ABLE (Action for a Better Life)

Glanmor

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Glanmor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide personal care and accommodation for up to seven people with mental health and associated health needs. At this inspection six people were being supported by this service.

This inspection took place on 8 and 9 October and was unannounced.

A registered manager was in post at the time of this inspection. The registered manager was on a period of absence from the service and was not available during our inspection. 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. Our inspection was supported by the director of the service and a deputy manager.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is part of an ongoing Local Authority safeguarding investigation and may in the future be considered by CQC under our specific incident process. The information shared with CQC about the incident indicated potential concerns about the management of risk of incident within the service. This inspection examined those risks.

At the last comprehensive inspection in June 2016, the service was rated Good overall and Requires Improvement in the 'Safe' domain. We undertook a focused inspection in May 2017 to check that they had followed their plan and to confirm that they now met the legal requirements. Following this focused inspection, the service was rated Good overall and in the 'Safe domain'.

At this inspection we found concerns across all the five domains and the 'Safe' and Well-led domains are now rated as Inadequate. We identified four breaches of the Regulations, Regulation 10 Dignity and respect, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing.

The overall rating for this service is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under

review and if needed could be escalated to urgent enforcement action. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed. Staff confided there were times when it had been hard to reach the registered manager and they felt isolated in dealing with situations without appropriate guidance being given.

There were people who at times expressed their frustrations and anxiety using behaviours which staff found difficult to manage. Approaches from staff were not always consistent and documentation in place lacked guidance and mitigation of the risks.

Risks in the home had not always been safely managed or action taken to prevent harm in a timely manner. We found serious fire safety concerns at Glanmor that potentially risked the safe evacuation of people and unsuitable measures in place to manage a fire. Following our inspection, we made an immediate referral to the Fire safety team who have since been out and inspected this service.

Medicine systems did not protect people from potential harm. There were inconsistencies between the records of medicines returned for disposal and records of medicines administered.

Measures to prevent and reduce the risk of infection control had not always been taken. Parts of the home were not clean and in need of maintenance and repair.

Staffing levels in the home were not reflective of the level of needs people had. Staff consistently raised their concerns about staffing levels and we saw during our inspection one staff was left to manage for several hours.

We observed the training matrix and saw there were gaps across training subjects that staff had not completed or refreshed their training. The registered manager of the service had also not refreshed their own practice within the designated timeframes. Staff had not received regular supervisions.

We found that there were inequalities in the way people were treated around the issue of smoking within the service. This had impacted negatively on some people who were being discriminated against.

Each person had a care plan in place, however we saw that these were not always person centred and were focused from the staff's perception. There was often a lack of guidance on how staff were to support people.

We have concerns about the provider and management team at this service to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care

Prior to this inspection the provider failed to notify us of two serious injury incidents to a person in the service. At this inspection we found a further incident of physical abuse had not been made to The Care Quality Commission. This had not been picked up through the provider's quality monitoring of the service.

Quality monitoring at the service was not robust. Effective monitoring or regular quality checks had not been completed by the management team in order to identify shortfalls and take timely action to protect people from receiving unsafe care.

You can see what action we told the provider to take at the back of the full version of the report. We are taking further action in relation to this provider and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed.

Risks in the home had not always been safely managed or action taken to prevent harm in a timely manner.

Medicine systems did not protect people from potential harm.

Staffing levels in the home were not reflective of the level of needs people had.

Is the service effective?

Requires Improvement

The service was not always effective.

We observed the training matrix and saw there were gaps across training subjects that staff had not completed or refreshed their training.

People were encouraged to make their own lunch and had access to food and drinks when they chose.

The home was in need of maintenance and redecoration in some areas. There were large tears in the carpets, which was a potential trip hazard for people.

Is the service caring?

Requires Improvement

The service was not always caring.

We found that there were inequalities in the way people were treated around the issue of smoking within the service. This had impacted negatively on some people who were being discriminated against.

We saw that staff were not always available to spend time with people and there was often lost opportunities for interaction or engagement.

People told us the staff were caring towards them. The staff told us how they showed to people they mattered to them through their approach.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred and there was often a lack of guidance on how staff were to support people.

We found that complaints had not always been dealt with effectively within the service.

The staff told us they found it hard to get people to engage in activities and we observed there was little time available for staff to interact with people.

