Glenside Care Home Ltd

Glenside Residential Care Home

Inspection report

179-181 Weedon Road
Northampton
Northamptonshire
NN5 5DA

Tel: 01604753104
Website: www.glensidecarehome.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 27 June, 4 and 19 July 2017. This residential care home is registered to provide accommodation and personal care for up to 30 adults. At the time of our inspection there were 24 people living at the home.

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

Improvements were required to ensure that people were kept safe in the home. People had risk assessments in place which did not specifically address their identified needs or reduce the matters which put them at risk. The environment in which people lived was not always kept clean and hygienic or free from strong odours.

People were not supported to receive the hydration and nutrition that was necessary to keep them in optimum health. Some people had been identified as being underweight and appropriate support was not always in place to monitor, review and help people to improve their nutritional intake.

Ineffective quality assurance systems were in place to monitor the care and support people received. The improvements that were required to the environment and people's care had not been identified in a prompt and timely manner, and there had been significant shortfalls as a result.

Improvements were required to ensure people received their medicines. Staff did not always take the time to ensure people had swallowed them and this meant there was a risk that people did not always consume the medicines they required. Improvements were required to review staffing arrangements to ensure people consistently received timely support, particularly around mealtimes which had been slow and unorganised.

People did not always receive appropriate support with their healthcare conditions, or the monitoring and on-going support with long term health conditions. In addition staff needed to be alive to people's changing needs to ensure they received the support they required at all times.

Further consideration needed to be given to the training, support and supervision staff received to ensure they were competent and capable of providing good care to everyone within the home. Staff had not received regular reviews or feedback about their performance and this was an area which required improvement.

People were not always treated with dignity or respect or have their choices respected. We saw that there were examples of good care however we also saw that some people were not supported to have clean and undamaged clothing and appeared unkempt. Staff did not always display caring attitudes or put people's

needs at the forefront of their mind.

People's care plans were detailed and written in great length however they were also repetitive and not specific to each identified need. Improvements were required to make them clear and succinct so care staff were in no doubt about the care each person received.

Many people and their relatives provided positive comments to the inspection team about the care they received. An activities programme was in place to add variety to people's day and we saw examples of staff interacting and praising people when they made attempts to join in.

Staff had an understanding of safeguarding procedures and how they should report any concerns and appropriate procedures were in place for the safe recruitment of staff. There were examples of good care and the registered manager was able to explain how they had made significant efforts to ensure one person could spend their birthday with the people they cared about.

We identified that the service was in breach of four of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and we have issued Requirement Notices in relation to three of these breaches which can be found at the end of this report. In relation to the fourth breach of the regulations, full details of this will be added to the report after any representations or appeals have been concluded.

Following feedback to the provider and registered manager, significant action had been taken to address our immediate concerns, particularly with the environment and managing people's nutritional needs. However further action was required to make further improvements and to sustain the changes that had been implemented.

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.

Improvements were required to ensure people had adequate risk assessments which reduced the risks to people.

Improvements were required to the cleanliness of the home.

Improvements were required to ensure people received support from staff when they needed it, particularly at mealtimes.

Improvements were required to the way in which people were supported to have their prescribed medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were required to ensure that people always received adequate hydration and nutritional support.

Improvements were required to ensure that people were always supported with their healthcare conditions.

Improvements were required to ensure staff had adequate training, supervision and feedback.

Is the service caring?

Requires Improvement

The service was not always caring.

Improvements were required to ensure that people were always given choices about their care and they were treated with dignity and respect.

Improvements were required to ensure that care staff displayed caring attitudes to people at all times.

Most people provided positive feedback about the staff and how they were treated.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required to ensure that staff were able to meet people's changing needs.

Improvements were required to ensure that people's care plans were specific and provided clear guidance to staff about how people required their care.

An activities programme was available to support a varied home life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were ineffective quality assurance systems in place which failed to identify poor practice and to make the required improvements in a timely manner.

People's records required improving to clearly and succinctly identify the care people received and required.

Appropriate notifications had been submitted to the Care Quality Commission as required.

