The Salvation Army Social Work Trust

Glebe Court

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

This inspection took place on 22 and 23 December 2016 and was unannounced. This meant the provider did not know we were coming.

Glebe Court is a residential home for up to 27 people. At the time of the inspection the service was providing support to 26 people. The additional room was reserved for respite care.

The service had a registered manager at the time of the inspection. 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 living in the service had their risk of experiencing avoidable harm mitigated by the provider's risk assessments and management plans. There were enough staff available to deliver care safely. Staff had been vetted and recruited appropriately. People received their medicines in line with the prescriber's instructions. The service had safe infection control practices and advanced emergency evacuation plans.

People were supported by trained staff who were skilled and supervised. People's rights under mental capacity legislation were upheld. People were supported to eat well and had access to healthcare professionals as their needs required. The building was adapted to meet people's mobility needs but people told us they would prefer to have en suite bathrooms.

People were supported by caring staff who treated them with dignity and respect. Staff promoted people's privacy. People were treated with compassion at the end of their lives and their relatives were sensitively supported during and following end of life care.

People had care plans which detailed how their assessed needs should be met. People were supported to participate in activities of their choosing. People's cultural and spiritual needs were identified and met. Relatives were welcomed at the service and felt informed. People and their relatives were encouraged to share their views and the service acted on complaints.

Good governance was evident at the service. People, relatives and staff felt the registered manager was experienced, approachable and open. Quality assurance checks were comprehensive and led to improvement. The service liaised with other providers and worked in partnership with health and social care professionals.

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's risks were identified and actions taken to reduce them.

Staff were recruited using safe recruitment processes.

There were enough staff to support people safely.

People received the medicines as prescribed.

People were protected by the providers emergency planning.

Is the service effective?

Good

The service was effective. Staff received supervision, appraisal and training.

People's rights under mental capacity legislation were upheld.

People had enough to eat and drink.

People had timely access to healthcare.

Is the service caring?

Good

The service was caring. People and their relatives told us the staff were caring.

People were treated with dignity and respect and their privacy was maintained.

People receiving end of life care were treated compassionately.

Is the service responsive?

Good

The service was responsive. People's assessed needs were met.

The service supported people to participate in the activities they chose.

People's spiritual needs were supported.

People and their relatives were encouraged to share their views with the service.

Is the service well-led?

Good

The service was well-led. Staff felt supported by the registered manager.

The manager was open and approachable.

A robust quality system was in use.

The service worked in partnership with health and social care professionals.

Glebe Court

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 unannounced inspection took place on 22 and 23 December 2016. It was undertaken by one inspector.

Prior to the inspection we reviewed the information we held about Glebe Court including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with six people, four relatives, the Chaplain and the registered manager. We also spoke with five staff. We reviewed 11 people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We reviewed 10 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted five health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I feel completely safe all the time." Another person told us, "Yes, I feel very safe, this is a good care home and I like it." A third person said, "The sad truth is I was at risk in my own home. I can see now that I wasn't doing so well back then with my eating and I was falling. I'm completely safe now and don't have to worry and the staff reassure me when I do."

People were safe because the provider had policies and procedures in place to safeguard people from abuse. Staff we spoke with had received training in safeguarding people and understood the provider's policy. Staff explained the different types of abuse and what they would do if they suspected someone was at risk of abuse. This included alerting the manager to their concerns.

People's risks of experiencing avoidable harm were reduced. People were supported with individual risk assessments which covered a range of areas including people's mobility and risk of falls. For example, staff supported a person to safely use their Zimmer frame following an assessment of this risk. Whilst the risk of another person falling was managed by two staff supporting them to transfer from their wheelchair to the toilet. Risk assessments were undertaken prior to people receiving a service and were reviewed at regular intervals or when people's needs changed.

People were assessed for their risk of pressure ulcers. Staff completed and regularly reviewed Waterlow Pressure Sore Assessments. These assessments looked at a number of factors including people's skin, mobility, continence and appetite. This tool measured people's risks of developing pressure ulcers. Where risks were identified, staff took action. For example, referrals were made to the district nursing team and people were assessed and supported with appropriate equipment such as pressure relieving cushions, turning plans and barrier creams. This meant people's skin integrity was protected.