Is the service well-led?

Inadequate

The service was not well-led.

The provider failed to notify us of incidents including serious injuries and physical abuse.

Effective monitoring had not been completed in order to identify shortfalls and take timely action to address these concerns.

We currently have concerns about the management of this service to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care.

Glanmor

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.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is part of an ongoing Local Authority safeguarding investigation and may in the future be considered by CQC under our specific incident process. The information shared with CQC about the incident indicated potential concerns about the management of risk of incident within the service. This inspection examined those risks.

This inspection took place on 8 and 9 October 2018 and was unannounced. The inspection team consisted of two inspectors. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spent time speaking with and observing people who were using this service. We spoke with four people living in the home, five staff members and the director.

We also received feedback following our inspection from two relatives and three health and social care professionals. We looked at the care records of four people and other records relating to aspects of the service including care, training and quality assurance.

Inadequate

Is the service safe?

Our findings

The service was not providing safe care to people living at Glanmor. The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is part of an ongoing Local Authority safeguarding investigation and may in the future be considered by CQC under our specific incident process.

The service is currently on a red alert status from Wiltshire Council, which means that no new placements will be made at the home until identified issues have been actioned and the alert lifted. Concerns that led to this included an incident that was not managed appropriately, where medical assistance was not sought in a timely manner. This had a detrimental effect on the person concerned, who had not been kept safe from harm. This incident had not been notified to The Care Quality Commission in line with the provider's registration responsibilities.

There were times including at night where there was only one staff member on duty. Staff told us they did not always feel supported when incidents occurred which required them to ring the on-call cover. They confided there were times when it had been hard to reach the registered manager and they felt isolated in dealing with situations without appropriate guidance being given. Not all staff had confidence that safeguarding concerns would be dealt with effectively by the registered manager. One staff explained, "For us it's very difficult to go against your manager, but we have been informed we can do this if necessary."

The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed. Further to this, there was a lack of provider oversight of what incidents had occurred, how they were managed and the true extent of people's behaviour. For example, In January 2018, one incident of physical abuse was recorded between two people living in the service. This incident was not reported to The Care Quality Commission. We saw some information about meetings held were recorded on loose bits of paper. There was a risk that these could be lost if not kept safely to provide a clear audit trail. We saw that the internal actions taken were insufficient. This included monitoring the people involved, but not how this would be done. It recorded one person had felt distress from this incident, but no information on how the service would support them was considered or taken in people's care plans and staff confirmed this had not been developed. The appropriate action and support had not been provided in a timely manner to support these people and people and staff had been left vulnerable.

There was no incident folder in place, incidents were recorded in the communication book with no details of investigations completed and measures taken to reduce a reoccurrence. Any accidents were documented in an accident book but these were not reviewed regularly and there was often a lack of detail on the ongoing actions. A record of an incident in November 2017 described one person as simply running off to their bedroom. It was recorded that there was no bruising, but the person had been hit on their back. There was no additional information detailing what the incident was or who was involved. This had not been investigated by the registered manager and staff had just recorded what they had witnessed but not raised it further as an incident. This demonstrated a lack of appropriate recording, investigation or what staff needed to be aware of going forward to keep people safe.

One staff member referred to hearing banging at night in the home, but did not know what this was. We asked staff if they had investigated this further and were told they could not understand where it was coming from and continued to raise it with the registered manager. We saw the communication book detailed this banging on and off for the last couple of months. One staff member told us, "We will have an incident folder soon, we are in the process of this." This meant that appropriate procedures to ensure people were not at risk of harm had not been followed.

There were people who at times expressed their frustrations and anxiety using behaviours which staff found difficult to manage. Some behaviours included inappropriate sexual comments which staff told us made them and visitors feel uncomfortable and unsure how to manage effectively. Some female staff told us that they felt vulnerable particular when lone working at night. During our inspection we witnessed this behaviour and observed staff taking inconsistent approaches in addressing this. One person made repeated inappropriate sexual references and became verbally abusive on another day when they felt that one of the inspection team was similar in appearance to their relative. Approaches from staff varied from being firm and saying "enough" to the person, to attempts at distracting them or just watching the behaviour play out with no attempts to intervene made. One staff told us they had struggled to manage the situation as usually saying "enough" resolved the situation.

