Mr Amin Lakhani

Glen Heathers

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 29 and 30 November 2016 and was unannounced. The inspection was bought forward as we had been in receipt of information of concern about the care and support people received.

Glen Heathers is a registered care home and provides accommodation, support and care, including nursing care, for up to 53 people, some of whom live with dementia. The home is separated into three wings across two floors, with access to communal areas. At the time of inspection there were 26 people living in the home.

At this comprehensive inspection a registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The service has a history of non-compliance with the legal requirements. In March 2015 we identified multiple concerns and took enforcement action, including serving the provider with three warning notices in relation to standards of care and welfare for people who used the service, the unsafe management of medicines, the manner in which people were treated and a failure to ensure consent was gained and where appropriate the Mental Capacity Act 2005 was being applied correctly. These warning notices required the provider to meet the legal requirements by 4 June 2015. In addition, a condition was placed on the registration of the provider for this home stopping them from allowing any new admissions to the home without CQC's prior permission. At this inspection the overall rating was inadequate and we placed the service in special measures.

In June 2015 we undertook a focused inspection to check the provider had taken action to meet the legal requirements in relation to the three warning notices served. Some improvements had been made but they had failed to make sufficient improvements regarding the manner in which people were treated and in providing safe care and treatment. We served two further warning notices for the same breaches and required the provider to become compliant with these regulations by 14 August 2015.

In November 2015 we undertook a further comprehensive inspection. Improvements had been made and they had met the warning notices. At this inspection the service was rated as requires improvement. Two breaches of regulations were identified in relation to the cleanliness of the premises and the accuracy of care records. These were judged to have a minor impact on people. Due to the improvements made the service was taken out of special measures.

At this inspection we found areas which had previously improved but had since deteriorated again.

The overall rating for this service is now 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Whilst staff understood their responsibilities in relation to safeguarding people at risk, the registered manager was unaware of some unexplained injuries in the home and no action had been taken to investigate these. Risks associated with people's needs had not always been assessed and plans developed to reduce these risks. Medicines were not always stored safely and prescribed medicines needed in an emergency were not available.

Recruitment checks were carried out to ensure staff were suitable to work with people. Staffing levels were appropriate to meet people's needs. Improvements had been made to the environment which was now much cleaner.

Training and supervision was available for staff, although their competency was not always assessed and their training was not always up to date.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Consent was sought where the person could provide this. Mental capacity assessments had been carried out but not always reviewed. Deprivation of Liberty Safeguards (DoLS) care plans had been implemented to guide staff following authorisation of the application, except for one person who had a care plan detailing how they were being deprived but no application had been made. We have made a recommendation about this.

People were supported to access other health professionals and received support to eat their meals.

People were treated with dignity by staff who were kind, caring and respectful. We have recommended the provider and registered manager review the process used to ensure people are involved in decision making about their care and the home.

Preadmission assessments were not consistently carried out and then used to develop personalised plans of care.

A complaints policy was in place and people knew how to make a complaint. Records were not always clear about the action that had been taken following receipt of a complaint.

The provider, their senior management team and the registered manager had not identified the concerns we had through their quality assurance processes. Records remained inaccurate.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

Whilst staff understood their responsibilities in relation to safeguarding people at risk, the registered manager was unaware of some unexplained injuries in the home and no action had been taken to investigate these.

Risks associated with people's needs had not always been assessed and plans developed to reduce these risks.

Medicines were not always stored safely and prescribed medicines needed in an emergency were not readily available to nurses.

Recruitment processes were safe and staffing levels were appropriate to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had access to training and supervisions. However their practical competence was not always assessed and their training was not always up to date.

Consent was sought from people and where people lacked capacity to make certain decisions the Mental Capacity Act was understood and applied, although this was not always reviewed.

Staff supported people to eat, drink and access other health care professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff who understood their needs and were caring and compassionate.

Staff demonstrated an understanding of respect, privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Pre admission assessments were not always completed. People and their relatives were not always involved in the development of care plans. Care plans were not always developed to meet individualised needs.

There was a clear complaints policy and people knew how to use this, though records were not always well kept. People were encouraged to share their feedback via surveys.

Is the service well-led?

Inadequate

The service was not well led.

Records were not always accurate and up to date. Systems were in place to monitor the service but these were ineffective.

People spoke positively of the registered manager who was described as open, approachable and supportive.