People were protected from the risk of malnutrition. Staff supported people to measure and record their weight each month. When people experienced a loss of five kilograms within three months the service took action. This including making referrals to GPs and dieticians and close monitoring, increasing the frequency with which a person's weight was measured and recording people's food and fluid intake charts. Staff had guidance on how to use mid upper arm circumference measurements to calculate peoples' body mass index if people did not want to be weighed. We found some people with poor appetites were offered energy dense meals which were high calorie but small portion sized meals. Whilst other people were supported to have their meals fortified with cream and full fat milk. People at risk of choking were assessed by healthcare professionals and were supported to receive their food in safe consistencies, for example pureed. Photographs of people and what they were allergic to were on display for staff in the kitchen. This meant people's nutritional needs were safely met.

The registered manager analysed accident and incident reports and looked for patterns to see if lessons could be learned. For example, one person was noted to have had falls shortly after waking to the toilet. The service responded by arranging for night staff to check if the person was awake and support them to use the toilet. Additionally, a sensor mat was placed on the person's floor to alert staff if the person had fallen out of

bed. This meant the person's risk of falling was managed.

People were able to summon staff assistance by using a call bell. Staff wore a pager device which alerted them when people used their call bells. The number of the room or toilet in which the call bell had been activated was displayed on the pager. We observed staff promptly responding to call bells. This meant staff were able to identify where people were as soon as they needed help.

There were sufficient numbers of staff available to safely meet people's needs. There were care staff and team leaders available throughout the day and people were supported by waking staff at night.

People were supported by staff who had been safely recruited. The provider vetted potential staff for their suitability to work with people. This included interviewing candidates, confirming their identities, addresses and eligibility to work in the UK. Criminal records and barring lists checks were coordinated by the provider's head office and communicated to the registered manager.

People received their medicines safely. Staff who had been trained to do so administered people's medicines and maintained accurate Medicines Administration Records [MAR] charts. Instructions for the use of 'when required' medicines were clear. This meant staff maintained consistency in safely supporting people to take additional medicines when they needed them. The manager coordinated the auditing of medicines and MAR charts and took action when errors were identified. For example, when one audit identified a medicines error an action plan was put in place to avoid recurrence and the appropriate authorities were notified. Medicines were stored and disposed of safely.

People were protected by the service's high state of readiness to deal with emergencies. People had personal emergency evacuation plans [PEEPs] which detailed the support people would need to safely leave the building. An emergency box was kept at reception. This contained critical information including lists of people's medicines, the telephone numbers of relatives, the local authority, GP and CQC. The emergency box also contained a map of the building layout, details of gas and electrical cut off points to be handed to attending emergency services personnel. The service had arrangements in place for the use of a church hall should a full evacuation be required and temporary accommodation sought and the service had blankets, incontinence pads and non-perishable foods stored off site for use following evacuation. The service rehearsed building evacuations and tested fire alarm call points each week. This meant people were safe as a result of the provider's plans in the event of an emergency.

People were protected from the risk of infection. Staff wore personal protective equipment when delivering personal care. For example, staff wore single use gloves and aprons when supporting people to wash. The service had a laundry staff team who used a colour coded bag system to separate items. For example, clinical waste was placed in yellow bags whilst soiled linen was placed in red bags. This prevented cross contamination. The kitchen staff prevented cross contamination during food preparation by using a colour coded chopping board system. For example, red boards for raw meat, yellow boards for cooked meat and blue boards for fish. Staff completed a twice daily kitchen cleaning schedule. This included ovens, work surfaces, serving trollies and the floor. Mop heads and all sponges were changed daily. Staff checked the temperatures of the fridge and freezer as well as food 15 minutes prior to serving. This meant people were protected from food poisoning.

Good

Is the service effective?

Our findings

People were supported by trained, skilled and knowledgeable staff. Staff undertook mandatory training in areas including, health and safety, manual handling, infection control, safeguarding, medicines and food hygiene. Staff also received training specific to people's needs including, dementia awareness, nutrition, consent and decision making and end of life care. Line managers, including team leaders, undertook an advanced level medicines training, specialist health and safety training and training in the delivery of supervision and appraisal to staff. Additionally, eight staff who were established in post and who had previously attained a National Vocational Qualification (NVQ) were supported to undertake and complete the Care Certificate. The manager explained this was to ensure that staff training was up to date and in line with current best practice.

