Miss C Marshall

The Glen Rest Home

Inspection report

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Southport
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of The Glen Rest Home on 22 and 24 October 2016. The Glen Rest Home is a 10 bedded care home located close to Southport town centre, within walking distance of shops and other local community facilities. The home has a stair lift to the first floor and there is a portable ramp at the front for people who may need the use of a wheelchair.

The home required 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. There was a registered manager in post who had been registered since October 2010. The registered manager was not present during our visit and did not participate in the inspection. The assistant manager assisted us with our inspection.

During our inspection, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 12 and 17 of the Health and Social Care Act 2014 Regulations.

These breaches related to the safety of the premises and the management of the service. You can see what action we told the provider to take at the back of the full version of the report.

People who lived in the home told us they felt safe and had no worries or concerns. From our observations it was clear that staff cared for the people they supported and knew them well. People's relatives also told us they felt people were safe. During our visit, however we identified concerns with the service.

During our visit we found that some areas of the home were in need of repair and improvement to ensure they were suitable for use, we also saw fire doors that had been wedged open.

We saw highly confidential personal information regarding the people living in the home was left in a communal area were visitors and other people living in the home would have been able to access it.

The policies and procedures had not been reviewed for a significant amount of time meaning staff did not have up to date guidance to support them in their work.

Care plans and risk assessments were in place, however some of these were not up to date and did not reflect the persons changing needs.

The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) had been adhered to in the home. We saw the people at the home who lacked capacity and that the appropriate number of Deprivation of Liberty Safeguard (DoLS) applications had been submitted to the Local Authority in relation to people's care.

The staff in the home knew the people they were supporting and the care they needed. We observed staff to be kind and respectful.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The arrangements in place for the administration of 'as and when' required medication was not sufficient.

The premises were poorly maintained and potentially unsafe.

People and relative told us they felt the service was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received an appropriate induction to do their job role effectively.

Staff had an understanding of mental capacity and how this applied to people who lived at the home.

People told us they received enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

Information relating to people living at the home was not stored confidentially.

People we spoke with told us the staff were kind and treated them with respect. Our observations confirmed this.

Confidentiality of people's personal information was not evident.

A service user guide was available had not been reviewed since 2004 and so held out of date information.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no suitable activity programme in place to promote

the emotional and social well-being of people who lived at the home.

Information on how to complain was available but it was out of date and insufficient.

People had access to a wide range of healthcare professionals as and when they needed it.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were no effective quality assurance systems in place to monitor the quality or safety of the service.

Staff said they felt supported by the manager.

The service had a manager who was registered with the Care Quality Commission.

The Glen Rest 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 22 and 24 October 2016 and was unannounced. The inspection was carried out by one adult social care inspector.

Prior to the inspection we asked for information from the local authority quality assurance team and we checked the website of Healthwatch for any additional information about the home. We reviewed the information we already held about the service and any feedback we had received.

During the inspection we spoke to five people living at The Glen Rest Home and two relatives. We talked with two staff on duty, as well as the deputy manager. We looked at the communal areas that people shared in the home and a sample of individual bedrooms. We reviewed a range of documentation including three care records, medication records, four staff files, policies and procedures, health and safety audits and records relating to the quality checks undertaken by the manager.

We looked around the premises and spent time observing the care and support provided to people throughout the day.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with said that they felt safe at the home. One person told us "I feel safe", another said that the staff were "Always helpful". A visitor we spoke with told us "I'm happy with the care". They said they visited the home regularly and felt confident that the person was safe.

On entering the home we saw a bicycle not belonging to a person living in the home had been left up against the hallway wall. This was a trip hazard. We entered the dining room that led onto the kitchen and saw that the door had a 'fireguard' device fitted to the bottom of the door. This device is meant to release and close the door in the event of a fire. This device was wedged open, which meant that the door would be unable to close if a fire occurred and the risk was heightened by the proximity to the kitchen. The door also had a large sign on it saying 'Fire door, keep shut' and 'Automatic doorguard, keep clear'. Neither of these signs were followed by staff.

