Care @ Robertsbridge Limited

Glottenham Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 Glottenham Manor on 31 October and 1 November 2016. The inspection was unannounced. Glottenham Manor is a nursing home registered to provide accommodation and personal care for people who require nursing for a maximum of 46 people. The home specialises in providing care to older people. At the time of our visit there were 36 people living in the home. Glottenham Manor is located in a rural setting, in its own grounds, and has accommodation over two floors; many of the bedrooms are on the ground floor together with the communal areas, such as the lounges and the dining area. The first floor is accessed via stairs or a lift and some bedrooms are on the first floor. Some people had illnesses or disabilities associated with old age such as limited mobility, physical frailty or lived with health conditions such as dementia. At the time of our inspection there was not a registered manager at the home. 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. However there was an acting manager who was in the process of registering with CQC.

There was sufficient staff to provide care to people throughout the day and night. However, we found some call bells were not answered quickly enough. You can see what action we told the provider to take at the back of the full version of the report.

People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. However, we observed some inappropriate use of language, such as addressing people by their room number and not their name. We have made a recommendation about this in our report.

Care plans ensured people received the support they needed in the way they wanted. However, people's preferences and views about their care were not always recorded. We have made a recommendation about this in our report.

When staff were employed they were subject to checks to ensure they were safe to work with people in the service.

Risks to people's safety had been assessed and actions taken to protect people from the risk of harm. The provider had systems in place to protect people against abuse and harm. The provider had effective policies and procedures that gave staff guidance on how to report abuse. Staff were trained to identify the different types of abuse and knew who to report to if they had any concerns.

Medicines were managed safely and people had access to their medicines when they needed them.

Staff were well trained with the right skills and knowledge to provide people with the care and assistance they needed. Staff met together regularly and felt supported by the manager. Staff were able to meet their line manager on a one to one basis regularly.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and received support from staff where a need had been identified. People's special dietary needs were clearly documented and staff ensured these needs were met.

The staff were kind and caring and treated people with dignity and respect. Caring relationships were seen throughout the day of our inspection. Staff knew the people they cared for well. People could have visitors from family and friends whenever they wanted. People spoke positively about the care and support they received from staff members.

People had freedom of choice at the service. People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

People felt well cared for and were supported with a variety of activities.

Peoples health needs were well managed by staff so that they received the treatment and medicines they needed to ensure they remained healthy. Staff responded effectively to people's needs and people were treated with respect. Staff interacted with people very positively and people responded well to staff.

The culture of the service was open and person focused. The management team provided clear leadership to the staff team and was an active presence in the home.

Audits to monitor the quality of service were being completed. They identified actions to improve the service and these had been carried out. However, audits did not contain call bell response times. We have made a recommendation about this in our report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were protected from avoidable harm and abuse.

Risk assessments were comprehensive and reduced hazards.

The provider had ensured that there were sufficient numbers of staff in place to provide safe care. However, some call bells were not answered promptly.

Medicines were stored and managed safely.

Is the service effective?

Good

The service was effective.

Staff received training that gave them the skills and knowledge required to provide care and support to people.

Consent was being sought and the principles of the MCA complied with.

People had access to a range of food options that was nutritious and met their needs. People were supported to maintain their diets when required.

People's healthcare needs were being met with support to routine appointments and appropriate referrals.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information effectively.

People and their families were involved in their lives.

People were treated with respect and their independence was encouraged.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff responded effectively to people's needs.

Complaints were responded to appropriately

Is the service well-led?

Good

The service was well led.

The culture of the service was open, person focused and inclusive.

The management team provided clear leadership to the staff team.

Quality monitoring systems had been effective and led to change.

Glottenham Manor Care 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 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 inspection took place on 31 October and 1 November 2016 and was unannounced. 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.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed 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 spoke to the local authority quality team to gather their feedback.