New staff completed the provider's induction programme in conjunction with the Care Certificate. New staff completed mandatory and were supported to orientate themselves with people's needs, care records and preferences as well as the care home environment. Weekly supervision was provided during the induction period whilst new staff shadowed their experienced colleagues. This meant people received support from new staff who were familiar with their needs and preferences for receiving care and support.

All staff received supervision from a line manager. Care staff discussed people's needs with team leaders and the head of care during their one to one meetings. Whilst records of domestic staff supervision showed discussion about the environment. For example, staff and their supervisor discussed the cleanliness of people's bedrooms. Where there were performance issues these were discussed in supervision. These included addressing issues of record keeping and punctuality. The performance of staff supporting people was evaluated by the manager during annual appraisals. These focused on what staff enjoyed about their roles and their personal development including training. This meant people were supported by staff who were supervised and evaluated in their roles.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people were treated in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).Where DoLS had been authorised care records detailed the process and its duration. This included the dates of application, assessment and authorisation as well as when the authorisation would expire.

People's nutritional and hydration needs were met. People told us they enjoyed the food they received. One person told us, "I like the food. I choose what I eat and the staff know what I like." Another person told us, "I'm happy with each course served generally. If I'm not I request an alternative and receive it." A third person said, "I like to eat a little, often. I don't have much of an appetite when I wake up so I have my breakfast late and call it brunch." One relative said, "My [relative] eats well now and that was a terrible worry before moving in here." Another relative told us, "They [staff] are always offering everyone [people and visitors] snacks and drinks. There's plenty of fruit and I like the choices my [relative] has." Records showed that Vegetarian and Caribbean meals were available. Where people declined the meals offered to them alternatives were offered and made. People who required assistance to eat were supported in line with their care plan.

People were supported to maintain their health. We found people received timely input from healthcare services. Care records noted the involvement and outcome from visits by healthcare professionals including, dieticians, nurses, GPs and physiotherapists. People also had regularly appointments with visiting opticians and audiologists.

People who presented with mental health needs had assessments and care records in place. Care records provided guidance to staff by describing the way conditions might affect people and the support they required when their mental health needs increased. Staff had information about known indicators that a person may be experiencing a relapse and the actions they should be taking. For example, contact the GP and their mental heal support team.

People and their relatives told us they liked the environment of the care home. They described it as homely and clean. A relative told us "The home has a nice feel and it looks cosy". However, people and their relatives told us they would prefer bedrooms to be en suite. The service had three lounges, with one located on each floor. Each lounge had a tea bar where relatives could make drinks and help themselves to biscuits when visiting. A lift enabled people to move between floors. People were able to use a spacious garden to the rear of the property because it was accessed using a ramp.

The inspection took place three days before Christmas. The home had decorations on display throughout. In response to the provider's observations and feedback from people most of the decorations were hung at the height of grab rails and below. This was because as a result of physical conditions such as scoliosis many people could not look up to see decorations on the ceiling. People showed us small Christmas trees that the service provided for each person's bedroom. There was a knitted nativity scene that people and staff had crafted exhibited in the reception area. People and relatives commented favourably about the "Christmas atmosphere" that the service had created.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. One person told us, "The staff are special people. They are thoughtful and kind." Another person said, "The staff are really nice." A third person told us, "Unfortunately my eyes have failed me. I used to love to read the Radio Times but staff read it to me every day. I could go on all day about the little things they do like that which shows how caring they are." One relative told us, "The staff are very, very caring. It is a major wrench putting a relative into a care home but it's the best decision I have ever made. I can leave here with complete peace of mind. I could never fault the care they've provided." A second relative said, "When my [relative] is feeling really down the staff are brilliant. They make the time to sit and talk to her one to one. By the time they're done she's smiling again. What more can you ask for?"

