Mr Amin Lakhani

Glen Rose

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This focused inspection took place on 22 November 2016 and was unannounced.

Glen Rose is a service that is registered to provide accommodation and nursing for up to 47 older people, most of whom are living with dementia. Accommodation is provided over two floors and there is a lift to provide access to people who have mobility problems. There are two communal areas on the ground floor and one on the first floor that people could choose to spend their time in. At the time of our visit 23 people lived at the home.

We had carried out an unannounced inspection of this home on 26 and 27 April 2016. We found breaches of the legal requirements in relation to; the environment and premises, governance systems and dignity and respect. The environment was unclean and not well maintained. Equipment to meet people's needs was not always available. Staff did not always demonstrate they treated people with dignity and respect and the systems in place to monitor the service and drive improvements were ineffective.

Following this comprehensive inspection we served three warning notices with respect to these breaches, on the registered provider of the service. We required them to achieve compliance with Regulation 15, Equipment and premises and Regulation 10, dignity and respect, by 21 June 2016. We required them to achieve compliance with Regulation 17, good governance by 20 October 2016.

We undertook this unannounced focused inspection to check they had met the legal requirements and made necessary improvements in relation to the warning notices served. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Glen Rose on our website at www.cqc.org.uk

We found some improvements had been made and the warning notices had been made. However, further improvements were needed and the improvements made needed to be embedded into the home.

At the time of the focussed inspection a registered manager was not in place. 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. The provider had appointed a new manager who had submitted an application to become the registered manager to the Commission.

More equipment had been purchased to ensure there was enough to meet people's needs. Areas in the home that required a level of maintenance had improved but further work was needed. Some areas were much cleaner and more systems were in place to monitor this; however, some areas remained unclean.

People told us the staff were kind and caring. No one had any concerns and said they were happy with the

care and support they received. Staff respected people's privacy and dignity and used their preferred form of address when they spoke to them. Observations showed that staff had a kind and caring attitude, though one member of staff told us they felt more training sessions would be useful to ensure staff practice remained person centred and not task focused.

Improvements had been made to the systems used to assess quality although further improvements were required to ensure these were fully effective and embedded into the service.

We found one breach 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?

Requires Improvement

The service was not always safe.

More equipment had been purchased to ensure there was enough to meet people's needs.

Areas which required maintenance in the home had improved but further work was needed.

Some areas were much cleaner and more systems were in place to monitor this. However, some areas remained unclean.

Is the service effective?

Requires Improvement

The service was not always effective

Some improvements had been made and work had been undertaken to make the environment more supportive to people living with dementia. However further work was required and the provider told us following the inspection a plan had been developed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were treated with dignity and respect and this had improved. However more work was needed to ensure good practice was embedded and all staff at all times treated people with respect and dignity.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements had been made to the systems used to assess the quality of the home; however, further improvements were required to ensure these were fully effective and embedded into the home.

Glen Rose

Detailed findings

Background to this inspection

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

This inspection took place on 22 November 2016 and was completed to check that improvements to meet legal requirements, regarding warning notices we had served had been completed by the registered provider. The service was inspected against three regulations which fall into four of the five key questions we ask about services: Is the service safe, is the service effective, is the service caring and is the service well led? This is because the service was not meeting some legal requirements.

The inspection team consisted of one inspector and an expert by experience in the care of older people. 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 our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents we had been sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with one person who lived at the home and four relatives to gain their views of the home in relation to the areas we looked at. We observed care and support being delivered by staff in all communal areas of the home. We spoke with the manager and general manager. We also spoke with four members of staff including; nurses and care staff. We also spoke to an external healthcare professional and an external social care professional.

We looked at records relating to the management of the service including incident and accident records and audits which we then crossed referenced to care records of six people to ensure the systems effectiveness. We reviewed staff training records, meeting records and some polices. Following the inspection we requested the manager send us further information regarding staffing and training. This information was

received.

Requires Improvement

Is the service safe?

Our findings

One out of four relatives told us they felt the home was not always clean and required a lot of maintenance work. The other three relatives did not have any concerns regarding this. Staff felt the cleanliness and general maintenance of the environment had improved.

At our inspection in April 2016 we found the registered provider had not maintained the environment which was unclean, areas of the home were poorly maintained and they had not ensured enough equipment was available to meet people's needs. This was a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 21 June 2016. Due to the lack of equipment and damage to the environment, we reported this under the key question: Is it safe? At this inspection this was no longer a safety issue, they had met the requirements of the warning notice but further improvements were still needed with the cleanliness of the home and additional maintenance; there was still a breach in this regulation.

