Memento Care Limited

Glenesk Care Home

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service: Glenesk is a care home that provides personal care for up to 22 people in one adapted building. It is registered to provide a service to older people who may be living with dementia or physical disability. At the time of the inspection 20 people lived at the home.

People's experience of using this service: People were placed at risk of harm as medicines were not managed safely. There had been a failure to learn from incidents. Improvements were required to ensure the home was clean and well maintained. There were not always enough, adequately trained staff available to meet people's needs. Action had not always been taken to protect people from improper treatment and abuse. Risks associated with people's care and support were managed safely. Overall, safe recruitment practices were followed.

Further work was needed to ensure people's rights under the Mental Capacity Act 2015 were protected. Staff required more effective training and support to enable them to provide high quality care. Mealtimes were positive experiences; however, more work was needed to ensure risks were managed safely. People had access to a range of health care professionals. Overall, the home was adapted to meet people's needs, but some areas were in a poor state of repair and there was limited private space.

People were supported by kind and caring staff. Staff upheld people's right to privacy and treated them with respect. People were enabled to have control over their lives and were supported to be as independent as possible.

People received the support they required from staff who had a good knowledge of their needs, wishes and preferences. People and their families were given an opportunity to discuss their wishes for the end of their lives. People were offered opportunities for meaningful activity. People were supported to raise issues and concerns and there were systems in place to respond to complaints.

Systems to ensure the safety and quality of the service were not fully effective. Where issues had been identified, improvements had not always been made or sustained. This failure to identify and address issues had a negative impact on the quality of the service provided at Glenesk. Sensitive personal information was not stored securely. The management team were responsive to feedback and took swift action to address issues identified in this inspection. There was positive partnership working with health professionals.

The service met the characteristics of Requires Improvement in most areas; more information is in the full report
Rating at last inspection: Requires Improvement (report published on 17 October 2017)

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: We found breaches in relation to safeguarding people from improper treatment and abuse,

safe care and treatment, consent and governance. Please see the action we have told the provider to take at the end of this report. In addition, the provider had failed to notify us of DoLS authorisations as required. This was a breach of regulation and we issued fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

Follow up: During our inspection we requested evidence of improvements made in in relation to medicines management. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Glenesk Care Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: This inspection was carried out by two inspectors and an expert by experience who had personal experience of caring for someone who uses services that support older people.

Service and service type: Glenesk is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did: Prior to the inspection we reviewed any notifications we had received from the service and information from external agencies such as the local authority. The Provider completed a Provider Information Return (PIR). This is information we require providers to send us to give key information about the service. We used this information to plan our inspection.

During our inspection we spoke with seven people who lived at the home and four visitors. We also spoke with four staff, a member of the catering team, the activity coordinator, the deputy manager, the registered manager and provider. We reviewed records related to the care of eight people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, four staff files and the staff duty rota. We looked at documentation related to the safety and suitability of the service and spent time observing interactions between staff and people within the communal areas of the home.

After the inspection we requested further information from the provider. This was provided within the

requested timeframe.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

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

Using medicines safely; Learning lessons when things go wrong; Preventing and controlling infection
• Medicines were not managed safely and people did not always receive their medicines as prescribed. We identified a range of serious concerns about medicines management. Some people had been given their medicines incorrectly. This posed a risk to people's health and wellbeing. Medicines records did not always contain the required information to ensure safe administration and this increased the risk of error. Medicines were not always stored safely or at the required temperature. These issues placed people at risk of harm.
• There had been a failure to learn from incidents. Although there were systems to reduce review and learn from incidents effective action was not always taken prevent the same thing happening again. In the past 12 months there had been three instances where people had left the home unsupervised, placing them at risk of harm. Although increased checks had been documented after each incident this had not been effective in reducing risk.
• The home was not clean in all areas and hygienic practices were not always followed. Some equipment such as commodes and mobility equipment had not been effectively cleaned. This coupled with unhygienic practices, such as the use of communal bath mats, could have increased the risk of infection spreading.
• Some areas of the home were not properly maintained, this did not promote good hygiene and increased the risk of infection. For example, some wooden surfaces were damaged and could have harboured infection.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our visit, the registered manager informed us they had taken action to ensure the safe management of medicines. We will assess the impact of this at our next inspection.

