Glendon House Limited

Glendon House

Inspection report

2 Carr Lane
Overstrand
Cromer
Norfolk
NR27 0PS

Tel: 01263578173
Website: www.norfolkcarehome.co.uk

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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

Glendon House is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Glendon House accommodates up to 36 people, some of whom may be living with dementia, in one adapted building. At the time of our comprehensive unannounced inspection on 24 April 2018 there were 29 people living in the home.

There was 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 2008 and associated Regulations about how the service is run.

People were cared for in a compassionate way by staff who understood their care needs. People and their relatives were involved in the planning of their care and people's care records reflected their personal preferences. People's care records were reviewed regularly and updated when people's care needs changed. Assessments were carried out prior to people living in Glendon House to ascertain if the service was the most suitable for them.

Support from other professionals was sought where concerns were identified about a person's health or wellbeing needs. Information about people's healthcare needs was shared appropriately with other professionals to ensure continuity of care.

Staff supported people to be as independent as possible and people would assist staff with daily tasks in the home. Adapted equipment to aid independent eating and mobilising was provided for people.

People were cared for in a way that promoted their dignity and privacy and staff took steps to ensure that this was maintained.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. MCA assessments had been carried out and staff understood the importance of giving people choice about their care.

Risks to people and within the environment were identified and continually assessed. Staff understood how to mitigate people's individual risks and what their responsibilities were in relation to maintaining a safe environment. People's dependency was regularly assessed to inform the number of staff required to support them safely. There were consistently enough staff deployed to care for people.

People's medicines were stored, administered and managed in a safe way. Records relating to people's medicines were complete and staff had undertaken training in the safe management of medicines.

The home was clean throughout and staff observed infection control procedures. The kitchen was clean and safe food hygiene practices were in place.

Mealtimes were a relaxed and people were given a choice of meals. People's meals were prepared according to their nutritional needs. Monitoring of people's food and fluid intake was in place where people were at risk of not maintaining a healthy nutritional intake.

Staff understood what constituted abuse and what procedure they would follow to report any concerns. Staff also received training in safeguarding. Recruitment processes ensured that appropriate employment checks were carried out to ensure suitable staff were employed.

Staff received training relevant to their role and were supported to access further training to develop their knowledge and practice. There was an induction programme in place for new staff which included shadowing experienced staff and the completion of the provider's mandatory training.

There was a variety of activities provided for people to take part in and staff had enough time to engage with people to follow their interests. People were supported to maintain relationships with their family and friends. There were no restrictions about when people could have visitors and there were a number of communal rooms where people and their visitors could spend time together.

There was clear and visible leadership in place. The registered manager was approachable and visible, as was the deputy manager and area manager. Staff felt supported in their role and the morale amongst the staff was good.

There were processes in place to involve people and their relatives in the running of the home. Further improvements were planned to ensure that people's views on the service were sought and acted upon.

A range of effective quality monitoring systems were in place to monitor and assess the quality of service being delivered. Action was taken where shortfalls had been identified.

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.

Staff had received training in safeguarding and felt supported in reporting concerns.

Individual risks relating to people's health and welfare had been identified and plans put in place to manage these risks.

Risk assessments were in place for the home and these detailed how environmental risks could be managed.

There were sufficient numbers of staff to support people safely.

Safe recruitment processes were in place to ensure suitable staff were employed.

People's medicines were managed in a safe way.

Steps were taken to protect people from the risk of infection.

Accidents and incidents were recorded and reviewed regularly.

Is the service effective?

Good

The service was effective.

People's care needs were assessed prior to them living in the home.

Staff received regular supervision and undertook training relevant to their role.

People were supported to maintain a healthy nutritional intake. Timely referrals were made when concerns were raised about a person's nutritional intake.

People were able to access other healthcare professionals in relation to their health and wellbeing.

The service had been adapted to meet the needs of the people living there.

Staff understood the Mental Capacity Act 2005 and there was clear documentation to show that people's capacity had been assessed.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who were attentive to their needs.

Both people and their families were involved in the planning of their care.

People could have friends and family visit without restriction.

Staff cared for people in a way that maintained their dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People's care records were person centred and reviewed and updated on a regular basis.

People were able to access a variety of activities.

Complaints were responded to appropriately and in a timely way.

People's preferences about their end of life care were documented.

Is the service well-led?

