Saffronland Homes

Glen Rose

Inspection report

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

Summary of findings

Overall summary

This unannounced inspection took place on 4 and 5 September 2017.

In May 2017 The Care Quality Commission (CQC) re-registered the provider Mr Amin Lakhani under the new business name of Saffronland Homes. There has not been any change in ownership of Glen Rose, just an adjustment to the business title/ provider name. As there has not been any change of ownership or leadership at Glen Rose, this report makes reference to how under the previous provider name of Mr. Amin Lakhani, Glen Rose was not meeting a number of the fundamental standards and was in breach of four Regulations. This inspection checked to see whether those required improvements had been made.

Glen Rose provides accommodation and nursing care for up to 47 older people who are living with dementia and have nursing needs. The accommodation was arranged over the ground and first floors. At the time of our inspection, 26 people were accommodated in the home. The home had two communal lounges and a conservatory although we were told this was not well used and there were plans to develop this into a memory library. During the inspection, the main lounge was not in use as it was being decorated as part of a programme to improve the environment for people using the service. Both floors had a wet room and there was also an assisted bath. A lower ground floor was occupied by the laundry, kitchen, training room and treatment room. There were plans to develop one of the rooms on this floor into a hair salon. There was a small enclosed garden to the side of the building and a larger garden to the rear. Parking was available.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's care and treatment needs and to ensure that the fundamental standards were met.

The management of medicines required improvement. The provider's records showed a high number of medicines errors had occurred within the service. We also found a number of gaps or omissions on people's medicines administration records. We could not be assured therefore that people were receiving their medicines as prescribed.

Staff did not always offer or provide people with support in a manner that promoted their dignity promoted their dignity. Staff did not consistently offer people choices about how they would like their care to be provided.

Risks associated with the safety of the premises and of the equipment within it had not been adequately assessed and planned for.

People did not always receive person centred care which was responsive to their individual needs. Care plans did not always contain the guidance needed to support staff to effectively and consistently respond to some people's needs. This had been a concern at our last inspection and was a Regulation that the provider was already in breach of.

Despite a programme of audit we continued to find a number of areas where the service was not meeting the fundamental standards. This meant that the quality assurance systems in place were not being fully effective at driving improvements.

Further work was needed to ensure that the Mental Capacity Act (MCA) 2005 was used effectively and consistently within the service. Deprivation of Liberty Safeguards had been applied for when people needed their liberty to be restricted for them to live safely in the home.

Improvements had been made to ensure that people's nutritional needs were monitored, but improvements were now required to ensure people were supported to eat and drink in a timely and dignified manner.

People took part in a range of activities. However, our observations and feedback from some relatives and staff indicated that it was often difficult for the staff member responsible for coordinating activities to focus on their role as they were often called upon to supervise the communal areas to help keep people safe.

Incident reports showed that people had experienced a high number of unexplained bruises or skin damage. Whilst these had been investigated by the registered manager, they had not been escalated to the local adult services teams. This is important as it helps to ensure that the relevant agencies have oversight of potential risks within the service and are able to support and advise the leadership team.

Overall the home and items of equipment used for people's care were clean.

Care staff demonstrated a good understanding of their roles and responsibilities in safeguarding adults at risk.

Appropriate recruitment checks were undertaken before new staff started work within the service.

People had access to healthcare professionals when they required this.

Improvements had been made to make the home's design to help counter the impairments that people living with dementia experience.

Staff were kind and caring. Where able, staff took the time to engage and listen to people and show concern for their wellbeing.

Complaints policies and procedures were in place and records were kept of the actions taken in response to complaints received.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date once any representations and appeals have been concluded

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.

There were insufficient staff deployed to meet people's needs.

Risks associated with the safety of the premises and of the equipment within it had not been adequately assessed and planned for.

Improvements were needed to ensure that medicines were managed safely.

Overall the home and items of equipment used for people's care were clean.

Care staff demonstrated a good understanding of their roles and responsibilities in safeguarding adults at risk.

Appropriate recruitment checks were undertaken before new staff started work within the service

Is the service effective?

Requires Improvement

The service was not always effective.

Further work is needed to embed a programme of supervision within the service. Staff were appropriately trained and inducted to the service.

Some improvements were needed to the mealtime experience.

Improvements were needed to ensure that people's rights were protected and to ensure the principles of the Mental Capacity Act (MCA) 2005 were being fully followed.

People had access to a range of health care professionals.

Improvements had been made to make the home's design to help counter the impairments that people living with dementia experience.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always offer or provide people with support in a manner that promoted their dignity. Staff did not consistently offer people choices about how they would like their care to be provided.

Information about people was not always kept confidentially.

Staff were kind and caring. Where able, staff took the time to engage and listen to people

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person centred care which was responsive to their individual needs.

People took part in a range of activities. However, our observations and feedback from some relatives and staff felt indicated that it was often difficult for the activities lead to focus on her role due to needing to supervise the communal areas.

Some systems were in place for the provider to seek people's views about the quality of their care and support.

