Glenholme Healthcare Limited

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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

We inspected Glenholme Healthcare Ltd on 10 October 2017.This was an unannounced inspection. At our previous inspection on 8 September 2015 the service was rated as good.

Glenholme Healthcare Ltd provides accommodation and care to up to 18 people with mental health needs. The home is made up of two adjoining houses Glenhome and Oakdean providing nine beds in each, with accessible office accommodation for staff on the ground floor. The care home is part of the Glenholme Health Care Group that provides the following range of services: Recovery and rehabilitation services for men with a history of Enduring mental illness, offending behaviour and substance misuse, and Recovery and rehabilitation for men and women with a history of enduring mental illness, Learning disability, and Asperger's syndrome On the day of our visit there were 15 people living in the home.

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

People told us they were very happy with the care and support they received. Staff working at the home demonstrated a good knowledge of people's care needs, significant people and events in their lives, and their daily routines and preferences.

Staff told us they enjoyed working in the home and spoke positively about the culture and management of the service. Staff told us that they were encouraged to openly discuss any issues and had been supported with promotion opportunities within the service. Staff described management as supportive and confirmed they were able to raise issues and make suggestions about the way the service was provided.

The managers of the service provided good leadership and people using the service and staff told us they promoted high standards of care.

The service was safe and there were appropriate safeguards in place to help protect the people who lived there. People were able to make choices about the way in which they were supported and staff listened to them and knew their needs well. Staff had the training and support they needed. There was evidence that staff and managers at the home had been involved in reviewing and monitoring the quality of the service to drive improvement.

Recruitment practices were safe and relevant checks had been completed before staff worked at the home. People's medicines were managed appropriately so they received them safely.

There were sufficient numbers of suitably qualified, skilled and experienced staff to care for the number of people with complex needs in the home.

The service was meeting the requirements of the Deprivation of Liberty Safeguards(DoLS). Appropriate mental capacity assessments and best interests decisions had been undertaken by relevant professionals. This ensured that any decisions were made in accordance with the Mental Capacity Act, DoLS and associated Codes of Practice.

Staff were caring and always ensured they treated people with dignity and respect.

People participated in a range of different social activities and were supported to attend health appointments. They also participated in shopping for the home and their own needs and were supported to maintain a healthy diet.

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 remains safe.	**Good**
Is the service effective? The service remains effective.	**Good**
Is the service caring? The service remains caring.	**Good**
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service remains well-led	**Good**

Glenholme Healthcare Limited

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 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.

We inspected Glenholme Healthcare Ltd on 10 October 2017. This was an unannounced inspection. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the home which included statutory notifications and safeguarding alerts.

We spoke with eight people who use the service. We also spoke with the registered manager, a deputy manager, the 'community builder' and two support staff.

During our inspection we observed how staff supported and interacted with people who use the service. We also looked at a range of records, including six people's care records, staff duty rosters, four staff files, a range of audits, the complaints log, minutes of various meetings, staff training records and medicine administration records for all the people using the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. Comments included "I do feel safe because the staff take good care of us" and "I am making so much progress. I do feel safe."

Staff were trained in, understood and followed appropriate safeguarding policies and procedures. They understood how to raise a safeguarding concern and were aware of the local authority protocols. We were told that the safeguarding policy was made more streamlined and each member of staff was required to sign it as soon as they had read it. Staff explained their understanding of what constitutes abuse and the action to take if observed. Their response was in line with the provider's policies and procedures. Staff told us they had received induction and mandatory refresher training in these areas. Training records confirmed that all safeguarding training was up to date. Staff told us the safety of those who used the service was a "fundamental part of our work" and "a major part of our work is to anticipate problems and act as swiftly as possible so that no harm comes to our service users."

People told us there were enough staff available to meet their needs. One person told us "I think we have enough staff. I would like to see less staff so we can get more funding."

Staff told us that staffing levels fluctuated from time to time. This impacted on the current staff team as they covered any shift shortages. Agency staff were not used since the service user group needs were too complex to introduce an unknown member of staff into. Staff told us service user safety was never compromised.