We saw several episodes of inappropriate behaviour recorded for this person. For example, recent incidents in August and September included staff being insulted, and a person being over familiar with staff and visitors and calling sexualised comments from their room window to a staff member. Other entries had people complaining about one person being naked in communal areas. We saw in October there was a potentially physically challenging incident where staff were threatened and they offered medicine to a person to resolve the situation. This person was able to go out freely into the local town, however there had been reports of verbal aggression towards people in the community. We saw there was no plan or guidance in place to monitor this situation effectively and reduce the risk other than remind the person it was not acceptable. This meant that the service did not know if this person was being inappropriate when they were out alone and if other vulnerable people may be at risk of this person's behaviours. The service had failed to mitigate the risks to people internally and externally to the home.

The provider's lone working policy did not provide adequate guidance to staff. For example, the times and responsibilities of lone working were not identified and there was no link to the on-call procedure. We saw one person becoming taken with a young female member of staff who had to keep being 'rescued' by other staff when they were in conversation with them and unable to leave and were followed. One staff told us, "You can't tackle a lot when on your own. We have had things happen and there needs to be two. We are at risk as locked in the sleeping room, if something was to happen to you they still have to get to you and the damage would be done. I have said I don't feel safe coming out at night but other staff say they do. It's hard to get hold of on-call manager at night, the only option is to phone the police." The provider had not taken enough action to ensure the safety of lone female staff working at night and reduce the potential risk of harm. Following this inspection, we wrote to the provider to seek immediate assurance on how this would be addressed and staff safety maintained. The provider responded and put a risk assessment, positive behaviour plan and expectations of behaviour guidance in place.

Another person in the home displayed incidents of physically aggressive behaviour. We saw incidents where the person had kicked furniture, thrown items at people and physically attacked them. One staff told us, "[person's name] behaviours can at times be a little extreme." The person's behaviour risk assessment stated, "Staff to be familiar with signs and symptoms", however these were not identified. The staff at the service told us that each person should have a positive behaviour plan in place. However, this could not be located for this person, despite staff searching for it during our two day inspection. The persons 2018,

annual review stated, "Considerable tension between [person's name] and other residents with verbal exchanges and some threats or actual physical violence towards individuals or property." The director told us "We did a lot of work around the positive behaviour plans but some these cannot be found." We saw that where behaviour plans were in place they did not always focus on exploring people's needs or the underlying behaviours, and the focus of medicine was often used as a first resort.

We saw variation in how staff recorded events as some incidents were documented in the communication books and others were on Antecedent-Behaviour-Consequence (ABC) forms (An ABC Chart is a direct observation tool that can be used to collect information about the events that are occurring within a person's environment). One person's last entry on an ABC form was from 2017, despite there being more recent events. This meant the incidents could not be appropriately monitored or managed due to the inconsistencies.

Risks in the home had not always been safely managed or action taken to prevent harm in a timely manner. We found serious fire safety concerns at Glanmor that potentially risked the safe evacuation of people and unsuitable measures in place to manage a fire.

The fire safety systems were not operating effectively. This included a faulty fire detector in the attic, fire doors which had been faulty since 2017 and a fire exit which was located in a locked room. There was no risk assessment in place to address this or plan of how people could be kept safe if the fire doors would not work as they should. The provider had raised these issues with the housing association company for over ten months, but the work had not yet been completed.

The service kept a 'grab file' at the front entrance which detailed the location of people in the building for the fire safety crew to evacuate them if necessary. We saw that it listed what room numbers people were in, however no one had a room number on their door. This meant the fire safety crew could be at risk of trying to find people by room number and put themselves at risk and delay successfully evacuating people form a fire. We raised this with staff and the deputy who were confused and told us the plan had always had room numbers on and they had not even thought that the rooms did not. One person who had left the service was still recorded on the evacuation list. This meant that fire safety crews were at risk of putting themselves in danger searching for a person who was not in the building in the event of a fire.

Weekly fire drills were completed and internal fire training on extinguishers was done annually with staff. We saw that two fire extinguishers were found to have be removed from the service leaving two areas vulnerable to electrical fire. We saw that an action plan had been put in place from this but there were no dates recorded on this. We asked staff about this and they confirmed the actions had not yet been done. The fire risk assessment had been reviewed in August 2018 and stated there were no concerns and no action required. This meant that the service was not taking fire safety seriously enough to ensure action was taken to keep people safe. Following our inspection, we made an immediate referral to the Fire services Safety team who have since been out and inspected this service. The Fire Safety officer told us that they had told the provider to take action and they will return to ensure this work has been completed.