The provider, their senior management team and the registered manager had not identified the concerns we had through their quality assurance processes.

Records remained inaccurate.

Glen Heathers

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 November 2016 and was unannounced.

One inspector, a specialist nursing advisor and an expert by experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection we reviewed previous inspection reports and looked at our own records such as any notifications of incidents which occurred (a notification is information about important events which the service is required to tell us about by law). We had also been made aware of concerning information from the local authority. This information helped us to identify and explore potential areas of concern.

During the inspection we spoke with five people and three relatives. We spoke with 13 staff, the registered manager and general manager. It was not always possible to establish people's views due to the nature of their conditions. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We looked at care records for nine people and the medicines records for everyone in the home. We looked at recruitment, supervision and appraisal records for three permanent staff, three seconded staff and 1 agency worker. We also looked at staff training records. In addition we looked at a range of records relating to the management of the service such as activities, menus, accidents and complaints, as well as quality audits and policies and procedures.

Following the inspection we spoke to the director of operations and the provider.

The registered manager and/or general manager was unable to provide us with all the information we needed during the inspection visits and we gave them a timeframe of seven days to send this to us. This information included policies and procedures, training records, staff meeting records, some audits, rota's and explanations/investigations into specific issues. We received some of the information we requested but

not all of this within this timeframe. We asked for care plan audits but did not receive these which the general manager told us they would provide, however we did not receive these.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Glen Heathers and relatives also felt this way. One relative told us, "The Staff are really on the ball, they are trying so hard to work with [relative] ..... My [relative] doesn't eat much at the moment which is a worry but I know when I'm not here they will encourage [them] to eat.....I know if [relative] wasn't happy [they] would tell us". A second relative told us "from a care point of view [relative] is in a safe place and staff are approachable".

Prior to the inspection we received a notification from the service which detailed unexplained injuries to people that had been reported to the Local Authority Safeguarding team. Information sent to us from the local authority highlighted that this related to more people than we had been advised of by the service.

The registered manager told us they had introduced daily body maps for everyone following the notification they sent. These were to be completed by staff which the registered manager said he reviewed daily and this alerted him promptly to any unexplained injuries to ensure action could be taken. However we were only able to view body maps for November 2016 and the manager confirmed that he had not completed an analysis of any body maps since the previous notification in August 2016.

Of the body maps we looked at for November 2016 we noted these had not been completed every day for every person as we were told. For one person we found body maps and daily statements which recorded injuries which were not explained. We identified these to the registered manager who was unable to provide an explanation to these. They confirmed they were not aware of them and that no investigation had been completed to establish the cause. On the second day of our inspection we were advised by the general manager of a new system that would be implemented to streamline the process of identifying any injuries and acting upon these.

In addition, we found a record of a senior manager visit instructing the registered manager to complete an investigation into unexplained bruising of a person in February 2016. The registered manager told us they did not recall who this related to. Whilst they held a central file of accidents, incidents, complaints and safeguarding matters, this was not recorded in these and the registered manager could not show us that an investigation had taken place. We asked the registered manager and/or the general manager to send this to us during the inspection and on three occasions following the visit, however we never received this. We were not notified of this incident in February 2016.

A failure to ensure systems and processes enabled appropriate investigation of potential safeguarding issues placed people at risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2014.

Staff told us they had received training in safeguarding people and were able to talk to us about the types of abuse and how to report this. All said they felt confident any concerns they raised would be dealt with appropriately by the registered manager

Risks associated with people's needs were not always assessed and plans to support staff in reducing any risks were not consistently implemented.

One person who had recently moved to the home had no risk assessments completed on admission which was not in line with the provider's policy. A discharge summary from the hospital identified this person was at risk of falls; however no assessment of this risk had been undertaken during preadmission, on admission or since admission to the home. Bed rails were in place and the person had agreed to the use of these, however no plan was in place to identify any risks associated with the use of bed rails and how this should be monitored and managed. This person had a diagnosed health condition which could have an impact on their health, however no assessment of this or plan had been developed to raise staff awareness of the risks of this and how to monitor and manage these risks. Since this person had moved into the home staff said and records confirmed they had eaten very little. Despite this their blood sugars had not been checked to ensure that the lack of food was not impacting on their health condition which could then cause them further complications.

