The Glynn Residential Home Limited

The Glynn Residential Home

Inspection report

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Wakefield
West Yorkshire
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Glynn is a residential care home providing personal care to 28 people aged 65 and over at the time of the inspection. The service can support up to 38 people.

The Glynn accommodates 38 people over two floors, with communal areas on the ground floor.

People's experience of using this service and what we found
People were at risk of avoidable harm because risks had not been adequately assessed, monitored or mitigated. Care records did not contain sufficient information for staff to know how to care for people safely or understand their individual risks. Staff had not received adequate safety related training. Equipment was not assessed for individual use, or robustly checked to ensure people could use this safely. Systems and processes did not ensure the safe management of medicines or suitably skilled and trained staff.

Quality assurance processes were weak and no improvement had been made to address the breach at the last inspection or recognise further breaches in regulations we identified at this inspection. Audits were incomplete and ineffective and did not identify issues highlighted through the inspection process. Records of people's care were not accurate or detailed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 13 July 2019) and there was a breach of regulation 17, Good governance. The provider sent us an action plan to show what they would do to improve. At this inspection, enough improvement had not been made/ sustained and the provider was still in breach of regulation 17, with further breaches identified in regulation 12, Safe care and treatment, regulation 13, Safeguarding service users from abuse and improper treatment and regulation 18, Staffing. There was a breach in part of the registration regulations in relation to the requirement to notify CQC of significant events.

Why we inspected
This was a planned inspection based on the previous rating. The inspection was prompted in part due to whistleblowing concerns received about poor management of risks. The inspection was also prompted in part by notification of a specific incident following which a person using the service died following a serious injury. This is subject to a separate investigation by CQC. The information CQC received about the incident indicated concerns about the management of individual risks to people's health and safety. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led

sections of this full report.

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

The provider took some immediate actions following the inspection, such as arranging for lifting to be serviced and referring to the GP for people's specific health needs.

We reviewed the information we held about the service. No significant areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Glynn on our website at www.cqc.org.uk.

Enforcement.
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safe care and treatment, safeguarding people from abuse, staff skills and staff training, and management of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Since the last inspection we recognised that the provider had failed to notify CQC of safeguarding concerns. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We met with the provider following the inspection, to seek immediate assurances about the concerns found. We liaised with the local authority to ensure their support for the provider to improve.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

The Glynn Residential 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
The Glynn residential home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. 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 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
We telephoned the registered manager on the morning of the inspection to announce the inspection. This was due to the Covid-19 pandemic to ensure we had prior information to promote safety.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioning and safeguarding teams. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to

make. We took this into account when we inspected the service and made judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service. We looked at some people's rooms and equipment used for moving and handling. We spoke with the registered manager and reviewed a range of care records.

After the inspection
We requested further information from the registered manager, including care plans and quality assurance documents, which we reviewed as part of the inspection process. We held a telephone meeting with the registered manager to clarify some information in the documentation sent and validate evidence found. We spoke with eight staff by telephone. We had a telephone discussion with the district nurse, the infection control team and the local authority safeguarding adults team.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not adequately protected from the risk of abuse. Relevant matters had not been referred as required to the local authority safeguarding adults team or to CQC.
- There were no adequate investigations carried out where people had been injured. For example, one person's bruising was recorded on a body map, but with no investigation as to how this may have happened.
- Assessments and care planning were not robustly recorded to keep people safe and promote their rights.
- Staff understood safeguarding procedures but were not all confident when they raised concerns about people's care, this would be acted upon by management.
- Appropriate safeguards were not in place where people were deprived of their liberty; the registered manager told us there were 10 people who required a Deprivation of Liberty Safeguard (DoLS) but only five of these were valid. The registered manager told us these had been applied for, but could not show us confirmation these had been received by the local authority and were in progress. Some people were cared for in bed, but there was no indication in care records about why this may be so and who had made the decision. There was no information people had been consulted in this decision.

Systems were not robust enough to demonstrate people were adequately safeguarded. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not managed safely and there was no indication current and professional guidance was being followed. There were no consistent competency checks to provide assurance staff understood how to support people with medicines.
- During our visit to the home, one person called out continuously for 40 minutes. We went to speak with the person and although they could not communicate verbally with us, they showed signs of distress. We asked staff whether the person might be in pain and whether they had considered offering pain relief if so. Staff said the person had been offered pain relief but regularly refused this. We checked the person's medicines administration chart and there was no record of them having been offered or refused pain relief. Some staff who worked at night told us they had received no training in medicines and so would not be able to provide any support to people, if for example they had pain during the night.
- There were no audits carried out to ensure the safe management of medicines. The registered manager showed us completed stock checks only. They told us they relied on staff to report any concerns or errors.