The home had an issue with pest control and a company had been making regular visits to the home to try and overcome this since August 2017. There was no risk assessment in place to manage this specific concern and the environmental assessment in place had not been updated since 2017. The service had not made any attempts to notify or contact any other leading authority to seek advice.

One person had an assessment in place for falls. The risk assessment was not dated or signed. There was a lack of information about how this person would call for help if they fell and no sensor mat was referred to

as potential measure to minimise the risk. The assessment did not explore all the actions that could be utilised to keep this person safe. Another person had experienced several falls from bed and had requested to have a bed rail in place. The assessment stated they are to be monitored putting the bedrails up and down and staff to complete checks to ensure they remain safe. However, staff were unaware of this and told us they did not put the bedrails or up or down. This meant the measure that had been put in place to keep this person safe was not being followed and they continued to be at risk.

We saw that the service's contingency plan in the event of an unplanned evacuation had not been updated since 2015. The director told us they would relocate people to one of the provider's other homes nearby but they would address the paperwork. We saw that the service did not have a Legionella (bacteria is commonly found in water) certificate in place. Staff spent time trying to locate this before informing us they would ring the company used and ask when the last check had been completed. We have not received evidence that this check has been completed.

We found some parts of the home were dirty and unkempt. Housekeeping staff were employed to clean for part of the week. We saw that infection control audits were not carried out. Staff told us "The home is not clean. People aren't as clean as we would hope and staff have to do it" and "It's not clean. Staff have to clean up in between people making meals and try and encourage people to do this. At night they eat throughout the night and things get dropped and they are left." We saw that in one bathroom there was no bin to put dirty paper towels in after washing your hands. Instead these had to be carried through into the kitchen and put in the bin there. We raised this with staff on the first day of our inspection but on the second day it had still not been addressed.

We looked for cleaning schedules to see evidence that people were having their rooms cleaned. The director told us this would be in people's care plans but it only documented the day they preferred to clean their room not if it had been done. We looked through the daily records and saw two people had been consistently refusing to clean their room. For one person it stated that staff would complete a full clean as the person was not doing it, but there was no timeframe to when this would be done.

Medicine systems did not protect people from potential harm. Medicines were kept in the cabinet and secured to the wall. At the front of each medication administration record (MAR) was a photograph of the person with personal details and known allergies. How people preferred to take their medicines was not included in the individual profile. We found the current MAR charts were signed to show medicines administered. We found however that there were inconsistencies between the records of medicines returned for disposal and records of medicines administered. In the record of disposal for February 2018 staff had documented one medicine was not administered for one person but when we checked the MAR for this date we found staff had signed the record as administered. A record of medicines carried forward was not maintained and staff said once this was introduced there would be better clarity.

The staff had documented within the MAR for one person that the prescribed medicines were self-administered. Risk assessments for self-administration were not in place. This meant there was no documentation on the assessments undertaken in relation to the level of risk to the person and others, how often the person's competency to administer their medicines was to be reviewed and safe storage of medicines. The staff had documented in a separate record the medicines given to the person for self-administration but had not included the name of the medicines. There were people who smoke and were prescribed with paraffin based creams and ointments. Fire risk assessments were not developed to ensure preventative measures were in place to reduce fire risks.

Procedures were not devised for all medicines prescribed to be administered 'when required', also known as

PRN. Where protocols were in place they lacked clear guidance on when staff were to administer PRN medicines. For example, the symptoms to look out for and when to offer the PRN medicines. One staff member told us, "People do not have PRN protocols, we are in the process of completing some of these, that is a fall down on our part." We were further told that, "Because of medicine errors made we came to the conclusion to have two staff administer." However, during our inspection we were told this had now stopped as there were insufficient staff on duty to do this.

People were prescribed with a range of medicines specifically to manage their mental health care needs which the hospital dispensed. MAR and medicine care plans did not give clear directions on administering multiple options of the same medicine. For one person there were three separate MAR entries with variable directions on the dose of the same medicine which we found difficult to follow.