Complaints policies and procedures were in place and records were kept of the actions taken in response to complaints received.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some people lacked confidence in the leadership to make improvements to the service.

Staff generally felt well supported but said they would value more opportunities for staff meetings.

Incidents that affect the health, safety and welfare of people had not been reported to relevant authorities.

Despite a programme of audit we continued to find a number of areas where the service was not meeting the fundamental standards. This meant that the quality assurance systems in place were not being fully effective at driving improvements.

Glen Rose

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 was 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 4 and 5 September 2017 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who was a registered nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the service tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with six people who lived at the home and five relatives. We also spent time observing aspects of the care and support being delivered and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot talk with us. We spoke with the registered manager, the deputy manager, the provider's head of operations and general manager. We also spoke with two registered nurses, eight care workers, the chef and the activities lead. We reviewed the care records of five people in detail. We also viewed other records relating to the management of the home such as audits, incidents, policies, meeting minutes, training and supervision records and staff rotas. We sought feedback from two health and social care professionals.

The last comprehensive inspection of this service was in April 2016 when concerns were found in a number of areas. As a result we took enforcement action in relation to premises and equipment, treating people with dignity and respect and assessing and monitoring the quality and safety of the service. We also found that the provider was not meeting three other Regulations. A focussed inspection was carried out in November

2016 during which we found the provider had made sufficient improvements to meet the enforcement notices. However, further improvements were needed with regards to the suitability of the premises. This inspection checked to see that the suitability of the premises had improved and to see that the other three requirements issued in April 2016 relating to relating to person centred care, safe care and treatment and staffing had also been met.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they did feel safe. A relative said, "I can't compare with other homes but I am sure my [family member] is safe." Another relative said, "It is safe, I did ask for a sensor matt and they got one". However, a number of people and their relatives also expressed concern to us about the number of staff deployed to meet people's needs. One person said, "There is not always staff around to help….I wanted a shower a week ago and I've still not had it". Another person told us, "I feel safe here, but there are not enough people to help." A relative told us, "There never seems to be enough staff, you cannot see anyone for an hour".

A number of people could display unpredictable behaviour that might challenge others, or were at high risk of falls and so also needed a high level of observation. We found there were periods of 15 or 20 minutes when people were left unsupervised in the communal areas. A member of staff told us that one person was "Vulnerable and a falls risk so we keep him in the lounge". We noted that this person was left, unattended by staff, in the lounge between 10:45am and 11am and between 11.30am and 11.50am.
During the inspection, the main lounge was not in use as it was being decorated as part of a programme to improve the environment for people using the service. As a result people were being cared for in alternative locations such as the conservatory and upstairs lounge. Whilst we accept that this may have caused some disruption or affected people's usual routines, it was evident from our discussion with staff and relatives that the lack of supervision of some people when in communal areas was an ongoing concern. For example, one relative said, "There are not enough staff, when we come in [family member] is in an upstairs lounge with three or four other residents, the buzzer is the other side of the room and people would have difficulty getting to it and then would not know how to use it." Minutes from a residents meeting in June 2017 show that relatives had raised concerns about the main lounge being unsupervised for a period of 40 minutes.

There were insufficient numbers of staff to ensure that people received the support they required at mealtimes and to ensure each person had a positive dining experience. In the conservatory, there were two staff present supporting eight people. Four of these people needed assistance to eat and drink. The others required encouragement or other interventions to manage their anxiety or agitation. The staff began assisting two people. One of the permanent care workers was seen to interact well with the person they were assisting and was trying to support them to eat in a person centred manner, however, they were frequently having to focus on other tasks, such as encouraging two people to stay at the table and eat their meals, serving puddings and reassuring a third person who was shouting out as they had finished their meal. One of the people eating in the conservatory had had their meal placed in front of them at 1pm. There was no staff available to support them to eat. They kept getting up from the table. The staff member, who was supporting another person, encouraged them to sit down and eat their lunch. However, at 1.15pm, this person had still not eaten any of their meal and was still frequently getting up from the table, or just sat in front of their meal watching others. At 1.40pm, another care worker entered the room and stood beside the person and started to offer them assistance to eat, albeit by standing over them. This was 40 minutes after their meal had first been placed in front of them. We were concerned it would now be cold, but no attempt was made to check the temperature of the meal, offer a fresh meal or reheat the food.

Staff were not always able to respond to people's request for assistance in a timely manner. We observed one person calling out for assistance to get up for 40 minutes. We went and sat with the person to reassure them until staff were available to support them.

We observed on both days of the inspection that care workers were constantly busy and often only had time to interact with people whilst completing care and support tasks. This was commented on by one of the relatives who told us, "The staff do go up to Mum and offer drinks, but there is no time for interaction." A care worker told us, "We are often short staffed and have to rush around". Another told us that performing people's morning personal care routines frequently took until lunch time, sometimes after, to complete. A third care worker told us, "As soon as tea-time is over you are under pressure to start personal care and get people to bed".

The registered manager used a systematic approach to determining the staffing levels within the service which they told us was based upon the dependency of people using the service. However, despite this, we were not confident that there were sufficient numbers of staff deployed to meet people's needs.