People received care and support from staff who knew them well. The majority of the staff had been in post for many years. One relative said, "The staff are like an extended family." Staff we spoke with told us in detail about people's preferences. Care records provided information that people wanted staff to know. For example, One document entitled 'Who I am' contained sections including 'things that are important', 'how I spend my time', 'things that help me relax' and 'things which may worry or upset me'. This meant care records offered staff a greater insight into people's needs.

People told us they did not feel rushed by staff. One person told us, "The staff are ever so patient." Another person said, "They never hurry you on or pester you." A relative told us, "The staff are attentive. They take their time with my [relative]. If they didn't their anxiety would go through the roof." Care records directed staff to support people at their own pace. For example, one person's care records guided staff to, "exercise time and patience", whilst supporting a person to dress due to the stiffness resulting from their health condition.

The support people required to sleep was noted in care records. For example, one person preferred their bedroom light turned off but their bedside light kept on. Peoples' preferences as to whether they preferred their bedroom doors to be open or shut when they slept were recorded. Additionally care records detailed peoples' ability to pull up and adjust their bedding and people's ability use their nursing call bell. This meant people's preferences were recorded and acted on.

People had their privacy and dignity protected. We observed staff knocking on people's bedroom doors and waiting for permission before entering. We saw staff speaking with people in a friendly and polite manner. Bathroom doors were closed when in use. All staff signed a declaration of confidentiality which was retained in their files and staff we spoke with understood the need to protect people's privacy.

People were supported with care and compassion at the end of their lives. People who were dying were supported with end of life care plans. These included people's 'preferred places of care' within their end stage plan. These stated where people wanted to be cared for at the end of their lives. For example, one person stated they wished to be in a hospice, whilst another person's records stated they wanted to be "in my own bed." End of life care plans included increased monitoring of people's skin, hydration and

breathing. To manage people's' discomfort the service used the Abbey Pain Scale. The Abbey Pain Scale is used to measure pain in people living with dementia through observation. For example, staff monitored changes to people's facial expressions, behaviour, vocalisation and body language. This meant people were supported to have a pain free death.

People were supported to have their loved ones with them as they died. The service made arrangements for relatives to stay continuously at the service during people's final days. The service's Chaplain met with people and their relatives to provide emotional and spiritual comfort. The provider produced and made available a booklet for relatives entitled 'Words of guidance and support'. The booklet contained information for relatives including the physical changes that may occur during the dying process and the emotions a relative may experience following death. The booklet advised relatives, "Staff will give you time so you can be alone with you relative to say your goodbyes but they are also around if you would prefer company or even a cuddle." This meant the service supported relatives during people's end of life care.

Good

Is the service responsive?

Our findings

People received care and support that was personalised and met their needs. People's needs were assessed prior to moving into the service to ensure the provider could deliver the care and support required. The service obtained information from people, relatives, healthcare professionals and referring local authorities to identify people's needs. Care Plans provided staff with clear guidance as to how people's assessed needs should be met. For example, one person's assessment identified that they had mobility needs. The person's care plan instructed staff to provide supervision and support when the person used their walking frame. We observed the person walking and staff were assisting them as directed in care records.

People were allocated a member of staff to be their designated keyworker. Keyworkers are member of staff with specific responsibilities for people's care and support. We found keyworker's liaised with families and healthcare professionals, coordinated activities with people and purchased clothes and toiletries. Keyworking activities were reviewed during staff supervision sessions to ensure people's needs and preferences were being met on a daily basis.

People were supported to participate in activities of their choosing. The service provided a range of activities including arts and crafts, sewing and knitting, table games, singing and reminiscence sessions. Some people chose to participate in one to one doll therapy sessions which were developed in partnership with the care home support team as a nurturing activity designed to reduce anxiety. A therapy dog visited the service for people who were animal lovers to pet. The service had an activities coordinator who facilitated sessions. A relative told us, "There is always plenty going on. None of that sit in a circle and nod off nonsense. Entertainers visit from time to time but it's when the school kids come to visit or perform that you really see people's eyes light up."