Systems and processes to safeguard people from the risk of abuse
• Action had not always been taken to protect people from improper treatment and abuse. During our inspection we were made aware of some allegations against a member of staff. This was known to registered manager, but they had not taken steps to safeguard people from harm until we raised this. These allegations had also not been reported to safeguarding.
• Incidents were not always referred to the local authority safeguarding adults team. A recent incident where a person left the building unsupervised was not reported to safeguarding until we intervened. This meant opportunities for independent safeguarding investigations could have been missed.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.
• Despite the above, people told us they felt safe. One person told us, "Yes (I feel) safe – I mean very safe." Records showed the registered manager had made safeguarding referrals for incidents other than the above.

Staffing and recruitment
• There were not always trained staff available to meet people's needs. Night staff were not all trained to administer medicines. This posed a risk that people who were prescribed 'as required' medicines for pain relief and symptom management may not get them in a timely manner. This placed people at risk of suffering unnecessary pain and distress.
• Following our inspection, the registered manager told us that arrangements had been implemented to ensure there were medicines trained staff at the home at all times.
• People's feedback about staffing levels was mixed. Some people told us there were enough staff. However, others told us there were not always enough staff to meet their needs quickly. One person said, "Sometimes I have to wait a long time for someone to answer my buzzer, but I realise I am not the only person in here and they have a lot to do." A relative told us, "I'm not sure there are enough staff, sometimes I think they could do with a few more."
• The registered manager and provider told us they used a tool to calculate how many staff were needed. They told us, and records showed, that staff were deployed according to the assessment tool. They told us they would review staffing practices based upon feedback.
• Overall, we found safe recruitment practices had been followed. However, when staff had previous convictions there was not always evidence that risks had been properly assessed. We have reported on this further in the 'Is the service well led?' section of this report.

Assessing risk, safety monitoring and management
• Overall, risks associated with people's care and support were managed safely. Plans were in place that detailed risks relating to people's care and support and how these risks should be managed. For example, when people had been assessed as being at risk of falls, preventative measures were in place. When people were at risk of pressure ulcers, equipment was used correctly to reduce risk and records showed people were repositioned frequently. The home had recently received praise from external health professionals for success in promoting the healing of a person's pressure ulcer.
• Some people sometimes behaved in ways that could put them or others at risk. There were plans detailing triggers to anxiety and specifying how staff should respond to keep the person and others safe. Records showed staff followed the guidance to successfully reduce risk.

Requires Improvement

Is the service effective?

Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.
• There was a risk people's rights under the MCA may not be protected. There was no evidence that some decisions resulting in restrictions upon people's choice, freedom and privacy, had been made according to the principles of the MCA. One person had restricted access to cigarettes. However, their capacity had not been assessed and there was no evidence that less restrictive options had been considered. Two other people had their movement continuously monitored by assistive technology, their capacity to consent to this had not been assessed.
• Images of people who lacked capacity to consent had been shared on a public access social media site. The registered manager told us people's families had been consulted, but there were no capacity assessments or best interests decisions for people who could not consent.
• Furthermore, there were restrictions imposed upon people who had capacity to consent. One person told us staff had taken their cigarettes and they were not always provided with support to smoke them when they wished. This did not respect their rights.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The registered manager had made applications for DoLS where appropriate. Action was underway to comply with conditions specified in DoLS authorisations.

Staff support: induction, training, skills and experience
• Although records showed staff had training in key areas this did not always ensure their competency. Most staff were trained in safeguarding, but safeguarding referrals had not always been made as required. Senior staff had received medicines management training; however, medicines practices were not safe. Further work was needed to ensure that staff were competent in key areas.

• Staff told us that they had enough training but commented that it was not always effective as most of training was online. Some staff commented that they had learnt by trial and error. They had requested more face to face training but told us this had not yet been provided.

We recommend the provider reviews it approach to training and development to ensure staff have the required competency to deliver safe and effective care and support.

• Staff did not always have regular supervision and support. Records showed supervision was infrequent for some staff. Staff commented that they did not always find supervision helpful. This meant opportunities to manage performance and support staff development may have been missed. When supervisions did happen, they were prescriptive and didn't allow the staff member to discuss their role. Nor did it allow them to raise any concerns about people they were responsible for key working.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to them moving into Glenesk. This information was used to form the foundation of their care plan. We reviewed the care records of people who had recently moved into the home and found they contained key information to ensure their safety and wellbeing.
• The tools the service used to assess people's needs were nationally recognised tools that helped the provider to deliver consistent care for the people they supported.

Supporting people to eat and drink enough to maintain a balanced diet
• People had enough to eat and drink. People told us they liked the food. One person told us, "I certainly have no complaints on that score. The food is beautiful. I was underweight when I came in here, but have put on 2 kilos. I've only been here [a short time] so that shows you how good it is."
• Mealtimes were sociable occasions and staff ate their meals with people. Overall, staff provided timely assistance to people when needed. People were offered choices and dietary preferences were catered for.
• Further work was needed to ensure risks associated with eating and drinking were managed safely. Some people required modified texture diets to reduce the risk of them choking; however, food was not always served at the recommended texture. This placed people at risk of choking.
• When people were at risk of losing weight, staff monitored their weight regularly and made referrals to specialist health professionals as needed.