During our visit, we did a tour of the building. We found that some areas were in need of repair and improvement. For example, we saw that one bedroom had rotted windows, another bedroom had a broken window that had masking tape put across it and third bedroom had the emergency call bell hooked behind a broken light situated above the bed. This meant that if the person had tried to ring their bell then there was a risk of the light coming off the wall, either onto the bed or if the person was lying down onto their head potentially causing injury.

We also saw that one bedroom had a radiator cover coming away from the wall, the window restrictor in the lounge was broken and we observed several doors wedged open causing a fire risk.

We saw that all rooms were en-suite with use of a sink. One room we saw had walking aids that did not belong to them, a child's buggy and wheelchairs blocking access to their sink. This meant the person did not have the option of using their own sink if it was needed for either personal care or to get a drink of water.

The service had two staff on duty during the day and they had the responsibility of preparing the food for the people living in the home, cleaning the home and attending to those who lived there. A family member of the manager came to support with the cleaning of the home. We saw evidence of cobwebs in people's rooms as well as mould around some windows. This meant the home had not been effectively cleaned. One visitor to the home told us "The décor leaves something to be desired".

We asked the deputy manager for evidence that the home's gas, electrical, water and fire alarm systems were regularly inspected by external contractors and conformed to recognised safety standards. We saw that the Gas safety certificate was up to date, however when we asked to see the electrical safety certificate this was not available. This meant that there was no proof that the electricity supply to the service was safe. We also saw that the last check for Legionella's had been carried out in 2013. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety Act 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. Shortly after our inspection, we received confirmation from the

manager that arrangements were in place to ensure the Legionella tests were to be undertaken.

All these findings were immediately brought to the deputy manager's attention.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was safe, suitable for purpose and met statutory requirements.

People's medication was stored securely in a locked cabinet. On the day of our visit we observed a large number of prescribed nutritional drinks that had been piled on a dining room table. On asking staff about this no one knew with certainty when this had been delivered and no one had checked the items in for whoever it was prescribed for. This meant that there had been no handover to staff about the new medications and as the prescribed items had been left on a communal dining room table this was accessible to the public.

We did a sample check of the quantity of medication in the medication trolley. We found that the balance of medication matched what had been administered. We saw that most items were dispensed in blister packs. Blister packs are individual containers of the person's medication. However, medicines which were not blister packed and were mainly 'as and when required' medication such as painkillers did not have the amounts that should be in the medicine trolley documented. This meant that here was a risk that mistakes could have occurred when administering 'as and when required' medications without being identified by the service.

We also looked at the records for accidents and incidents, however although the service had recorded any accidents and incidents these had not been appropriately reported to the Care Quality Commission to whom these incidents should be reported.

We noted that risks to people's safety and well-being had been identified, such as the risks associated with moving and handling, falls, pressure area care and nutrition and that plans had been put in place to minimise risk, however we saw how some risk assessments had not been updated. An example of this was when a person came out of hospital and the risk assessments had not been reviewed to reflect the persons changing needs, this included a significant change to the person's mobility. Another example was a person's falls risk assessment had not been updated since January 2016. This meant there was a risk that staff may not know what to do.

During our tour of the building we saw that the home had a 'bed statement' showing information on who was in which room and their degree of mobility in case of emergency for example fire. We saw that this was not up to date and we saw that one person whose mobility had deteriorated had not been changed on the notice. This meant that emergency services would have the wrong information if an evacuation of the building was needed.

These incidences were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to assess, monitor, improve and mitigate risks for those using the service.

We viewed four staff recruitment files and found that all the appropriate recruitment processes had been followed and that and checks had been made. All files contained two references, proof of identification and had appropriate criminal records checks on each person.

Requires Improvement

Is the service effective?

Our findings

All of the people we spoke with told us they were well looked after by staff at the home. People's comments included "They're very attentive" and "I'm looked after very well". A relative told us "They [staff] are faultless".