Learning lessons when things go wrong

● There was little evidence of learning through previous experiences, such as incidents. For example, one person had recently left the home unnoticed. Our review of the incidents records showed there were no details of lessons learned, why the person left, and impact on the person and what could be done to prevent this happening again. Another person fell from their chair but there was no evidence of a management investigation into how this happened. The person had not been reassessed to ensure the equipment was suitable for their needs and safe to be used.

Assessing risk, safety monitoring and management

● People were not adequately protected from avoidable harm. Individual risks were not thoroughly identified, mitigated or monitored to ensure people received safe care and treatment. There was insufficient information in care records where people had specific health needs, such as diabetes or epilepsy, for staff to understand how to care for them safely. Staff did not all understand where people required support to reduce the risk of avoidable harm.

● There were not enough thorough checks of equipment to ensure this was safe for people to use. The most recent safety checks of the hoist and the passenger lift were in October 2019, yet the lifting equipment regulations state this equipment should be checked every six months. The provider arranged for checks to be made when we brought this to their attention. However, the certificate of thorough examination we requested was not submitted. One person had bedrails with no protective bumpers and there was no assessment of the risk of the person becoming injured or entrapped in the rails.

● People's moving and handling needs were not properly assessed and there was insufficient and conflicting information about the equipment they needed. Where people needed to be hoisted, this was not always carried out. People were not assessed for the use of hoisting slings and more than one person shared the use of the same sling. Staff lacked adequate safety-related training. They did not complete any practical assessments or demonstrations of their competence in moving and handling. Staff did not all understand people's moving and handling needs and gave us different information when we asked about individual people's support needs.

● There were poor systems in place for supporting people's skin integrity and skin care plans lacked detail. The registered manager told us people were supported to change position regularly if they were at risk of developing pressure ulcers. Records of repositioning were in place, although there was no information about how frequently people needed repositioning or how this should be done. One person's care record stated they needed two staff to reposition them. However, one member of staff repositioned a person without the support of their colleague. We asked the member of staff how many staff were needed to help the person change position safely and they told us two, but said they had done this alone.

● The registered manager told us the district nurse team were involved where there were concerns about people's skin, although any advice given by the district nurses was not recorded in people's care records. The registered manager said if people had any wounds or bandages then their care was the responsibility of the district nursing team. There was no information to show how often the district nurse team attended to each person, or how staff at The Glynn were supporting people's skin care in between district nurse visits.

● Some people were at risk of choking, but their care records had contradictory information. For example, one person's record stated they needed a soft diet, yet also stated they could have their food cut up into pieces. Another person's care record stated they were at high risk of choking, but their risk assessment made no reference to the thickener they needed to be added to their drinks for safe swallowing.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This also demonstrates systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider was unable to demonstrate sufficient staff were suitably qualified, competent, skilled and experienced to care for people safely. Staff had not received recent practical training in moving and handling, medicines or first aid. Some staff told us they lacked confidence in caring for people safely because they had not had enough training. The registered manager told us they relied on the experience of senior staff to help ensure new staff knew what to do, and they themselves had a 'train the trainer' qualification. However, we noted this had expired.

● Staff were not routinely assessed as competent to carry out their roles and there was no effective monitoring of their learning and development needs to ensure training requirements were met.

● There was no systematic approach to determine the number of staff and range of skills and competence needed to care for people living at The Glynn. The registered manager told us they preferred to have three staff on duty at night, but at times they had fallen below this level and only two staff were available. Staff who had worked a day shift had also continued working to cover the night shift on some occasions. Staff told us when there were only two staff on duty at night, they did not feel able to provide safe care.

There were not enough suitably qualified, skilled and experienced staff to ensure people's needs were met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The infection prevention and control team reported positively about completing training with the staff team during the Covid-19 pandemic. The registered manager told us no-one had experienced any Covid-19 symptoms and they were following government guidelines to keep people safe.

● The home was visibly clean and there were no malodours during our inspection.