During the course of our inspection, we observed how at no time staff appeared to be under pressure whilst performing their role. There was a calm atmosphere in the home and those who used the service received staff attention in a timely manner.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw that people's risks were identified in respect of their mental health. Indicators of deterioration in people's mental health were set out in people's files and we saw that staff were monitoring the signs. Where concerns were identified staff told us that action was taken swiftly including liaison with health and social care professionals. Risk assessments formed part of the person's agreed care plan and covered risks that staff needed to be aware of to help keep people safe. Staff showed an understanding of the risks people faced. People's care plans contained risk assessments that enabled them to take risks that were acceptable to them and encouraged them to be as independent as possible. There were risk assessments for aspects of people's daily living. For example, where one person smoked in their room, there were clear guidelines for staff about how to minimise related risks. The risk assessments were reviewed regularly, adjusted when people's needs and interests changed, and contributed to by those who used the service and staff. We were told that risk assessments were drawn up in such a way as to minimise control and promote freedom of choice.

Medicines were administered safely. People had regular reviews with their GP to make sure their needs were

met by the medicines prescribed. Medicine kept by the home was monitored at each shift handover. We saw there were audits each month and actions taken to address any identified issues. For example, one audit identified a number of times when the signature of the dispensing staff member was missing. This matter was raised in a team meeting and addressed individually with the members of staff. Staff we spoke with were aware that this was identified as a problem and said it was discussed at a team meeting. Subsequent audits noted that there was no further recurrence of this problem. A recent audit by the supplying pharmacist did not identify any issues or matters of concern. We saw that the temperature of the medicines fridge was recorded on a daily basis and was consistently within the accepted safety range.

Medicines were safely stored in a locked facility and appropriately disposed of if no longer required. Medicines were obtained in a timely way so that people did not run out of them; they were stored safely, and administered on time. The medicine records for all people using the service were fully completed and up to date. Protocols were in place for 'as required' [PRN] medicines and we saw that these were regularly reviewed. PRN medicines such as analgesics for pain relief were given only occasionally and not on a consistent basis. We saw that the PRN record included reasons for taking the medicine. We saw that all staff had received appropriate medicine training that was mandatory and regularly updated. We were told that staff did not administer medicines until they have completed their induction training, an on-line course in medicines administration and a written assessment, overseen by a senior carer. A senior carer told us "This is a good system; it is too important to rush and well-trained staff means there are fewer mistakes made." The deputy manager told us that it could take six months before a member of staff was deemed competent and confident to administer medication. Support workers supported most people who used the service with their medicines. Two people retained their own and were responsible for taking it. One person consented to showing us how they stored their medicines which were kept in a locked cupboard in their room and they retained the key. They told us there was also a key in the office should staff need to access the cupboard for any reason. They told us part of the agreement for them to be self-medicating was the understanding that staff would do random checks to ensure compliance with medicating. We subsequently saw there was a risk assessment in relation to their self-medication, which outlined how staff could support the person if they requested it. It also identified changes in behaviour for staff to be aware of which could be an indicator that the person was not taking their medication and what resultant actions were to be taken.

Appropriate recruitment practices were in place. All of the relevant checks had been completed before staff began work, including Disclosure and Barring Service checks, previous conduct where staff had been employed in adult social care, and a full employment history.

Good

Is the service effective?

Our findings

People were supported by staff with appropriate skills and experience. Staff told us they received training and support to help them carry out their work role. Staff received induction and mandatory training that was comprehensive and included core training aspects such as safeguarding, infection control, basic life support, conflict management, mental health awareness, food hygiene, equality and diversity and the person centred approach. It also provided information about staff roles, responsibilities, the home and organisation's expectations of staff and the support they could expect to receive. An independent consultant delivered specialist training on drugs and alcohol. The provider was in the process of changing over to a new training system and the most recent compliance level with this was 56%. Some training was still in date under the old system and the registered manager told us it was expected that there would be 100% compliance with the new training system by May 2018. We checked training records for both systems and confirmed that between the two, all staff training was up to date. The provider expected all staff to complete the 'Care Certificate Common Standards' by December 2017.