We looked at the training records in the personnel files of five staff members to check that staff were appropriately trained to care for people effectively. We found the majority of staff had received appropriate training with relation to safeguarding, moving and handling. However we looked at any information regarding initial induction one recently employed staff member had received, this member of staff had never worked in health and social care before. There was no evidence that the member of staff had received any and on discussion with both the deputy manager and the staff member neither were able to tell us of any induction plan for the staff member. This meant there was no evidence that they had the skills and knowledge to care for people safely.

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 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. It was clear that the manager had an understanding of the MCA and its application and when we spoke to the staff they were able to discuss the training they had attended and how it applied to their role.

We talked to one staff member about the support they received from the manager and deputy manager. They told us they felt supported in their role and they were able to tell us that they met regularly with the registered manager one member of staff commented "Yes the meetings are helpful, I sometimes have questions on things and we get feedback". We saw some evidence in staff files of supervision and appraisal. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns they have and to plan future training needs.

We noted that the home had a communal dining area and we saw staff taking food to those who wanted to stay in their bedrooms. We saw that the same meal was served to each person and when speaking to people living there one person told us that if they did not want the prepared meal they were able to ask for something different "If you don't like anything then I always get a choice", however another person told us "It's all edible but there's no choice at lunch". We noted that people who were prescribed nutritional supplements were given them when prescribed in the day. Meals were served promptly and pleasantly by staff and portion sizes were adequate.

We saw that the home had recently been inspected by Environmental Health and were given actions to ensure a safe environment for the preparation and serving of food. We saw the organisation had started to refurbish the kitchen and make the appropriate changes to meet Environmental Health standards.

The home had a stair lift to the first floor and there was a portable ramp at the front for people who may have needed the use of a wheelchair.

Requires Improvement

Is the service caring?

Our findings

We asked people if staff treated them well. People said that they did. People we spoke with spoke positively about staff at the home. People's comments included "They're very attentive" and "Yes definitely, you're wishes are respected". A visiting relative told us "The care is impeccable". We spoke to the staff who told us "The residents come first. As a group we look after people really well and the relatives I speak to are happy with the service we supply".

During our initial tour of the building we saw a sideboard in the dining room that had a large amount of laundry piled up, these items belonged to the people living in the home. We also saw confidential information that was concerning the people living in the home. Examples of this included medication records belonging a person living in the home, personal information about a person needing a urine sample, 'do not resuscitate' information, national insurance numbers and if people were under a deprivation of liberty safeguard order. This information is highly confidential and had been left in a communal area were visitors and other people living in the home would have been able to access it.

These incidences were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure they maintained securely an accurate record of the care and treatment provided to the people living in the home.

A service user guide was available and provided information to people about the home and the care provided. We saw that this document had not been reviewed since 2004 and so some of this information was out of date. For example information about how people could make a complaint referred to out of date contact details.

We did not see any formal relatives meeting to enable people to be involved in discussions about the running of the home. However we spoke with relatives of people living at the service who told us they had been involved with the care being delivered, one person said "Yes I would liaise with them", and another person told us that they "Were informed of any changes".

We observed staff throughout the day supporting people who lived at the home. The atmosphere was warm and welcoming. When we spoke with the staff they showed an awareness of the health needs of the people who lived in the home and were able to tell us of what care was needed and preferred. It was obvious from our discussions that the staff knew the people well and they spoke about them warmly. Interactions between staff and the people they cared for were positive. All the staff we observed were respectful of people's dignity and supported them at their own pace. It was clear from our observations that staff had good relationships with the people they cared for.

At the time of our inspection there was no one currently receiving end of life care, however we saw that some staff had previously received training regarding end of life care.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they were satisfied with the way care was provided and they felt listened to. We were told "It's satisfactory, I can't complain". We asked if people felt comfortable raising concerns or complaints. Everyone we spoke to told us "Yes". People were also able to identify the registered manager as a person to go to with any concerns and complaints.

We looked at the provider's complaints procedure and saw that it had not been reviewed since 2004. It gave incorrect contact details for The Care Quality Commission and other contact details for other organisations people could contact in the event of a complaint were also incorrect. This meant people may not know who to direct their complaint to, or which external bodies to escalate their complaint with, should they be dissatisfied with the manager or provider's response to their complaint in the first instance. The provider's complaints policy was stored on a shelf in the manager's office and so was not visibly displayed for people who lived at the home to easily
see.