A record of medicine errors was seen. This showed there were eight medicine errors between February and March 2018. Within the reports the effects on the person were recorded and the action to prevent further reoccurrences was detailed. The staff we spoke with told us there was additional refresher training to address repeated medicine errors. The deputy manager told us disciplinary procedures were followed for repeated medicine errors.

The record of the medicine cabinet temperatures was inconsistently maintained. For example, up to the 7 October 2018 the recording of temperatures was missed on two days, six days in September and on two days in August. This meant staff were not ensuring that medicines were stored at the recommended temperature. The director told us, "The inconsistencies had already been picked up by [manager of another service], and had been dealt with, although I acknowledge that they were not adequately managed prior to [manager of another service picking them up."

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

Staff consistently raised their concerns with us over the staffing levels in the home. The rota in place showed there were should be two staff on duty during the day and one member of staff asleep in the premises at night. During our inspection one staff member was left on the floor to attend to six people whilst another staff had to leave the home to attend a meeting. Despite the meeting having been arranged a week prior to the inspection, no cover had been arranged. We observed that this had a negative impact on people in the home. One person was distressed about having no tobacco and the staff member was unable to leave to go and buy some for this person. The person continually came to the office to ask for this throughout the day and each time had to be turned away. The staff member text the other staff to ask they get some on their return but this was not until late afternoon.

Staff comments included, "The staff team are working their socks off to the point that we are staff members down and still doing the same job. It's spoken about in meetings about staff being on their own, but they haven't got the staff to fill it", "It has been difficult, one staff left and one is on long term sick. There has not always been enough staff", "Staffing has been challenged" and "The morale goes up and down with the staffing." Another member of staff said it was a "struggle" but a new member of staff had been recruited to cover some vacant hours. Staff confirmed there was lone working from 10pm onwards and sometimes during the day for periods of time. One relative told us, "They get short sometimes, it is stretched sometimes."

We raised our concerns about the level of peoples' needs in the home and the staffing, but the director felt that the staffing was adequate. They commented, "There was two vacant shifts on the rota for last week,

these are always covered and staff do this at the team meeting. They acknowledged that it had been busy prior to [name of person] leaving us, but now they had enough time to give individuals the one to one time they need." However, this was not what staff told us or what was evidenced during the observations at this inspection. The director did not have a staffing tool in place to demonstrate how they knew the staffing was adequate and the decided staffing levels were not based on the level of people's dependency.

We saw that one person's Local Authority review from January 2018 referred to the impact this person's behavioural needs was having on the staff. The review stated, "[person's name] need for attention from staff is having a negative impact on other residents and may be taking a toll on staff who seem to be burning out under the pressure. There have been reports of more staff sickness for longer periods of time." Staff told us that the sleeping night was often a disturbed night and then they had to work the following day. One staff said, "We only have one sleeping night but you are up, as people are up in the night and we have to work the next day. This is very, very heavy going because they all get up when you go to bed. It has not been reviewed." The director confirmed this had not been reviewed.

This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were robust for staff applying for vacancies, but there were limited opportunities for staff to express interest in promotional posts. We asked the director about promotional posts and we were informed there had been a quick appointment of a senior post without this being part of a fair selection process.

Staff told us they had attended safeguarding training. They described the types of abuse and the expectation that they report any concerns. The deputy manager was appointed a safeguarding champion and a decision had been taken for all staff to report safeguarding concerns to the lead authority. People we spoke with told us they felt safe living at the home. One person said "I am happy to tell staff any concerns. I have no concerns around safety in living here." Relatives we spoke with also confirmed they had no concerns that their family members were unsafe.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff that had up to date knowledge and skills. The staff told us training was a combination of online training from and face to face training which covered "different areas." They said there was ongoing training, which included first aid and safeguarding was completed through an external course. We reviewed the training matrix and saw there were gaps across training subjects that staff had not completed or refreshed their training. For example, four out of nine staff had not updated their health and safety, infection control or mental capacity training. Seven staff had not done fire safety and two staff had not completed the fire practical training.

Training in managing incidents of challenging behaviour was offered however, six staff had not completed aggression in the workplace, only one staff had completed challenging behaviour and de-escalation training was ongoing for staff. This meant not all staff were equipped with the necessary training despite supporting people with high levels of challenging behaviour.

