Lawton Group Limited

Glebefields Care Home

Inspection report

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31 January 2019

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Glebefields Care Home on 31 January 2019 This inspection was carried out in part, following concerns that had been raised by the public surrounding clinical practices within Glebefields Care Home. We also wanted to check that improvements to meet legal requirements planned by the provider after our June 2018 inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This is because the service was not meeting some legal requirements and the concerns raised to us related to safety and leadership within the service.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

When we completed our previous inspection on 13 June 2018 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). These failings related to staffing levels and the systems in place designed to improve the service. At this inspection we found the service had made improvements in these areas. However, we identified a further breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014), relating to the safe management of medicines.

Glebefields Care Home is a 'care home' near Banbury. People in care homes receive accommodation and nursing or 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.

Glebefields Care Home accommodates 48 people across two separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. At the time of our inspection 39 were using the service.

At the time of our inspection the service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the home manager had applied to become the registered manager.

What life is like for people using this service:

The provider did not always ensure that people received safe care and treatment. This was because people did not always receive their medicines as prescribed. Medicines were not always stored in line with the manufacturers guidance. The service did not always seek guidance from professionals when administering medicines covertly.

People complimented the continuity of care provided by the right level and mixture of skilled and competent staff. Risks to people's well-being were assessed, recorded and updated when people's circumstances changed. The staff ensured any lessons learnt were reflected to improve the service delivery. However, the systems designed to improve the quality of the service were not always effective.

You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

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 always safe.
Details are in our findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.
Details are in our findings below.

Glebefields Care Home

Detailed findings

Background to this inspection

The 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 was carried out in part following concerns that had been raised by the public surrounding clinical practices within Glebefields Care Home.

Notice of inspection:

This inspection took place on 31 January 2019 and was unannounced.

Inspection team:

The inspection was carried out by two inspectors.

What we did:

Before the inspection we reviewed the information, we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we observed how staff interacted with people. We spoke with six people, three relatives and one professional to gather their views. We looked at records, which included six people's care and medicines records. We checked recruitment records for six staff. We looked at a range of records about how the service was managed. We also spoke with the provider, the manager and seven are staff. After the inspection we contacted commissioners to obtain their views about the service.

Requires Improvement

Is the service safe?

Our findings

People were not always safe and protected from avoidable harm.

Using medicines safely:

● The medicines management was not based on current best practice. For example; one person had not received their medication as prescribed as it had been out of stock. Another person had not received their medication as prescribed because of a recording issue on their medicine administration records (MAR).
● Medicines were not always stored safely. For example, the fridge temperature was out of the recommended range for several days which could have an impact on the integrity of the medicines stored in the fridge.
● Handwritten MAR's were not always double-checked to confirm their accuracy. This is not in line with national best practice.

This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management:

• Risks to people's well-being were assessed, recorded and updated when people's needs changed.
• People's risk assessment included areas such as their mobility, skin integrity or medicine management. Staff were familiar with and followed people's risk management plans.
• The provider had a system to record accidents and incidents. We viewed the accidents log and saw appropriate action had been taken where necessary.

Systems and processes:

• People were supported by staff that knew how to raise safeguarding concerns. One staff member told us, "I would report any concerns to my manager or contact the safeguarding team".
• The provider had safeguarding policies in place and copies of both the local authorities' (they worked with) safeguarding procedures were available in the office, the team reported concerns accordingly.

Staffing levels:

• People were supported by consistent, reliable, punctual staff and praised the continuity of care received. One person said, "There are always staff about if you need anything". A staff member told us, "Staffing has really improved".
• We saw that care staff answered call bells promptly on the day of our visit. People we spoke with told us they did not use their call bells very often, but when they did, care staff came within a reasonable time. We saw staff responded to people's request for support during the day.
• People were protected against the employment of unsuitable staff as the provider followed safe

recruitment practices.

Preventing and controlling infection:

• The provider ensured staff were trained in infection control. People told us staff washed their hands and use disposable gloves and aprons where required.

Learning lessons when things go wrong:

• The provider ensured they reflected on where things could have been improved and used this as an opportunity to enhance the service for people and for staff.

Requires Improvement

Is the service well-led?

Our findings

Service management and leadership systems did not always support the delivery of high-quality, person centred care.

Managers and staff were clear about their roles, and understood quality performance, risks and regulatory requirements:

●The service had made significant improvements to its systems and arrangements that were designed to monitor and improve the quality and safety of the service. However, the systems were not always effective, for example the service monitoring system had not identified the concerns we found relating to the safe management of medicines.
• There was a clear staffing structure and staff were aware of their roles and responsibilities.

Leadership and management:

• People and relatives told us the service was well run. One person said, "The new manager is really good, she seems to know what needs sorting". A relative said, "The new manager seems very nice".
• Staff told us the manager and the provider were very supportive. One staff member described a situation where the new manager had encouraged them to aim high and apply for a promotion. They told us, "She's really supportive".

Plan to promote person-centred, high-quality care and good outcomes for people:

• People and relatives praised the service received and how the service was run. People we spoke with felt the service was well managed and open.
• The manager promoted an open culture which contributed to staff work satisfaction. There was good team work and staff morale. One staff member said, "I love my job and I love coming to work".

Engaging and involving people using the service, the public and staff:

• The provider involved people in various ways. People had opportunities to attend meetings, complete surveys or raise any comments via an open-door policy at any time.
• The staff told us they felt listened to, valued and praised the team work.

Working in partnership with others:

• The service worked in partnership and collaboration with a number of key organisations to support care provision, joined-up care and ensure service development.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines as prescribed.