As part of the inspection we spoke with the acting manager, deputy manager, maintenance manager, the cook and kitchen staff, an activities co-ordinator, two registered nurses, seven care staff, nine people using the service and six people's relatives. As some people who live at Glottenham Manor were not able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. We looked at a range of records about people's care and how the service was managed. We looked at eight people's care plans, medication administration records, risk assessments, accident and incident records, complaints records and quality audits that had been completed. We last inspected Glottenham Manor in December 2013 when we had no concerns.

Requires Improvement

Is the service safe?

Our findings

People felt safe living at Glottenham Manor, and all of the people we spoke to told us they felt safe. One person commented, "Staff help me in the morning, they get me in the hoist, then into the chair and then at night back to bed. I feel very safe when they do it, and if they are not sure they will get someone to show them." When asked whether they had used the call system the person told us, "Yes they are pretty good, they come as soon as they can, I would recommend the home to anyone, and they are all nice." Another person told us, "I used to fall and now there is someone there for me, I feel safe now."

Staff told us they had enough staff members on duty to meet peoples care needs but felt they were busy. One staff member told us, "I think we have enough staff. Some days are busier than others but we cope." Another staff member commented, "We'd normally try and get within five minutes to answer the bell and there can be a delay some mornings if we're all doing personal care. The manager notices if the bell is ringing and will ask people to answer it." One person told us, "Staff are wonderful, really caring, but I don't think there are enough of them. Sometimes [after using the call system] I have to wait for a long time: it hasn't been a disaster so far." We spoke with another person who commented that they didn't have any concerns but did say that they felt there were not enough staff at the weekends and consequently they had to wait longer for assistance. A relative told us, "X sometimes has to wait quite a while after lunch [for the call bell]." We checked rota and found that staffing levels were sufficient to keep people safe and that the staffing levels set by the manager were consistently provided. The registered provider had increased nursing staff so that there were two nurses on duty in the daytime, instead of one. Our observations showed that people were not left for long times in communal areas on their own.

However, there were not always staff members available to answer call bells within an appropriate timeframe. Call bells were ringing frequently in the morning during the busy time when staff were providing personal care. We checked call bell records to see the response times on the day of our inspection and found that the majority of calls were answered in less than three minutes. However, we also found that some calls were not answered within an acceptable time frame. One call went unanswered for 17 minutes, another call was unanswered for 16 minutes and five more calls were unanswered in 10 minutes or more. We spent time observing care in communal areas. We conducted a short observational framework for inspection [SOFI] observation in the lounge in the afternoon, after an activity. A SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used to capture the experiences of people who use services who may not be able to express this for themselves. We found that in the afternoon people were responded to by staff as they walked past the lounge and were not left alone for long periods of time. Subsequent to our inspection we received a complaint from a member of the public regarding a number of concerns, one of which was around how long it took for some call bells to be answered. We raised the concerns with the registered manager who provided a written response. However, from the call bell records we saw call bells are not always being answered in a timely fashion.

The registered provider did not ensure that ensure that there are sufficient staffing levels to answer peoples' call bells in a reasonable time frame. This is a breach of Regulation 18 of the HSCA Regulations 2014.

People were protected against the risks of potential abuse. The staff members we spoke with told us they had undertaken adult safeguarding training within the last year. We examined the provider's training matrix and staff files. We noted that staff members were recorded as having completed safeguarding training in the last year. Staff members were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local adult social services safeguarding team should be made, in line with the provider's policy. One staff member told us "I would let you [CQC] know if a manager didn't do something about abuse." Another staff member said, "I think poor care is abuse, as well as treating someone badly." A third staff member told us, "Safeguarding means creating a safe environment for the residents so they feel safe from neglect or abuse." The safeguarding folder in the office contained an up to date safeguarding policy and a log of all safeguarding referrals made. All safety certificates were up to date for e.g., electrical safety, gas safety and fire safety systems and regular checks were made to ensure that the environment was safe.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. We asked staff members about their understanding of risk management and keeping people safe whilst not restricting people's freedom. One staff member told us, "We don't stop someone doing something for themselves if they can. We let them go where they like in their own home". Our observations on the day confirmed this positive approach to risk. Two people left the home to go out for an hour and we were told this was a daily occurrence. The two people told us they came and went as they wished, going to the local village, the pub, for a walk or sometimes taking train journeys to the coast. Sufficient suitable equipment, such as hoists and wheelchairs, were available for staff to use. Each person's care plan contained a Personal Emergency Evacuation Plan [PEEP], and all firefighting equipment was checked to be in good order and serviced regularly. PEEP's were individualised and gave staff clear information about the support they would need to safely evacuate the building in an emergency.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible.