Glenside Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 June, 4 and 19 July 2017 and was unannounced. The inspection was completed by two inspectors, one inspection manager and one expert by experience. An expert by experience is a person who has personal experience of using a service like this, or has experience of caring for someone who uses a service like this. On this occasion the expert by experience had experience of caring for someone who uses a service like this.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home, and Healthwatch England, the national consumer champion in health and social care to identify if they had any information which may support our inspection.

During our inspection we spoke with seven people, four relatives, six members of care staff, one member of housekeeping staff, the registered manager and the registered providers. We also reviewed information we had received from healthcare providers that had raised some concerns about the cleaning practices within the home.

We looked at care planning documentation relating to six people, and three staff files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, cleaning schedules, training information for care staff, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

People were not protected from the risks that they had been assessed as being vulnerable to. People had risk assessments in place, which identified when they could potentially be at risk of harm however the risk assessments did not competently address or manage those risks. The risks to people that had been identified were serious and posed a potential for people to come to significant harm. For example, one person had been identified as being at risk of attempting suicide however, this person's risk assessment failed to adequately address or minimise this risk. The risk assessment failed to provide sufficient guidance to staff to reduce the risk and staff were not taking sufficient action to encourage safe care and treatment for the person. After a serious incident involving this person the risk assessment had not been adequately reviewed or amended and their care had not changed to reflect their current needs. We asked the provider to take immediate action to mitigate the risk of this person coming to harm.

On the second day of inspection the provider took immediate action to provide the support this person required to help reduce the risks known to them. The provider arranged a meeting with the person to agree how the risks could be minimised. Staff were aware of the changes that had been put in place and these were followed through.

Other people living at Glenside Residential Care Home were recorded as being at risk because they smoked in their room or did not maintain adequate nutrition. The control measures in place for these people to mitigate the risks to them were ineffective and irrelevant to these areas of concern and did not reduce the risks associated with these areas. There was no management of the risk and no regular action was taken by staff to prevent the potential harm that could arise from these risks. Risk assessments were not competently updated as people's needs changed and there was a lack of understanding from the registered manager about how people's risks should be managed.

Staff were aware of the risks for each person but the actions they took were ineffective in reducing these risks. For example, the people that attempted to smoke in their bedrooms were not adequately monitored to ensure this was prevented or that they were able to do so safely. The risk assessments were not clear what action staff should take if they identified somebody smoking in a no smoking area and this left people at risk of harm because of the lack of guidance and the lack of adequate action that was taken.

This was a breach of Regulation 12 (1) (2) (a) (b) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

People were not supported to live in a clean and hygienic environment. On arrival at the home on the first day of inspection we identified significant offensive smells throughout the home and particularly in some people's bedrooms. We examined 17 bedrooms and found that many of them had recently been updated with new furniture however the furniture and the room had not been sufficiently cleaned and at least six of them had overwhelmingly unpleasant smells. We found that one person's bed was wet from urine however, the bed had not been cleaned and bed sheets were put on top of the wet mattress to appear that the bed was ready for use. We found that mattresses that had protective covers on them had not been cleaned and a

number of stains including urine and faecal matter were present on them. The stains were cleanable and could have been removed. People's bed sheets, duvet covers and pillow cases were stained with bodily fluids but were made up ready for people to use.

People's bedframes were stained and behind and under people's beds was dust and debris that had not been cleaned. Bedroom carpets were stained and had debris in them. In one person's bedroom that had just been cleaned we found two empty cups under the bed that had been there for some time. Bedroom skirting boards were stained and dusty and people's window sills and shelves were dusty. People's window frames were heavily dirty and it was apparent no cleaning had taken place for some time.

In the kitchen there was debris and stains on the floor. The kitchen cupboard doors had drip marks and stains on them and inside the cupboards was dust and debris. The fridge and freezer doors and sides were not clean and there was dirt and debris inside the freezer floor. The windowsills had dead insects and dust on them, the cooker was dusty and in need of cleaning and the sink bowl was dirty.

Three of the bathrooms were not sufficiently clean with stains on and around the toilet and strong smells of urine emanating from them. The bathroom walls were stained and the side of at least one bath and hoist had paint missing and was rusty. We also saw that underneath the bath seat there was mould and it was not clean.