Good

The service was well led.

The registered manager was approachable and staff felt supported in their work.

There was a positive morale amongst the staff team.

Regular meetings were in place for people and their relative to attend.

There was a range of quality monitoring processes in place to monitor and assess the quality of service being delivered.

Staff worked with other agencies and health care professionals in a collaborative and open way.	

Glendon House

Detailed findings

Background to this inspection

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

This unannounced inspection was carried out on 24 April 2018 by one inspector, a bank inspector 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 the inspection, we asked the provider to complete a Provider Information Return (PIR). 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 looked at information we held about the service, including statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we spoke with five people who lived in the home, one person's relative and two people's visitors. Some people were not able to tell us about the care they received so we made observations of the care and support people received at the service throughout the day. We also spoke with the registered manager, the area manager, the deputy manager, three members of care staff and the cook.

We reviewed three people's care records and medicine administration record (MAR) charts. We looked at three staff recruitment files as well as training, induction and supervision records. We also viewed a range of monitoring reports and audits undertaken by the registered manager.

Good

Is the service safe?

Our findings

The service was safe. All of the people we spoke with told us that they felt safe living in the home. One person commented, "I do feel very safe here, the staff couldn't be more caring." A second person told us, "I certainly feel safe and cared for…The carers are very good."

Staff knew the different types of abuse and knew how to report any concerns and to whom. One member of staff told us that they had to report a safeguarding concern. They added that they were supported by the area manager to do this and that appropriate action was taken. All of the staff we spoke with told us that they had received training in safeguarding. Training records we looked at confirmed that staff had attended this training.

Individual risks to people had been identified. There were risk assessments in people's care records which provided staff with detailed guidance about how to manage known risks. People were consulted in relation to their risk assessments. For example we saw that specific risks around one person's bedtime routine were adequately assessed and mitigated.

There were risk assessments in place for the home. All known environmental risks had an associated risk assessment in place which guided staff about how to mitigate risks within the home. Moving and handling equipment was serviced twice a year to make sure it was safe to use with people. Gas, electricity and water supplies were routinely inspected to ensure they were safe. Fire extinguishers and fire alarms were inspected yearly and weekly tests of the fire alarms took place. We saw that each person had a personal emergency evacuation plan in place. This plan detailed the support that each person would require to safely evacuate the building in the event of a fire.

There was consistently enough staff to support people in a safe way. People we spoke with told us that they thought there were sufficient numbers of staff. One person explained, "Yes, there do seem to be enough staff, there's always plenty here." A second person commented, "There's always someone around here, [the staff] check on me from time to time." Throughout our inspection visit we saw that call bells were responded to promptly.

People's care needs were assessed on a monthly basis by the registered manager. We looked at the dependency tool that they used to work out how many staff were required to support and care for people in a safe way. The registered manager told us that they would adjust staffing levels according to people's changing care needs to ensure that there were always enough staff on duty.

There were processes in place to ensure that suitable staff were recruited. We looked at the recruitment files for three members of staff and saw that appropriate references had been sought and that satisfactory checks from the Disclosure and Barring Service had been obtained.

People's medicines were stored, administered and managed in a safe way. We looked at a selection of people's Medicines Administration Records (MAR) and saw that these had been completed fully and

correctly. We checked the stocks of medicines for three people and noted that the number of medicines remaining corresponded with the amount on the MAR chart. We observed staff giving people their medicines and noted that there was pleasant interaction with people. People's preferences about how they liked to take their medicines was documented in the medicines folder. For example, some people liked their medicines with water and another person liked to take theirs with some yoghurt.

Staff had received training in the safe handling and administration of people's medicines. In addition to this training, a member of the management team would observe staff administering people's medicines regularly to ensure that staff maintained good practise in this area.

The home was clean throughout and staff wore disposable gloves and aprons where necessary. There were cleaning schedules in place for all areas of the home. One person we spoke with told us, "I get my room cleaned every day." We noted that the kitchen had a food hygiene rating of four and the cook told us that they had completed their food hygiene training.

Accidents and incidents were fully recorded and any subsequent action taken after an accident was documented. For example we noted that one person was falling several times a day. We saw from the person's daily notes that staff suspected that this was due to a change in their medicines and the person was referred to their GP. Accidents and incidents were regularly reviewed by both the area manager and the registered manager. This was so they could identify any patterns such as whether more people had falls at a certain time of day and take any necessary preventative action.