This is a breach of Regulation18 (1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that there were sufficient numbers of staff deployed to meet people's needs.

Since the inspection, the Operation Manager has advised us that an experienced nurse manager has been appointed along with two permanent registered nurses working nights. Moving forward this will help to bring stability to the clinical team and provide support the registered manager.

Our last comprehensive inspection had found that the provider had not ensured that risks associated with people's care were effectively assessed and action taken to mitigate these. This inspection continued to find concerns regarding how the service managed risks to people's safety and wellbeing.

Improvements were needed to ensure the safety of premises and of equipment within it. Staff told us that some of the alarm mats used to alert them that people at high risk of falls were moving could not always be heard when activated, increasing the risk that staff might not be able to respond in time if people who were at risk if they left their beds without supervision.. We discussed this with the registered manager and general manager, they told us the mats would be replaced that day.

We checked the four suction machines used by the service. None were found to be in good working order on the first day of the inspection. Suction machines are used to remove substances or blockages from people's airways to prevent them choking. A number of people living at the home had been assessed as being at risk of choking. The lack of working suction machines could have placed people at risk of significant harm. We were concerned that registered nurses had recorded that they had made weekly checks of the suction machine with no concerns noted. On the second day of the inspection, the general manager confirmed that the machines had needed new filters and were now working. Two new machines had also been ordered.

We noted that wardrobes were not attached to the walls to prevent them toppling over and potentially harming people. We discussed this with the registered manager who has taken action to address this.

Our previous inspection had found that a room in the basement referred to as the conference or training room was cluttered and could present a fire risk. We continued to find that this room was cluttered. The registered manager told us this had already been identified as an area which needed to be readdressed and that this would be completed by the 12 September 2017.

People had not been protected from other risks associated with the environment. We found a sluice room unlocked. It is important that these remain secure to prevent people from gaining access to hazardous substances which can cause harm. This was brought to the attention of the nurse in charge. The water being discharged from sinks in a number of people's rooms had been recorded as being in excess of safe temperatures as determined by the Health and Safety Executive in July 2017. We asked for some additional records regarding this, but these were not provided. We could not be confident that timely action had been taken to address this concern. This placed people at risk of scalding.

When inspecting the kitchen, we found that raw meat had been stored on the same shelf as milkshakes. This is unsafe food hygiene practice. The chef told us a momentary lapse of concentration that had led to this. The food was removed. The service had had a food hygiene rating in July 2017 and been awarded a score of two. The registered manager told us this was because raw and cooked meat was not being appropriately stored.

The provider had not ensured the ongoing safety of the premises and of the equipment within it. This was a breach of Regulation 12 (2) (d) and 12 (2) (e) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Other risks to people were being well managed. People had moving and handling risk assessments and falls risk assessments. Where people were at risk of falling from bed, bed rails were used once appropriate consent and risk assessments had been completed. Manual handling equipment such as hoists and stand aids were available and used. Hoist slings were checked and found to be in good order and person specific. Pressure relieving mattresses were being checked daily to ensure they were at the right setting to remain effective. One person was unable to eat and drink due to swallowing difficulties. They had appropriate care plans regarding this with risk factors identified and planned for.

People were monitored and checked for injuries following falls and the registered manager was working with healthcare professionals to analyse and learn from the circumstances around people's falls to reduce the risk of these happening again. Each person had a personal emergency evacuation plan which detailed the assistance they would require for safe evacuation of the home. A fire risk assessment had been completed and fire equipment tests were up to date and staff were trained in fire safety. The provider had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.
Improvements were needed to ensure that medicines were managed safely. This particularly related to how staff followed procedures in relation to how they recorded administered medicines.

According to the agreed protocols within the service, staff were meant to check each other's medicines administration records (MARs) after each medicine administration round to see that the medicines had been administered correctly. This was not always happening. During the inspection we found a number of examples where there was a gap in the person's MAR but no code had been used to indicate the reason why. This meant we could not be confident that people were receiving their medicines as prescribed. Despite a programme of audit and competency assessments, the provider's records show that there continued to be a high number of medicines errors within the service. For example, between 14 and 18 August 2017 there were 48 medicines errors recorded. All of these errors had been made by agency nurses. None of the errors had resulted in harm to people and a meeting was planned with Adult Services to review the errors and to ensure that all of the relevant remedial actions were in place to prevent further errors from occurring.

Where people were prescribed topical creams, topical cream administration records (TMARs) were in place,

but these did not include sufficient information about where and when the creams should be applied. Staff were not consistently recording when creams had been applied, we could not therefore be assured that people were receiving their topical medicines as prescribed.

Homely remedies were kept by the service, these are a range of frequently used medicines which people are able to buy to treat minor illnesses. One person was prescribed 'as required' or PRN paracetamol, but records suggested that staff were also administering paracetamol to the person from the homely remedies kept within the service. This increases the risk of the person being offered an unsafe dose of the medicine. Staff were not consistently recording the reason why 'as required' or PRN medicines were given in line with the provider's policy. This is important as it allows staff to monitor how effective the medicine is.

