Care Quality Commission

Glenholme Senior Living Limited

Glenholme Holdingham Grange

Inspection report

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Holdingham
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Date of inspection visit:
15 May 2019

Date of publication:
04 July 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Glenholme Holdingham Grange 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 the care provided, and both were looked at during this inspection. The home provides accommodation for older people including people living with dementia. The home can accommodate up to 64 people. The home is divided into four units. Currently three of the four units are open. The units were, Carres providing residential support, Handley, providing nursing support and Elsaforde which specialised in providing support to people living with dementia. At the time of our inspection there were 30 people living in the home.

People's experience of using this service:

Regular quality checks had been carried out, however these checks had not identified some of the issues we found on inspection.

Processes were not in place to ensure medicines were administered and managed safely.

We observed occasions when people were not treated with respect and dignity.

People told us that there was usually sufficient trained and experienced staff however on the day of inspection we observed occasions when there were insufficient staff available to respond to people.

There were activities on offer. However people in one of the units did not participate in any activities during the day of inspection. The activities coordinator was looking at how they could develop this area further.

The environment in Elsaforde was not adapted to support people living with dementia.

People were supported to have maximum choice and control of their lives. The processes in service did not consistently support this practice.When people were unable to make decisions about their care and support, the principles of the Mental Capacity Act (2005) were followed. However, best interest decisions were not specific to individual decisions.

Care plans did not consistently reflect people's personal preferences and how they liked their care to be provided.The care plans had been reviewed and contained information about people and their care needs.

People enjoyed the meals and their dietary needs had been catered for. This information was detailed in people's care plans.

Staff followed guidance provided to manage people's nutrition and pressure care.

Staff had received training to support their role.

Staff had received regular supervision and plans were in place to ensure people received this on a regular basis.

People had good health care support from professionals. When people were unwell, staff had raised the concern and taken action with health professionals to address their health care needs. The provider and staff worked in partnership with health and care professionals.

People felt well cared for by staff.

When required notifications had been completed to inform us of events and incidents.

We identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to safe care and treatment and dignity. Details of action we have asked the provider to take can be found at the end of this report. More information is in the detailed findings below.

Why we inspected: This was a scheduled inspection. The inspection was the first inspection for this location following their registration in July 2018. We brought the comprehensive inspection forward because there had been a number of reported incidents where we had concerns.

Follow up: We have asked the provider to send us an action plan telling us what steps they are to take to make the improvements needed. 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 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 not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Safe findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always Well led Details are in our Well led findings below.	**Requires Improvement**

Care Quality Commission

Glenholme Holdingham Grange

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 inspection was carried out by an inspector, a specialist advisor (SPA),an assistant inspector and an expert by experience(Ex by Ex). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this instance dementia care. The SPA had expertise in nursing care.

Service and service type:
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This was a comprehensive service inspection and was unannounced. We inspected the service on 15 May 2019.

What we did:
Prior to the inspection we examined information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

During the inspection we spoke with four people who lived at the service, three relatives, five members of

care staff, a nurse, the provider, and the registered manager. We also looked at six care records in detail and records that related to how the service was managed including staffing, training, medicines and quality assurance.

We completed checks of the premises and observed how staff cared for and supported people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We used the SOFI to observe how staff interacted and cared for people living with dementia.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm
Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

•Medicines were not consistently managed safely. We observed a person's glass of water on the bedside cabinet with two tablets in the water. The person told us, "I put them in there because I didn't want them." The room was not locked which meant the tablets could be accessed by other people. We checked the MAR and saw they had been signed as given by the registered nurse. This meant medicine which had been signed for had not been taken.

•Another person also preferred their medicines to be left with them. We checked with the person an hour after the medicine round and confirmed the registered nurse had not checked that the person had taken their medicines. However, the registered nurse had signed on the MAR to confirm they had been administered. People were at risk of illness because assurance had not been sought to ensure people had taken their medicines.

• Written guidance was not consistently in place to enable staff to safely administer medicines which were prescribed to be given only as and when people required them, known as 'when required' (PRN). There was a risk people would not receive their medicines when they needed them. Following our inspection the provider has confirmed they have taken action to address this issue.