For a second person who we saw had three falls in a period of two weeks in November 2016, no falls risk assessment had been undertaken and no care plan developed to reduce the risk of falls for this person. Whilst the 72 hour care plan detailed how staff used an alarm mat and a crash mat when the person was in bed, this did not identify how the risk of falls may be minimised and had not been updated since the three falls.

For a third person we saw they required oxygen therapy at all times. A sign was on their bedroom door identifying this. Their care plan identified how this was to be delivered and the effects of this monitored. The care plan instructed staff to monitor the person's respiratory rate, ease of breathing and depth of respirations. However, whilst we saw their oxygen levels were checked daily, we could not see that the other actions were followed. The plan did not identify what action to take should the person's clinical symptoms indicate this was ineffective. The Personal Emergency Evacuation plan did not highlight this person required oxygen therapy.

For a fourth person their medical history showed they had a diagnosed condition which impacted on their bloods ability to clot and stop bleeding. No risk assessment had been completed and no plan developed to raise staff awareness of the risk of this condition and ensure they knew what action should be taken to prevent the risks and manage them if they presented.

One person who had recently moved into the home had eaten very little. This was a known area of concern when the person moved into the home. Records showed staff had contacted the GP who did not wish to prescribe any supplements at that time. However, since then records showed the person had eaten a total of 20 mls of soup and 10 spoonfuls of porridge in four and a half days. Staff confirmed that this person did not eat well. Despite this no further action had been taken by staff and the person's weight had not been rechecked to ensure they were not losing weight. Food and fluid charts showed this person was offered food and drinks by staff but their risk of malnutrition had not been assessed and no specific plan had been developed to try and address this concern.

People's weight was monitored regularly however we were not confident unplanned weight loss was always recognised, investigated and acted upon. For two people, their records showed they had lost significant amounts of weight which the registered manager told us was not planned. No action had been taken to identify the cause of the weight loss to determine if there was an underlying condition. One of these people's care plans detailed that if weight loss was noted to recheck their weight and if the loss persisted to ensure the registered nurses working in the home were made aware and refer to the GP. This person had lost weight

consistently since April 2016. The second person's care plan stated the person's weight was maintaining. However it had not identified a 13 kg loss in weight since they were admitted to the home in July 2016, and records did not reflect any contact with the GP of other professional about the weight loss.

Following our inspection the director of operations for the provider told us a full audit of everyone's weight, care plans and risk assessments would be completed and appropriate action taken.

A failure to ensure risks associated with people's needs was assessed and plans were developed to mitigate these was a breach of Regulation 12 of the Health and Social Care Act 2014.

Medicines were not always stored safely. Certain medicine cupboards must be secured in a particular way. We found one of two of these cupboards had not been secured safely and in line with regulations. The general manager told us they would take action to address this as they were unable to confirm it was correctly secured.

Medicines were not always available. One person was prescribed medicines to be used in the event of an emergency; however a registered nurse was not able to find this medicine at the time of the inspection. Following the inspection we received an email from the service which stated "the rescue medication is already available". In addition we were advised that this medicine had been present during the inspection. However, in the event of emergency registered nurses would need to be able to access this promptly but the registered nurse we spoke with could not find this. Staff supported people to take their medicines and people told us they always received their medicines on time. However, we observed one occasion when a person had been given their medicine and the member of staff had not ensured they had swallowed this before moving on to administer the next person medicines. The nurse confirmed this was paracetamol which she stated she had thought had been chewed. However they also told us this person is known to hold their medicine in their mouth on occasions and also said they had referred the person to speech and language therapy (SALT) as they appeared to be having difficulty swallowing and eating. Not ensuring this person was observed to take their medicines when there was a potential risk associated with their ability to swallow was not safe practice for this person.

A failure to ensure the medicines needed were available and to ensure the safe storage and administration of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008.

Other medicines were stored in locked trolleys in a locked room. Temperatures of the room storing medicines and the medicines fridge were checked daily. Tablets and capsules were mainly administered from blister packs. Liquid medicines in other containers such as bottles and eye drops were clearly marked with the person's name and the date the container had been opened. Records of medicines received into the home were maintained by documenting this on people's Medicines Administration Record (MAR) sheets. Each person's MAR contained information about allergies, "when required" and "variable dose" medicines. PRN (as required) protocols were in place for all except two people who were prescribed PRN medicine. We identified two gaps in the recording of the administration of medicines which had not been identified by the home staff or their medicines audit process. Following our inspection we were advised that a new auditing system had been introduced.

