Glebe Housing Association Limited

Glebe Court Nursing Home

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 9 and 10 November 2017 and was unannounced. This inspection was partly prompted by an incident which had some impact on people using the service and this indicated a potential concern about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks.

At our last inspection of the service on 13 and 14 September 2016 we found the service to be meeting regulatory requirements and was rated 'Good'. Glebe Court Nursing Home 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.

Glebe Court Nursing Home provides personal and nursing care support for up to 51 older people some of whom have a physical disability or sensory impairment and may be living with dementia. At the time of our inspection there were 46 people using the service. The home had a registered manager in post. However they had recently left the service and a new manager had been appointed and was applying to the CQC to become the registered manager. 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.

Risks to people were assessed and recorded, and staff acted to manage identified risks safely. Medicines were managed, administered and stored safely. People were protected from the risk of abuse, because staff were aware of the types of abuse and the action to take if they had any concerns. There were systems in place to ensure people were protected from the risk of infection. Accidents and incidents were recorded and acted on appropriately. There were safe staff recruitment practices in place and appropriate numbers of staff were deployed throughout the home to meet people's needs.

There were processes in place to ensure staff new to the home were inducted into the service appropriately. Staff received training, supervision and appraisals that enabled them to fulfil their roles effectively. Staff were aware of the importance of seeking consent from people and demonstrated an understanding of the Mental Capacity Act 2005. Staff were also aware of the conditions under which a person may be deprived or their liberty, and acted in accordance with the Deprivation of Liberty Safeguards, to ensure people were only lawfully deprived when this was in their best interests. People's nutritional needs and preferences were met and people had access to health and social care professionals when required.

People told us staff treated them with kindness and their privacy and dignity were respected. People were involved in day to day decisions about their care and had care plans in place which reflected their individual needs and preferences. People were supported to maintain relationships with relatives and friends. There was a range of activities available to meet people's interests and to promote stimulation. The service

provided appropriate care and support to people at the end of their lives. People's needs were reviewed and monitored on a regular basis. People were provided with information on how to make a complaint. The service worked with health and social care professionals to ensure people's needs were met and the home made connections with people within the local community. There were regular volunteers who supported and facilitated entertainment and activities within the home.

People and relatives were aware of how to make a complaint and expressed confidence any concerns would be addressed by the management. There were robust systems and processes in place to monitor and evaluate the service provided. People's views about the service were sought and considered through residents meetings and satisfaction surveys. People, relatives and staff spoke highly of the management, and told us the service had improved in recent months.

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.

Risks to people were assessed, and care plans were in place to manage identified risks safely in line with the provider's policy.

Medicines were managed, administered and stored safely.

There were arrangements in place to deal with emergencies.

People were protected from the risk of abuse because staff were aware of the signs and action to take if they had any concerns.

Accidents and incidents were recorded and acted on appropriately.

There were safe staff recruitment practices in place and appropriate numbers of staff were deployed to meet people's needs.

There were systems in place to ensure people were protected from the risk of infections.

Is the service effective?

Good

The service was effective.

Staff received an induction when they started work and staff were supported through regular supervision and appraisals of their practice and performance.

Staff received training that enabled them to fulfil their roles effectively and meet people's needs.

People's needs were assessed and staff provided appropriate support.

Staff sought people's consent and acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) where applicable when people lacked capacity to make decisions for themselves.

People were supported to access a range of healthcare services when needed. People's nutritional needs and preferences were met.

Is the service caring?

Good

The service was caring.

People were supported to maintain relationships with relatives and friends.

Staff were knowledgeable about people's needs with regards to their disability, race, religion, sexual orientation and gender and supported people appropriately to meet their identified needs and wishes.

Staff respected people's privacy and dignity.

Staff treated people with kindness.

People were involved in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People's care needs and risks were assessed and documented within their care plan to reflect their individual needs and preferences.

People were supported to take part in a range of activities.

People received appropriate end of life care and support.

People were provided with information on how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The home had a registered manager in post at the time of our inspection. However they had recently left the service and a new manager had been appointed and was applying to the CQC to become the registered manager. They were knowledgeable about the requirements of a registered manager and their responsibilities with regard to the Health and Social Care Act 2014.