•Instructions for medicines which should be given at specific times were written on the medicine administration records (MAR) and additional reminders were in place. However, when we checked medicines which were recorded as needing to be given at 7.00 am we saw they had been signed as given at 8 am. It was not clear whether these medicines were given at the prescribed time. Another person required Insulin 30 mins before meals however it was not clear from the records what time insulin was given in comparison to the person having a meal. Not following specific timings for medicines could increase the risk of people experiencing adverse effects from medicines, or the medicine not working as intended. Following our inspection the provider has taken action to make the recording of information in relation to the administration of insulin clearer.

• Records we reviewed stated on twelve occasions the medicine was not required. However as this was not a PRN medicine it should have been administered as per the prescription or a review carried out with the GP to ensure the person's needs were being met. The prescribed medicine had not been given as directed. Following inspection the provider confirmed the person had refused their medicine and had capacity to do this. Medicines were not administered as prescribed due to the persons wishes. In order to ensure medicines were being administered as needed a review should have been carried out with the GP.

It is recommended the provider review medicine recording and management processes to ensure they are in line with current best practice guidance.

•At this inspection we found medicines were stored securely and access was restricted to authorised staff.

•There were appropriate arrangements in place for the management of medicines that required extra checks. Staff regularly carried out balance checks of controlled drugs.

•Medicine administration records (MAR) contained photographs of service users to reduce the risk of medicines being given to the wrong person. All records clearly stated if the person had any allergies. This reduces the chance of someone receiving a medicine they are allergic to. Documentation was available to give people their medicines according to their preferences.

Staffing and recruitment

•Staffing arrangements varied across the units. We observed some occasions when there were insufficient suitably skilled staff available to meet people's needs.Staff told us they felt there were sufficient staff. However, we observed the activity coordinator was constantly interrupted to carry out other tasks for example, in the Handley unit a call bell was ringing, and they responded because it continued to ring rather than a member of the care team. Similarly, we observed the senior carer administering medicines was also interrupted on a regular basis for advice.

•On the day of inspection there were two agency carers who had not previously worked at the home. We saw they struggled to interact with people because they did not know the people they were supporting. This was particularly evident in Elsaforde. A senior carer who usually worked in Elsaforde had also been moved to cover in Carre and this left two staff on this unit which meant people received little interaction during the day.

•We observed periods in Elsaforde when there were no staff around to support people. The people in this unit were living with dementia and some were unable to call for help which means it is important to have sufficient skilled staff around to provide care in a timely manner.

•The registered persons had undertaken the necessary employment checks. These measures are important to establish the previous good conduct of the applicants and to ensure that they were suitable people to be employed in the service. The registered persons had carried out checks with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct.

Assessing risk, safety monitoring and management

•We found that risks to people's safety had not been consistently assessed'. People's plans included risk assessments for nutrition and skin integrity. However, where people preferred their medicines left with them risk assessments had not been completed.

•Care records included personal evacuation plans to guide staff on actions they would need to take to support people who needed assistance in an emergency.

•Where people utilised specific equipment to assist them with their care appropriate checks were made regularly to ensure it was safe.

Systems and processes to safeguard people from the risk of abuse

•People told us they felt safe, one person told us, "Yes I do I feel safe living here, accidents can happen. I got up to go to the toilet last night and I fell and hit my head. I feel a bit rough today. I rang the bell and they came straight away, they were very good."

•We spoke with staff about the protection of vulnerable people. Staff were able to tell us about the procedures to follow if they suspected bad practise or observed altercations with people who used the service. Records showed that care staff had completed training.

•Where incidents had occurred the registered manager and staff had followed local safeguarding processes and notified us of the action they had taken. Staff told us they thought people were treated with kindness and they had not seen anyone being placed at risk of harm.

Preventing and controlling infection

•A system of monitoring infection standards was in place. One person told us, about the cleanliness of the home, "Oh very clean yes, they come in every day and clean my bedroom." Another person said, "It's a nice sparkling new place."