The communal hallway had debris on the floor and cobwebs in the corners. The doorframes, doors and skirting boards had stains and dirt on them. The windows and window frames were significantly dirty and required cleaning.

This was a breach of Regulation 15 (1) (a) Premises and Equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

During our first day of inspection we showed a number of the cleaning issues to the registered manager. The provider was on leave however we also provided feedback over the telephone about the issues we had raised. We were given assurances that action would be taken to quickly remedy our concerns. On the second day of inspection we found that there had been minimal improvements. We could smell that cleaning products had been in use in various areas of the home however, there were still overpoweringly strong offensive smells and we found repeated concerns of the issues already identified. We found that the most improvement was in the kitchen area however we also found debris on the floor that had been present on the first day of inspection. The cleaning regime had not been thorough and had not resolved our concerns. Following this, an external cleaning company was contracted to provide a thorough deep clean of the entire premise. The provider had also made arrangements to have the outside area cleaned of debris and cobwebs and we saw that whilst significant improvements had been made there were still areas that were unclean and required attention, which included resolving the significant smells in a number of areas of the home.

Improvements were required to the way people were supported to take their medicines. We saw that people were given their medicines however; staff did not always take the time to ensure they had been fully consumed. We saw that staff offered additional support when they realised that people had not swallowed their medicines however the way in which people were initially supported, was not in accordance with policies and procedures and left people at risk of not always receiving their medicines. People had detailed information about the medicines they required and suitable arrangements were in place to order new medicines and dispose of medicines that were no longer required.

During our first day of inspection we were concerned that there were not always enough staff to support

people. For example, we saw that people were left unsupported in the lounge areas and people did not receive timely support at mealtimes. The layout of the building made it difficult for staff to hear people in the lounge if they were in the dining room as this was quite some distance away. We provided feedback to the provider about this and they took prompt action to arrange for extra staff to work on duty. We saw that improvements were achieved to the timeliness of people's support.

People were supported by staff that knew how to recognise when people were at risk of harm and knew what action they should take to keep people safe. People living at the home told us they felt safe at the home and that the staff treated them well. One person said, "Yes I am really safe here. They [the staff] are alright here to me. They are kind generally." Another person said, "I feel safe here, yeah I do, someone is about here or there all the time it helps." Relatives we spoke with where happy that their relatives were safe at the home and did not report any concerns to us. Staff told us they had received training and understood that if they had any concerns people were at risk of harm they would need to take action. One member of staff said, "I would report it to the senior, or the manager directly. Maybe go directly to the council, depends what it is. I would write it down as they said it." Another member of staff said, "I would let a senior member of staff know, maybe the manager. I would try and resolve complaints myself if I could but I would pass on safeguarding things." We saw that appropriate safeguarding referrals had been made to the relevant authorities and investigations had been completed when concerns were identified.

People were protected against the risks associated with the appointment of new staff. There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Records showed that staff had the appropriate checks and references in place and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Improvements were required to ensure that people's hydration and nutritional needs were well managed. On our first day of inspection we found that five people had been identified as being underweight however, the registered manager had not taken sufficient action to ensure they were supported to have their nutritional needs met. One person was 10.4kgs under their recommended minimum weight and no significant action or strategy had been taken to support them to eat on a regular basis, or to obtain professional advice and guidance about how they could best be supported to maintain adequate nutrition. Another person had been consistently losing weight and had been below their minimum recommended weight since April 2017. No significant action or strategy had been implemented to support this person with their nutritional needs.

Staff had a limited knowledge about the support people required to maintain their nutritional needs. When we asked one member of staff how they supported people to ensure people have enough to eat and drink they told us, "We weigh people and we make sure that if they don't like the food we get them something else." Another member of staff told us, "We give some people milk shake drinks. But mostly we just watch to ensure they eat." We saw that staff were not robust in watching or encouraging people to eat.

We found that one person who was under the recommended minimum weight level had been referred to a dietician. The dietician had submitted a full nutritional plan to support the person's nutritional requirements. This plan had been received by the registered manager in April 2017 however the plan had not been followed and the registered manager had failed to understand this plan. The person continued to lose weight and the registered manager had failed to request a further review with the dietician or recognise that they still were not following the dietician's advice. As a result of the inspection the registered manager became aware of what action they should be taking and began to take steps to implement this.