The registered manager had gaps across all of the 22 training subjects offered, which did not promote a good example to the staff team. One staff told us, "There are training concerns, it's not good. I have told the director and given them an up to date list of what they need to do to get staff up together."

The director told us the gaps in training were being addressed and they were looking at staff completing some external training in addition to the in-house training offered. They had looked into report writing and communication training for staff and first aid training had been started to bring staff up to date. Following our inspection, the director contacted us to say, "Training had been booked in for person centred planning and Mental Capacity."

Staff told us one to one supervisions meetings were with the line manager and the intended practice was for supervisions to be six weekly. They said the agenda for the one to one meetings covered concerns, performance and training needs. The records of supervision for two staff we reviewed were based on a reflection of practice and personal development. We saw that these records did not support that one to one meetings were held six weekly. One staff commented, "Supervisions are ok, not regular. A lot of the time you say things and it doesn't get acted on." The director confirmed with us that supervisions had not followed the supervision agenda or had taken place as intended.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff told us their induction was a combination of in-house training and the Care Certificate (The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life). They said the induction had prepared them for their role and they felt confident to carry out the responsibilities of their role. However, another staff told us their induction experience had not been so positive. We saw one person being inducted during our inspection and completing training regarding the management of medicines. The director told us that staff had the opportunity to undertake both Level 2 and

Level 3 Diplomas and this enabled staff to assist in the induction of new team members.

One person told us they made refreshments, sometimes prepared their own lunch and the staff generally prepared the main meal. Another person told us they mostly "ate in town". People had access to a small kitchen at all times, where there were facilities to make refreshments and to prepare lunch and snacks. There were range of foods and drinks available. The menu of evening meals was on display in the small kitchen and there were posters reminding people about hand hygiene. The large kitchen was kept locked and a keypad for access. A member of staff said people were supervised by staff when they participated in meal preparation.

People made suggestions of meals to be included in the weekly menus. Each person selected a favourite meal which staff included in the menus. Staff then did the shopping to ensure food items for these meals were at the home. Menus for evening meals were varied. We noted there was a variety of fresh vegetables and fruit as well as fresh and frozen meat. One person said, "I'm happy, it's good food, I don't cook or go shopping. We get a menu choice once a week, it's not very often there are snacks available, there are things in the fridge but not a lot."

There was confusion around the monitoring of one person's food and fluid intake. One member of staff told us, "We are not monitoring anyone's food currently", whilst another staff said they were. One staff told us, "We were monitoring [name of person], but not anymore. They are not a risk now I presume, they eat what they want, chocolates, crisps, fish and chips. I don't think they are losing weight. This staff looked for a food chart and told us the last time it was monitored was 26 August before staff were told to stop as there were no concerns. We looked at this person's weight chart and saw the last recorded entry was for May 2018, despite the care plan recording this was to be done regularly preferably monthly. This had not been followed.

The person's care plan had an entry after the food recording had been stopped in September 2018, which stated staff needed to observe what this person ate and drank, which was to continue as long as necessary. We observed at lunchtime there was only one member of staff working and they were in the staff office. We asked how staff knew what and if people had eaten and were informed "We don't know if people are eating enough, we see them mostly eat an evening meal, and at breakfast." The director told us they had reinstated this person's food and fluid chart at the start of October, following the request of Wiltshire Council. This person's intake was not always being monitored in order for staff to record this accurately and take timely action if needed. Further to this not all staff had been made aware that this form had been reinstated. This had not been managed effectively to ensure this person received sufficient food and fluid to maintain their physical health.

People were registered with a GP. The people we spoke with said the staff arranged and accompanied them on their health appointments. Staff documented outcomes of visits in the daily diaries which made it difficult for reference as separate recording of health care visits were not maintained. This meant staff had to re-read back copies of visits for reference. Reports kept in files showed people had access to specialists such as psychiatrists and community health care such as district nurses and dentists. We saw that people had a health action plan in place, however this contained very brief details and did not document the support needed to attend appointments or how people felt about their own health states. We saw one person had a hospital passport in place to ensure important information would be transferred to any new setting. However, this did not have any dates on or indicate if it had been reviewed and remained current. It also did not record about the displays of aggression that could be exhibited by this person, in order for this to be managed appropriately.