Medicines should be clearly labelled with the person's name or other identifying information to ensure that they are only administered to the right person. We found an insulin pen stored in the medicines trolley that was not labelled and four prescription topical creams in use that were not marked with a person's name.

The provider had not ensured the proper and safe management of medicines. This is a breach of Regulation 12 (2) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The proper and safe management of medicine.

During the inspection we observed a registered nurse preparing medicines, but then giving these to a care worker to administer to people. The registered nurse was signing the MAR even though they had not seen the person take the medicine. This could lead to an increased risk of medicines errors.

Controlled drugs were stored securely. We completed a random audit of the controlled drugs in stock and found records were accurate. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971. Most people had protocols and guidance in place for 'as required' medicines. Fridge and room temperatures were checked and we found medicines were stored at safe temperatures. There were appropriate procedures in place for the disposal and return of medicines which staff followed.

Care staff demonstrated a good understanding of their roles and responsibilities in safeguarding adults at risk. They were able to describe different types of abuse and the action they would take if they had concerns. They were confident that the leadership would take action to investigate concerns about people's safety. Staff were aware of whistle-blowing procedures and were clear they would raise any concerns with the registered manager.

Recruitment checks were undertaken before new staff started work within the service. The provider had obtained references from previous employers and checks had been made with the Disclosure and Barring Service (DBS). These checks help to ensure new staff members had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals. In the case of one care worker, their records did not include a full employment history. We discussed this with the registered manager who ensured that this information was obtained during the inspection.

Overall the home and items of equipment used for people's care were clean. Daily cleaning schedules were in place for people's rooms, equipment and the communal areas. We did find that some of the bed rail bumpers in use needed to be replaced as they worn and would be difficult to clean.

Requires Improvement

Is the service effective?

Our findings

People and their relatives gave us mixed feedback about the effectiveness of the service. One relative said, "On the whole the care is good, although last week, I found her eating cold dinner". Another relative said, "I couldn't find anywhere much better, I'm quite satisfied…they keep [their family member] nice and comfortable". A third relative told us, "We come at least twice a week. [family member] is well cared for the carers are lovely. [Family member] gets a hair wash once a week. She seems happy. She gets up into the chair at least two or three times a week. I keep on top of things, if I am worried then I speak to them and it is put right. Although I told them we were away for three weeks and when I came back [family member] had only been up twice in that time".

New staff received a first day induction which involved learning about some of the key safety and practical elements of their role such as fire safety, infection control and accident reporting procedures. They also had an opportunity to shadow more experienced staff and undertake their moving and handing training. Staff were also enrolled on the Care Certificate. The Care Certificate is a nationally recognised qualification and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

Our last inspection had identified that staff were not receiving adequate supervision. Records viewed as part of this inspection showed that supervision was still not being consistently provided. Supervision is an important tool and helps providers and managers be confident that staff understand their role and responsibilities, it can be delivered in a number of ways including one to one sessions, group supervisions and observations of practice. Where one to one supervisions or practice observations had taken place, the records relating to these were good, showing that staff were being encouraged to reflect upon their practice and where this could be improved. Most of the staff we spoke to generally felt well supported and felt they could approach the registered manager for advice when needed. However, records still did not show that all staff were being provided with regular supervision and therefore, the supervision programme in place was still not being operated effectively. Further improvements were therefore needed to embed a robust programme of formal supervision within the service.

Staff completed training in subjects such as moving and handling, food hygiene, first aid, infection control, health and safety, safeguarding and fire safety. Most staff had now either attended or been booked to attend training in the Mental Capacity Act (MCA) 2005 and in caring for people whose behaviour might challenge others. Staff had also undertaken training in caring for and communicating with people living with dementia. Staff could access distance learning training and 'micro-teaching' sessions were held on specific subjects. The registered manager told us the provider had plans to develop a 'Care Practitioner' role. The care practitioners would be provided with additional training to take on key responsibilities and support the clinical care provided.

Drinks were available throughout the day and we observed staff encouraging people to drink fluids and milkshakes prepared by the chef. The chef had information available to them about people's dietary needs and their likes and dislikes. The meals were cooked on site by the chef and were based around a four week

rolling menu which contained mainly traditional meals such as fish and chips, roasts, stews and pies. Vegetarian options were provided. The main meal was now served in the evening, with lunch being a lighter meal such as soup, omelette or sandwiches. The registered manager had consulted with people and staff about this change which they said had brought benefits to people included weight gain, more alertness in the afternoon and sleeping better during the night. Following the main meal at 5pm there was also the option of supper at 8pm when the night care workers arrived for their shift. We received mixed feedback about the food. One person said, "I get what I ask for if they can do it. It varies with the cook and not so good when it is an agency". A resident said "The food is good, but half of it ended up on the floor". This was because they had not been provided with the assistance they needed to eat their meal. A relative said, "I think the food is ok, he eats it all."