People, relatives and staff spoke highly of the management, and told us the service had improved in recent months.

There were robust systems and processes in place to monitor and evaluate the service provided.

People's views about the service were sought and considered through residents meetings and satisfaction surveys.

The service worked well with health and social care professionals and made connections with people within the local community.

Glebe Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 10 November 2017 and was unannounced. This inspection was partly prompted by an incident which had some impact on people using the service and this indicated a potential concern about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks.

The inspection team consisted of two inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned to the service on the second day. Prior to our inspection we reviewed the information we held about the provider. This included notifications received from the provider about deaths, accidents and safeguarding. A notification is information about important events that the provider is required to send us by law. The provider also completed a Provider Information Return (PIR) prior to the inspection which we reviewed. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority responsible for commissioning the service to obtain their views. We used this information to help inform our inspection planning.

During this inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with seven people using the service, six visiting relatives and 11 members of staff including the provider's CEO (chief executive officer), the newly appointed home manager, nursing and care staff, kitchen staff and the activities coordinator. We looked at eight people's care plans and records, staff records and records relating to the management of the service such as audits and policies and procedures. We also looked at areas of the building including communal areas and external grounds.

Good

Is the service safe?

Our findings

People told us they felt safe within the home and staff treated them well. Comments included, "Oh yes, I do feel safe", "I feel very safe, the staff are lovely", "Yes, I definitely feel safe here", "That's the best thing about this place", "I'm safe, quite happy here", and, "Yes, I do feel safe in this home." Relatives also told us they felt their loved ones were safe and staff responded well to their needs. One relative commented, "I have no concerns about the care my relative gets here. The staff are all very good."

This inspection was partly prompted by an incident which had some impact on people using the service and this indicated a potential concern about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks. We saw the provider had an up to date risk management policy and procedure in place which aimed to explain and to give practical guidance to staff on the identification and management of risk including actions taken to minimise risks to people due to some behaviours that may challenge the service.

Staff were knowledgeable about the people they supported and told us they received training that enabled them to safely manage risks and behaviours. One member of staff said, "Training we have is good. For example it helps us to manage people's behaviour by using techniques to calm them if they become anxious. Staff know people really well here and how best to help them so we are very aware of all the risks." We observed a member of staff supporting one person who presented with some behaviour that required a response. We saw they were aware of the person's behavioural care plan and the potential triggers that may cause changes in the person's behaviour. We saw that the member of staff used de-escalation and defusion techniques to manage situations in the safest and least restrictive way.

Risks to people were identified and assessed and plans were put into place to ensure the safe management of risks. Risk assessments evaluated levels of risk to people in areas such as, mobility, physical and mental health, medicines, personal care, nutrition and hydration and behaviour amongst others. Risk assessments we reviewed included guidance for staff on how areas of risk should be managed safely. For example, we saw that one person was assessed as being at high risk of falls. We saw clear appropriate guidance documented for staff on how best to support the person to mobilise safely whilst maintaining and promoting their independence. This included detailed information on the person's routines, equipment required to promote safe mobility, effective communication methods and details of the person's physical condition which impacted on their ability to mobilise safely. Staff were aware of the areas in which people were at risk and knew what action to take to manage them safely whilst reducing the risk of reoccurrence.

Accidents and incidents were recorded, managed and monitored to assist staff in reducing the risk of reoccurrence. We looked at the provider's accident and incident folder and found that accidents and incidents were referred to local authorities and the CQC when appropriate. Staff took prompt actions to identify concerns and to refer to health and social care professionals when required. For example we saw that several accidents suffered by one person and been identified by the provider as a risk and action was taken to seek external health professionals intervention. Accident and incident information was also reviewed by the provider's management team to ensure appropriate actions had been taken and to improve

the safety of the service that people received.

There were systems and policies and procedures in place to protect people from possible abuse and harm. Policies and procedures provided guidance to staff on the processes to follow to protect people from the risk of abuse. These were reviewed by the provider to ensure they were reflective of current safeguarding and whistleblowing practice. Records showed that staff received safeguarding training to ensure they were aware of the appropriate actions to take if they had any concerns. Staff demonstrated a good understanding of their safeguarding responsibilities. One member of staff told us, "We receive regular safeguarding training here. We are all aware of how to manage any concerns and I feel very confident that action would be taken to protect people if needed. I am also aware of the provider's whistleblowing procedure and would use it if I needed to."