We spoke with registered nurses about medicines management. We examined the Medicines Administration Records (MAR) for 25 people living at the home. We also observed the dispensing of medicines and examined the provider's medication management policy. We asked if staff received regular training or updates. The staff we spoke with told us there was regular training provided in medicines management. Our examination of documentation confirmed this. We noted all staff dispensing medicines underwent a process of regularly checking their competency to do so, conducted by the acting manager. We noted medicines trollies were locked when left unattended. Staff did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts. We noted MAR charts contained relevant information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as warfarin. In addition, each person taking 'as needed' medicines, such as pain killers, had an individual protocol held with the MAR charts. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects. We spoke to staff and they were knowledgeable about the medicines they were administering.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "It's perfect; they are so good [in terms of skills]." Another person explained that the quality of care had gone down and several months ago they had considered moving somewhere else; however there had been changes in the summer and they told us, "It hadn't been good, but it has since [manager] took over; all the staff are wonderful, the new Chef is good and [manager] is great." One relative told us, "From the cook to the blue top, or whatever they are called, they are excellent. They are fantastic, caring and everything."

Staff told us they had the training and skills they needed to meet people's needs. Comments included: "I like the training and it's available for us all the time. I think it's changing though". One staff told us, "I've done all the basic training such as mental capacity act and safeguarding. I was able to spend time with the last person in my role doing a couple of days a week shadowing for a month." However, another staff member told us, "It's pretty much all online. I would prefer if it was done a different way". We spoke with the acting manager and the new provider's area manager. We were told that they were unsatisfied with the current training programme at the service and that it would be replaced by an 'in-house' service which would be more reflective of people's needs. They informed us that new training system had been sourced, funded and it is planned to be implemented in 2017. The registered provider had made standard training available for all staff in areas such as, infection control, health and safety, fire awareness and safeguarding vulnerable adults. In addition to this staff members were given the opportunity to undertake more specialised training in order to meet the needs of people they were caring for. These courses included dementia awareness, The Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). In addition, nine staff had completed, or were progressing through, National Vocational Qualifications (NVQ) at several levels.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "The manager is really good and they will always listen." Another staff member said, "I can say what I like. It's very open and honest." Staff told us they felt supported by the acting manager, and other staff. New staff members were supported to complete an induction programme before supporting people on their own. The Care Certificate was being undertaken by all new care staff. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. The acting manager had checked all staff had undertaken this training and where there were gaps they had retrained staff members.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Records showed that the service had made appropriate

referrals for DoLS and were using the principles of the MCA to protect people. Care plans showed that mental capacity assessments had been undertaken appropriately. Consent had been sought and obtained from people, relatives and representatives in areas such as information sharing and photography for identification purposes. The registered provider had ensured that people's freedom had not been restricted, and where this was necessary, systems were in place to keep people safe. For example, one person received medicines covertly, that is without their knowledge or permission. This person's care plan showed that they had received a mental capacity assessment which judged the person could not safely judge the risks of not taking their medicines. There had been a best interests meeting held, with input from the person's representatives, GP and staff at the home, to decide that the person required their medicines to stay safe.