People gave mixed feedback about mealtimes and whether they enjoyed their food. One person said, "It's ok – well ok most days. We do get a choice both lunch and tea time. Not just sandwiches which I like." Another person said, "They give us more or less what we want – roasts at the weekend are good." However one person said they were unhappy they were not able to have more food from their own culture they enjoyed and another agreed there was not much variety. The provider advised us that frozen meals to meet people's cultural needs were available, but sometimes people chose not to have these.

Staff told us they found mealtimes difficult as there were not enough members of staff to provide people with the support they required. One member of staff said, "We manage most of the time but we really struggle at mealtimes. Two people need feeding one to one in the dining room plus one person in their room. Several others need assisting with prompting to eat, and others needing help to eat. With the senior doing the medication round at mealtimes, she is not able to help, so we are really stretched. Even with the kitchen assistant serving the food onto plates, we have to take it out to people and then after that help the people that need assistance."

We observed one person who was underweight eat their meal. They ate their meal well and appeared to

enjoy eating however staff failed to recognise that the person had not been offered a dessert and it took a member of the inspection team to intervene to ensure they did so. This was even more worrying as this person was already underweight and effective plans were not in place to ensure they were given ample opportunity and encouragement to have sufficient meals.

Mealtimes were slow and disorganised. People were encouraged to eat their meals in the dining room and staff supported people to move into this room which meant some people were waiting for almost 25 minutes before staff engaged with them or brought them anything to eat or drink. We saw that people were restless and frustrated at how long it took to receive their meal and many people who needed support were not given the attention they required. We saw that one person was given a meal and staff cut this up for them. There was no further staff interaction and nobody identified that the person had not eaten any of their meal. Staff told us that the person could eat independently but often chose not to. Staff were not alert to this and did not offer any encouragement. A member of the inspection team intervened and alerted staff that the person had not eaten any of their meal and they were offered a sandwich instead.

We saw that two people required staff support with their meals and needed staff assistance to eat as they were unable to do so for themselves. We saw one member of staff assisting two people to eat at the same time. This was not conducted in a person centred way, there was no engagement with either person about their meals and the manner in which they were supported was undignified. This member of staff was left alone in the dining room with many of the people that lived at the home and on at least one occasion they had to stop supporting the two people that needed assistance with eating to go and support another person who was putting their food into their drink.

After a lengthy wait we saw three people get up and leave the dining room telling staff that if they wanted them to have a dessert they would have to come and bring it to them. Staff supervision of people eating their meals and the organisation of meal times was insufficient.

This was a breach of Regulation 14 (1) Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We provided feedback about this aspect of care and we found significant improvements had been made when we returned to the service for day three of our inspection. The provider had completed a full review of people's nutritional needs for everybody within the home and reviewed their weights to identify if anybody was at risk of malnutrition. A dietician had completed a review of the people the provider had highlighted as being at risk and formal referrals were made for those that required professional input. Additional staff were put in place to support people at mealtimes and we could see there were benefits to people who required support; however there was still a lack of organisation to ensure each person received timely meals and the encouragement that they needed to eat them.

People's healthcare needs were not always adequately met in a timely way. One person with restricted communication had indicated to staff that they were having pain in their teeth and they wished to see a dentist. This was not arranged in a timely way and the person repeated their concerns. Following the inspection, the person was supported to see the dentist and receive dental treatment.

Arrangements were in place for the doctor to visit the home on a fortnightly basis. Most people told us they were happy with these arrangements. One person said, "They are very good with your health, luckily I have not needed to see anyone since I came but they will get the G.P. if you ask." One person's relative told us, "[Name] went to hospital when they fell; they rang and told me straight away. [Name] sees the district nurse 2 to 3 times a week. They are looking after her health well here." We saw that appropriate action was taken

to support people to see a doctor on a day to day basis however improvements were required to ensure that people's long term conditions were supported and followed up, for example people with mental health conditions and eating requirements.