One health and social care professional who told us they had found the staff helpful. Their guidance was followed by the staff, who offered to document the guidance to ensure this was followed. The staff had encouraged this person to follow the professional's advice in between their visits. Another health and social care professional told us, "When I have discussed things with staff, they have always appeared to act on any suggestions made."

The home was in need of maintenance and redecoration in some areas. We saw marks on the walls, and parts where plaster was missing. The carpets were stained and on the stairs, there were large tears in the carpets, which was a potential trip hazard for people. We were informed that the housing association company responsible for the building were not always responsive in ensuring the upkeep was maintained for people. The provider had raised these issues with the housing association company, but the work had not yet been completed. One staff told us "We ring them when something needs fixing and then record it on a sheet and record when things are fixed. They are not quick, we go through the book in staff meetings. I wouldn't recommend them."

A staff office was situated downstairs which was also a through route to the garden where people smoked. From this room the staff also administered and stored people's medicines. We observed that this room became very chaotic at times with people passing through, staff trying to complete documentation, people accessing their medicines, cigarettes and attempting to talk to staff. The director told us this room had been moved around to several other locations in the house whilst they decided where the best place was to have it. We saw at times this compromised the concentration of staff who were trying to manage several tasks at once whilst supporting people's queries and needs.

We saw that people's rooms were decorated in the style they chose to have them. We observed one person did not have a bed but a futon that lay floor level. We were informed this was the person's choice after having trialled other beds.

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. We saw that the service had put consent forms in people's care plans to consent to things including staff keeping their cigarettes, information sharing and for receiving care and treatment at Glanmor. However, these had not always be signed or recorded if verbal consent had been obtained. There was no date on these to show when consent had been given and if it had been reviewed since that time.

One person's care plan stated they were able to make daily decisions about their everyday life but that there were two capacity assessments in place around the care and support given. This was because they were unable to give informed consent in some areas of their life. These capacity assessments could not be found in the care plan or located by staff. The director was also unsure where these might be.

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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We saw that one person's relative had signed to give consent for decisions including information sharing and for the person to have bedrails in place. However, this relative did not have Lasting power of attorney (LPA) to make decisions on behalf of this person. LPA is a legal document that lets a person appoint someone to make decisions on their behalf.

A mental capacity assessment for another person detailed that relatives were to request deputyship or lasting power of attorney (LPA) for finance and for care and welfare. The actions from the mental capacity

meeting was for "staff to gain from the family member evidence of deputyship or LPA." The staff told us a relative managed this person's finance and showed us a copy of a letter sent from this relative confirming the arrangement. The staff accepted this letter as evidence of deputyship. The meant staff had not acted within the principles of the MCA.

People told us they made all their decisions. A member of staff told us they had attended training in the MCA principles. They said these principles were based on "promoting choice and giving information in the best way people understood. Promote their rights it's their choice, their right to refuse." People made "Everyday decisions" and staff would help people reach decisions. This member of staff said, "It's their choice and I can't judge them even if they made unwise choices." People were not accompanied by staff in the community. A member of staff said, "One person likes to go into town every day and we ensure we note the time they are leaving."

Requires Improvement

Is the service caring?

Our findings

We found that there were inequalities in the way people were treated around the issue of smoking within the service. This had impacted negatively on some people who were being discriminated against. The service had previously allowed smoking to take place in people's bedrooms. However, on arrival we were informed the house was now a non-smoking house and everyone now had to smoke in the garden. A notice in the staff office further confirmed this had been in place since April 2018.

Staff informed us that this was true for all but one person, who had not complied with this new house rule and had continued to smoke. The director told us the decision had been taken to let this one person continue to smoke in their bedroom, but everyone else had to smoke outside. One staff told us "It is not fair to people that one person is allowed to smoke in their room but the rest of the house is non-smoking to everyone else. We have raised this." Another staff told us "They did say they would give notice to the person but they didn't and when they allowed smoking again [name of person] laughed. Because others don't make a fuss they get away with it."

Staff told us about the negative impact this decision had upon one person who had not been outside of the building for ten years. One staff said, "When the no smoking rule came in this person now has to go outside and is so anxious they hardly smoke any of their cigarette as they are desperate to get back inside." We observed this happening during our inspection and staff would go out after this person and retrieve the barely smoked cigarettes they had discarded. Staff told us that people all knew one person was allowed to smoke but because they were more respectful of rules they went along with it. Staff commented, "I don't think it's fair to other people when they are told it's non-smoking and yet we have one person smoking" and "Poor [name of person] hasn't left the premises and smoked for years inside but [person's name] has a smoking bedroom."

