

Glenholme Senior Living Limited

Glenholme Holdingham

Grange

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Glenholme Holdingham Grange is a residential care home providing personal and nursing care to 39 people aged 65 and over at the time of the inspection. The care home can accommodate 74 people in two purpose-built buildings. The service is divided into five units, Carre, Greylees, Eslaforde, Handley and Meadowbeck.

People's experience of using this service and what we found

Staff had access to personal protective equipment (PPE) and followed national guidance around putting on and removing (donning and doffing) PPE. Staff did not consistently wear PPE according to national guidance.

The home was clean and an infection control policy was in place. The QA systems were not consistently effective.

Medicine guidance for 'as required' medicines (PRN) was not consistently in place in Eslaforde.

Staffing arrangements did not consistently ensure people's care needs were met. There were not always adequate numbers of staff to ensure people were well supported. Staff had received training for their roles. New staff were recruited safely.

The risks to people's care were assessed and measures were in place to mitigate these risks. People were cared for safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff knew how to keep people safe from abuse and were confident to raise concerns with the registered manager or external agencies. When required, notifications had been completed to inform us of events and incidents.

People and their relatives knew how to raise a complaint and would feel confident to do so if needed.

People had access to a range of professional support and working arrangements were in place with healthcare professionals.

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

Rating at last inspection

The last rating for this service was requires improvement (published 4 August 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the

provider was no longer in breach of regulation 10 but remained in breach of regulation 17.

Why we inspected

We received concerns in relation to staffing, staff attitudes and responses to people. As a result, we undertook a focussed inspection to review the key questions of safe, caring and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the failure to ensure quality monitoring systems are effective.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information 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 caring?

The service was not always caring.

Details are in our caring 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 ●

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by three inspectors.

Service and service type

Glenholme Holdingham Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

The inspection was unannounced

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We received feedback

from the local authority team who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with two people who lived at the home, a nurse, two carers, the registered manager and the quality manager. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at a variety of records relating to the management of the service including policies and procedures.

After the inspection

Following our visit, we spoke by telephone with the relative of one person, who used the service, about their experience of the care provided. We also spoke with the person who used the service. We spoke with three members of care staff. We continued to seek clarification from the provider to validate evidence found. We looked at training records, quality audits and staffing rotas.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

We made a recommendation at the last inspection. We recommended that the provider review medicine recording and management processes to ensure they are in line with current best practice guidance. At this inspection we found the recommendation had not been consistently addressed.

Using medicines safely

- Guidance for 'as required' medicines (PRN) had been put in place. However, we found seven occasions when PRN protocols were not available. Processes to manage the updating of the MAR failed to ensure all necessary information was in place to ensure people received medicines when required. There was a risk people would not receive their medicines when needed.
- Allergies were not consistently recorded. We found three occasions when allergies were recorded on the identity sheet in the medicine file but not recorded on medicine administration sheets (MARs). This meant it was unclear as to whether people were allergic to certain medicines. There was a risk people could receive medicines they were allergic to as the information on the MAR is used to administer people's medicines.
- Where people required their medicines to be administered without their knowledge, in food (covertly) we saw arrangements were in place to ensure people received these safely.
- Risk assessments were in place where people self-administered their medicines.

Staffing and recruitment

- The registered manager told us they had vacancies for night staff and were using bank and agency staff to cover shifts, once or twice a month. For example, on the day of inspection the registered manager was initially unavailable because there was a possibility, they may have had to work a night shift on that evening. However, this was resolved. During the inspection we saw no evidence of people waiting for care or of staff being unable to respond to people's needs. However, in Eslaforde we observed two occasions when staff were unavailable in communal areas. On one occasion a member of staff asked a senior manager who was visiting the unit to stand in the lounge area as there was no other member of staff available to assist another member of staff to provide care. If the senior manager had not been available people would have been left without a member of staff to support them. We observed an occasion when people were left without support one person entered another person's room and removed personal possessions from the room.
- The provider used a dependency tool to help them calculate the number of staff required to support people safely. However, staff we spoke with told us they were concerned about meeting people's needs at night if two members of staff were required to support a person as there have been occasions when a unit has had to be left without a staff member. One member of staff told us at night people must wait for attention when they use their call bell, and this has resulted in people being uncomfortable or having a fall. Another staff member told us they often had to manage on their own to support people when the senior staff member was busy.

- Staff had the skills to ensure they could meet people's needs. Staff told us they had received training to support them in their role. We looked at the training matrix and saw training was either up to date or planned to take place.
- There were safe recruitment processes in place to ensure people were supported by suitable staff. Checks such as references from previous employers and checks through the disclosure and barring service (DBS) were made for new staff. This check is made to ensure potential staff do not have any criminal convictions that may affect their suitability to work with vulnerable people.

Preventing and controlling infection

- People were protected from the risks of infection. Staff had access to personal protective equipment (PPE). When we spoke with staff, they were able to tell us how they used the equipment. However, we observed four occasions when staff were not wearing their masks according to guidance.
- Staff had received training with reference to preventing infections and working within the pandemic. However, we observed in Eslaforde, a member of staff remove dirty laundry from a person's room and carry it unbagged through the communal areas. There was a risk of cross infection.
- Care plans were in place for people in the event of a Covid 19 outbreak. This is good practice to ensure the home is prepared for an outbreak.
- The home was clean and well maintained. Regular checks had been carried out to ensure cleaning regimes were effective.

Assessing risk, safety monitoring and management

- People were protected from risks associated with their care needs. We found that risks to people's safety and the environment had been assessed. People's plans included risk assessments. These told the staff about the risks for each person and how to manage and minimise these risks.
- People had personal emergency evacuation profiles in place.