At the inspection in April 2016 there was insufficient equipment to meet people's needs. Staff told us eight people required fall out chairs but there were only five available. (These are chairs which prevent people from falling out of them). They said this meant if all eight wanted to get out of bed at the same time they would not be able to. Staff told us only one stand aid (a piece of equipment used to support people who had difficulties with their mobility) was available which was shared across both floors, and this made it difficult at times as they needed to wait for this to become available.

At this inspection staff told us and we saw that this had improved. More specialised chairs had been purchased, more specialist beds, mattresses and pressure relieving cushions had been purchased. Staff had access to more wheelchairs and a further stand aid had been bought. Staff told us they felt there was enough equipment to meet people's needs at the time of inspection but expressed that they believed this may need to increase if the number of people living in the home increased. We asked the manager and general manager how this would be managed and they assured us they had discussed this and would ensure this was assessed at pre admission. They said people would not move into the home if they did not have enough equipment to meet their needs.

At the inspection in April 2016 we found that areas of the home were poorly maintained.

At this inspection some areas of refurbishment had been completed. The ground floor shower room had been refurbished and a new bath had been installed in the first floor bathroom. Repairs had been made to a ground floor toilet that we had found in April 2016 required repair. A radiator cover we had found in April 2016 that was not secured to a wall had been repaired. Some bedrooms had been redecorated since the last inspection and the manager told us there were plans to do all of the rooms, however we saw the maintenance plan showed that six bedrooms had been redecorated prior to our April inspection, 7 since the April 2016 inspection and a further 2 bedrooms had been decorated but no dates were recorded for these.

However, we found further work was required. For example at our inspection in April 2016 we found that the door leading to the kitchenette area, paint work was worn. The provider's action plan stated that this servery area on the ground floor was "being repainted" but did not specify when. We did not see this on the maintenance plan and this door remained in the same state of decoration as it was at the time of the previous inspection in April 2016. The home had a total of 32 bedrooms but 13 bedrooms were not included on the redecorating plan.

Generally the decoration was worn and tired throughout the corridors of the home. Paint work on walls was dirty and paint work on door frames and handrails was chipped and worn. The maintenance plan identified these areas as having been redecorated in May 2016 but had no further plans documented to redo this work. We asked if the provider had a rolling or further planned maintenance programme regarding the general decoration of the service and were told the maintenance plan we were provided with was "a working document that we assess and add to all the time. This includes adding emergency work and re scheduling due to changes in priority."

The basement walls (only accessed by staff) had significantly large areas of plaster which had fallen off and appeared to have come from damp. We were told a structural engineer had visited and deemed the building safe. It was thought this had been due to a leak from the underfloor heating and plans were in place to fit a new heating system and repairs the walls by end December 2016. However, the manager did not have access to the structural engineers report and did not know if a risk assessment had been conducted.

A room referred to in the basement as the conference room was untidy and full of equipment, paperwork and boxes. It was disorganised and could present a fire risk. The manager told us they had made arrangements for some paperwork to be shredded and the general manager told us the provider was looking at storage for archiving facilities. We asked if a risk assessment had been completed regarding this room being used as storage and were told it had not; however by the end of the inspection visit the manager presented us with a document titled risk assessment which recorded a plan to address this room, some of which they had begun to address during the inspection.

At the inspection in April 2016 we found that areas of the home were unclean. At this inspection we found suction machines were clean and records were maintained showing when these were checked to ensure they were working and cleaned.

The manager told us the pressure relieving cushions had been labelled and the laundry staff were responsible for ensuring these were cleaned thoroughly once a week with care staff ensuring they were wiped clean daily. Equipment used to support people with moving and handling was clean. Chairs people spent time sitting in were clean. The first floor was clean and tidy.

However, we continued to find areas of the home on the ground floor were unclean. The skirting boards and floors under some beds on the ground floor were heavy with dust. Some of the floors under people's beds contained debris and rubbish and were stained from liquids. A shower bag was on the floor of a toilet throughout the day, the inside of the bag was heavily stained. The manager removed this when we showed it to them. Some hallway walls had clear perspex covering them and liquids had been spilt behind these. A cleaning member of staff told us behind the perspex was not cleaned routinely.

One person's mattress contained crumbs and another person's bed side were not clean as they had a substance stuck to them. One person's bed bumper was significantly worn, meaning it could not be cleaned effectively. Care staff told us they were required to wipe these areas daily and to undertake a deep clean of these on a monthly basis. We saw records which suggested they had all been done for the month of

November 2016, although the actual dates these were completed was not recorded.