● One lifting sling we looked at was stained and staff told us this sling was used for more than one person. Following our visit the registered manager said steps had been taken to obtain more slings so each person had their own.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection there were weaknesses in the audits of quality and safety. This was a breach in regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there had been a deterioration in quality and safety and the provider was still in breach of regulation 17.

- The registered manager did not demonstrate robust understanding of their responsibility to ensure people receive safe care in line with the regulations. Audits did not identify the widespread safety related failings found at this inspection.
- Systems and processes were not robust enough to ensure good governance in the home. Where there were audits, such as weights audit, these were not effective and did not take into account relevant information. For example, in May 2020, one person's GP recommended they be weighed weekly because there had been weight loss. However, May, June and July weights audits did not refer to this person or the need for close monitoring. Medicines audits were not properly carried out to identify any areas to improve. Equipment audits stated 'checked' and 'all ok' against a list of equipment, but did not show how or by whom these had been checked.
- There were no regular spot checks of practice made by the management team; the registered manager said they expected staff to report to them if they had any problems. The registered manager said senior staff had carried out some early morning spot checks in response to recent whistleblowing, but these were not recorded.
- There was a lack of oversight of accidents and incidents and little evidence taken to ensure people were robustly monitored and observed after falls. One person's daily notes showed they had appeared confused and sleepy after an unseen fall, yet there was no follow up action to consider whether medical attention was needed. Root cause analyses were not completed to identify reasons why incidents occurred and how to prevent reoccurrence.
- Risk assessments and care records for some people contained information which was no longer relevant, but these had not been updated.
- Care plan audits were not consistent or robust to ensure information was accurate and up to date.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This

placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager knew each person well who lived at The Glynn and considered they were very well cared for, happy and safe. The registered manager was able to provide more information about people's care than was documented.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager said they had an open door policy and was available for staff to approach at any time. Some staff told us they felt well supported. However, not all staff were confident to approach the registered manager or the provider and did not feel supported at all or safe to raise concerns in confidence. From speaking with staff, it was evident there was a lack of team working across different shifts, with different cultures between days and nights staff. Some staff reported cliques within the staff team and management which they felt was a lack of equality and a barrier to teamworking.

● The registered manager was aware there had been some discord within the staff team, although there was no evidence to show what was being done to address this in a positive way or to promote an open culture. Where whistleblowing information had been reported to CQC, the registered manager had not taken steps to understand the possible reasons, or to embed positive values and behaviours within the whole staff team.

● Staff meetings took place and these were in keeping with the need for social distancing, so some had been held in the garden. Minutes of staff meetings were available for reference should staff not be able to attend.

● There were visiting restrictions but people had been able to maintain contact with relatives during the pandemic and the registered manager had kept relatives informed of what was taking place in the home through various means, such as newsletters, social media and telephone contact. The registered manager engaged with the local community.

● There was little evidence of people's equality characteristics being considered; care plans made no reference to these for staff to understand people's needs and some language used in documentation was not person-centred.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager told us they had informed a person's advocate when they had fallen from their chair, although there was no other evidence of this discussion having taken place.

● The provider had failed to comply with the legal requirement to notify CQC of specific incidents. This was a breach of regulation 18 of the CQC (Registration) Regulations 2009.

Working in partnership with others

● CQC carried out an Emergency Support Framework call in May 2020 during the Covid-19 pandemic, which recommended the provider develop closer partnerships and networks to share good practice ideas.

● The registered manager was aware of the support available from the local authority, although they had not been able to join in with the weekly provider conference calls which were set up during the Covid-19 pandemic. The provider had declined the care home support team 'perfect ward' assessment to help them with their quality assurance processes. Good news stories about people's experiences during the pandemic had been shared with the local authority when requested.

● There were positive comments from the GP surgery in relation to partnership working with The Glynn and people had access to their GP when needed. Visits to people from other health professionals was recorded and showed regular district nurse and GP attendance as required.

● None of the people living at The Glynn had been seen by a dentist in support of their oral care. Care plans for people's oral care were not adequate. One person's care plan stated they had their own teeth and could not manage their own mouth care needs, but did not want staff to support them either. However, there was no consultation with a dentist.

● The infection prevention and control team gave positive feedback and had worked with staff at The Glynn to ensure they had up to date knowledge of procedures to help protect people against the risk of Covid-19.