Systems and processes to safeguard people from the risk of abuse

- Where the registered manager had been made aware of any safeguarding concerns, they had worked with the local authority safeguarding team to investigate and learn from events.
- Staff had received training in how to keep people safe from abuse. They were clear on their responsibility to raise concerns and information available in the office supported them to raise concerns with external agencies.
- The provider had a whistleblowing policy in place and staff were aware they could use this to raise concerns under the whistle blowing protections.

Learning lessons when things go wrong

- Incidents were identified, recorded and action taken to keep people safe. The registered manager ensured that all accidents and incidents were recorded. This allowed the registered manager to monitor the action taken to keep individuals safe.
- The registered manager monitored the trends in areas such as accidents. This allowed them to identify if there were any patterns which could be addressed through a change in people's care plans.

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.

At our last inspection the provider had failed to ensure people were treated in a dignified manner. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- CQC had received four notifications of concerns prior to inspection about staff attitude. On the day of inspection, we did not find any concerns relating to this. However, when we spoke with staff and people who used the service, they expressed concern about some members of staff and how they responded to people. We discussed this with the registered manager who told us they were looking at the issues.
- As recorded in safe, staff raised concerns about staffing numbers at night. Staff told us as a result a person was often left wet because they could not get to them in time.
- Care was not consistently person centred. For example, we observed, a person had requested pain relief but was not provided this until the medicine round which was thirty minutes later. A relative also told us there were some staff who spoke to people in a 'patronising way'. In addition, they expressed concern that their family member had to purchase the foods they liked rather than have it provided by the home.
- 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.
- Records detailed people's preferred name and preferences for care.
- One person had been supported to have their spouse stay at the home for a period prior to their death, enabling them to spend quality time together and with their family for whom the home facilitated visits.

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

- We found that 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, MARs explained how people preferred to have their medicines and we observed staff followed this guidance.
- Where people had difficulties communicating verbally, arrangements had been put in place to support them. For example, a care record explained how to speak with a person in order to ensure they understood and were able to respond.
- We observed a person struggling to speak with their relatives by telephone. A staff member assisted them

to move to a quiet place and provided support to them so they could have a meaningful conversation with their relative.

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

Respecting and promoting people's privacy, dignity and independence

- We found people's dignity was respected. For example, staff knocked on people's doors before entering and called people by their preferred name.
- We observed lunchtime and saw this was a pleasant experience in all four areas. People were supported to make choices between available meals.
- 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.
- When supporting people to move, staff supported people safely and explained what they were doing and explained how the person could assist.
- We observed staff were familiar with people's needs. For example, we observed when serving drinks staff were aware of people's preferences and ensured these were met.

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.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Audits were in place and actions had been carried out following audits. However, the quality assurance processes had failed to identify some issues highlighted at inspection. For example, a recent medicine audit carried out in Eslaforde in February 2021, detailed that PRN protocols were in place, however, we found this not to be the case. The registered manager told us the protocols had been filed incorrectly. This error had not been identified at the time of inspection as the audit for March 2021 had not been completed.
 - The provider had failed to ensure staff consistently followed guidance. For example, staff did not wear their masks according to PPE guidance.
 - Where people were unable to consent, capacity assessments were in place. However, these were not stored consistently in people's records. The registered manager told us the provider was in the process of looking at an improved electronic system for care planning and records.
 - Care documents had not been updated to reflect people's needs. For example, two people's RESPECT (Recommended Summary Plan for Emergency Care and Treatment) forms had not been reviewed to ensure the instructions regarding people's possible deterioration was reflective of their needs and wishes.
 - At the last inspection we put a recommendation in place around medicines. At this inspection we found the recommendation had not been fully met.
 - The provider provided an action plan to address the issues previously identified at inspection. At this inspection we found the actions although completed had not resulted in sustained improvement.
 - Prior to inspection we had received a number of concerns about staff attitude. Despite these issues being raised with the Registered Manager they had failed to be resolved.
- This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Monitoring and analysis of issues such as people's weights and falls were undertaken each month, and actions staff needed to take to support people were communicated to them.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Some staff told us that action had not been taken to address issues they had raised such as staff shortages and attitude of some staff.
- Meetings were held with people who lived at the home. However, we saw some of the issues raised at the home had not been resolved. For example, during lunchtime a person expressed dissatisfaction about the temperature of their meal, and we observed this had been raised at a recent residents meeting. The registered manager told us they had provided equipment to maintain the heat of meals however this still appeared to be an issue for people.
- Staff we spoke with told us that although there were arrangements in place to update them and facilitate discussion, they did not feel all staff were treated equally. They told us that consequently there were occasions when tasks did not get completed due to a failure by staff to agree who should carry out the task. One person told us they felt staff did not always support each other.
- We observed where issues were identified at the inspection the registered manager had addressed these in a timely manner.
- Arrangements had been put in place to facilitate safe visits for relatives during the pandemic. Relatives were able to see their relatives through a glass screen and speak with them via a telephone. At the time of inspection, the home had recently had two cases of Covid 19 which had meant visiting had been suspended, however new arrangements were being put in place in line with national guidance to facilitate visiting in the home. In addition, telephone and video contact would also continue for people to maintain contact with their friends and relatives.
- The provider had carried out quality surveys with relatives. We observed responses were positive. Regular updates had been provided to both relatives and people who lived at the home by way of a newsletter.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager was aware of their responsibilities to inform us of significant events at the service as they are required by law to report to us.
- We saw that a complaints policy was in place and relatives were aware of how to make a complaint if required.

Working in partnership with others

- We saw evidence of referrals being made to external agencies including doctors, dietitian and the falls team.
- The registered manager told us they worked collaboratively with other agencies, for example, the local GP practices and pharmacy.