The manager told us they did a weekly walk round of the home to check the cleanliness but had yet to do it for the week of our inspection due to other commitments. The previous one had been completed the week prior to our inspection. We saw this was not a complete walk around but a sample of bedrooms and ensuites. This did not identify any areas requiring cleaning. One infection control audit had been carried out following the April 2016 inspection in September 2016 and did not identify any concerns.

The failure to ensure all areas of the premises were well maintained and clean was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At our inspection in January 2015, the environment was not always supportive for people living with dementia and we made a recommendation about this. At our inspection in April 2016 we found the registered person had not taken sufficient action to ensure the environment was appropriate to meet people's needs. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served the provider with a warning notice requiring them to become compliant by 21 June 2016. Whilst areas identified within the warning notice had been completed, further work was needed to make improvements to the environment for people living with dementia.

The environment can have a huge impact on a person living with dementia who may see the world differently causing them confusion and anxiety. As Glen Rose support people living with dementia the provider must ensure the environment is supportive of them. The general manager told us they were using guidance produced by Stirling University to help them. This university provides guidance about orientation, the use of lighting, the importance of colour and contrast, communal areas and getting outside. The manager advised of the areas that had been done since our last inspection, in line with the provider's action plan.

For example, during the April 2016 inspection we found the use of visual aids to support people living with dementia to recognise the functionality of rooms and equipment were not sufficient. At this inspection this had improved and further signage had been implemented. The majority of these were larger and pictorial. The manager had also identified further signage and was taking action to implement this.

At the last inspection we found people's names were on their bedrooms doors, however, this was in small letters and very high up, which made it difficult to read. At this inspection, contrasting coloured frames with people's pictures and a picture of interest to them had been fitted to each person's bedroom door, to support them to recognise this as being their room.

At our last inspection we found at meal times the dining area was sparse. Tables were bare, with no cutlery, table clothes or condiments. The lack of visual connections for people living with dementia would make it difficult to recognise the purpose of this area. At this inspection, this area had improved. The dining area was laid out prior to meal times supporting people to recognise the function of this room.
In addition the manager advised and we saw that handrails had been painted a different colour to the wall. On the first floor door frames and radiator covers were a contrasting colour. Contrasting colours can help people living with dementia to identify areas. However we saw that one door frame had been painted white and a second had been primed. The manager and general manager were not sure if all the door frames were being painted white. They told us colours had been decided by head office staff. All door frames and radiator covers on the ground floor were still white and blended into the wall colour.

The manager had printed pictures of ideas to make changes to the environment and had sought the views of relatives about this. However no plan was in place which showed how this Stirling University guidance had been explored and plans developed to make the environment suitable and more supportive for the

people living in the home. Following the inspection the director of operations advised us that the manager and provider had agreed a plan to further develop the environment to support the needs of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People were complimentary about the care they received. They and their relatives felt staff were kind, caring and knowledgeable of their needs.

At our inspection in April 2016 we found people were not always treated with dignity and respect by staff. Staff were able to describe the importance of respecting people's privacy and dignity. However, we observed some practice which reflected people were not consistently treated with respect. This was a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 21 July 2016.

At this inspection we found this had improved and the provider was no longer in breach of the regulation and the warning notice was met. However, further improvements could be made to ensure good practice was consistent across all staff at all times.

The manager told us they had commenced discreet observations and were in the process of doing this with all staff, focusing on dignity and respect. They told us this involved observing staff without their knowledge and feeding back to them. Of seven staff records we looked at we saw this had taken place with all of them including seconded agency workers. The manager provided feedback to the staff and asked them to reflect on the observation also. Staff told us of mini training sessions that had been held regarding dignity and respect. They told us how these had been helpful refreshers and reminded them to think about the person rather than be task focused. One staff member told us that whilst these had been helpful they were concerned that not everyone had attended these sessions and as new staff had started practice may slip. We saw that of 25 staff currently working in the service, 19 of these had not attended these sessions. The manager and general manager agreed these mini sessions should restart.

At this inspection the majority of our observations showed that people were treated with dignity and respect by staff. Staff responded quickly to people when they asked for assistance and noticed when people needed support. They provided support in discreet ways in order to prevent any anxiety. For example, on one occasion we observed a member of staff promptly notice how the actions of one person may cause distress to another person. They discreetly distracted and redirected the person to prevent any anxiety being caused.

During conversations with people, staff spoke respectfully and in a friendly way. Staff explained what they were doing and why. They used people's preferred form of address and got down to the same level as people and maintained eye contact. Staff spoke clearly and repeated things so people understood what was being said to them. They offered reassurance when this was needed.