•We observed suitable measures were in place for managing hospital acquired infections. Staff had access to protective clothing and we observed staff used these appropriately, for example, when serving meals.

Learning lessons when things go wrong

•Records showed that arrangements were in place to record accidents and near misses, and arrangements to analyse these so that they could establish how and why they had occurred, were also in place.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

•The environment was not adapted to assist those people who were confused or had difficulty with orientation around the home. This was particularly important in Elsaforde where there were people living with dementia and adaptations would assist people with daily living such as orientating themselves around the building. We observed the environment was bland and there was nothing available for people to occupy themselves with or to stimulate people's memories and conversation. The registered manager told us they were in the process of reviewing this area to determine how it could be best altered in order to meet people's needs.

•Where people required specific equipment to assist them with their care this was in place and regular checks carried out.

Ensuring consent to care and treatment in line with law and guidance

•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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•We found that arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Staff supported people to make decisions for themselves whenever possible. However records showed that when people lacked mental capacity to make specific decisions a decision in people's best interests had not always been put in place.

•Where people were unable to consent, the provider had collated information where relatives had legal

responsibility to make decisions on people's behalf. However consent documentation had not been completed according to this. There was a risk relatives could make decisions on people's behalf when they did not have authority to do so and decisions would not be made in people's best interest.

•We found that staff had a good understanding of MCA and DoLS and had made appropriate referrals to the Local Authority. People's capacity to make day to day to day decisions had been assessed and documented which ensured they received appropriate support. Staff demonstrated an awareness of these assessments and what areas people needed more support in making some more complex decisions.

•Where people could consent, documentation was included in the care records. Do not attempt cardiac pulmonary resuscitation orders (DNACPR) were in place where appropriate and had been reviewed, to ensure decisions remained in accordance with people's needs and wishes.

•We found where DoLS were in place conditions were being met.

Staff support: induction, training, skills and experience

•We saw staff had access to regular updates on issues such as first aid and moving and handling.

•Staff we spoke with were knowledgeable about their roles and responsibilities around the caring and supporting of people who lived at the home.

• Supervision and appraisals had taken place on a regular basis. These are important because they provide staff with the opportunity to review their performance and training needs.

•Introductory training was in place in line with the National Care Certificate for new staff. The National Care Certificate sets out common induction standards for social care staff.

•People told us they thought staff knew what they were doing and had their best interests at heart.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•Care plans were regularly reviewed and reflected people's changing needs. People said they had been involved in discussions about their care plans.

•Assessments of people's needs were in place, expected outcomes were identified and care and support were reviewed when required. These were carried out prior to admission by either the registered manager or a senior member of staff, in consultation with the person, their relative and/or another person who's knew them well. A member of staff told us, "I went to meet someone and complete the pre- admission assessment, I chatted with them and their daughter about health needs and past interests, so we can incorporate this into their care plan."

Supporting people to eat and drink enough to maintain a balanced diet

•We observed lunchtime in three areas. Staff were familiar with people's needs and likes and dislikes and where people required adapted cutlery and plates these were available.

•A range of meal options were available to people and we observed where people did not want their original choice alternatives were offered. We observed at lunchtime staff offered the person alternatives to their

main meal. A person told us, "The food is good, yes there's enough to eat." Another said, "The food's wonderful, I can't fault it." At night they'll always bring me some milk and biscuits."

•We observed drinks were provided throughout the day.

•Fluid charts were fully completed. This helped to ensure people received the appropriate hydration.

•Where people had specific dietary requirements, we saw these were detailed in care records and staff were aware of these.

Staff working with other agencies to provide consistent, effective, timely care.

•We saw from looking at people's care records that there was evidence that all the people who lived at the service had access to health professionals, to ensure that their on-going health and well-being. Records showed that staff were proactive in their approach and made referrals to health professionals in a timely manner.

•We saw a grab sheet had been developed in case people needed emergency hospital treatment.

Supporting people to live healthier lives, access healthcare services and support

•Records confirmed that people had received the help they needed to see their doctor and other healthcare professionals such as specialist nurses, dentists, opticians and dieticians.