Recruitment records showed that appropriate checks had been carried out before permanent staff began work. Candidates were required to complete an application form and were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed, including reference requests and disclosure and barring service checks. These help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who

use care and support services. Registered nurses professional registration was checked. Staff confirmed they did not start work until all recruitment checks had taken place. However, the service was using a high number of agency staff in the home and the registered manager had confirmed that some of these were seconded on a semi-permanent basis while they recruited. Records regarding their character and fitness to work were not always available and one of these was out of date.

People and their relatives did not raise concerns about the staffing levels. Most staff felt they had enough staff to meet people's needs but two expressed concerns that if staff go off sick at weekends they are not always able to replace them and a third felt that people would benefit from more staff to do activities. We were told the provider and registered manager used a dependency tool to assess staffing levels in the home to ensure they met the needs of people; however this had not been completed since September 2016. The registered manager confirmed that the service needed two registered nurses and 6 care staff throughout the day and one registered nurse and three carer staff throughout the night, to meet people's needs. Rotas did not always reflect this, however we were sent rotas following the inspection which showed changes had been made and two registered nurses were on planned to work throughout the day.

In addition to care staff the provider also employed kitchen and domestic staff to work each day and an activities co-ordinator who worked three days a week. Our observations throughout our time in the home showed staff responded quickly to people's needs and requests.

At our inspection in November 2015 we found the registered person had not ensured effective infection control measures were in place. Areas of the home were dirty and much of the building was in a bad state of repair. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements were seen. An environmental cleanliness checklist/Audit tool had been implemented. The last audit carried out in October 2016 identified areas which identified no concerns with the cleanliness of the home. We saw the environment was much cleaner. Maintenance work had taken place to improve the decoration upstairs. Area's where hoist and wheelchairs were kept were clean and tidy and records showed these were checked regularly. When a spillage occurred this was cleaned promptly using appropriate disinfectants. Staff wore personal protective clothing and were seen to wash their hands in between providing care. Cleaning records were maintained and infection control audits carried out. A bathroom and shower room had been refurbished. Some areas in the home still required redecoration as some walls were scratched and damaged. One room had a large crack in the ceiling plaster, the en-suite bathroom paint was peeling and we were told by a relative the tap dripped constantly. A second en-suite toilet that was not in use at the time of the inspection was rusted and the floor was bubbling. We saw plans in place to redecorate these rooms. People told us they were happy with their rooms and the environment they lived in so the impact of poor decoration in places was minimal.

Requires Improvement

Is the service effective?

Our findings

Staff confirmed they felt supported by the management team at Glen Heathers and were able to tell us that supervisions and observations of their practice took place, although they did not know the frequency.

The registered manager confirmed that all staff were required to complete the Care Certificate Standards. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The registered manager told us staff attended three day workshops which covered all 15 standards. The training matrix showed 13 staff had completed these standards however the registered manager was unable to confirm if any work based competency assessments were then required and confirmed no assessments had been completed. Following the inspection the registered manager told us staff were required to complete a practical assessment book.

The registered manager had confirmed that they had felt that the concerns raised prior to the inspection in the notification sent to us about unexplained bruising may have been as a result of poor moving and handling practices. During the inspection moving and handling practices by staff were seen to be safe. However, we found records which raised concerns about the safety of moving and handling practices. The action plan following the identification of unexplained bruising in August 2016 recorded that the training matrix was checked to ensure all staff were up to date with training in moving and handling and agency profiles were also checked for this. This training should be completed annually and the training matrix we were provided with recorded that this training was out of date for eight staff that provided direct care in August 2016 and remained out of date at the time of our inspection. This also showed that a further five staff who provided direct care were out of date with this training at the time of inspection and two had yet to receive this since starting work in the home. In addition as agency profiles were not always received we were not able to determine if these workers had received appropriate training. The registered manager and provider had not ensured all staff had received up to date training they required to support them with moving and handling practices. Following the inspection we sought clarification about what action was being taken to ensure staff were trained. We were advised that all staff would have received this training by 23 December 2016.

The lack of training to ensure staff were competent was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff also told us that staff were encouraged and supported to complete a vocational qualification in health and social care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Other training was available in various subjects including health and safety, fire safety, safeguarding, mental capacity and Deprivation of Liberty Safeguards In addition some staff had completed training in dementia and diabetes.