People did not always receive support from staff that were fully trained or had the competency, knowledge and skills to consistently meet their needs. We found that people living within the home had a variety of needs and backgrounds. This included people with backgrounds of alcohol abuse and mental health conditions. Staff had not received sufficient training about these conditions or how to support these needs within the home. Staff were unaware of de-escalation techniques and when we spoke with one member of staff about how they supported people with behaviour that may harm themselves or others they told us they attempted to remove the person from the area. Another member of staff told us this was not always successful but they were unaware of any other measures that were in place which could help reduce these behaviours. They said, "We try to encourage them to go to another area of the home but this doesn't always work." After we provided feedback to the provider about this, arrangements were put in place for additional training for staff. The first training session had been arranged for staff to understand how to support people with mental health conditions.

Two people who lived at the home were alcohol dependent and we found that there was little professional expertise within their care plans. We spoke with staff about what support they needed and whilst staff were aware that they needed alcohol on a daily basis there was a lack of understanding about what to do if they drank too much or too little. The care plans provided minimal guidance or direction to staff to demonstrate what to do if these people had too much or too little alcohol, or at what point they would need to seek professional help.

Staff did not receive regular feedback and supervision to help enhance their performance and progression, or to ensure they were competent in their role. One member of staff told us, "We have supervision once a year with the provider but we don't have anything monthly." Staff told us they did not get regular feedback about their performance and they were often unclear about how they could progress their career within the home. There were no systems in place for the management team to regularly observe how staff carried out their role and therefore opportunities for staff to receive feedback about their individual performance were limited. Following our feedback the provider immediately arranged supervisions with all members of staff and was committed to increasing the supervision they received.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA and we saw that they were not always doing so. The 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 found that when it had been identified that people did not have the capacity to make their own decisions the management team followed the principles and if necessary, sought applications with the Deprivation of Liberty Safeguards (DoLS) team appropriately. However we also found that one person had been assessed as having the capacity to make their own decisions surrounding their finances however the staff did not always comply with their requests to have access to their money. The registered manager explained that she felt they were acting in the person's best interests as they would lose money or give it away however no agreement with the person had been made and this was a frequent source of frustration for the person. During the inspection the person asked a number of times for access to their money and this

was not actioned. We raised our concerns with the provider and an agreement was drawn up between the two parties which set out how the staff could support the person to keep their money safe.

Requires Improvement

Is the service caring?

Our findings

Improvements were required to how staff showed respect to people and maintained their dignity. Staff were accepting of the unclean surroundings people were expected to spend their time in and this did not support a caring environment. Some people's clothing had holes and stains on them and there had been no significant effort to ensure people's clothing was clean and smart.

Most people were happy with the care they received. One person said, "The staff are very good to us here. They help me get washed and dressed; I had a shower this morning. They come around 8.00am every day and then they take me down to breakfast." However we saw that staff attitudes to people were variable with some staff taking great care with people to provide the support they required, and to do so with compassion. Yet we also saw unacceptable attitudes with one member of staff showing frustration to other staff when one person was resistant to the support that had been offered. Another member of staff lacked empathy and the manner in which they spoke to people did not support that of a caring service.

Improvements were required to ensure that people were given choices in their care. We saw that some staff went to great lengths to ensure people were able to make the choices they wished. For example, staff asked people where they would like to sit, or supported people when they changed their mind about what they would like to eat or where they would like to be, however, we also saw that some staff did not give people a choice. For example, we saw staff putting protective clothing on people at mealtimes without any interaction or options for people to choose if they would like to wear this. Staff did not always communicate with people effectively and for people that had difficulty communicating we noticed that there were little interactions using a show and tell method or using visual communication.

We saw that there were times when the service made significant efforts to help support people. For example, one person's relative had asked for support to have one person at their own home for a birthday party. The registered manager explained they went to great lengths to do all they could to facilitate this successfully. We also saw that some staff had developed positive relationships with people and there were occasions when people and staff laughed, danced and sang together.

People were able to personalise their own bedrooms so that they had items around them that they treasured and had meaning to them. The provider had recognised that people needed to be fully involved in how their bedrooms were kept to ensure they met their current requirements. For example, by ensuring that continence pads were not on show and people still wished for cards or flowers to be on display. In contrast some people's bedrooms contained very little personalisation resulting in them looking stark and unhomely. The provider told us they helped and encouraged people and families to personalise their bedrooms, whilst also respecting the wishes of people that did not want to personalise their bedrooms.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in a confidential document or discussed at staff handovers which were conducted in private. However we noticed that staff did not always knock on the doors when they were entering rooms

with people inside.