Our inspection in April 2016 had found that people's nutritional and hydration needs were not adequately monitored. This inspection found that overall sufficient improvements had been made with regards to this. The registered manager audited the fluid charts each week to ensure that people were receiving adequate hydration. They told us they would take action to refer people to their GP or relevant specialists if their fluid or food intake was consistently poor. We did note that in one case, care workers had recorded that the person had eaten all of their meal; this was not the case as we were aware a significant amount of their meal had fallen into their lap. We have discussed this in more detail elsewhere in this report.

We did see examples where staff were supporting people in a person centred manner, offering encouragement and engaging them in conversation. For these people lunch was a more positive experience; however this level of person centred care was not consistently available for each person.

Improvements were needed to ensure that food was always served hot. On the second day of our inspection, we noted that the porridge was brought into the one of dining areas at 8.45am. The same porridge was still being served to people at 9.30am. It was lukewarm. At lunch time, the food was delivered to the dining areas in a heated trolley. On both days of our inspection, care staff failed to plug the hot trolley in which meant food held in the trolleys was not being kept warm effectively.

We saw that some food was left out for extended periods of time without being covered. For example, on both days of our inspection we found plates of sandwiches left out uncovered. They were no longer fresh. We were also concerned that someone for whom this type of food was not safe or appropriate could have eaten one of the sandwiches placing them at risk of harm.

Improvements were needed to ensure that the principles of the Mental Capacity Act (MCA) 2005 were being fully implemented. The MCA 2005 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. A number of people were receiving their medicines covertly. Covert administration of medicines is the term used when medicines are administered in a disguised format such as in food or drink without the knowledge or consent of the person receiving them. Covert administration should only be appropriate where a person has been assessed as not having the capacity to understand the consequences of their refusal and the medicine is deemed essential to the person's health and wellbeing. We looked at the records for two people receiving their medicines covertly. Whilst there was evidence that a consultation with relevant health and social care professionals had determined that the covert administration was felt to be in the person's best interests, we were unable to see that an assessment of the person's capacity to understand the consequences of refusing their medicines had first been carried out.

We did see other examples where if a person's ability to consent to their aspects of their care plan was in doubt, a formal assessment of their capacity had been undertaken as part of the care planning process. However, it was not always clear that staff had always involved other professionals and family members in reaching best interests decisions about how people's care and support should be provided.

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). Relevant applications for a DoLS had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

People had access to a range of health care professionals including opticians, GP's, speech and language therapists and occupational therapists. A health care professional told us they were asked to visit in a timely manner and for appropriate healthcare needs.

Some improvements had been made to make the home's design to help counter the impairments that people living with dementia experience. The walls in the corridors had been decorated with artwork and reminiscence material to provide opportunities for interaction or stimulus. One area had been designed to look like a post office and included a working post box. The registered manager told us that people enjoyed walking through this area and chatting with staff about their memories. One corridor had a memory tree. People were supported to place leafs on this tree describing an important memory to them. The aim was that this would be used to stimulate conversations between people and staff about the things that were important to people. We saw the activities coordinator use the tree in this way. A relative told us, "They have made some improvements to the environment, they have done some decorating, I generally find it clean, nice and cheerful".

Requires Improvement

Is the service caring?

Our findings

People told us, staff were "very kind" and "funny". One person told us "staff are pretty good to me". A relative said their family member was "treated nicely". Staff spoke fondly of the people they were looking after. One care worker told us, "I look after these residents like they are my own family". Another said, "I want to do the best I can for the residents". We saw that the staff had received a compliment which read, 'I would like to thank you all for your kindness in helping [the person] settle in his new home…your patience is appreciated. Most of all I would like to thank [staff member] for his great sense of humour and kindness…he made the breakthrough and made him laugh and be happy'.

However, our observations indicated that people were not consistently treated with dignity and respect. Staff did not always offer people support in a discreet manner that did not draw attention to the fact that the person might want the toilet for example. We observed one person being hoisted in a communal area. This person was wearing a skirt and had a catheter. The staff hoisted this person without attempting to protect her dignity and modesty during the intervention. We observed three people whose dignity had been compromised as their catheters had been left exposed. No attempts had been made to offer the person a blanket for example.

We observed lunch on both days of our inspection. In the upstairs lounge, one person had their meal placed in front of them at 12.50pm. They were not able to eat independently. Carers walked past and offered verbal prompts but were busy serving meals and assisting other people. On two occasions a carer stopped to spoon some food into the person's mouth and then proceeded with other tasks. At 1.20pm the person tried to support themselves to eat, they scooped food up and tried to eat this, but most the food dropped into their lap. Staff placed another person's dinner out of reach on their bedside table. He was seen to manage to pull table to him and then stretch to get his food. We observed other people being supported to eat and drink by a variety of different care workers as staff were multi-tasking or called away to support someone else. This is not a dignified way in which to support people to eat and drink.

We saw a number of examples of staff taking the time to offer people choices about how they would like their care to be provided, however, these good interactions were not consistent. For example, we saw that some staff placed clothes protectors on people without seeking the person's consent. Another person had their drink taken away from them with no indication from the care worker that this was going to happen. We observed that this caused the person some distress. Another staff member stepped in and gave the person an alternative drink. Some staff told us that people were not always able to make choices about when to get up or when to go to bed or when to have a shower. One care worker told us, "People love to have showers but you may have to say wait until tomorrow, it's horrible to have to say no".