People appeared to enjoy mealtimes and have access to the food and drink they liked. One person told us, "The food is good, if you don't fancy something they will get you something else. Everything is very nice, there is always a choice." Another person told us, "The food is excellent they will do anything for you, and I mean anything, within reason. Occasionally I have asked for something nice like smoked salmon and if possible, they get it. It [the food] is always fresh." A relative told us, "I think the food is quite good, X's food is pureed but it is in different types on the plate so you can see what it is." The same relative told us that they sometimes ate the same meals as people who live at the service, and it was always very good. Another relative commented, "X decided not to eat [earlier in the year] but the staff gently persevered and the last time we were there she was happily eating and was drinking again, and they had done that by persuading her and not forcing her."

The menu was based on a four week rota. Food was prepared on the premises and obtained fresh from local markets. There was a choice of meals on offer and care staff asked people about their food preferences shortly before providing it. If people changed their minds at the dining table, alternatives were offered. People's likes, dislikes and special requirements were documented and kept in the kitchen, accessible to staff. Kitchen staff spoke with people every day about what kind of food they would like that day. If a food item was on the menu that was unlikely to be universally popular, then a third item was added. This did not affect people's rights to choose something different. We examined temperature recordings for fridges and freezers and these were displayed in the kitchen. All surfaces and food preparation areas were clean and tidy and subject to a cleaning rota, signed off by kitchen staff when completed. There were also audits in place to ensure the on-going safe and effective management of food and drink provision.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. We looked at care plans in order to ascertain whether people's healthcare needs were being met. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included GPs and community nurses. We found evidence that advice and guidance given by these professionals was followed and documented. People's individual care plans contained their own health needs and this was reflected in the referrals made to professionals. For example, one person's file showed that they had had 10 GP visits in the last year as well as visits from a chiropodist, dentist and optician. One person told us, "I had a Doctor this morning. I guess someone must have called her as I've had this cold and cough. She told the girl [carer] I was OK." One relative told us, "They are very good about getting a Doctor if needed and they recently arranged flu jabs." We spoke with a local GP who told us, "I come every Monday and see people on my rounds. They [the service] are good at drawing attention to things, such as pressure wounds or possible infections." The GP commented that the service were good at communicating concerns to the local medical practice.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "Staff are excellent and are as good as can be. They wash and shave me every morning and get me dressed." Another person commented, "I get a shower about once a week, they use a proper shower chair and take good care of me." A third person told us, "Staff are wonderful and really caring." Whilst a fourth person said, "Staff are friendly and kind" and added that they were glad they got washed and shaved every morning. A relative told us, "I tend not to let them know I'm coming so I can walk in and see what's happening and not happening. I've often seen them sitting and talking to X. They talk nicely to her and sensibly and not as though she cannot understand them." Another relative commented, "Yes staff are caring. When X needs medical care or little things like if she needs a handkerchief they will go and get it for her."

People received care and support from staff members who had got to know them well. The relationships between staff members and people receiving support demonstrated dignity and respect at all times. We observed good interactions between people and staff who consistently took the time to ask people's permission before intervening or assisting. One staff member told us, "If you build up a relationship you notice if something's wrong. One man can suffer from pressure wounds and doesn't like going back to bed to rest, but if I promise him I'll get him up before I leave at six he trusts me to put him to bed because I've built up that rapport." There was a high level of engagement between people and staff. On several occasions we saw people being supported to move with the use of a hoist. On each occasion the person had each stage of the process explained to them. On one occasion a person was being supported to sit in the dining area. When the move was completed the person was given a teddy bear to hold by their staff who stroked their hand gently as they tried to support the person to drink. At first the person wouldn't take the drink but after a few minutes of gentle support with hand on hand care and using the teddy bear as a focus the person was supported to drink.

People's care plans did not always show that they were supported to express their views and be actively involved in making decisions about their care, treatment and support. We looked at eight people's care plans and daily records in order to see how the service involved people and their families with their care. Care plans and risk assessments were reviewed monthly and signed by staff and some were signed by relatives or representatives. However, we found no evidence that people or their representatives had regular and formal involvement in on-going care planning or risk assessment. Consequently, there were no opportunities to alter the care plans if people and their representatives did not feel their care plans reflected their care needs accurately.