Safeguarding records we looked at included local and regional safeguarding policies and procedures, reporting forms and contact information for local authorities to assist in managing any concerns if required. We saw that safeguarding referrals were appropriately made to local authorities when required and information for people was displayed within the home for their reference. We spoke with the provider's chief executive who told us they were in the process of introducing a safeguarding lead for the home and were developing further safeguarding roles within various staff disciplines. They told us they hoped this would further develop and enhance staff knowledge and practice.

People and their relatives told us they received their medicines as prescribed by health care professionals. One person said, "I get my tablets regular as clock work. The staff are very good at that." Another person commented, "The nurse always gives me my tablets when I need them." A relative commented, "I have visited when the nurse does the medicines so I know my relative gets them when they should. I've never had any concerns about that."

Arrangements were in place to manage medicines safely. Medicines were stored securely. Nurses and senior care staff used a hand held computer to access the provider's electronic system for medicines administration records (EMAR). The system prompted staff to support people with their medicines at the correct time, and to make sure medicines continued to be stored securely. Where people had medicines to be taken "as required" the EMAR had information about the prescribed dosage and issued a warning if sufficient time had passed since the last dose. If the person did not require, for example, an analgesic, then this had to be noted on the EMAR as offered and refused. This meant that people's discomfort and pain levels were regularly monitored and maintained.

Suitable arrangements were in place for medicines which needed to be kept refrigerated. Fridge temperatures were recorded daily to ensure medicines were fit for use and we saw they were within the correct temperature range and there were no gaps in recordings. Controlled drugs (CD) were stored and managed safely. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. We saw that there were always two signatures when a CD was administered as per requirements. We counted a variety of medicines and confirmed the stock balances were well managed.

Staff told us the EMAR system had reduced errors and made it easier to find information and to audit and check that medicines were administered as prescribed. Once received, medicines were scanned which automatically uploaded information such as dose and frequency to the person's EMAR. However, whilst we were told there were two people on covert medicines, these details were not added to the EMAR. Covert administration of medicines is the administration of any medical treatment in disguised form. This usually involves disguising medicines by administering them in food and drink. As a result, the person is

unknowingly taking medicines. The decision to administer medicine in this way is considered under the Mental Capacity Act 2005, and a best interest's decision is made. Whilst the staff member we spoke with acknowledged that the relevant information was not on the EMAR, they were able to tell us how and why the medicine was administered covertly and records we looked at confirmed this. We found there was a third person who should have been on covert medication, but their medicine was not administered in this way. The decision to adapt a covert method was made in August 2017 but not shared with the wider staff group and not added to the EMAR. We discussed these matters with the manager and the provider's chief executive officer. People's EMARS were amended by the end of our inspection and we saw that no harm was done to any person and they received their medicines as prescribed. We also saw that correct processes were followed in keeping with the Mental Capacity Act 2005 as best interest's decisions in relation to covert medicines administration were taken in consultation with a GP, pharmacist and nurse.

People and their relatives told us they thought there were enough staff deployed throughout the home to meet their needs. One person said, "There are enough staff but they are a bit busy in the mornings." Another person said, "The response to calls for help is generally quick." A third person commented, "Generally there are enough staff and there is little staff turnover." A fourth person told us, "They do respond when I need help and staff numbers are consistent." There were sufficient staff on duty to keep people safe and free from harm during our inspection and rotas confirmed that this was the usual practice. As a nursing home the service employed nurses, care staff and an activities coordinator. There were also kitchen, housekeeping, maintenance and administration staff. Staff told us that they felt there were enough staff working at the home to ensure people's needs were met. One member of staff told us, "Staffing levels, I think they are okay. If someone goes off sick we have a good team here, and always help each other out so it's not a problem." Another staff member commented, "I think the staffing is adequate. I don't usually feel stressed." We saw that staff rotas were planned four weeks in advance and on examination showed the staffing levels reflected what we had seen on the day of our inspection and what we had been told about the planned staffing levels. This meant there were suitable numbers of skilled staff to meet people's needs at any given time.