•Where people had specific health needs for example diabetes, care plans reflected this and detailed how to meet these needs.

Requires Improvement

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

People did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

•We found people's dignity was not consistently respected. For example, in Elsaforde we observed staff did not knock on people's doors before entering a bedroom or explain who they were and why they were entering the room.

•We observed lunchtime in Elsaforde. Three of the five people currently living in the unit used the dining room for their lunch. Two staff were available however we observed the support they provided did not enable people. For example, one person was trying to eat ice cream, but could not manipulate it onto their spoon which resulted in them using their fingers to eat this.

•Another person stood up after eating their lunch and wiped themselves with a tissue inappropriately however the staff did not notice this, and the person continued to eat food without being supported to wash their hands. When they left the dining area they said, "I'm really really full, I've had enough." However, staff did not respect this, and one member of staff told the person to, "Stay here, pudding's coming in a minute." They then supported the person to return and put a bowl of ice cream and then semolina in front of them. The person pushed both deserts away.

•We observed two occasions when staff used inappropriate language to describe people. For example, one staff member described a person's behaviour when they were distressed as 'kicking off'. Another staff member described people as 'the best ones' when telling us about those people who were taking part in external visits.

•People we spoke with in Carre and Handley told us staff were respectful when supporting them with personal care and they had never felt undignified or embarrassed.

•We found that suitable arrangements had been maintained to ensure that private information was kept confidential. Computer records were password protected so that they could only be accessed by authorised members of staff.

Ensuring people are well treated and supported; equality and diversity

•A relative told us, "I have to constantly remind staff that my [family member] can't see, they are visually impaired and have poor hearing. They never give [family member] a spoon, [family member] was assessed by sight services as it was an issue." We observed lunch was put down in front of this person, leaving another

person to explain what the meal was and cut it up for them. We looked at the care record and found there was no detail about the person's difficulty with their sight. The person was not supported to be independent and there was a risk they would receive inappropriate care.

•During the afternoon we observed the bedroom doors to three of the bedrooms in Elsaforde were closed although people were in their rooms. We heard people calling for assistance regularly but did not observe any staff attending to them. We observed a member of staff completing care records and asked why the doors were closed. They told us it was to prevent other people entering the bedrooms. Most people living in Elsaforde were unable to use call bells because of their illness. This meant the people in the bedrooms were unable to access support easily and staff could not observe their demeanour to ensure their care needs were met.

•When supporting people to move staff supported people safely however we observed in Elsaforde staff did not always explain to people what they were doing or provide encouragement, so people were able to participate. For example, we observed staff lifted a person's headrest, so they could provide personal care to them however they did not explain what they were doing and why.

The above demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

•We noted that staff understood the importance of promoting equality and diversity. The provider recognised the importance of appropriately supporting people if they identified as gay, lesbian, bisexual and transgender.

•We observed staff working in Carres and Hanley were familiar with people's needs. One staff member said, "We have someone who likes to see staff around their room, so when I have my paperwork to do I sit where they can see me." Another told us, "One person can become anxious and vocal it's important that we speak in a quiet calm voice so as not to escalate the situation"

Supporting people to express their views and be involved in making decisions about their care

•We found that some people had been supported to express their views and be involved in making decisions about their care and treatment as far as possible. For example, one person told us, "I have my breakfast in my room, it's my choice."

•Where people were unable to communicate verbally arrangements had been put in place to support them. For example, a care record explained that to support a person to make a choice about the clothes they were staff needed to, 'show me my choices' and to use pictures to help them to choose meals.

•Most people had family, friends or representatives who could support them to express their preferences. Furthermore, we noted that the provider had access to advocacy resources. Advocates are independent of the service and can support people to make decisions and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•Care plans were not always person centred as they did not consistently provide detail about people's individual preferences. For example, a care plan stated a person preferred a bath but did not detail how they liked to take their bath and what support they required.

•People's files we looked at included assessments of their care and support needs and a plan of care. They included areas such as; supporting people with their personal care, eating and drinking, keeping the person healthy and safe, supporting the person with activities and their likes and dislikes. These had been kept under review.