However one relative told us, "We have regular meetings and they were saying for example, X had bed rails and they [the service] felt that it was a restraint and they wanted to take away the rails as if she wants to get up she should be able to get up and I was involved in that decision." Another relative told us, "I've been through her care plan with them [the service] and if anything's wrong they contact me. X had a [medical device] for a long time and they've been taking it for a test every six months and last March the hospital called to say she needs a new one but they cannot do the operation. I was involved in these discussions and also when X was refusing to eat and drink." On a day to day basis people could make decisions for

themselves and these choices were respected by staff. For example, one person was offered a protective apron at lunch time and refused. A staff member responded by saying, "It will keep your nice white shirt nice and clean" and the person replied, "No, I don't want it thanks." This decision was respected and the staff member offered the person a serviette instead.

We recommend that the registered provider reviews all care plans to ensure that people, their relatives and their representative's views about their care are clearly recorded.

People's privacy and dignity were respected by staff. One relative told us, "Yes they respect privacy. They told me they lock away people's notes when I asked to see them, and I've seen they do this to protect X's privacy as there's lots of personal information in the notes." Another relative told us, "If she needs changing they take her to somewhere private; if she's had an accident they change her quickly." A third relative commented, "I can only observe other people and I'm confident that they do respect privacy and dignity." Staff were respectful and kind to people living at the home. For example, those people requiring the use of a hoist in communal areas were protected by the use of screens. One person spilled food on themselves during a mealtime and a staff member very discreetly helped the person to clean themselves without drawing other people's attention to the situation.

We observed instances of genuine warmth between staff and people. For example, one person who was sat in the lounge was holding a teddy bear and a slipper in their hands. When a staff member noticed this they tried to support the person to put their slipper on but the person did not want to let go of the teddy bear. The staff member gently talked to the person about the bear and asked what the name was, what was on TV etc. until they could support the person to put their slipper back on. People could have privacy and between meals they went where they wanted within their home. Some people chose to go to the lounge and others chose to go to their rooms, where they could have privacy. People told us that they were well cared for and everyone looked clean, tidy and dressed appropriately. People's independence was encouraged where possible. At mealtimes people who needed assistance to eat were given assistance but were encouraged to still make choices about what they wanted to eat and the order in which they ate their meals.

Good

Is the service responsive?

Our findings

People were receiving a person centred service. One staff member told us, ""Each person's care is different. We have that in mind". Another staff member told us, "It [person centred care] is about giving people choices and making sure they have what they want, e.g. the gender of their carer. Basically we put ourselves in their shoes and think what would I want?" One relative commented, "The main thing X gets pleasure from is music and yesterday the singer came and X really enjoyed it. I have a CD player in the room and from the first day there was a note in the front of her file to say X love music." However, our observations revealed that some staff displayed a task oriented approach to their work. For example, on several occasions we heard staff refer to people by their room numbers instead of their names whilst other staff members addressed people by their names. We raised this with the acting manager who told us that they were aware of the issue and were addressing it when it arose as well as in staff member's supervisions.

We recommend that the registered provider reviews the induction and training in the service so that all staff are consistently addressing people by their name.

Care plans were personalised and showed daily routines that were specific to each person, reflecting the choices people made every day. Care plans contained detailed information about people's care needs, as well as actions required in order to provide good care. One person told us, "I have a shower about once a week. They make it nice, little things like they will put on a bit of perfume or talc me up." Another person, who was unable to communicate verbally, had a care plan that stated they should be, "treated with dignity and respect and to chat to X even though they cannot respond." The care plan directed staff to put music on for the person to listen to and to chat about a country where they used to live. Staff were also directed to talk through every step of personal care and to give reassurance whilst doing so. People whose care plans stated that they liked to read were offered magazines by staff as they sat in the lounge. We saw one person sat in the lounge whom staff approached and asked, "Would you like a magazine my dear?" The person was offered a selection of age and gender appropriate magazines and sat and read for an hour. There were also books for people located at various places around the home.