There were safe recruitment practices in place and appropriate recruitment checks were conducted before staff started work to ensure they were suitable to be employed in a social care environment. Staff files contained completed application forms, previous employment history, identification and right to work in the UK where applicable, and criminal records checks to ensure staff were of good character and suitable for the roles they were applying for. Records relating to nursing staff were maintained and included their up to date PIN which confirmed their professional registration with the Nursing and Midwifery Council.

There were systems, policies and procedures in place to protect people from the risk of infections, to deal with emergencies and to maintain the home environment. Alcohol gel dispensers were available throughout the home to protect people from unnecessary infections. We observed domestic staff cleaning the home using colour coded mop heads to prevent cross infection and cleaning products were stored appropriately in locked cupboards. The safe management of linen and laundry was maintained to minimise any risk of infection. We saw there were fire alarm tests carried out every week and the provider carried out six unannounced fire drills per year and scheduled such that different shifts were covered both night and day. Water temperatures were tested on a regular basis to ensure they were within the recommended temperature ranges to prevent scalding and Legionella tests were contacted to ensure the water was safe to use. Portable equipment and gas appliances were safety tested and a fire safety assessment was carried out in June 2017.

Good

Is the service effective?

Our findings

People and relatives told us they felt staff had appropriate skills and experience to meet their needs. One person said, "They know what I need." Another person commented, "Staff are very good. They all know me and what everyone here needs; I think they are very well trained." A relative commented, "They know how to look after my relative." A second relative said, "They know their stuff. I see them working with people whenever I visit and they know everyone so well."

The provider had robust systems in place to ensure staff new to the home were provided with an induction into the service in line with the Care Certificate. The Care Certificate sets out learning outcomes, competencies and standards of care that are expected of all new social care workers. Staff induction included a period of offsite training for one week intensive induction before returning, shadowing experienced members of staff and completing training the provider considered mandatory. The provider's induction mandatory training included moving and positioning, support with eating, safeguarding and basic life support. Staff confirmed that they had received an induction and training when they started and records we looked at confirmed this.

Staff spoke positively about the training they received. One member of staff said, "Training we have is very good. It covers all different areas and is appropriate for the people we support." Another member of staff commented, "Training is very organised and we have regular updates. I always find the training we have informative." The provider had recently changed the in-house style of training from predominantly e-learning to face to face training. Staff told us this was a much more effective way to learn with one person commenting, "We can share our work experiences and learn from each other." The change of system meant that the mandatory training completion level in October 2017 was at 82 per cent instead of the provider's expectation of 100 per cent but the provider's training administrator told us this would soon be reached.

The training administrator had developed a robust system to ensure that courses were booked and staff rotas allowed for members of staff to attend mandatory training. We saw that staff were e-mailed with details of the courses they were booked on to ensuring training was kept up to date. We noted that wound care and Mental Capacity Act 2005 training had recently taken place and there were future dates for these to be rerun to enable all staff to attend. Mandatory training for all staff included manual handling, infection control, equality and diversity, health and safety, safeguarding adults, end of life, nutrition and hydration, dignity in care, basic first aid and fire safety. Training also included other appropriate areas such as pain management, dementia care, loss, death and bereavement training; as well as wound and skin tears, falls prevention, hydration awareness and pressure ulcer training. This meant that staff had the skills required to meet the needs of people they supported.

Staff records showed that most staff received supervision and appraisals on a regular basis when required. However, we noted there were five members of staff out of approximately 60 who had not received supervision since April 2017. This was acknowledged by the manager who told us that staff supervision was of paramount importance in order to ensure all staff were able to deliver good care and that this would be addressed. It was their intention to initiate a robust supervision programme in keeping with the provider's

supervision policy which was updated in September 2017. This stated that "all staff will be provided with formal supervision at least six times a year, with the agenda covering all aspects of practice; philosophy of care of the service and career development needs." It also stated that one to one supervision could be supplemented by group or team supervision meetings. The manager told us that nursing and senior care staff were being supported to undertake supervision responsibilities. To equip them for this, they received training from an external trainer on how to supervise, support, lead and manage staff. One member of staff told us they had almost completed their training on how to supervise. They said they were excited at the prospect of supervising staff and valued the opportunity for career development which it gave them. Staff told us supervision sessions included the opportunity to request training and discuss career progression. One member of staff told us they requested training that meant they could assist nursing staff when they were taking blood and had recently completed this training.