•Our observations during the inspection indicated that some staff had a good knowledge of people and knew how to support them with their individual care needs. We spoke with a member of staff who was working in Carre about people living in Elsaforde. They told us they usually worked in Elsaforde and were able to tell us about the people living there and how to meet their needs. We spoke with the registered manager about this and they told us this was true, but they had moved the person because they needed a senior carer in Carre.

•People's views on and experience of the activities provided in the home were varied. A relative we spoke with told us "The activities are not personalised." We observed people in Elsaforde did not have access to activities throughout the day.

•One person told us, "We went to the garden centre, just once there may be more trips. I'm not bored." They also showed us an activity timetable which they had a copy of this included both internal and community activities such as visiting a garden centre. We saw people from Carre and Handley enjoying time in the garden area in the morning as part of a gardening activity.

•Care plans and other documents were written in accordance with the Accessible Information Standard so that information was presented to people in an accessible manner. The Accessible Information Standard is a law which sets out the legal expectations to ensure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Improving care quality in response to complaints or concerns

•There were arrangements to ensure that people's concerns and complaints were listened and responded to, improve the quality of care. Complaints had been responded to appropriately and resolved. However,

people we spoke with were not sure about how to make a complaint of they needed to.

•A policy for dealing with complaints was in place. This was available in both written and audio format.

End of life care and support

•Arrangements were in place to support people at the end of their life if required. For example, staff liaised with specialist services such as Macmillan nurses.

•Do not attempt resuscitation records (DNACPRs) were in place and had been reviewed to ensure they were still relevant for people.

•Staff had received training in the administration of medicines via a syringe driver to ensure people could receive the pain relief they required at the end of their life.

Requires Improvement

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

Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

• Quality checks were in place for a range of issues such as care plans, medicines, infection control, however checks had not consistently addressed the issues found at this inspection. For example, we looked at medicine audits from January to April 2019 and found these had not identified that some PRN protocols were not in place despite a record that the PRN protocols had been checked.

•Good practice guidance was not consistently followed. PRN protocols did not include information recommended by NICE guidelines to ensure people received their medicine when they needed it. When administering medicines staff did not follow best practice guidance and ensure people had taken their medicines. Following our inspection, the registered manager confirmed they had amended PRN protocols to reflect best practice.

•Systems were not in place to ensure records accurately reflected practice. For example, medicine records were signed to show medicines had been taken when they hadn't been. This meant the MAR could not be relied on as an accurate record of medicines administration.

•The provider is currently implementing a new electronic care planning system. Where electronic records had been completed we found they did not consistently include information about people's individual preferences.

•Arrangements were not in place to ensure people within Elsaforde received care appropriate to the needs of people living with dementia. The registered manager was unaware of the issues we identified.

Continuous learning and improving care

•The provider did not ensure national guidance was consistently followed. For example, BIAs were not issue specific.

•There was insufficient oversight to ensure the standards set by professional bodies was followed so that medicines were administered safely.

•The provider did not work according to their policies. We checked the medicine management policy and

saw it detailed the need for PRN protocols however these were not consistently in place.

The above demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

•The registered manager and registered provider were receptive to feedback throughout the inspection and responded quickly to address concerns and improve the service.

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

•Records showed that the registered persons had correctly told us about significant events that had occurred in the service, such as accidents, incidents and injuries.

•The service had clear line of organisation and staff were clear about their roles and responsibilities.

•To improve the service the provider had engaged a number of external professionals to provide advice and support. This included support with the design layout of the building.

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

•We found that people who lived in the service, their relatives and members of staff had been engaged in the running of the service. For example, a relative told us, "I suggested the events calendar and the notice board listing staff on shift. I suggested the doorbell."

•We looked at minutes from a staff meeting and saw that staff were engaged in discussions about staffing and how to improve allocation of staff.

Working in partnership with others

•Working relationships had been developed with other professionals to access advice and support. For example, the GP and local pharmacist.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated in a dignified manner to ensure their independence and care needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective to ensure effective record keeping and best practice. The providers quality checks had failed to identify issues found at inspection.