The registered manager had an understanding of advocacy services and had utilised these when people required independent support, for example with their finances. We saw that visitors, such as relatives and people's friends, were able to visit people as they wished and they were encouraged to help people with their care. For example, we saw that one person's relative was able to support them whilst they ate their dinner and they were knowledgeable about how the support the person required.

Requires Improvement

Is the service responsive?

Our findings

Improvements were required to the pre-assessment procedures that were in place to ensure that all members of staff had the appropriate knowledge and skills to meet people's specific needs before they arrived. For example, the service had accepted people into the home with backgrounds of alcohol dependency without ensuring staff had the abilities to provide people with the support they required.

People were not always supported to receive care that was responsive to their changing needs. For example, a number of people had significantly dirty nails and the soles of one person's feet were significantly dirty. Staff told us that they had offered support to people but this had been declined. There were no effective strategies in place to ensure people were given a number of options to receive help with their personal care and to ensure their personal hygiene was maintained. We saw that some people required a pressure relieving mattress and that this was not always accurately set in accordance with their weight. Following feedback about this, the provider took action to ensure that staff were clear about the settings the pressure mattresses should be.

People's care plans contained information about people's care needs but improvements were required to ensure they contained current advice and guidance to staff about how they could support people. The care plans were not always clear about what staff should do; they repeated information and contained irrelevant information, which led to potential confusion about peoples current needs.

The registered manager made an effort to involve people and their relatives in reviews of people's care. One relative said, "We had a meeting with the manager just last week to review [Name's] care. That's how I know [name] has put on weight since they came here. [Name] is at risk of falls, but I don't know what is in place to avoid them." We saw that people and their relatives were given information about people's care and were given opportunities to make any changes to the care they received and this was given consideration by the management team.

People were supported to participate in activities they enjoyed. We saw that some people were supported to participate in games such as hangman, and other people were encouraged to complete jigsaws. We saw that staff provided individual support to people if they required it to enable them to participate. Staff encouraged people within their own abilities and if necessary assisted people to participate if they wished. We saw staff interact and praise people when they made attempts to participate.

A complaints procedure was in place which explained what people or their relatives could do if they were unhappy about any aspect of the home. The people we spoke with told us if they wanted to make a complaint they would ask for help from their relatives. At the time of the inspection no formal complaints had been received however we found that when people provided negative feedback there had not always been recognition that they may wish to make a complaint and have their issues investigated.

Requires Improvement

Is the service well-led?

Our findings

Procedures to review the quality of the service were insufficient and required significant improvement. The management team had failed to recognise that the home was dirty and the cleaning was not adequate. This included on a day to day level, but also on a longer term basis where it was clear that smells and odours were overwhelming and the standard cleaning was not resolving the problem. The systems in place had failed to adequately review and monitor the standards of cleanliness of the premises, or the equipment such as wheelchairs, to ensure they were safe and pleasant for people to use. Kitchen staff had cleaning schedules however they were not reviewed or challenged when they had not been completed as per the provider's expectations, and there were no checks in place to ensure the cleaning had been completed to the required standards.

Quality assurance systems were not robust enough to identify that people had not been supported to have their hydration and nutrition adequately managed. They had not identified that staff were failing to follow the advice of a dietician to ensure they were not malnourished, and had failed to ensure that professional healthcare advice was sought when it was necessary.

There were insufficient quality assurance systems to observe and review staff performance and ensure that people were treated with dignity, respect and were given choices about the care they received, and that people received their medicines safely. There were no systems in place to review if the staffing levels and skill mix were suitable for the current needs of people living at the home. The service did not take into account the layout of the building and the challenges this placed on staff to ensure people in all areas of the home received timely support. There had been little review of staff competence and performance to ensure that staff had suitable attitudes, abilities and competencies to provide good care for people and to keep their home clean, fresh and hygienic.