The registered manager had a plan in place to conduct one to one formal supervisions, observations of practice and annual appraisals with staff. Whilst this was in place from September, we noted that the plan for September, October and November 2016 had not been completed in full. The registered manager told us that they had not been completing supervisions sessions with staff on a regular basis and records confirmed the frequency of the formal one to one supervisions was not in line with the provider's policy. Of 23 direct care staff on the duty rotas, records showed that 11 had received at least one, one to one supervision session. The registered manager told us a further one had received an observation of practice supervision as well as five staff who had had a supervision meeting. No records of these were available at the time of the inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke to were able to tell us in detail how they supported someone to make decisions for themselves on a day to day basis. They described how they would support them to make safer choices but respect their decisions and adopt a least restrictive approach. They were able to explain how people could make some decisions for themselves but may need help with other decisions.

Records confirmed people's capacity to make decisions was mostly assessed but they were not always reviewed.

One person's capacity had been assessed regarding their ability to consent to the use of bed rails, a best interest decision had been taken involving their family member and a care plan implemented.

For a second person an assessment of the person's ability to agree to their care plans had also been completed and showed they had capacity to do this and had verbally agreed to these. In addition, their capacity had been assessed regarding the administration of their medicines, the use of bed rails and the flu vaccine. Best interest decisions recorded that families were aware of the support their relative required in these areas. However these had been completed at least one year prior to our inspection and we could not see they had been reviewed. A third person had a capacity assessment completed in 2015 regarding their medicines. This detailed that they lacked capacity to make decisions relating to their medicines and that the families were aware. Medicine care plans were in place detailing how staff supported them to take their medicines which were reviewed monthly; however their capacity assessment had not been reviewed. Without review of capacity assessments there is a risk that should a person's ability to make these decisions change, this would not be identified and used to inform their support.

DoLS only apply to people who lack capacity; therefore in order for a service to determine an application is needed they would have to assess their capacity to make decisions relating to this. Four people whose DoLS we looked at did not have any recorded capacity assessments. The registered manager said these had taken

place but was unable to show us the records of these.

DoLS application had been made to the supervisory bodies where needed and those which had been approved were held in peoples files. We noted that no conditions had been attached to the authorised DoLS we viewed and care plans had been implemented regarding the DoLS. Where people were able to access the community independently, this was encouraged and supported. However we were concerned that one person had a care plan written by the registered manager which told staff the person was under a DoLS and was unable to leave the home of their own free will. The registered manager confirmed a mental capacity assessment had not been completed and a DoLS application had not been made for this person. This put the person at risk of having their liberty deprived unlawfully.

We recommend the provider and registered manager review the processes in place to ensure capacity assessments are reviewed and information available to staff about deprivation of liberty safeguards is correct.

Feedback about the food was positive. One told us they enjoyed the food and there was plenty of choice. Ancillary staff told us they visited everyone every morning and asked people what they would like to eat. They told us picture cards were available should anyone need these to support them to choose. They also told us "If there is anyone that doesn't like the choices we have then we will make them an alternative meal".

Kitchen staff told us permanent staff were extremely good at informing them of a person's changing needs. However, we were also told that due to high use of agency nurses there can be a breakdown in communication and often if a person's needs had changed the information wasn't passed onto the kitchen staff.

Most people had care plans in place regarding their eating and drinking which detailed the support they might require. For example, one person's care plan guided staff to the persons need for plate guard and spoon. A second person's detailed the position they should be seated in when eating and drinking. These provided information about the type of diet a person should be receiving and kitchen staff were aware of this.

Observations over the lunch time period reflected that staff provided support to people who needed this. This support was either verbal encouragement or physical prompts dependant on their needs. Those people who required a specialised diet such as soft or pureed were given this and these people were observed throughout their meal.

People relied on staff to enable them to access a range of healthcare professionals. We saw people had been visited by opticians, dentists, GP, nurses and chiropodists. Referrals to other health professionals were made. People were confident that medical attention would be sought and that a GP or emergency services would be called if needed.

At our inspection in November 2015 we recommended that the service explored and implemented relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

At this inspection minimal changes to the environment had been made to support people who live with dementia. Coloured frames with people's names and picture on some bedroom doors had been implemented.