The registered provider and staff team were aware of the risk of social isolation and took appropriate steps to provide people with the level of support they chose. Several people preferred to be in their bedrooms and chose not to get involved in planned activities as they preferred privacy and quietness. One staff member told us, "It can be the person's choice; one person has visitors but doesn't like being in the lounge, but in the summer they will sit in the garden. Another person is very introverted and likes their own company." The activities co-ordinator commented, "When I do one to one support I focus on people who normally stay in their rooms." We saw the records for one to one support which included activities such as nail care. One person told us, "the carers do my makeup every couple of days and my fingernails are painted regularly: it didn't used to happen." The acting manager said that they try to paint people's nails, for those that want it, as it cheers them up. One person who was cared for in bed explained that there was always an activity and where possible they brought it to the room. The person gave an example where animals had visited the home and the staff had brought a giant snail to him.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. The activities co-ordinator told us, "I've tried to make activities more efficient so there is always a reminiscence activity, arts activity, a physical activity etc. each week. I've introduced bingo and a film club and I've recently introduced a questionnaire with activities and interests so we know what each person wants to do." The service has an activities planner with all internal activities as well as external activities that come in to the home. For November activities included a Halloween party, bonfire night with fireworks, a visiting singer and a company bringing animals for people to handle. In addition there were weekly sessions for people to have a hand massage, seated aerobics and a religious service on Sunday. One visiting activities provider told us, "It [Glottenham Manor] is more like a family now than it ever used to be. The staff attitude has improved and there's more cheerfulness and people are ready for their activity when I arrive."

People were able to engage in activities that were not planned. One person was supported to sit at the piano. They then played, without the need for sheet music for at least 20 minutes. The person clearly enjoyed this activity and regularly went back to the piano throughout out visit. The home had two long haired cats which had the freedom of the home and appeared to be appreciated by people. People's bedrooms were individualised and decorated to reflect their tastes and interests In every bedroom there was a copy of the latest edition of the homes' newsletter "Glottenham Times" which is published monthly and has details of people's birthdays for that month, upcoming events, e.g. Halloween party, and details of the next residents meeting. Resident's meetings were held monthly and an agenda was put on the activities board in advance so that people could raise topics for discussion.

People and their relatives spoke highly of the support that they and their loved ones received. One relative told us, "One thing that's really nice is mum can't tell me anything due to her dementia and some of the younger people living at the home have told me 'your mum is well looked after' and they've been able to tell me it's a nice home and the food is good here; it was nice as mum can't tell me these things." Another relative commented, "I think it's quite nice there; all the residents seem happy and the staff are nice." A third relative commented, "I was glad I went to look at other care homes before so I can compare and at Glottenham the staff have a sense of humour and from the first time the way they spoke to X it got a good response."

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service records all complaints in a complaints log and there had been six complaints recorded in 2016. These complaints were all logged under the previous registered manager and registered provider. One complaint from earlier in the year had been from someone who was unhappy with a relative's short stay at the service and this had been investigated. The most recent complaint had been in relation to the decoration of a person's bedroom. The registered provider had ensured that the redecoration work had been completed and a letter had been sent to the complainant. This complaint was resolved. There had been two verbal complaints that were recorded on the complaints log. One was about poor picture quality of TV's in the service. The registered provider had replaced all aerials to the whole building. Another verbal complaint related to a lack of hot water and the boiler was repaired and serviced. One relative told us, "I've not made any complaints yet: If I did I'd go straight to the manager who I've dealt with since she's been there and is a very nice person." Another relative told us, "There was an issue once when a resident hit X but they were on the phone straight away to me and asked me if I wanted to complain."