People's cultural and religious needs were met. The service had a Christian ethos and was provided by the Salvation Army. Many people had been officers within the organisation in Britain and overseas. The service had its own Chaplain, who was a minister within the church. They led prayer meetings on three afternoons each week and a full service on a Sunday. The Chaplain also provided one to one talk therapy sessions with people and visited people when they were admitted into hospital. The service ensured that events that were important to people were marked. For example, there were celebrations for the Harvest festival, Easter, Christmas and the Queen's birthday and Remembrance Day was honoured. At some events the Salvation Army Band performed for people.

People's bedrooms were personalised. People were supported to arrange their bedrooms as they chose and to display personal affects. For example, some people chose to hang wedding and family photographs. Other people displayed their art work. People had soft toys displayed in their rooms if they chose.

The provider sought the views of people and their relatives. One relative told us, "The manager and the staff make it so that I'm never anxious or worried if I want to talk about a problem. I really appreciate that." Another relative told us, "I always feel listened to. If I'm banging on about something they hear me out, we talk it through and they act on it straight away." Residents and relatives meeting were held every three

months. These forums were used by the service to obtain feedback. For example, satisfaction was expressed by people about the performance of a harpist at the service. The provider acted on suggestions made by people and relatives at the forums. For example, the service was taking photographs of keyworkers to be placed in people's rooms to aide their recall of their key staff member.

People and their relatives told us they knew how to make a complaint. The provider had a clear complaints policy and responded appropriately to complaints within the timeframe stipulated in the policy.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of the inspection who had been in post for ten years. They led a management team which included a Chaplain, Head of care, administrator and four team leaders. People and their relatives knew the management team and told us they found them open and approachable. One relative said, "The manager has an open door policy. She is never anything but friendly. She welcomes my views and makes sure care in the home is tip top."

The manager promoted an open culture. Team meeting minutes showed that staff were given the opportunity to raise concerns and share ideas about improving the service. The manager used the meetings to discuss people's changing needs and shared feedback with staff. Positive feedback included comments from an independent mental capacity advocate and a nurse from a palliative team. This meant good practice in the delivery of care and support were highlighted and promoted. The provider organised a care staff forum entitled 'Your say' for staff to openly share their views about the delivery of care and support.

Staff told us they felt supported by the registered manager and the service's leadership. One member of staff told us, "The manager is so genuinely caring it's inspiring. She is a role model for us all." Another member of staff said, "I respect people who lead from the front and [the registered manager] is one of those people who wouldn't ask you to do something they wouldn't do." A third member of staff said, "I have always felt supported by the managers."

The registered manager ensured that care records were accurate. Care records were the subject of regular audit and staff updated information as people's needs changed. Daily notes were entered into people's care records detailing how staff met people's needs. For example, daily records for one person at risk of pressure ulcers stated "skin intact, no discolouration and barrier cream applied". Team leaders used a communication book to ensure that the service's leadership were in possession of up to date information. For example, records detailed a person's discharge from hospital and the physiotherapy support that was required.

The registered manager supported staff who cared for people at the end of their lives. Six weeks after a person's death, staff involved in their care were supported to attend a reflective de-brief meeting. These meetings were used to talk about the person, their life and their end of life journey. Records showed that at the conclusion of the meeting the registered manager invited staff to answer two questions, "What did we do well?" and "What can we do better?" This meant the service continually sought to improve the experience of end of life care for people, relatives and staff

The registered manager carried out audits of the service. These included reviewing care plans, risk assessments, food hygiene practices, health and safety, medicines, cleaning programmes, activities and people's finances. Additionally, six monthly quality audits were undertaken by the provider organisation. Where checks revealed issues the registered manager produced an action plan and ensured improvements were made.

The registered manager and her leadership team received support from the provider organisation. The manager undertook training and attended bi-monthly meetings with manager's form the provider's other care homes. The manager also attended the local authority's provider's forum where best practice was discussed.

The registered manager understood the legal responsibilities of the registration with CQC and the requirement to keep us informed of important events through notifications when required.

The service worked in partnership with health and social care professionals. Records showed staff worked in collaboration with social workers, occupational therapists, speech and language therapists, palliative care specialists, general practitioners and district nurses to support people's changing needs. This meant people received the timely input they required from health and social care professionals to ensure their needs were met.