Quality assurance systems had not identified that people's care plans and risk assessments did not provide current and specific guidance to staff to ensure people received their care in accordance with their preferences and in a safe manner. They were not adequately reviewed when changes were required and auditing systems were not in place after a serious incident to ensure that people's care records reflected the care they needed to keep them safe. Systems were in place for people to provide feedback however they were not always effective at taking reasonable steps to resolve people's concerns, or to consider if people wished to make a formal complaint.

Care planning and risk assessments were completed by the registered manager and they were responsible for ensuring they were accurate. Robust systems were not in place to regularly check that the care plans had been accurately updated when changes occurred or that risk assessments and care plans were effective and contained appropriate guidance for staff to follow. The provider completed a quarterly audit of all care matters within the home. This was effective at highlighting where there had been gaps or when actions had not been followed up however the timing and depth of these audits where not sufficient and had not identified the failings identified during this inspection.

Records were insufficient to show the outcome of doctors' visits and any outcome or advice was routinely recorded in people's daily notes. This made it difficult to quickly identify when the GP or any healthcare professional had reviewed each person and what their advice had been. As a result we found a number of people should have been referred onto another service or healthcare professional, for example community mental health services, but this had not happened and no action or recognition had been taken by the staff at the home.

Staff lacked direction and appropriate guidance from management to ensure that all people living at the home received the care and support they required at the times they required it. For example, there was no structured approach to mealtimes to ensure that everybody had their meal, and that it was appropriate for their needs. Staff were not organised to ensure that people received person centred care and their needs and wishes were respected.

People were not always confident in the management systems. One person had repeatedly expressed concern about the way that their money had been handled and ineffective actions had been taken to move forward or resolve their concerns. Staff also expressed some concern that if they wanted anything doing or any action taken quickly they would prefer to speak with the provider as they would be more likely to receive a prompt response.

The culture within the home required improvement. The management team did not challenge staff when they displayed an inappropriate attitude towards the people they were caring for and this reflected on other staff who also failed to challenge poor practice. For example, we saw one person walking around the home with no shoes or socks on and this was not challenged by the registered manager or any other member of staff. Staff did not always talk to people in a friendly and kind way and this was not challenged by any member of staff. The cleanliness of the home was apparent for everyone to see but this had not been challenged by any member of home. The culture within the home was one of acceptance of poor practice and this needed to change.

This was a breach of Regulation 17 (1) (2) (a) (b) (e) (f) Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Following this inspection the provider and registered manager recognised that the quality assurance systems had been ineffective and required a major overhaul. Plans were in place to design, implement and embed a strong auditing system that would be challenged and scrutinised with regular reviews to ensure that it was effective at identifying and resolving where improvements were required. The provider was committed to tackling the unsuccessful systems that we identified during this inspection and was heavily involved at remedying the issues. The provider had begun disciplinary investigations where necessary and was in the process of meeting with every member of staff for a one to one supervision meetings. This had already proved to be successful as it had highlighted where staff practice had differed from the home's policies and procedures. The provider recognised that full review of the induction of staff, particularly housekeeping staff was required to ensure staff understood expectations and requirements.

The provider had taken seriously the concerns that had been raised throughout this inspection and had begun the process of rectifying our concerns. Within the kitchen a leak had been identified and the provider had identified the need to resolve this fully by removing a sink and parts of the equipment surrounding it to identify and resolve the problem. A new sink had been ordered, along with new kitchen cupboard doors to make immediate improvements. Prior to the inspection, the provider had already ordered new mattresses for every bed and the delivery of those was imminent.

The provider recognised that there was still a significant amount of work to do to ensure new systems were suitable for use and would ensure people received good care. The Registered Manager and provider were committed to continue to making the improvements required and we took this into account when we considered our enforcement options.

The registered manager had a good understanding of what notifications the Care Quality Commission required and sent these promptly when necessary.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not have adequate risk assessments in place which reduced their known risks. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutrition was not well managed and people identified at risk of malnutrition were not regularly reviewed or supported with their needs. Regulation 14 (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not cared for in a home that was clean, hygienic and free from unpleasant odours. Regulation 15 (1) (a)

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 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were ineffective and had failed to recognise that people were not receiving the care they required, or that they were supported in a home that was unclean and unhygienic. Regulation 17 (2) (a) (b) (e)

The enforcement action we took:

Impose a condition