Staff were aware of the importance of obtaining consent and told us that they sought consent from people when offering them support and respected their wishes. One staff member said, "I make sure residents take part in all decisions; no matter how small. I like to consult and wait for their answer." People and their relatives told us that staff always sought their consent and respected their choices and wishes. One person commented, "It is normal for staff to gain consent before doing something." Another person told us, "Staff do gain consent before doing tasks." A relative commented, "They do ask my relatives consent when dealing with them."

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 so that they can 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.

Care plans showed that where people lacked capacity to make specific decisions for themselves, mental capacity assessments were conducted and decisions were made in their best interests, in line with the requirements of the MCA. We saw that applications had been made to local authorities to deprive people of their liberty where this was assessed as required. Where these applications had been authorised we saw that the appropriate documentation was in place and kept under review and any conditions of authorisations were appropriately followed by staff.

Assessments of people's needs were completed upon their admission to the home to ensure staff and the home environment could meet their needs safely and appropriately. Assessments took into account and reflected people's daily needs, choices and preferences and incorporated a range of areas including people's physical and mental health, nutrition and hydration, recreation and activities, personal care requirements, consent, resident's rights and communication needs amongst others.

We saw that people's diverse needs, independence and human rights were assessed, recorded, promoted and respected by staff. For example one member of staff told us of the work they were doing to ensure effective communication with one person who had reverted back to speaking in their native tongue due to their physical ill health. They said, "I am trying to get a volunteer French speaker to spend time with the person. They have lost the ability to communicate in English, so I am seeking help from an agency. Some staff here can speak French which is good and we do also communicate using other methods."

People and their relatives told us they thought the meals on offer at the home were good and there were sufficient amounts of food and drink supplied throughout the day to meet their needs. Comments included, "The food is very good, there's always a choice", "Portions are big enough and the food is always hot", "We get tea and coffee in the mornings and afternoons", "I enjoy the food here, I usually eat everything", and, "I think the meals are nice. They always ask what we would like to eat." Relatives commented, "The meals seem good, reasonable choices and portions are OK", "Staff cut up meat for those who need it", "There is always a drink available", "Mum likes the food", and, "He likes the food here, he eats everything."

We observed the lunchtime meal in the dining room on two units of the home. We noted that people were free to eat their meals where they wished, for example in the dining rooms, in their rooms or in communal areas and we saw staff respected this. The atmosphere in the dining areas was relaxed and friendly and there were enough staff on hand to support people promptly where required. Staff communicated effectively with people about the choices on offer and used sample plates to support people in making their choice of meal. We observed staff supported people with their meals on a one to one basis where required, giving people time and support to eat their meal at their own pace. People's independence at mealtimes was promoted through the use of dining equipment such as adaptive cutlery. Care plans demonstrated that people's needs were assessed with regard to their nutritional requirements, and where risks had been identified staff sought the involvement of healthcare professionals such as dietitians or speech and language therapist to meet their needs appropriately.

People and their relatives told us they were supported to maintain good health and had access to health and social care professionals when required. Comments included, "They organise the chiropodist, hairdresser and physio", "The doctor visits two or three times a week and you can see who is due in", "All medical services are provided, if needed", "The GP serves most residents here", "We do get appointments and they arrange transport and accompany you to the appointment", and, "The GP comes in regularly and can be asked to see me." Care plans and records confirmed that people had access to a range of health and social care services when needed, including GP's, speech and language therapist, dentists, chiropodists and opticians. Records of people's appointments with health and social care professionals were maintained by staff to ensure they were aware of people's on going needs.

Good

Is the service caring?

Our findings

People and their relatives told us they were involved in making decisions about their care and support and staff communication was good. One person said, "Yes I feel involved, staff always speak with me and ask for my views." Another person said, "Staff communication with me is good." A visiting relative commented, "The home gets in touch with me if I need to know anything about mum." Another relative said, "Yes, I am involved with the planning of my relative's care and they do communicate with us as a family if there are any issues."