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the acting manager, the management team and the registered provider. One staff told us, "Things have changed a lot since the new owners came in. They are interested. The previous owners just didn't want to spend any money." Another staff member said, "It's much better now than it was. It was terrible before if I'm honest. The new manager is great and the new owners really seem to care." One relative told us, "I really don't have any concerns since the new company took over. Since [name] is acting manager, it's been very good. When [manager] first came here X was a carer, so as manager she knows all about the place." Another relative commented, "She [manager] is very good. If you have any issues they sort anything out and they always answer questions for you." A third relative told us, "It's good to have [name] as manager as she's been in the home for so long she knows all about it."

The service had a positive culture that was person-centred, open, and inclusive. One staff told us, "Ever since [manager] has been here she's the type to move things forward. She's dealt with lateness and sickness issues which were getting the staff down. If she sees something's wrong she'll fix it." The staff member went on to give an example of how staff had complained for years about incontinence aids and latex gloves being kept in people's bedrooms. The manager trialled three small cabinets in people's rooms and it worked well so she ordered them for all bedrooms. The staff member said, "People's rooms are less clinical and more like a bedroom now. Now I feel listened to: before things were ignored or put on the back burner but [manager] listens." The acting manager told us that there had been an increase in the nursing hours after the new registered provider had reviewed the rota. This had positively affected the culture within the service. The acting manager told us, "That had a massive impact on the nursing team as they were trying to do everything, but now they have two [nurses] they have the time to make sure everything is running well."

The service encouraged a culture that was empowering. People had access to residents meetings and staff had access to staff meetings in which they were able to give their views on the service. There were also questionnaires that people, their relatives and staff were encouraged to complete. The questionnaires sought people's opinions on a range of issues such as the quality of the food, activities on offer, if care needs were being met and if people are treated respectfully and in a dignified manner. The questionnaire's showed that people were satisfied with the service they received. Where people gave a negative response this was followed up by the acting manager.

The acting manager provided clear leadership to the service and people felt well supported by the management structure. One staff member told us, "[manager] is good, I like her. Even when she previously worked as the administrator I went to her to get things done. Confidentiality has improved with the change in manager. If a staff called in sick with an illness the whole house used to know about the illness." The member of staff explained to us about how they had made a complaint about some of their colleagues' attitude and work ethic to the acting manager. We were told that the acting manager spoke to the staff members, investigated the complaint and that both staff no longer work at the service. We spoke to the maintenance manager who told us, "The new manager and owner are on the ball and get things done straightaway. I waited over two months for a plumber to change some valves and two days after telling the

new provider about it, the work was done." The acting manager told us, "I am present in the home and I have standards. The staff haven't got a problem coming to see me if they need any help at all. I'm a positive person." Supervisions were beginning to happen regularly after a period when their regularity was inconsistent.

The registered provider had effective systems in place to monitor the quality of care and support that people received. There were monthly audits to check the quality of the service people received. These audits checked areas such as medication to ensure that there were no medicines errors and correct stock was in place. The acting manager conducted a monthly audit of key performance indicators that examined areas such as pressure wounds, risk assessments, capacity assessments, and hospital admissions amongst other topics. These audits were leading to positive changes within the service. The acting manager told us, "I've just started generating action plans from the audits. I identified that care plans were not up to date so I actioned it by speaking to [area manager] and we were given supernumerary time of 18 hours a month for three people to update all the plans." The acting manager had identified 16 areas that needed action to put them right and had written a clear improvement plan. We saw that this plan had been put in to effect. For example, the acting manager had identified that there was no key worker system in place for people who would be knowledgeable about a specific person's likes and dislikes. A key worker is a person who co-ordinates all aspects of a person's support and has responsibilities for working with them to develop a relationship to help and support them in their day to day lives. We saw that a key worker system had been put in place and staff were aware of whom they were key working.

The registered provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered provider confirmed that no incidents had met the threshold for Duty of Candour.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff deployed to answer people's call bells in a timely fashion.