The general manager told us that they had met with a local authority trainer a few days prior to our inspection, who had agreed to deliver some training to staff. In addition they had advised the general manager of some dementia champion training that was available. The general manager told us they would be accessing both of these training opportunities for staff at Glen Heathers in the new year. They said following this training they planned to meet with staff to look at how the environment could be improved.

Good

Is the service caring?

Our findings

People were happy with the care and support they received. They told us they were well looked after and said all the staff were kind and caring. One person told us "Staff are lovely, they cheer you up and are very happy. They are gentle with me and always knock on my door before entering, I'm deaf so they knock loud." A second person told us "I've never experienced kindness like it". One relative told us "Staff are always courteous, kind and caring, they treat Mum with respect and are fully aware of her needs." A second relative said "The staff are caring and treat the residents with dignity and respect. [Relative] came to look on the staff as [their] second family."

Care staff were knowledgeable of people's life histories and preferences. They appeared to understand people's needs. When able, staff spent time talking with people however; this was limited to times when they were providing direct care. Staff explained what they were doing when they supported people and gave them time to decide if they wanted staff involvement or support. Staff spoke clearly and repeated things so people understood what was being said to them.

People were offered choices and these were respected. Staff showed they had a caring attitude towards people and recognised when they needed support and provided reassurance. For example, one person described to us how they suffered with anxiety. They told us staff were kind, patient and had done everything to offer them reassurance and support, including arranging their bedroom to reduce their anxiety levels.

Staff demonstrated a good understanding of the need to respect people's dignity and privacy.
Staff gave examples of how they ensured people's dignity and privacy. Signs were used to reflect who staff preferred support from and to ensure people did not enter rooms when personal care was taking place. Staff knocked on people's doors and waited for a response before entering. Glass panels in doors had been covered to obscure the glass. Staff used people's preferred form of address, showing them kindness, patience and respect. When speaking to people staff got down to the same level as people and maintained eye contact. Staff understood confidentiality and the need to maintain this. They told us that details about people should not be discussed outside the home.

People were unaware of their care plans but told us staff always asked them what they liked and didn't like. They said care staff asked them how they wanted to be supported and ensured they had choice over this and were able to make decisions.

At the inspection in November 2015 the manager told us they had introduced resident meetings to ensure people were engaged and involved in decisions about the home and their care. However, at this inspection the registered manager said that these meetings had not taken place. They told us they talked to people individually about things such as decoration and menus but these discussions were not recorded. People could not recall being asked about decisions relating to the home.

We recommend the provider and registered manager review and take action to improve the process of

involving people in making decisions about the service and their care.

Requires Improvement

Is the service responsive?

Our findings

People said they had access to GP's when they needed it. They felt staff listened to them and knew how to support them but they were unaware of their care plans.

The provider's policy detailed that before people moved into the home a pre assessment was to be undertaken to ensure the home could meet their needs. The provider's policy was that following preadmission assessments, care plans were developed to ensure staff had guidance that reflected people's preferences, needs and the support they required.

However, one person had been admitted to the home and although a preadmission assessment was in their file, other than contact details, no further information was recorded. The registered manager told us they did not get any information from the hospital this person was being discharged from. A lack of information gathered before a person moved into the home placed them at risk of not receiving the care and support they needed and preferred. A 72 hour care plan had been developed which gave very basic information about their needs. It did not provide any information about the person's preferences. No specific plan of care had been developed in relation to the support they needed to eat and drink even though this was identified as a concern in their 72 hour care plan and confirmed by their family.

The registered manager told us they used a "This is me" document to support relatives to be involved in decisions about their family members care. However for two people who had recently moved into the home these were not in place. For one of these people their family member had confirmed they had not met anyone from the home prior to their relative being admitted to the home. They said they had not been asked about their relative's needs, likes or dislikes prior to them being admitted.

This person care records lacked information about some of their needs. For example, they person lived with dementia however no plan of care had been developed to show how this how this presented itself, how it impacted on them, any trigger areas that may cause upset or stress, what brings them comfort and what helps them with their activities of daily living. Gathering information from a family member about this condition could help to ensure they received the support they needed.

For other people care plans were not developed to guide staff. For example, body maps for one person showed they had a dressing on their arm; however no plan of care was in place to guide staff to the type of wound and management of this.

Given the high number of agency nurses being used, accurate guidance about the support people needed and how their conditions impacted on them would be vital in ensuring they received the appropriate care and treatment.