Staff had good knowledge of the people they supported including their preferences and they were aware of people's communication needs. For example, we saw that for people whose first language wasn't English staff used a variety of communication methods including written words and pictures, family members to interpret, staff that spoke a variety of languages and independent advocates where appropriate. We also saw that for one person whose first language was not English, their favourite reading material was purchased in their language of choice. We noted that information was available to people on the use of advocacy services should this be required. Staff were also aware of the importance of keeping records and information about people confidential. We saw that care plans and records were kept securely in staff offices throughout the home and when staff were not present, office doors were locked to maintain security and confidentiality.

People and their relatives told us staff treated them respectfully, maintained their dignity and respected their privacy. One person said, "Staff are very respectful to me and everyone here." Another person said, "Yes they do respect me, particularly if they are helping me with personal care." A relative commented, "Staff do help to maintain people's dignity. I have seen this when I visit and by the way staff speak with people." Staff gave us examples of how they maintained people's dignity and privacy. One member of staff told us, "If I am helping someone with their personal care I always make sure the door is closed and speak with the person so they are aware of the support I am offering. I always make sure they are comfortable with what I am doing and in agreement." During the course of our inspection we observed staff speaking with people and their relatives in a friendly and respectful manner and knocking on people's doors and waiting for their consent before entering.

Comments from people and their relatives about the care and support they received from staff were largely positive. Comments included, "Staff are extremely caring, they go over the top to help you", "The carers are lovely", "Staff are always friendly to me, they are very helpful", and, "I find some staff are more caring than others but they are all nice." Comments from relatives were also positive. "The way staff approach people has improved", "Staff seem caring with all of them", "The staff are very nice", "The staff are kind, actually they are very good", and, "The staff are good with my relative and very friendly towards all residents and visitors."

During our inspection we observed positive interactions between staff and people using the service. We saw that staff were attentive to people's needs and requests and regularly checked on people's well-being. We also noted staff were prompt to offer support and reassurance to people when they showed signs of anxiety or distress and were skilled in approaching people and supporting them in times of confusion.

Good

Is the service responsive?

Our findings

People told us they received care and support that met their needs and preferences and they were involved in the planning and reviewing of their care. One person said, "I definitely get the care I need and if I can't get it from one carer, they will call an extra one." Another person told us, "I am aware of my care plan and my family see it." A third person commented, "I get all the care I need. The staff are great and know what I need help with, it's all in my care plan."

Care plans were developed with people, and their relatives where appropriate, based on their assessment of needs to ensure staff continued to meet people's needs. Care plans documented the support people required in a range of areas relevant to their daily lives and choices. Areas included physical and mental health, personal care, mobility, nutrition and hydration, communication, medicines, recreation and activities, religion and language, advance end of life care planning and last wishes and residents rights amongst others. People's care needs were also identified and documented from their life histories, likes and dislikes, and the things that were important to them. We noted that some people's rooms displayed information on their life stories to enhance reminiscence and also to support staff in their knowledge of people's care and support needs. One member of staff said, "It's very important when supporting someone that you try and get to know all about them. This helps us to provide good care."

Staff told us care plans were reviewed on a regular basis, to ensure they remained reflective of people's current needs. Staff were aware to be observant for any signs and changes in people's physical and mental health, and knew how to report and record any changes to ensure care plans and risk assessments were updated accordingly on the provider's electronic care plan system. Care plans and records we looked at were reviewed on a regular basis where required, however we did note that not all sections of people's care plans were reviewed at the same time. We spoke with the provider's chief executive officer and home manager who told us and showed us the newly implemented plan to ensure care plans and records were reviewed in their entirety on a regular basis. They told us they were in the process of introducing a 'resident of the day' system whereby one person's care plans and records would be completely reviewed every day. We will check on the progress of this when we next inspect the service.