Good

Is the service effective?

Our findings

The service was effective. People's health and wellbeing needs were assessed prior to them moving in to Glendon House. This was so the registered manager could be assured that they could fully meet people's needs. We saw that the pre-admission assessments detailed people's physical and wellbeing needs. They also documented what medicines people were on and people's personal history.

The provider had a training programme in place for the staff. New staff completed the mandatory training set by the provider within the first few days of their employment. This training included fire awareness, infection control and safeguarding. Staff would also spend time shadowing more experienced members of staff and they were introduced to people who lived in the home.

Staff completed training relevant to their role. Training included, management of pressure ulcers, moving and handling and dementia. Staff completed their training using a variety of formats, such as face to face and online. One person's relative was positive about the training that staff received and told us, "It's ideal here for people with dementia, it's the attention the staff give them, they need a lot of patience."

Staff were supported to access further qualifications such as the Diploma in Health and Social Care. This diploma gives staff the opportunity to develop their knowledge in topics such as nutrition, communication and person centred care. One member of staff told us that they were being encouraged to apply for their level three diploma which builds on their knowledge from the level two diploma.

Staff received regular supervisions with the registered manager. Supervision is a confidential meeting that staff attend to discuss any training needs, what support they may need to carry out their job and if any personal difficulties are affecting their work. One member of staff we spoke with told us that they thought that supervision was useful for identifying their strengths and weaknesses in their role.

People we spoke with told us that they enjoyed the food served in the home. One person commented, "[The food] is beautifully served, I just can't fault it." A second person explained, "The chef is brilliant, you wouldn't get better food in a hotel." People's preferences about how they liked their meals to be served were also taken into account. One person told us, "[The staff] give me a smaller plate, I don't have a big appetite, and they remember."

We observed the lunchtime meal being served. There was a nice ambience and there was music playing in the background. Staff went around the dining room and offered people a choice of drinks. The atmosphere was calm and the food was taken out to people quickly. People were able to choose where they would like to eat and we saw one person being supported to eat their lunch in one of the lounges. We observed that staff would provide gentle encouragement to people who required support with their meals.

Prior to lunch staff members had shown people pictures of the food choices being offered for that day and there were larger photographs of the dishes displayed in the dining room. This helped people to decide what meal they would prefer. Desserts were shown plated-up to enable people to make an immediate

choice.

Where there were concerns relating to a person's nutritional intake, prompt referrals were made to the Speech and Language Therapy Team (SALT). We saw that any advice given by the SALT team was included in people's care plans. The cook told us that they were kept informed of people's dietary needs and preferences. They showed us a folder where they kept records of people's dietary requirements and how people's food should be prepared to meet their needs. One member of staff told us that people's food and fluid was monitored if they were concerned about their nutritional intake. We looked at people's food and fluid charts and saw that there were detailed and completed after every meal. We were also assured that people were supported to maintain a healthy intake of fluid. We saw people being offered drinks throughout the day and people's fluid intake was recorded.

Staff worked in collaboration with other professionals to ensure that people's care needs were met. For example, when people were admitted to hospital, staff would liaise with hospital staff to ensure that they passed on any information relating to people's care needs. Each person had a 'patient profile' record in their care records. This profile gave an overview of the person's medical history, next of kin and details of any other professionals involved in their care such as GP and social worker. The registered manager told us that this profile was given to staff at the hospital so the hospital staff could quickly familiarise themselves with the person's care needs.

People were able to quickly access their GP and other healthcare professionals if any concerns were raised about their health or wellbeing. One person told us about being supported with regular hospital appointments, they commented, "The ambulance picks me up and it works well." Other people we spoke with informed us that they saw other professionals such as the dentist, optician and chiropodist regularly.

The premises had been adapted to meet the needs of people living in the home. Each person had a personalised sign on their bedroom door. This helped people to recognise their individual private space. The gardens of the home were easily accessible and areas within the home were free from clutter and trip hazards. This meant that people could move about the home easily and in a safe way.

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 and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications to deprive people of their liberty were detailed and included why the application was being made and that the least restrictive options had been considered. Staff had received training in MCA and DoLS and understood the principles of the MCA.