Nurses were responsible for writing care plans however one nurse told us they felt the system to do this needed to be more robust and felt reviews of care plans were more system based than person based. Care plans were reviewed monthly on the computer but information gathered wasn't used to address a person

changing needs. For example, nutritional assessments which showed weight loss were not used to ensure appropriate plans were in place. Waterlow assessments used to assess the risk of skin breakdown were not used to ensure skin integrity care plans were in place.

Registered nurses did not always follow up when concerns were raised. For example, we saw the GP had been involved following a period of weight loss for a person and further investigations had been requested and carried out by the GP. No staff were able to tell us about the results of these investigations and if a cause of the weight loss had been identified. Staff had not chased up the result until we pointed this out to them. Whilst they were responsive to the weight loss to start with this had not been followed through.

One member of staff told us they had never looked at the care plans while two others told us they didn't have time to read them. They said when they did have time they preferred to spend this with people rather than reading records.

The lack of involvement of people in the development and review of care plans, together with the lack of clear care plans and actions when concerns were present was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, other plans of care were more personalised and detailed. For example one person's eating and drinking care plan detailed the importance of hand hygiene when eating and to ensure staff offered to assist with a change of clothes if these were soiled from food. Their elimination care plan ensured staff were aware that the person gets embarrassed when incontinent which exacerbates their anxiety. Their hygiene care plan ensured staff were aware they could make their own decisions and included consideration regarding nail care, leg creams and the importance of routine for the person.

The provider sought feedback from people and their relatives via the use of surveys. Feedback from people included that they were not always involved in activities or care plans, were not always aware of the complaints procedure and only sometimes felt their views and comments were listened to. Feedback from relatives and friends included that not everyone was aware of complaints procedure and did not feel their views or comments were listened to. Over 50% felt there were aspects of the service that could be improved. The analysis reflected that the majority of the concerns related to the use of agency staff, the high turnover of staff and difficulties in communicating with some staff. We saw that the provider's action plan dated March 2016 stated that recruitment strategies would be reviewed and engagement with agencies to ensure consistent agency staff worked at the home was taking place. This also detailed how communication would be discussed in team meetings. The provider had engaged with agency companies to ensure consistent staff were being supplied to provide continuity to staff.

There was a complaints procedure in place. People knew how to raise a complaint but said they had not needed to. We reviewed the complaints records and saw that a log of these was held but records of investigation were not always present and the response provided to people was not available. We saw one complaint made by a family member had been addressed and the local authority was involved. Two further complaints had been made in the last year. The registered manager told us how this was addressed however they did not have any records of this. They told us the other complaint was in the process of being investigated.

Inadequate

Is the service well-led?

Our findings

People, their relatives and staff spoke positively about the registered manager who they described as approachable, supportive and "hands on". The registered manager told us they aimed to ensure the service focused on the people living there, ensuring they had a quality of life which provided them with choice and independence. Staff reflected this in their discussions with us and told us they felt the registered manager had encouraged all staff to think about people and not just tasks.

Staff stated they felt able to talk to the registered manager and felt supported by them. They stated the registered manager was open to their feedback and views about how things could be improved.

The provider, their senior management team and the registered manager had not identified the concerns we had through their quality assurance processes.

The registered manager had not ensured that the providers policies were adhered to and had not ensured people's needs were assessed prior to admission to the home. They told us of one person who they stated they had assessed to come to the home. The pre admission assessment was mostly blank.

The previous imposed condition which restricted admissions to the home was removed by the Commission in May 2016 because the service had shown significant improvements. The provider had confirmed to the Commission that pre to anyone moving into the home a detailed pre admission assessment would take place and be forwarded to the director of operations before the person was admitted to ensure the home could meet their needs. They also confirmed they would not admit people on a Friday without written confirmation of clinical support available to them. We could not be confident the information provided to us by the provider was accurate as they should have identified what we had in that one admission took place on a Friday with an incomplete pre admission assessment.

Despite having reported concerns regarding unexplained bruising in August 2016, "the registered manager and provider had not ensured the identified actions had led to further actions being identified and acted upon." For example, the report we received from the provider in September 2016 stated "The in house moving and handling trainer immediately ensured all staff had up to date moving and handling training and the training matrix was referred to." However we found that training for multiple staff was out of date at the time of this report being sent to the Commission. We could not be confident that information sent to us was accurate.