People's diverse needs and independence were promoted and respected. We saw that where required people had access to equipment that enabled greater independence and promoted dignity, for example walking frames, hoists, wheelchairs and electronic bathing equipment. Care plans contained guidance for staff on the use of specialist equipment and we saw equipment was subject to routine servicing when required. Staff received equality and diversity training as mandatory to ensure people's needs could be met and staff told us that they felt the provider was committed to providing support which met people's needs with regards to their race, religion, sexual orientation, disability and gender. Care plans and records showed spiritual support was available to people in the home including regular visits from a priest for those who wished to speak with them. We noted there were also faith groups for people to attend if they chose to. One person told us, "A church minister visits me every two weeks." Another person commented, "My religion is important to me and staff respect that."

People received effective and responsive support and care at the end of their lives. Care plans documented discussions held with individuals and their relatives where appropriate, about their advanced care plan and end of life care wishes and needs. Advanced care plans included people's wishes in relation to advanced decisions such as DNAR forms (do not attempt resuscitation advanced directives), preferred priorities for care which included information on people's final hours and choice of funeral arrangements and any outcomes or further wishes such as LPA's (lasting power of attorney). The home was awarded the GSF (Gold Standards Framework) platinum re-accreditation award for end of life care, which was valid for three years from March 2017. The Gold Standards Framework is a national accreditation recognised for the provision of end of life care. We saw a plaque was displayed in the reception area displaying staff achievement in maintaining the platinum award which the provider's chief executive officer told us they were very proud of.

People were supported to maintain relationships that were important to them. One person told us, "My family visit me all the time. They can come when they want and the staff make them tea." A visiting relative told us, "I visit several times a week and I'm always made to feel welcome. Staff are very friendly and offer drinks and snacks. I also join in with the activities sometimes." During the course of our inspection we observed relatives, friends and professionals visiting the service with no restrictions placed upon them. We saw that staff were friendly and welcoming on arrival.

A range of activities were offered to people within the home if they chose to take part, to support their need for social interaction and stimulation. People and their relatives told us they enjoyed the activities on offer at the home, comments included, "We have quizzes, piano recitals and entertainers come in", "The programme of activities seems to suit most", "She does take part in activities if she can, she likes the musical items", "They do themed events, like meals", "The activities and entertainment are good, I'd say the programme gets nine out of twelve", "The activities co-ordinator is amazing", "The programme of activities is varied and Mum likes some of them", and, "There is a good programme of entertainment."

The activities coordinator offered a schedule of activities for 30 hours per week, Monday to Friday and supported care staff to carry out activities on Saturdays and Sundays by suggesting activities and setting out the relevant equipment in advance. An activities time table was posted around the home for people's information and activities on offer were varied and matched the timetable on the day of our inspection. The home celebrated special days such as fireworks night, Remembrance Sunday, Christmas and Easter. We saw that people who were restricted to their rooms due to ill health had one to one sessions with the coordinator; this included reading together, pampering or listening to music. The activities coordinator told us they ensured as far as possible that those who were restricted to their rooms did not miss out on some form of activity and stimulation. People were helped and encouraged to stay involved with previous friends and interests. Local school children and Brownie packs visited the home to spend time with people and to perform or sing, including Christmas carols. The Glebe Court Friends group funded a music therapist who visited on a regular basis and worked with groups of people and on a one to one basis. There was also a well-established volunteer group of people who visited the home to work with people and which included musicians, befrienders, and those who shared their hobby of painting or music.

The provider had a complaints policy and procedure in place which was included in the residents' guide when people moved into the home. We noted that the complaints policy and procedure was also displayed throughout the home for people and visitors to refer. The procedure included information on what people or their relatives could expect if they raised any concerns, including details of the timescale in which they could expect a response, and the action they could take, if they remained unhappy with the outcome. Complaints records we looked at showed that when complaints were received these were responded to appropriately and in line with the provider's policy to ensure the best outcomes for people. People and their relatives told us they were aware of how to raise a concern and felt confident their concerns would be

listened to. One person told us, "I've never complained, but would if I had to." A relative commented, "I have no complaints but if I did I know it would be dealt with."

Good

Is the service well-led?

Our findings

The home's long standing registered manager had recently left the service and the provider organisation's CEO (chief executive officer) was based at the home managing the day to day running of the service in their absence. A new home manager had been appointed by the provider before our inspection and they were in the process of applying to the CQC to become the registered manager for the service. They were an experienced home manager and were knowledgeable about the requirements of a registered manager and their responsibilities with regard to the Health and Social Care Act 2014. Notifications were submitted to the CQC as required and the CEO and newly appointed manager demonstrated good knowledge of the needs of the people using the service and the needs of the staffing team. Throughout our inspection the CEO and manager were visible within the home and people, their relatives and staff commented that the CEO was responsible for a great improvement within the service in recent months.