Information about people was not always kept confidentially. There was a list on the wall in one of the communal lounges showing which people had a 'Do Not Resuscitate' decision in place. Booklets containing records used to monitor aspects of people's care were left in a communal lounge/dining area.

This was a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations

2014. Dignity and Respect.

We did however; also observe a number of kind and caring interactions. Staff approached people and smiled, they reached out for people's hands, they spoke kindly. Some people experienced a positive mealtime experience, with the staff member assisting them being attentive, readily chatting with them and encouraging them to eat and drink. We observed a care worker gently stroking one person's face telling them that their lunch was here. The person opened their eyes and smiled. We saw one care worker say to a person jokingly, "Can I wipe your face as you have been eating chocolate without me".

We saw staff being patient, reassuring and supportive to people who were distressed. Where able, staff took the time to engage and listen to people and show concern for their wellbeing. The permanent staff appeared to know people well. For example, one care worker told us, "This lady likes to have personal contact and for carers to touch her, and feel that someone is near". We saw another care worker approach a person and say, "Are you feeling ok, as you don't look quite yourself today." We did note that staff often referred to people as 'sweetheart', 'darling' or 'honey'. Whilst staff were using these names as terms of endearment, for people living with dementia, reinforcing their identity through the use of their preferred name is important and therefore takes on additional significance. We looked at three people's care records to check if they preferred to be called by these terms of endearment, there was nothing recorded to suggest this was the case.

We saw examples of people being encouraged to remain as independent as possible. For example, we heard a care worker say to one person, "Would you like me to help you or do you want to do it yourself". Another care worker was seen to be encouraging a person to stand. They said, "That's good well done".

Requires Improvement

Is the service responsive?

Our findings

At our inspection in April 2016, we found that care had not always been designed and delivered to meet people's individual needs. This inspection found further concerns and the service continues to not meet this Regulation. Some of the care practices within the home were institutionalised. By that we mean care was delivered in the same way to each person and at the same time. For example, staff told us they carried out 'pad rounds' to care for people who could not manage to use the toilet. Supporting people with their continence care should be in response to people's individual needs and not part of a 'group round'. Medicines were not administered in a person centred manner. For example, a nurse interrupted one person's meal to apply cream to their knees. Another person's meal was interrupted to administer their inhaler. Following this, they were reluctant to continue eating their meal.

We observed a number of neutral interactions where the staff member was noted to be more focused on the task rather than communicating or making eye contact with that person. For example, one person was supported to eat and drink by an agency worker with almost no interaction throughout. A person told us, "They [the care workers] do a job and that is it…staff are under pressure so there is no time to find out about what is going on for me." Staff told us they were committed to providing person centred care, but that this was not always possible within the current staff levels and the competing demands on their time. One care worker said, "You can't do everything, you can't spend time with them and do the pad rounds".

During our observations, we noted, that at times, staff spoke about the people they were providing care to in terms of tasks. For example, people were referred to by staff as 'feeds', 'washes', 'singles' and 'doubles'. There is a risk that this kind of language supports a culture where care becomes task based rather than one which is person centred.

Whilst care plans were generally detailed and included some good information about people's care and support needs. We also found examples where people's care plans did not have sufficient guidance to support staff to effectively and consistently respond to some people's care and treatment needs. One person with a catheter had no catheter care plan in place. People who frequently displayed behaviour which challenged others did not consistently have a detailed care plan which provided information about the specific strategies and interventions staff could use to support the person and de-escalate agitation or aggression. A review of a number of ABC charts indicated that staff were not always intervening effectively with one person who could display behaviour which challenged others. For example, one chart read, '[the person] shouting at the other residents and running over their feet hurting them'. The chart recorded that to address this, staff had 'removed [the person] to the other part of the lounge and explained not nice'. The outcome was recorded as '[the person] continued to be disruptive. The next day there was a similar incident. The intervention was recorded as 'explained his behaviour not acceptable'.

Records relating to the delivery of care needed to improve. Whilst appropriate wound care plans were in place and photographs had been taken of wounds or skin damage, none of these included measurements of the wound which is recognised best practice. One person who had a catheter had no catheter care plan in place.

People did not always receive care from a stable staff team who were familiar with their needs. Records showed that wherever possible, the registered manager used regular agency or seconded nurses and care staff to cover sickness, leave and vacant posts. However, staff told this was not always the case and they expressed concerns to us about how this could at times impact negatively upon care delivery. For example, a care worker told us that when people did not know the staff looking after them, they were more likely to refuse support. They told us how one person would not take their insulin for an agency nurse. They said, "So I went and had a general chat with [the person] told her what could happen if she didn't take it, told her it would make her feel better, she then said yes, I watched the agency nurse do it to reassure [the person]. We observed that an agency registered nurse had not been able to recognise and respond appropriately to one person's needs. They had not made a timely decision to administer prescribed medicines to alleviate the person's symptoms. We were also concerned that this person's bedroom door had been closed meaning that staff would not be readily alerted to the fact that the person was agitated or distressed. Staff have now been reminded of the need to ensure that this person's door is left open unless they are receiving care. The person has been reviewed clinically to ensure their care remains appropriate. Another person told us, "I want to walk more. I go to the physio, but I have trouble getting out of my chair and I am not helped to walk as much as I would like."