Adapting service, design, decoration to meet people's needs
• The home was adapted to meet people's needs. However, it was not well maintained in some areas. The provider informed us they had an ongoing programme of modernisation and people were involved in this.
• There was a large accessible garden. The provider and activity coordinator described their plans to improve the garden space when the weather improved.
• Consideration had been given to people's needs in the design and decoration of the building. There were two communal living areas which meant people had space to spend time socialising. However, there was no private space in the home, other than people's bedrooms. This lack of space had a negative impact on people's privacy.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People told us they were supported with their health needs. Some people said their health had improved since being at Glenesk. One person commented, "I came in here on oxygen but I am off it now, and it's all down to the care I have had."
• Records showed staff sought advice from external professionals when people's health needs changed. Care plans contained personalised and detailed information about people's health needs for staff to provide

effective support.
• Systems were in place to ensure information was shared across services when people moved between them. The electronic care planning system could produce an information pack should people be admitted to hospital. This helped ensure people received person centred support when they moved between services.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• People were positive about the atmosphere of the home and the caring attitude of the staff. One person told us, "The staff really care about me, they are kind and considerate, they are lovely." A relative said, "All the staff are really kind and caring, they welcome me in and I join in with activities and such like." Throughout our inspection, we saw staff had positive relationships with people living at the home.
• People told us staff knew them and understood what was important to them. It was clear that staff had a good knowledge of people's individual support needs and their likes and dislikes. Most care plans contained information about the person's history, important relationships and their individual preferences.
• Staff cared about people's wellbeing. One person told us, "I had a chest infection and had to go to hospital. A member of staff came with me and stayed with me all night. When she visited me the following day I said, "you shouldn't have come in" she said, "I couldn't rest until I knew you were alright."

Supporting people to express their views and be involved in making decisions about their care
• People told us staff consulted with them about their care and said they felt listened to. One person said, "I can do what I want. If I want to go downstairs I can and if I want to stay up here I can. It's up to me." A relative told us that, although their relation was no longer able to communicate their choice, staff tried hard to find out what they wanted to do.
• People had access to an advocate if they required one to help them express their views and there was information about advocacy displayed in the service. Staff advocated on behalf of people. For example, one member of staff had helped a person express their views to their family. This had a positive impact upon their wellbeing.
• People's relatives felt involved in the care of their family members. A relative told us, staff always called them to let them know about changes in their relations care, they said, "When [relation] started eating a bit more (the staff) actually phoned me to tell me. It is the little things like this which make it such a good place for [relation] to be."
• Although most staff had a good understanding of people's communication further work was needed to ensure people were aware of what was happening in the home. A fire drill took place during our visit. Seven people were left in the dining area alone, some of these people were clearly confused and asked us where everyone had gone.

Respecting and promoting people's privacy, dignity and independence
• As far as possible, people's right to privacy was respected by staff. People felt staff listened to them and treated them with dignity, for example, by closing the bedroom door whilst they were helping them to get dressed. One person told us, "They are very caring, they respect your privacy, but they are still there if you want them."

• Despite the above, there were times when sensitive discussions could be overheard by people in communal areas. This did not respect people's right to privacy.
• People were supported to be as independent as possible. One person explained that managing their own medicines gave them a sense of "autonomy." A relative commented, "Staff really encourage [relation] to be as independent as they can be." Care plans contained information about how to promote each person's independence and staff were clear on their role in this area.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People received consistent support which met their needs. People told us staff understood their individual needs and responded in timely way. One person said, "Staff come in every morning and every evening and you get a shower and everything."
• People and their relatives were involved in planning their care and care plans were focused on people's individual needs and preferences. One person told us, "Oh yes I have been involved in the care plan and look at it from time to time." Our conversations with, and observations of, staff demonstrated that they had a good knowledge of people's support needs and preferences and used this to inform support.
• The staff team were responsive to people's preferences and routines. A relative told us, "[Relation] is often up in the night and the staff bring them to somewhere they can keep an eye on them and make cheese sandwich and something to drink."
• People were provided with a range of opportunities for activity. Overall, people told us they had enough to do and could get involved with activities if they wished. The provider employed an activity coordinator who was relatively new in post. They told us they organised group activities and events. There were also activities led by external specialist companies, such as, exercise classes and group entertainment.
• There were links with the local community. A member of staff told us a recent visit from the local Brownies had been a great success. The home had an adapted vehicle which people used for getting out and about. One person used to be driving instructor and had helped ensure staff were competent to drive the vehicle. This had brought them great joy. Peoples' relatives were also able to use this vehicle to take their relations out.
• People's diverse needs were identified before they moved in to the home and care plans contained details of any support people required to ensure their needs were met. People's religious and cultural needs were accommodated. Local religious groups visited the home and staff supported people to attend local places of worship if they wished. The registered manager was planning to find out more about how best to support older people who may be lesbian, gay, bisexual or transgender.