Staff told us that they felt supported by the management team and had regular formal and informal supervision with one of the senior staff. Regular staff meetings were also taking place at the home to facilitate communication, consultation and team work within the service.

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 authorisation 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. Mandatory training for all staff included MCA and DoLS. Those staff we spoke with demonstrated a thorough knowledge of how to apply them to ensure people's human rights were respected. DoLS required the provider to submit applications to a 'Supervisory body' for authorisation. Applications under DoLS were submitted by the provider and had been or were awaiting authorisation. There was one person under DoLS; we saw that a renewal application had been recently submitted to the local authority.

People were supported to maintain good health and had access to health care support. Where there were concerns people were referred to appropriate health professionals. People also had access to a range of other health care professionals such as a nurse specialist in epilepsy, dentist, and optician. The care files included records of people's appointments with health care professionals. The registered manager told us there was good contact with the local Community Mental Health Team, whose advice was frequently sought and followed as required.

People were encouraged to cook for themselves and were supported to do so if required. The provider

supplied milk and supplies for breakfast as well as fresh fruit and vegetables and dry stocks such as rice, pasta and condiments. In addition to this people were given a weekly allowance to buy their own food, The registered manager told us, "We want people to leave here with independent living skills and being able to cook is very important." We saw that the role of 'food and nutrition champion' was advertised within the staff group and that a number of people were attending cooking classes at a local college. We saw that people had weight monitoring charts in their records to ensure they maintained a healthy weight.

Good

Is the service caring?

Our findings

People told us they were happy with the approach of staff and felt they were treated with dignity and respect. Comments included "They look after you. They help me get dressed. They give us medicine and we behave ourselves. They talk to you if you are depressed. They look after us they are lovely." and "We have freedom of choice, they do respect your privacy."

People's preferences were recorded in their care plans. The staff had discussed people's likes and dislikes with them on a regular basis so they could make sure they provided care and support which met individual needs. Staff demonstrated a good understanding of the importance of privacy and dignity.

People's personal histories were well known and understood by staff. Support workers knew people's preferences well, and what they should do to support people who may have behaviour that could cause themselves or others anxiety. Staff were able to identify possible triggers that caused people to become anxious. We observed occasions where workers noticed when people had the potential to become anxious. The staff members were able to use techniques to distract people or support them to manage their anxiety before it escalated. We observed staff interacting with people using the service throughout the day. At all times staff were polite and caring. Staff were able to tell us about people's different moods and feelings, and reacted swiftly when they identified that people needed extra support.

People using the service were able to make daily decisions about their own care and we saw that people chose how to spend their time. People told us they were able to choose what time to get up and how to spend their day. Staff told us they encouraged people to be as independent as possible. We saw that staff did as much as they could to support people to maintain contact with their family. This was done in a variety of ways, including helping them to make telephone calls and to accompany them on home visits.

The provider had recently appointed a 'Dignity Champion.' The registered manager told us the role was to ensure that people who used the service were confident their dignity was upheld. An e-learning pack was purchased to enable the appointed champion to understand how to apply their role effectively.

Good

Is the service responsive?

Our findings

People were happy with the home and the way in which they were being cared for. Care records showed that people had been consulted about the support they received, the social activities they took part in and the food they ate. We saw that their levels of satisfaction had been recorded and the staff had used these records to review and improve personalised care for each person.

People had participated in a range of different social activities individually and as a group and were supported to access local community activities .The service had recently appointed a 'community builder' who had responsibility for organising activities and establishing links with the local community. They told us that they were setting up 'community builder profiles' on each person that would identify what they enjoyed doing in and out of the community. They also told us that it was difficult to engage the male residents in the home and was looking into alternative activities such as pool competitions and paint-balling. A person using the service told us "I go to college to study English. I work voluntary with the British Heart Foundation. I go to the Comic book shop to play a strategic game of cards. Sometimes we go to visit the attractions in London, for example, two weeks ago we went to the market in Hertfordshire." People participated in shopping for the home and their own needs, and some people regularly attended individual activities that they enjoyed such as pottery, jewellery making and pamper days. Some people were also supported to go to college, to take cookery lessons and visits to family and friends. The home also had a pet cat, which people clearly enjoyed.

