

Meadowcare 2

Glenview Nursing Home

Inspection report

8-9 Belvedere Road
Redland
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Tel: 01179734910

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service:

Glenview is a care home that provides personal and nursing care for up to 40 older people. The service is provided in accommodation over four floors. At the time of the inspection, 30 people were living at the home.

What life is like for people using this service:

People were not always protected from unsafe care. Staff were not all aware of how to safely use moving and handling equipment. The records did not provide detail about the equipment needed.

Staff did not always report injuries so appropriate safeguarding referrals were not always made.

Staff had not received sufficient training to carry out their roles. The records showed that staff had not all received moving and handling training or safeguarding training, so people were not always protected from unsafe care.

Medicines were safely managed.

People were supported to access health care services and regular visits were undertaken by their GP.

People's dietary needs were assessed, and people were offered choices at mealtimes.

Where people's foods, fluids and change of position needed monitoring, records were completed and up to date.

Audits were not consistently completed. Shortfalls were not always identified and where improvement actions were needed, actions were not always taken.

Medicines management checks were regularly completed and where improvement actions were needed, these were completed.

More information is in detailed findings below.

Rating at last inspection:

Good (report published in April 2019).

Why we inspected:

Safeguarding investigations were ongoing at the time of our inspection because there had been a number of

concerns relating to the care and treatment of people living in the home and the ability of staff to effectively meet people's needs. As a result, we undertook a focused inspection to review the Key Questions of Safe, Effective and Well-led only.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this report.

We have identified breaches of the regulations in relation to safe care and treatment, staffing and quality assurance at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Follow up:

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 was not always safe

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our Well-Led findings below.

Requires Improvement ●

Glenview Nursing 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 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

A safeguarding investigation was ongoing at the time of our inspection because there had been a number of concerns relating to the care and treatment of people living in the home and the ability of staff to effectively meet people's needs.

Inspection team:

The inspection team consisted of two inspectors.

Service and service type:

Glenview is a 'care home'. 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.

There was no registered manager in post. The registered manager had not been in post since February 2019. They had not completed the de-registration process with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. An acting manager who will be referred to as the manager in this report, was in post.

Notice of inspection:

The inspection was unannounced, so the provider, registered manager and staff team did not know we would be visiting.

What we did:

Before the inspection we reviewed 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 spoke with five people who lived in the home, and briefly with others, and one relative. Most people were unable to fully express their views about the service, so we spoke on the telephone with three relatives to obtain their views. We observed how people were being cared for. We spoke with the provider, the manager, deputy manager and seven staff that included a registered nurse, catering and care staff.

We reviewed a range of records that included five care plans, daily monitoring charts and medicines records. We checked staff recruitment, supervision and training records. We also looked at a range of records relating to the management and monitoring of the service. These included audits, quality assurance surveys and minutes of meetings. We contacted the local authority commissioning team and obtained their views of the service.

After the inspection:

We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

Safe-This means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection in February 2019, this key question was rated Good. At this inspection we found that staff were not always safely recruited, appropriate actions were not always taken when people sustained injuries, moving and handling was not always safely undertaken and appropriate infection prevention and control measures were not in place for slings.

The rating for this key question has deteriorated to Requires Improvement.

Systems and processes to safeguard people from the risk of abuse.

- People living in the home were not always protected from the risk of abuse.
- One person had sustained unexplained bruising in April 2019. This was recorded on a body map and updated on skin integrity check sheets on a number of occasions. The bruising had not been reported to the manager. Investigations had not been undertaken to determine the cause of the injuries, so further actions, such as reporting to the local authority safeguarding team, or to the Care Quality Commission, or actions to prevent recurrence, had not been taken.
- Most people were unable to fully express their views or tell us if they felt safe. Three people had been assessed as requiring one to one support from staff to keep themselves and others safe, and this was being provided. People did look comfortable and relaxed in the presence of staff.
- Most staff had not received safeguarding training although staff we spoke with told us they knew how to recognise signs of abuse and that written guidance was provided. Staff had not reported the unexplained injury noted above to the management team so further actions had not been taken.

Assessing risk, safety monitoring and management

- Risk assessments and risk management plans were recorded. These included risks associated with falls, skin condition, moving and handling, mobility, malnutrition and dehydration.
- The risk management records for people who needed to be moved with hoists was not fully completed. The records did not provide details of the type of hoist or sling each person required. Staff were unable to tell us what each person needed to support them to move them safely. This meant people were at risk of harm and injury because they may be moved unsafely.

People were not always safeguarded because injuries were not always reported. Staff were not always able to demonstrate how to move people safely. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

Staffing and recruitment

- Staff recruitment procedures were not always safe. Interview notes were not always completed so there

was no evidence that gaps in employment were fully explored. Additional checks, such as confirmation of current registered nurse registration with the Nursing and Midwifery Council (NMC), were not always completed.

- Checks were completed with the Disclosure and Barring Service (DBS) so that staff unsuitable to work with vulnerable people, such as those living in care homes, were identified.
- During our inspection, there were sufficient staff on duty to provide the care and support people needed. The staff rotas showed an inconsistency in the staffing numbers on duty each day.
- A dependency assessment tool had been recently introduced to calculate staffing levels required. At the time of our inspection, this had not been embedded and we found errors that meant the staffing levels required had not been accurately calculated.
- Staff told us they usually had enough staff on duty to meet people's needs.

Using medicines safely

- People were supported to take their medicines safely and as prescribed.
- Medicines were safely obtained, stored, administered and disposed of. Sufficient storage was provided, and systems were in place for medicines that required cool storage and medicines that required additional security.
- Audits were completed that showed actions taken when shortfalls were identified.

