires improvement

Is the service responsive?

Our findings

One relative we spoke with told us, “My [relative] is really well looked after, I’ve never had any cause to complain”. Another told us, “I’ve never had any complaints. There’s a nice atmosphere in the home”.

The service ensured that people were given a welcome pack on admission and a survey on the admission process was available for them to complete. This helped the service look at what worked well and where any difficulties lay to help them improve the admission process.

We looked at a sample of six care plans to understand how the service personalised and responded to people’s needs and how they involved people who used the service in planning their own care. The six care files we looked at were divided up into six sections; residents life history, care plan, risk assessments, contact sheet, medical services, and accident reports. However, of the six files we looked at, each one was presented in a manner that was not easy to read, with some sections having blank pages. There was an inconsistent approach to how information was recorded. Five of the six care files contained information sheets that were loose and could easily have fallen out or been misplaced.

The style in which the care files were written appeared to follow a medical model of task based care delivery. There was a section of the care file that provided a brief history of the person’s life but in all of the care files reviewed none of these had been updated since the person was admitted to the care home.

We found no evidence in each of the six care files to demonstrate how each individual who used the service engaged in meaningful activity on a day-to-day basis, although we did see evidence of activities within the home. There was no evidence to demonstrate the interests of the individual, their likes and dislikes and the choices they had made. The registered manager agreed to review and change the care plans to ensure they were more reflective of person centred care.

There was an activities co-ordinator and there were a range of activities on offer for people. These included exercises, church services, pet therapy, visits from a local befrienders’ group, crafts, trips out and entertainment. Celebrations took place at Christmas and Easter and people’s birthdays were also celebrated.

The service carried out monthly surveys on a range of subjects including laundry, menus, staff, facilities and activities for people who used the service to complete. The results of these were looked at and used to help improve the service for people.

The complaints procedure was outlined in the service user guide and the manager planned to display this in the reception area. No complaints had been received by the service in the last year. Relatives we spoke with told us they had no complaints, but said they would speak with the manager if they had any concerns.

Good

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the care Quality Commission to manage the service. Like Registered Providers they are Registered Persons. Registered Persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with, including people who used the service, relatives, staff and professional visitors all told us the management at the home were approachable and helpful.

Supervisions and appraisals for staff were undertaken on a regular basis, providing an opportunity for staff to receive updated information, evaluate their learning, discuss competency and skills and identify training requirements. Some supervisions were themed, for example, there had been recent sessions around MCA for all staff. Other supervisions were general and some were tailored to the particular requirements of the staff member to address any shortfalls in knowledge or competence. The records demonstrated that supervisions were up to date. We also saw that senior staff had supervision meetings with the district nursing team so that information, for example around pressure care, could be passed on to them. Senior staff could then disseminate this information to other staff.

We saw minutes of staff meetings which were held regularly. Subjects discussed included medication, handovers and daily reports, contracts, staff cover, activities and laundry. Meetings provided a forum for staff to raise any concerns or put forward any suggestions to the management. Staff we spoke with were confident that if they requested specific training this would be arranged by the management.

We saw that the service worked in partnership with a number of other professionals and agencies. Professionals with whom we spoke felt that referrals were made appropriately, communication between themselves and the service was good and instructions and advice was followed by staff.

Regular feedback was sought from people who used the service to help ensure they were receiving appropriate care. We saw evidence that these questionnaires were analysed to help drive improvement to service delivery.

There was documentation relating to a number of regular audits which were undertaken at the home, including infection control, medicines, staff development, health and safety, accidents and incidents and falls. All the audits included action points with reference to the responsible person and the date for completion of the actions.

The service worked in partnership with other professionals and agencies in order to meet people's care requirements where required. Involvement with GPs, dieticians, district nurses and other professionals were recorded, Hospital appointments were noted and people who used the service assisted to keep these appointments.

The management team were involved with the local care home group, at which changes and best practice were discussed. They also took part in regular meetings with the local authority to ensure they were up to date with the local authority guidance and local protocols.