We asked people about the activities on offer at the home to occupy and interest them. One person told us "A singer used to come". We looked to see if there was any information about any activities provided. We could find no information. We asked the deputy manager about this who told us about people having access to the hairdresser. This meant there was no evidence that a suitable programme of activities were provided to ensure people who lived at the home lived in a social stimulating environment that maintained their quality of life as stated in 'The Glen Rest Home Service Users Guide'.

During our inspection we looked at three care plans, these contained information on how to support people's needs including mobility, personal care and nutrition however some of these had not been appropriately reviewed. An example of this was when a person came out of hospital and the care plans had not been reviewed for the persons changed needs.

We also saw inappropriately completed sections of the care file. An example of this was one section within the care file that had the heading 'Spiritual wellbeing (including end of life and resus issues'. This was the section where information regarding any resuscitation wishes and any support needed for spiritual well-being should have been documented. None of this information available, however we saw comments surrounding watching television and family visits.

From people's care files, we saw that people had access to a wide range of healthcare professionals as and when they needed it. We asked people if they were able to access any services and we were told yes. One person told us "Oh yes they deal with calling the G.P.". Families also told us that other professionals were accessed immediately and we noted in people's files that there was a record of hospital visits.

We asked people if they were able to leave the premises and go to places of their choice. One person told us about how they were able to go out. We also asked people if they were able to have family/friends visit at any time. All said yes with one person commenting "Oh yes, they all come [visitors]".

Requires Improvement

Is the service well-led?

Our findings

We asked the deputy manager for evidence of quality monitoring systems in place that ensured the health, safety and welfare of people who lived at the home. Limited evidence of any such systems being in place was provided. We were provided with one monitoring form dated in July 2016 and following our inspection we were provided with another from September 2016. Both of these monitoring forms stated parts of the environment were free from signs of damp and mould. We saw that this was not the case. This meant the provider had no effective way of ensuring the care provided to people who lived at the home was safe, effective, responsive and well led.

We found some risks in relation to people's care were not adequately assessed and managed. We asked if any care plan audits were undertaken to ensure the planning of people's care gave staff adequate information on people's needs. The deputy manager told us that no care plan audits were currently undertaken. This meant there were no adequate systems in place to check that people's assessment and care plan information was accurate and sufficient.

We saw that accident and incidents records were completed as and when accidents or incident occurred. We asked the deputy manager if this information was audited and analysed in any way to identify any potential trends in when, where and how accidents or incidents occurred so that preventative action could be taken. We were told no accident and incident audits were undertaken. This meant that staff had no opportunity to learn from the way accidents and incidents occurred in order to prevent them in the future. We also saw that these incidents had not been reported to the Care Quality Commission as appropriate.

We looked at the homes policies and procedures and saw that they were all out of date with misleading information. These documents had a form at the front of each policy where staff were to sign to say they had read the policy. The last date staff had signed was 2007. This meant staff did not have access to up-to-date guidance to support them in their work.

These incidences were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to assess, monitor, improve and mitigate risks for those using the service.

We saw evidence that a relative's satisfaction survey was undertaken in 2016. The response from people and their relatives was all positive. This meant people and relatives had had an opportunity to express their views about the quality of the service.

Staff we spoke to felt supported in their role. One member of staff said, "They're easy to talk to, if you have any issues you can go straight to them and they'll sort it out".

We asked people living at the home if they knew who the manager was and they were able to tell us that they did. This showed that the registered manager was a visible presence around the home and was approachable. One relative told us "Oh yes I know the manager" and a person who lived at the home told us

"Yes I know the manager [name], she's on holiday at the moment".

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 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess and monitor their service against Health and Social Care Act Regulations or to assess, monitor and mitigate the risks to the health, safety and welfare of people who used the service, or maintain securely records in respect of each service user.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have suitable systems and processes to ensure the premises were safe, suitable for use and met statutory requirements.

The enforcement action we took:

We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.