Staff ensured that they sought consent from people before providing any care. Throughout our inspection visit we observed staff asking people if they would like support with anything. For example, after the lunch time meal we heard a member ask one person if they would like support to go to the lounge. Staff we spoke

with know the importance of offering choice. One staff member commented, "Don't assume anything." Another staff member explained, that if they went to assist a person with personal care, and the person did not want it, they would explain why they were wanting to give them support with their care.

Good

Is the service caring?

Our findings

The service was caring. People we spoke with told us that they felt cared for by staff. One person explained, "I like it here, they've got two cats; that always helps, they just feel warm and friendly, it's homely." A second person commented, "[The staff] are excellent, they're keen, you can see that, it lifts my spirits, very much so." Staff treated people with compassion and took opportunities to interact with people and ask if they needed anything. Staff helped people to mobilise around the home. Staff held people's hands to gently and patiently guide them to where they wanted to be.

Staff offered people choice and ensured that they were comfortable. We observed one staff member in the lounge asking one person if they were comfortable and asking another if they were warm enough. There were a number of activities being provided in the home and we heard staff asking if people would like to join in. Staff were attentive to people's care needs. One person was having their hair done by the hairdresser. We observed a member of staff asking the hairdresser not to use any hairspray as they were concerned that this was irritating the person's skin.

People and their relatives were involved in the planning of their care. One person told us that they were asked to be involved in their care planning but they told us that they did not want to contribute. They added, "I'm quite happy with everything." One person's relative told us about how they were involved in the care planning when their relative first started living in the home but they were unable to recall if they had been involved since. Staff we spoke with told us that they had enough time to spend speaking with people about their care needs and engaging them in general conversation.

Staff supported people to maintain their independence as much as possible. We saw that one person used an adapted plate so they could eat independently. Another person's food was cut up for them so they could manage to eat their meal without staff support. Some people in the home helped staff with jobs. For example, we saw one person helping staff lay the tables for the lunch time meal.

Staff communicated effectively with people according to their needs. For example we saw from one person's care plan that they preferred to be spoken with using shorter sentences. We saw that staff would speak with this person in a way that met their needs and the person was given time to respond.

People were cared for in a way that upheld their dignity and maintained their privacy. Staff were quick and discreet when supporting one person to wipe their face after eating their lunch. We saw that staff knocked on people's bedroom doors and waited for a response before entering. Staff we spoke with explained how they would maintain people's dignity when assisting them with personal care. This included ensuring doors and curtains were closed.

There were no restrictions about when people could have their relatives or friends visit. We saw that people's visitors were made to feel welcome by staff. Staff spent time talking with people's relatives and relatives would approach staff if they wanted to speak about the person they were visiting.

Good

Is the service responsive?

Our findings

The service was responsive. Many of the people who lived in the home were living with dementia. The registered manager explained to us how they tried to make people's move to Glendon House as least distressful as possible. They went on to say that staff at the service would try and arrange the lay out of their bedroom to match the one the person was used to living in, be it at home or at another service. They would encourage the person to bring personal items and furniture so they felt surrounded by familiar items.

People's care plans and risk assessments were individualised and provided clear guidance for staff about what support people needed. Regular reviews took place of people's care records and these records were updated when people's care needs changed. Staff kept detailed daily notes about how people had been throughout the day and night. These notes helped staff to continuously monitor the changing needs of people. We observed a staff handover. Staff gave clear and detailed information about how people had been and what staff coming on duty were required to follow up. For example, one person was returning from a stay in hospital and it was handed over what time they were likely to return.

People's communication needs were identified and staff used a variety of ways to communicate with people. For example, for one person, staff had developed picture cards. Staff showed the person pictures of activities so they understood what was on offer that day and they could choose what they would like to participate in.

There were a number of communal areas in the home. There was a conservatory, games room, lounge and dining room. Some areas were quieter than others, this gave people the opportunity to socialise with other people or the chance to sit somewhere quieter depending on what they wanted to do. This also meant that people were not confined to having their relatives or visitors see them in their bedroom.

People we spoke with told us about the activities they could participate in. One person commented, "They have a music appreciation thing, one of the [staff] plays music, different composers and we have a chat about it, I enjoy that." Another person explained, "[The staff] try to put all sorts of things on for us, all sorts of things, on the whole I like to join in, but I don't have to."