Preventing and controlling infection

- We saw that one person who was supported to move with a hoist, had their own sling which was kept with them during the day. Staff told us other people had shared slings, and we saw a store cupboard where these were communally stored. This was not in line with nationally recommended best practice.
- The care home was clean throughout and staff were observed using gloves and aprons appropriately.
- The kitchen had achieved a rating of five following a recent visit from the food standards agency. This is highest rating that can be awarded.

Learning lessons when things go wrong

- There was a procedure in place for reporting and recording accidents and incidents.
- Action plans had been developed in response to safeguarding concerns and incidents. Improvements were needed to make sure actions were consistently implemented as planned.

Is the service effective?

Our findings

Effective-this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection in February 2019, this key question was rated Good. At this inspection we found staff received insufficient induction and training, pre-admission assessments had not always identified where people's needs could not be met.

The rating for this key question has deteriorated to Requires Improvement.

Staff support: induction, training, skills and experience

- Staff did not receive sufficient induction and training to support them to carry out their roles effectively.
- Records of induction and training were incomplete. Whilst staff told us they had received moving and handling training or had been shown how to use hoists, it was not clear how this had been provided and what had been included.
- We gave the provider the opportunity to review their records and send us updated information after the inspection. The updated information was still incomplete. For example, it showed that out of 34 staff named on the training matrix, seven had completed moving and handling training, 16 had completed first aid training and 16 had completed safeguarding training.
- Concerns had been raised from different sources on a few occasions about communication skills of staff who did not speak English as a first language. One of the actions agreed was that staff would complete English lessons. However, this had not been completed at the time of our inspection.
- On the day of the inspection, the care staff communication with people who used the service was effective. We spoke briefly with a member of 'non-care' staff. They were not able to understand what we were saying, and they were unable to respond to a simple and direct question.

The lack of training to support staff to carry out their roles effectively was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments were carried out before people moved into the home. However, the service had been unable to meet the needs of some people they had admitted to the home, specifically people with behaviour that could be considered challenging to others.
- Regular checks were made using assessments and screening tools. For example, where it was identified people were at risk of losing weight, actions were taken that included additional monitoring and a referral made to the GP.
- Relatives comments included, "They are really very good, I have been kept informed and found everyone so kind and respectful," and, "They do their best and I always get a call if Mum's had a fall."

- People's needs were reviewed monthly and when their condition changed. The provider had recently introduced electronic care records, and at the time of our inspection, staff were recording on electronic and paper records. The electronic records provided 'alerts' if records had not been updated.
- The newly appointed deputy manager told us their role specifically included supporting staff to provide care for people living with dementia or with behaviours that could be considered challenging to others. We saw the positive influence this member of staff had when they communicated with a person who was distressed.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported with food and fluids and overall, people received a healthy and nutritious diet.
- People were offered drinks, snacks, cakes and biscuits during the day.
- The chef told us how they were made aware of people's likes, dislikes, needs and preferences. They were provided with dietary information sheets for each person and updated when there were changes.

Supporting people to live healthier lives, access healthcare services and support: Working with other agencies to provide consistent, effective, timely care

- The service made sure people living in the home had access to healthcare services. These included social workers and the dementia wellbeing team. They also received regular visits from their GP.

Adapting service, design and decoration to meet people's needs

- The adaptation of the building into a care home had been thoughtfully and tastefully completed.
- A recent action plan, agreed with the safeguarding team, included actions to be taken to enhance the environment to make it more 'dementia friendly.'

Ensuring consent to care and treatment in line with law and guidance

- 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.
- The care records did not always show that decisions made in people's best interests were the least restrictive options and that other options had been considered. For example, for one person their records stated, 'It has been decided for best interests of [person's name] to use bed rails when he is in bed to ensure safety.'
- People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to care and treatment.
- Some people had authorised DoLS in place and others had applications that were being processed by the local authority.

Is the service well-led?

Our findings

Well-led-This means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care, supported learning and innovation and promoted an open, fair culture.

At our last inspection in February 2019, this key question was rated Good. At this inspection we found shortfalls as noted in the safe and effective domains and relating to safe care and treatment and staff training. The shortfalls had not been identified in the provider's quality assurance systems.

The rating for this key question has deteriorated to Requires Improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was no registered manager in post. A manager was in post and a deputy manager had recently started in post.
- Some systems were in place to monitor and evaluate the quality of the service provided. For example, medication audits were undertaken, areas for improvement were identified and actions completed. However, most checks were not sufficiently robust and did not identify the shortfalls we found and have reported in the safe and effective sections of this report. An action plan was not in place to address shortfalls identified from previous incidents and safeguarding investigations.

The lack of robust systems to identify, monitor and mitigate risks to people's health, safety and welfare was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager knew what notifications they had to send to the CQC. These notifications inform CQC of events happening in the service.

Planning and promoting person-centred, high quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- It was clear from our discussions with the provider that they aimed to provide an excellent service. However, they had experienced staffing difficulties, communication challenges, management changes along with admissions of people into the home with complex care needs that could not always be met.
- The relatives we spoke with were positive about the care provided. We had also received less positive feedback that related to recent complaints and safeguarding concerns.
- Staff felt well supported. Comments included, "Best support from managers here," and, "Everything is good with our managers. They are good people."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Surveys were completed for people using the service.
- Staff meetings were held, and staff felt confident their views and feedback would be listened to and acted upon.

Continuous learning and improving care and working in partnership with others

- There had been a period of change and challenges since the departure of the registered manager, in February 2019. The change had led to a deterioration in people's care. However, a manager was in place and a deputy manager had started in post during the week of our inspection.

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
Treatment of disease, disorder or injury	People did not always receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance systems did not always assess, monitor and mitigate risks to the health, safety and welfare of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Sufficient training was not provided to enable staff to carry out the duties they were expected to perform.