All but one observation during lunch time showed people were not rushed to eat their food and staff were attentive and encouraging. However, one observation showed one person sat in a communal area alone for the majority of the time. They were provided a drink without being offered a choice and staff were coming back and forth scraping left over food off plates into a tub placed in front of the person on the table they

were eating their meal.

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. They advised they knocked on doors, ensured personal care was discreet and listened to people. One relative told us "Staff always knock on the door, they have consideration and respect for my [relatives] dignity when dealing with [their] personal care, I really can't fault them." Whereas one person told us "Some staff treat me with respect but not all of them, they knock on my door and are considerate when they help me to shower." They could not give us any examples of when they felt staff were disrespectful.

Staff understood confidentiality and the need to maintain this. They told us that details about people should not be discussed outside the home. However, whilst staff understood this we found numerous records relating to people and staff not held in unlocked rooms which anyone could access within the home. We advised the manager and general manager who told us they would resolve this promptly.

Requires Improvement

Is the service well-led?

Our findings

One relative told us, "If I was asked whether I would recommend the home I certainly would, I know my [relative] is as happy as [they] can be given [their] circumstances." They told us they "attend the Residents/Relatives meetings every few months, it's our opportunity to put any suggestions forward or if there is need for improvements we can discuss it."

At our inspection in April 2016 we found the provider had reviewed the system they were using to ensure the quality of the service. However, we remained concerned about its effectiveness. A number of audits were conducted including, falls, incidents, infection control, dignity in care and clinical /care support audits. These had been ineffective in identifying risks and taking appropriate action. Systems were not always effective in identifying areas that required improvement or subsequently ensuring the actions were taken promptly. Despite seeking feedback from people and their representative comments made were not always explored further and actions were not always planned to drive improvements.

This was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 20 October 2016.

At this inspection they had met the requirements of the warning notice and were no longer in breach of this regulation but further work was required to ensure the systems were fully embedded and effective.

At this inspection the provider had commissioned the involvement of an external company to undertake quality audits of the service. Two audits had been completed since our April 2016 inspection. The first focused on the environment and the manner in which people had been treated. The audit had made a number of recommendations, some of which we could see had been acted upon. For example, the manager had ensured they could evidence that observation paperwork was completed; a review of the use of shared rooms was being given to by the provider. However other areas had not been planned into the action plan. For example, the audit recommended the provider commission dignity and respect training for all departments. No formal training had been completed and 19 of 25 staff who provided direct care had not attended the mini training sessions. No other departments had completed this training. This action was not incorporated into the action plan. The audit also recommended the provider commission a specialist dementia consultant to advise of the environment. This was not included in the action plan. The general manager told this had not been done but they were using guidance by Stirling University to work on this and were meeting with head office staff to discuss. The second audit carried out in September 2016 did not follow up on recommendations at the previous audit.

Care plan audits had not been completed since July 2016. The audit report gave very little information. They did not include which people's records were looked at therefore making it impossible to ensure actions were taken. The general manager showed us a new care plan audit tool that they had just introduced. They were completing this at the time of our inspection. This allowed for identification of the person's records seen and a clear action plan. However as this had not been competed at the time of the inspection we were

unable to assess its effectiveness.

The manager advised that they had changed the system used following any incidents or accidents. Once an incident or accident, concern or complaint was reported to them they undertook an investigation and formally recorded their findings and actions taken. We noted that the investigations may benefit from including a further actions needed section. We tracked through accident/incidents reports and investigations to care plans to ensure the information gathered had been used to inform the care plans. We found this had taken place. In addition where these related to a specific need, staff were aware of these. The manager told us they would also be undertaking trend analysis but at the time of inspection had not collected enough data.

Other audits introduced by the manager included weekly auditing of people's fluid intake to ensure appropriate action was being taken if there was a concern. A dignity in care audit had been completed in November 2016 and looked at aspects of care associated with dignity and respect towards people. This had identified that staff needed to be reminded to knock on people's doors before entering. We did see people knock on doors before entering during our inspection. It also identified that people would benefit from clocks in their rooms (this can help people living with dementia to orientate themselves) and moulds needed to improve the appearance of pureed meals. The manager confirmed these were being sourced at the time of our visit. In addition a health and safety audit had been carried out in October 2016, this identified that further fire training was needed for staff. The manager told us a new company had been commissioned to deliver this training and they were awaiting a date. Timescales and people responsible for taking forward the actions were not always documented meaning it was difficult to track and ensure these were completed within effective timescales.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had failed to ensure the environment was well clean and maintained to meet service user needs. Regulation 15(1)(a)(e)