Agency care workers were not currently given a copy of the handover sheet which detailed all of key information about people's needs. We were told that the handover sheets were only for nurses. A healthcare professional felt that the consistency of staff was an area which needed to improve. They told us, "The agency nurses do not know the patient". A relative told us, "There are too many agency nurses, they need more permanent staff". Another care worker said, "It depends who is on and the makeup of the team, we are trying to get regular agency but we need more permanent staff".

Whilst people's care records contained valuable information about their life histories and their interests, staff were generally unable to tell us about this. This information helps staff to interact with people in a person centred manner. Some staff told us they had not read people's written care plans and did not yet have access to view people's electronic care records.

Care was not designed and delivered to meet people's individual needs. This was a continuing breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

The service employed one full time staff member to lead the activities provision within the service who worked during the week. We observed people doing activities such as painting, reading the newspaper, listening to music and jigsaw puzzles. A small secure garden had been developed to the side of home and we were told that people had been involved in growing their own vegetables in this area. Over the summer, arrangements had been made for an ice cream van to visit which people had enjoyed. Outside entertainers were booked to sing or play music and visits had been arranged by a local clothing company and animal handling groups. Tea parties were held to celebrate birthdays. A 'community of friendly fish' had been introduced which were told had proven very popular with people. During the inspection we observed a chair based exercise activity taking place led by an external professional.

There was evidence that the activities person also spent time engaging with, and providing activities for people cared for in their rooms. However, our observations and feedback from some relatives and staff indicated that it was often difficult for the activities person to leave the communal areas to visit people in their rooms as they were being relied upon to supervise people at risk of falls or to prevent, incidents from occurring between people. One care worker said, "[activities lead] tries to get to people upstairs, but it's unsafe for her to leave the lounge as we have too many high falls risk". We also noted a number of occasions

when people had beads or necklaces placed in front of them, but without support, they were not able to interact with these or use them for stimulation or enjoyment. These people were not experiencing meaningful activities and interaction.

We recommend that the registered manager review the activities provision within the service to ensure that there are sufficient staff available to support this to be provided in a person centred and responsive manner.

Basic quality assurance surveys had been undertaken with relatives and staff in June 2017. The majority of the eleven relatives that responded felt the home was clean, that their family member was well cared for and that the atmosphere in the home was good or ok. Where areas for improvement had been identified, the leadership team were planning to seek more specific feedback to try and develop an action plan to address these. The main concern raised in the staff feedback was the effectiveness of the handover, which was also a concern raised with us. We were able to see that the registered manager was addressing this through attending handovers to assess their ongoing effectiveness. It was planned that surveys designed to be accessible for people living with dementia would soon be issued to seek people's views about their care.

Records showed that meetings with people and their relatives took place on a quarterly basis. The meetings were an opportunity for people to comment on the care provided. At the last meeting, people had raised issues regarding staffing levels, the redecoration of their rooms, clothing disappearing and made a request for the menu to be adjusted. Whilst the registered manager had responded to the points raised, we continued to find similar concerns during this inspection. For example, concerns had been raised about the lounge being left unsupervised placing people at potential risk and about people's meals being interrupted to administer their medicines. We could not be confident that sustained improvements were being achieved in response to people's feedback.

Relatives told us they were kept well informed and that they had been involved in reviews of their family members care. They felt able to visit throughout the day, and we observed them sharing in aspects of their loved ones care.

Complaints policies and procedures were in place and records were kept of the actions taken in response to complaints received. Records noted two complaints so far in 2017. Both had been investigated and responded to. However, we received mixed feedback about whether complaints or comments were always followed up effectively. One relative said "If I want to make a complaint I would talk to the management. Another said "Some issues we bring up at meetings. However, one relative said, "I would make a complaint to Head Office as [the registered manager] won't do anything."

Requires Improvement

Is the service well-led?

Our findings

Glen Rose had a registered manager in post. We observed the home manager knew people well and appeared to enjoy spending time with them. Their office was usually open and people living at the home were readily invited in to sit with them for as long as they wished or to visit for just a chat. People seemed very much at ease with the registered manager.

We received mixed feedback from people and their relatives about how well led the service was. Some relatives told us the home was well organised. Others told us they lacked confidence in the ability of the leadership team to drive improvements. One person said, "The home have four or five really good carers, but they [the leadership team] don't seem to have the sense to keep the good ones." Another person said, "I would not recommend this home to anyone. The management are not able to do anything." A relative said, "We do attend meetings and ask for things to be changed, but this rarely happens."