People and their relatives were complimentary about the management of the home, the CEO, the newly appointed manager and staff and told us they were very friendly, approachable and they listened. Comments included, "There is an open culture here. The management is open to queries", "You can approach the management", "I feel comfortable about approaching the management about anything at all", "The management is a listening one", "Management do listen and take on board any suggestions", "There is a new manager who seems pleasant and on the ball", "The manager and executive are listeners, they are good", "The CEO has had a positive effect on the running of this home", "The management is very good, they will always try to get what you need", and, "The CEO has been terrific with my relative and has made changes for the better."

Staff were positive about the culture of the home and its purpose to provide good quality care and told us that they felt they were included in making decisions. One member of staff said, "There have been changes in management recently but it's all been for the better. We are a good team of staff that are committed in ensuring people get good care." Another member of staff commented, "We have meetings on a regular basis where we can share our thoughts and ideas to help make the home better for people. I feel listened to and changes are made as a result." Staff also told us they were encouraged and supported by management to develop professionally. One member of staff said, "I have been told to set my sights high and I really think I will be supported to grow and develop in my career."

We saw there were effective lines of communication within the home providing staff with the opportunity to meet and communicate on a regular basis. Records showed that the CEO and manager held regular meetings with staff to discuss the running of the service. We observed a daily handover meeting held in which discussions around people's needs and conditions took place and how best staff could meet and manage them. Minutes of other staff meetings held showed that topics discussed included care plans and records, staff training, safeguarding and managing behaviours. Management records also demonstrated the home had good links with community based health and social care professionals, in order to promote people's safety and well-being and connections that had been made with people within the local community many of whom were involved in events to raise funds for the service. There were also regular volunteers who regularly supported and facilitated entertainment and activities within the home.

There were systems in place to ensure the provider sought the views of people using the service and their relatives on the service they received through regular residents and relatives meetings, annual surveys and by inviting people to submit feedback through the use of a comments box located within the reception area. People and their relatives told us they felt listened to and were provided with opportunities to give feedback on the service. One person told us, "They are always asking if I'm ok and if there is anything I want to change." Another person said, "Every couple of months there is a meeting for residents and relatives." A relative told us, "There are meetings for residents and relatives which I try to attend. It's good because I feel management do listen as there have been changes." Another relative commented, "Management did get things changed when I complained a while ago, so they do listen."

We looked at the results for the relative's' survey that was conducted in September 2016. Although an action plan had not been implemented as the registered manager had left the service, we saw that results from the survey were largely positive. 100 percent of respondents felt that staff treated their relatives kindly and respectfully, 100 percent said they were made to feel welcome and 100 percent said their comments and complaints were listened to and taken seriously. The CEO told us that a residents' survey was currently being conducted for 2017 and results would be analysed and shared once received. We also saw that a restaurant survey had been conducted in September 2017 with feedback gained from both residents and their relatives. We noted an action plan was implemented as a result and changes to menus were implemented as requested by people. For example people said there was too much food served in the evenings and portion sizes had been reduced as a result. The provider also sought feedback from staff to help drive improvements and we saw results from the staff survey conducted in September 2016. Results showed that 97 percent of respondents felt satisfied with their job, 89 percent understood the systems in place for monitoring the quality of care and 93 percent received an induction and training when they started working at the home.

The provider recognised the importance of regularly monitoring the quality of the service and there were systems in place to do this effectively. Records showed that regular checks and audits were conducted in a range of areas, including care plans and records, health and safety, infection control, medicines, accidents and incidents, safeguarding, staff records and training and checks on equipment and the homes environment. For example where people required the use of pressure relieving equipment, we saw correct pressure settings were identified and recorded, and these were checked by staff to ensure they were maintained correctly. We also saw other actions were taken to address any issues identified as a result of audits undertaken, for example, a recent staff audit identified the completion rate of staff training required further action which we saw had been taken and addressed by the provider.