Improving care quality in response to complaints or concerns
• People felt comfortable raising any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns.
• There was a complaints procedure on display informing people how they could make a complaint. Complaints had been investigated and responded to in an appropriate and timely manner.

End of life care and support
• People were given the opportunity to discuss their wishes and preferences in relation to care at the end of their lives. Where appropriate staff had supported people to think about their wishes for end of life care and this was compassionately recorded in people's support plans.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Systems to ensure the quality and safety of the service were not always effective in identifying and addressing areas for improvement. For example, infection control and medicines audits had not identified the issues we found at our inspection. This placed people at risk of receiving support which did not respect their rights or ensure their safety.

• Audits conducted by the provider were infrequent which meant areas for improvement were not identified or addressed in a timely manner. For example, the provider had conducted an environmental control audit in June 2018. There had been no audit since and we found ongoing concerns about the environment during our inspection. This failure to identify and address issues cited in this report, had a negative impact on the quality of the service provided at Glenesk.

• Where issues had been identified, improvements had not always been made or sustained. The local authority had conducted an audit in January 2018. This had identified similar issues to those found in our inspection. Although some improvements had been made, issues remained in relation to MCA, staffing and confidentiality. The failure to take swift action to address known issues compromised the quality of the service at Glenesk.

• Staff did not always feel supported and said poorly organised systems had a negative impact on them. Staff were not always given adequate notice of their shifts, they told us this made it difficult to plan and organise care for dependants. Although the registered manager told us they supported the diverse needs of staff, this view was not always shared by staff. Some staff told us they did not feel supported and despite raising issues, such as training not being accessible to them, changes had not been made.

• Sensitive personal information was not stored in line with the legal regulations. On our arrival to the home we observed that files containing sensitive personal information had been left unattended and accessible in a communal area. This posed a risk that information could be accessed by people who used the service or visitors.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There had been a failure to notify CQC of some events within the service, which the provider is required to by law. We had not received any DoLS notifications from Glenesk since it's registration in 2015. A failure to notify us as required has a negative impact on our ability monitor service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations.

• It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. The provider had displayed their most recent rating in the home and on their website.
• Throughout our inspection the management team were responsive to feedback and took swift action to address areas of concern. After our visit they provided us details of action taken to reduce risk.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• The provider and manager had a shared vision for the home. They aimed to provide a person-centred service and were aiming to provide outstanding care to people. The understood much work was needed to achieve this goal and were committed to making it work.
• People and their families were very positive about the home, staff and management team. A relative told us, "This home certainly is well led. They are wonderful people." Another relative told us, "You could not improve on the love and care people get in here."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their families were involved in some decisions about the home. Regular meetings were held where people were consulted about activities, food and the decoration of some areas. People and their relatives were invited to share their feedback in regular quality assurance surveys. Most feedback from the most recent survey was positive and action had been taken to address any suggestions for improvement.
• There were regular staff meetings for all designations of staff, these were used to share news and information with staff and to discuss areas of concern and improvements needed.

Working in partnership with others
• The team at Glenesk worked in partnership with other organisations to ensure people got the care they required. We spoke with a visiting health professional who was positive about the approach of staff and told us staff implemented advice given by them.
• The home had been praised by external health professionals for a they video produced to promote good pressure area care. Consequently, they had been put forward for a local award.

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 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act 2005 were not always protected. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored or managed safely. Effective action was not always taken to learn from accidents and incidents. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate action was not always taken to safeguard people from abuse and improper treatment. Regulation 13 (1)

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 18 Registration Regulations 2009 Notifications of other incidents We were not notified of Deprivation of Liberty authorisations as required. Regulation 18 (1)

The enforcement action we took:

We served a fixed penalty notice for this breach of regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the safety and quality of the home were not always effective. Sensitive personal information was not stored securely. Regulation 17 (1)

The enforcement action we took:

We served a Warning notice asking the provider to become compliant with this regulation by 6 May 2019.