Staff generally felt well supported and were positive about the registered manager. One care worker said, "She has got all the paperwork to do, there is so much going on, she can't do it all at once, she does try and help us". Another said, "They are a good manager, dedicated, we can go to her". A number of staff told us they would value an opportunity to have more frequent staff meetings. The last one had taken place in March 2017. Minutes of the meeting were brief, did not include a list of which staff had attended and focussed on delivering management updates rather being an opportunity for staff to share concerns, raise questions or make suggestions on how the delivery of care could be enhanced.

The registered manager, their deputy and the general manager completed a variety of audits aimed at ensuring compliance with the Regulations and to assess, monitor and improve the quality of care provided. For example, environmental audits were undertaken weekly as was a wound audit. A medicines audit was completed monthly. Six monthly health and safety audits were completed. The provider had commissioned an independent auditor to undertake six monthly checks of the service and the general manager undertook monthly monitoring visits to the service. Infection control audits were also undertaken. Trend analyses were undertaken of the falls and incidents that took place usually on a quarterly basis. Most of these audits had actions plans attached that identified clear timeframes for improvement, who would be responsible for this and a record of whether the improvement had been achieved.

However, despite the audit programme, the quality assurance systems in place were not being fully effective at driving improvements and we continued to find a number of areas where the service was not meeting the fundamental standards. For example, a care plan audit completed by the registered manager on the 17 July 2017 had indicated that a behaviour care plan was needed for one person. This was still not in place on the 4 September 2017 despite the person displaying several episodes of behaviour which might challenge others. The continuous improvement plan developed in response to the external audit completed in February 2017 had identified that a robust system of supervision be implemented. This was still not in place. The same audit had identified that a system for ensuring that food was served at a suitable temperature needed to be implemented. We continued to find concerns regarding this. A dignity audit had not been repeated since November 2016 and no dignity champions were yet in place. We found people were not always receiving

care that was mindful of their dignity.

The failure to have an effective quality assurance system in place was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Incidents that affect the health, safety and welfare of people must be reported to relevant external bodies. Incident reports showed that between April 2017 and June 2017, there had been fifteen incident reports relating to unexplained bruises or skin damage of people who lived at the service. Whilst these had been investigated by the registered manager, they had not been escalated to the relevant external authorities. A review of one person's care records found that there had been two recent incidents which raised potential safeguarding concerns but these also had not been escalated to the local authority safeguarding teams. This has now been done. Escalating concerns is important as it helps to ensure that the relevant agencies have oversight of potential risks within the service. We have discussed these incidents with adult services who have told us they plan to work with the service to support their understanding of expectations around reporting and escalating concerns to the local authority.

During the inspection we found the registered manager and general manager open to receiving our feedback about the service and they both showed a desire to improve. A number of improvements were implemented during and immediately following the inspection which showed a commitment to address any areas of concern. In addition, the registered manager had a service improvement plan in place. A service improvement plan is a detailed formal plan that sets out and prioritises the improvements that the provider hopes to make to service delivery. It considers the resources needed to achieve these and the timescales within the improvements should be made.

The registered manager understood the challenges facing the service. They told us that the staffing arrangements within the service was their greatest concern and it was evident that the ongoing recruitment challenges and regular agency use were impacting upon their ability to consistently drive improvements. They explained that their main priority was the recruit and retain more permanent staff so that the use of agency staff could be reduced. They also wanted to continue to develop the environment to support people living with dementia. Some links had been developed with the local community. For example, staff had held a McMillan Coffee morning and local churches and schools visited to meet with people. The registered manager was keen to explore more ways of doing this in the future. The general manager advised that the provider planned improvements to their website and to their brochures which would include the use of more positive language to describe caring for people living with dementia. The registered manager told us they were proud of the improvements that had been made with regards to care planning and of the team work displayed by the staff group who they said worked hard and did their best.

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 9 HSCA RA Regulations 2014 Person-centred care Care was not designed and delivered to meet people's individual needs.

The enforcement action we took:

We imposed a condition on the provider's registration requiring them to submit weekly staffing rotas and to undertake a range of monthly audits and submit actions plans arising from these to the Commission on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were consistently treated with dignity and respect.

The enforcement action we took:

We imposed a condition on the provider's registration requiring them to submit weekly staffing rotas and to undertake a range of monthly audits and submit actions plans arising from these to the Commission on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the ongoing safety of the premises and of the equipment within it. The provider had not ensured the proper and safe management of medicines.

The enforcement action we took:

We imposed a condition on the provider's registration requiring them to submit weekly staffing rotas and to undertake a range of monthly audits and submit actions plans arising from these to the Commission on a monthly basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

There had been a failure to ensure that there was an effective quality assurance system in place.

The enforcement action we took:

We imposed a condition on the provider's registration requiring them to submit weekly staffing rotas and to undertake a range of monthly audits and submit actions plans arising from these to the Commission on a monthly basis

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of staff deployed to meet people's needs.

The enforcement action we took:

We imposed a condition on the provider's registration requiring them to submit weekly staffing rotas and to undertake a range of monthly audits and submit actions plans arising from these to the Commission on a monthly basis.