People's needs were assessed before they moved in. The staff told us they had access to the care records and were informed when any changes had been made to ensure people were supported with their needs in the way they had chosen. Care records included a profile sheet which recorded people's backgrounds, interests, hobbies and life skill needs. The care plans showed that people's needs were regularly reviewed and re-assessed with them and amended according to their changing needs. They were individualised, person-focused and developed by identified staff as more information became available and situations changed. They were formalised and structured and information was accessible and clearly set out. During out inspection we observed a handover session where details of how people had spent their morning were discussed. People told us the staff had discussed the care and support they wanted and knew this had been recorded in their care records. Staff were required to sign care plans as a way of ensuring their awareness and understanding of the care plan and therefore the person's needs.

Each person had an assigned keyworker who was responsible for reviewing their needs and care records. Staff told us that they kept people's relatives, or people important in their lives, updated through regular telephone calls or when they visited the service. Relatives were formally invited to care reviews and meetings with other professionals.

Indicators of deterioration in people's mental health were set out in people's files and we saw that staff were monitoring the signs from the handover meetings and daily records we looked at. Where concerns were identified staff told us that action was taken swiftly including liaison with health and social care professionals.

There was a clear complaints procedure. People we spoke with told us they knew what to do if they were unhappy about anything. Comments included "There is a comments and complaints box in the hallway. If it was an emergency I would talk to the manager if she was here or the team leader. I have made a complaint before. They resolved it."

Good

Is the service well-led?

Our findings

The service had a clear management structure including a registered manager who had been in this role since April 2017. Comments from people included "She is lovely. She is a good manager. And I feel listened to; we have a meeting once a month. I like the meetings. I like talking. I have improved and I am quite happy." and "She is all right I find her really good. I find it is run really well. Most of the time they do listen, we have a residents meeting. We can talk about anything that we want to."

During our meeting with the registered manager and our observations it was clear that she was familiar with all of the people in the home and was very 'hands on' in her interactions with the people who used the service. It was clear from the feedback we received from people who used the service, and staff, that managers of this service had developed a positive culture based on strong values. We saw that the values of the organisation, which managers reported as being central to the service, such as compassion, respect and caring, were put into practice on a day-to-day basis. The registered manager spoke of the importance of motivating and supporting staff to promote these values, through training, supervision and strong leadership. They also told us that they had introduced a number of new initiatives since our last inspection. This included the introduction of champions in 'dignity', 'nutrition' and 'equality and diversity'. The registered manager told us they tried to include people's participation in aspects of the running of the service, including interview panels and general redecoration of the premises.

Discussions with staff found they were motivated and proud of the service. A member of staff told us "I feel well supported. We are a good team and the manager always has lots of good ideas and she always involves us." We found that staff turnover was kept to minimum ensuring that continuity of care was in place for people who used the service. Staff also told us that they were supported to go for promotion and were given additional training or job shadowing opportunities when required. The registered manager told us "It's difficult to find good staff, so you must find ways to keep them." The provider had achieved Investors in People accreditation, a national standard that recognises good people management and training.

The provider sought the views of people using the service, relatives and staff in different ways. People told us that regular resident meetings were held. We saw the minutes of the last meeting where items discussed included food, health and safety, equality and diversity.

Regular audits were carried out by the registered manager covering areas such as health and safety, recruitment, care plans, complaints, medicines, and training. This ensured that the service was able to identify any shortfalls and put plans in place for improvement.

We saw there were systems in place to monitor the safety of the service and the maintenance of the building and equipment. The registered manager told us that they had access to a maintenance team and that there was no delay if repairs to the building were required.

The registered manager told us she regularly attended managers' meetings at the provider's head office and also received on-going support from the senior management team.