The registered manager told us they had introduced a daily body mapping exercise for all people. These were not completed daily by staff for everyone. These did not reflect that the registered manager had checked these and where we identified that these body maps showed injuries or bruising, these could not be explained and the registered manager was unaware of these. The only records available to us had been November 2016's and the registered manager confirmed no analysis was available for any previous months. The provider and their senior management team had not identified through their quality assurance processes that this system was ineffective. Following the inspection the provider's senior management team

told us that the process of reporting accident and incidents would be reviewed and future investigations would include "lessons learned" and would ask the question, "could it have been avoided".

During the inspection the registered manager was unable to confirm if any work based competency was required following completion of the care certificate workshops and stated that none had been completed for staff. Following the inspection they confirmed this was needed. The provider and their senior management team had not identified through their quality assurance processes that this had not been taking place.

At our November 2015 inspection we made a recommendation that the service explored and implemented relevant guidance on how to make environments used by people with dementia more 'dementia friendly'. Whilst the general manager could tell us of plans to train some staff and then look more specifically at the environment we were concerned that we made the recommendation a year previous and the provider had taken little action to address this.

At our inspection in August 2015 we found people's records were not always up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements to records had not been made. Care plans were computer and paper based. Care staff could not access the computerised records and often the paper records were not updated to reflect the computerised information. For example one person's paper based records did not contain the mental health and wellbeing, wound and mobility care plans that were on the computer. For another person their care plan stated they had a 'Soft diet and thin fluids' whereas their Hospital Passport (a document which is ready to go with the person in case of admission to hospital with all relevant care and social information) stated they were to have a 'liquidised diet and 1 scoop of thick and easy in fluids'. A nurse who worked at the home told us this person had a pureed diet and is not prescribed thick and easy. People's care records were not always accurate and did not reflect their needs. For example, one person's records told staff they had a catheter in place however this had been removed several months before the inspection. A second person's care records identified they required the use of an alarm mat to alert staff to their movement. However staff told us this was no longer in use. Risks associated with people's needs and support was not always assessed and plans developed. When they were assessed and showed a high risk, plans were not always developed.

Given the high number of agency nurses being used, accurate records would be essential in ensuring staff had the information they needed to give people appropriate care and support.

Systems to assess the quality of the service and drive improvements were not effective.

The medicines audit was not always effective in identifying concerns and taking action. Medicines were not always stored safely and medicines were not always available. We identified two gaps in the recording of the administration of medicines which had not been identified by the home staff or their medicines audit process. Following our inspection we were advised that a new auditing system had been introduced.

We identified numerous concerns regarding care plans and risk assessments associated with people's needs, including a lack of them where needed and care plans that were not accurate. The registered manager told us they had not carried out any audit of care plans and no records were available which reflected care plans had been audited this year. We asked for the last three months care plan audits to be emailed to us following the inspection. We were told these would be sent. We requested copies of these on multiple occasions however, we did not receive these audits or an explanation. The last "Dignity in Care

Audit" which looked at care plans had not been undertaken since May 2016. We were not assured this was effective or the frequency of care plans audits was appropriate. Following the inspection the provider's senior management team told us that a full audit of all care plans, risk assessment and people's weight would be completed.

A staffing audit had been undertaken in May 2016 which looked at training but had not been completed since May 2016. The training matrix showed that four staff's moving and handling training was out of date at this time. The audit did not identify this.

The provider had commissioned an external company to undertake audits of the service. We found that the last audit undertaken in September 2016 had identified some of the concerns we had included a lack of falls risk assessments. The action plan stated that this was to be completed by 'Nov 16' and recorded that they were in place where needed. However we found that this was not accurate and falls risk assessment or plans of care were not always in place. The previous audit in June 2016 identified that work was required to make improvements to care plans and whilst we did not assess if the specific areas identified within the audit had been addressed as no action plan was present, we were concerned that our inspection was still identifying concerns with care records. Whilst the external audits were identifying some of the concerns we had we were not confident these audits were used effectively to drive and sustain improvements.

The ongoing inaccuracy of people's records and the lack of effective systems to assess the service quality and drive improvements for people was a breach of Regulation 17 of the Health and Social Care Act 2008.

Other audits carried out by members of the provider's senior management team were in place and the registered manager told us these were held in a central file. We reviewed this and saw audits including, health and safety, infection control and the environment were completed in August 2016 and reviewed in October 2016.