There was an activities coordinator who worked full time. During our inspection visit, we saw people being engaged in a number of activities. In the morning we saw the activities coordinator spending one to one time with people painting their nails and in the afternoon there was a game in the dining room. A games room which was being made to look like a pub was still in the process of being completed. On the day of our inspection we saw one member of staff playing a game of pool with one person while two people were sat watching the game. There was a fun atmosphere and everyone involved was laughing and joking with each other. A number of themed events also took place. The activities coordinator showed us pictures and items from a 1940s themed party. There was a menu which depicted pies and puddings relevant to the era and each person had a personalised placemat with a ration book design on it.

People and their relatives we spoke with told us that they felt comfortable about raising a complaint. One

person explained, "I'd go to [any member of staff], I feel totally confident here." One complaint had been received in the past year. We saw that this had been dealt with fully and in a timely manner in line with the complaints policy.

Staff working at the home sometimes cared for people who were at the end of their lives. We saw that people's preferences about their care was documented in their care records. This included what, if any, religion or faith they practised and if they did not want any life-saving treatment in the event of a cardiac arrest.

Good

Is the service well-led?

Our findings

The service was well led. People and their relatives we spoke with told us that they thought the home was well led. We were informed that both the manager and the deputy manager were a visible presence in the home. One person's relative commented, "[Registered manager] is approachable, there's no question." The visitor of one person explained, "The manager was here with the area manager asking [person's name] if they were happy with their room and they included me in the conversation." Staff we spoke with were positive about how the home was managed. One member of staff told us, "I feel as though I can go and speak to [registered manager], if she is busy, she makes me feel as though she can spare 10 minutes." Another member of staff told us that the recently appointed area manager had made, "A huge difference."

The registered manager told us that they were supported in their role by both the area manager and the providers. They added that the providers resourced the home well and felt able to approach the providers if they required anything to improve the service.

Staff reported to us that morale within the home was good and that they enjoyed their work. One member of staff commented, "Quite a positive vibe, we have got some good characters. Everyone is quite willing to help out." A second member of staff explained, "At any time I can turn to fellow carers and they will help. No 'not on my list' approach and managers will come and help as well."

The registered manager was aware of their responsibilities regarding notifying us of important events. We looked at the statutory notifications sent to us by the registered manager. A notification is information about important events, which the provider is required to send us by law. The notifications provided accounts of the incidents reported to us and we were informed of these events in a prompt manner.

Staff understood their responsibilities. The registered manager had introduced a system where staff were divided into groups for each shift. This included what their main duties were and what people they were responsible for providing care for. The care team leader also had a list of what their responsibilities were for the day and they recorded what tasks they had allocated to each member of staff. The care team leader was responsible for ensuring that these tasks were carried out.

Regular staff meetings were also held. Records of these meetings showed that issues such as staff support and staffs' responsibilities were discussed. Staff we spoke with told us that the staff meetings were useful as they felt involved in the development of the service. A second member of staff commented that they were able to raise any concerns they had in a staff meeting.

Meetings were held for people and their relatives to attend. We looked at the minutes of the most recent meeting and saw that people made suggestions about what activities and outings they would like to see provided. The discussion about how these could be facilitated was documented. Any planned changes to the service were also communicated to people through these meetings.

People's relatives were invited to complete an annual quality survey. We looked at the responses for these

and saw that a majority of the responses were positive. Where improvements had been suggested, we saw that there was a plan in place to address any concerns. There was not a quality survey in place for people who lived in the home. The registered manager informed us that they were going to introduce one and that discussion about this was scheduled for the next managers meeting.

There were robust quality monitoring procedures in place. The registered manager undertook regular audits which covered all areas of the service. These included audits of people's care records, health and safety audits and infection control. In addition to this, the area manager would check to ensure that any remedial action as a result of the audits had been completed within the specified timescale. The area manager carried out their own in depth audits. The providers made unannounced visits and reported on these. We saw from the records of these visits that they would highlight any shortfalls and what action was required to address any concerns found.

Staff at the service worked alongside other organisations to improve the quality of care delivered. This also promoted collaborative working with other professionals. The area manager told us that they attended regular meetings with the local clinical commission group. This meant that they could be kept up to date about any changes in relation to the commissioning of services and how this may impact on the people living in the home. When people moved between services, such as being admitted to hospital, there were processes in place to ensure that information about their care needs was shared with staff at the hospital. This showed that staff worked openly with other agencies.