We reviewed the provider's policy on equality and diversity which stated that "It recognises that treating people unequally can result in their losing their dignity, respect, self-esteem and self-worth and ability to make choices. This had not been considered when making this decision and did not demonstrate people's human rights were being respected within the service. The director told us they would review the decision made.

This was a breach of Regulation 10 (2) (c) Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the director contacted us to say training had been booked in November for staff on dignity and respect and that "Staff will also be undertaking a Level three equality and diversity training course which will require them to be observed to gain this certificate."

We saw that staff were not always available to spend time with people and people were often turned away and asked to come back in ten minutes. Staff were mainly centred around completing tasks in the office and people would come there if they needed staff. This meant there was often lost opportunities for interaction

or engagement and people would return to their bedrooms staying there for long periods of time without any meaningful interaction or activity. One member of staff told us "The clients need attention and they don't get it as there are not enough staff to give it to them." We observed lone staff juggling visitors to the home, medicine administration, taking phone calls, and people's requests for cigarettes. Staff informed us it was always like this within the service.

One person had requested a conversation with staff in private to discuss their concerns about another person in the home. During this conversation the staff member had to get up to answer the door twice and then proceeded to take a phone call whilst the person waited. This did not demonstrate that the person's feelings were being valued or time given to reassure them effectively. One staff told us, "Glanmor has historically been a difficult house and was hard to get people to engage, but there are moments where staff could do more one to one things. Staffing is adequate but we aren't utilising the time. I have seen people being turned away by staff."

People told us the staff were caring towards them. One person told us, "I like living here, I am very happy, I have good jokes with the staff." Another person said, "Staff are sociable, some are, some aren't, they help me clean my room, they do my washing, the manager is in quite often, I see them if I need to." Relatives told us the staff were friendly and approachable when they visited commenting "The girls are all friendly. My relative is happy there" and "For what my relative needs, it's brilliant."

The staff told us how they showed to people they mattered to them. A member of staff said, "I listen to people, give people choices and my approach is caring, I like to go home knowing I achieve all that needs to happen." Another staff said their tone of voice was always calm and they recognised it was people's home and it's their responsibility to ensure they know it. "I listen and ask question about them. We have life history information in the care plan. Some are patchy for some people and for others their history is not documented." One health and social care professional told us "I have always found staff approachable. In my experience I would say they have a very good knowledge."

The staff told us some people needed a lot of encouragement and prompting to undertake personal care routines. A staff member said, "We encourage it massively, there are daily tasks. One person has help putting washing on but they will hang it up, we help them clean their bedrooms so they are getting involved." One person told us their privacy was respected because they could lock their bedroom door. A member of staff said, "Giving people choice not judging and making sure I don't show prejudice, try to be impartial." Another member of staff said people's "Rights are respected through the choices people make. It's people's choice to refuse. When something becomes a health and safety issue, then we advise and give reassurance."

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan in place, however we saw that these were not always person centred and were focused from the staff's perception. There was often a lack of guidance on how staff were to support people. For example, the communication care plan for one person stated the staff must "familiarise themselves with the signs and symptoms" of anxiety. This person was to be encouraged to spend "one to one time at least monthly with their keyworker." This did not give information on what signs and symptoms might be exhibited by this person for staff to be aware.

One person had a limited reading ability and needed to maintain good eye care and attend appointments regularly. Consideration had not been given around providing this person with care plans in line with the accessible information standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. NHS and adult social care services need to comply with AIS.

There was a lack of proactive responses in people's care plans or evidence of goal planning and progression. For example, one person had periods of time when they became upset or angry, but there was no information of how this could be managed in a better way and how the person could be supported to reduce this behaviour. We asked two people if they had a care plan or if there was a "file" about them. One person was not sure and asked the staff to confirm.

We saw some people had issues with choosing an unhealthy diet which was impacting negatively on their physical and mental health. The person's care plan did not have any information around if attempts had been made to encourage a healthy diet, it just stated the person's preference and routines around unhealthy diet options. There was no information around supporting the be involved in shopping or meal preparation or encouraging an interest in food.

Care plans were not evaluated which meant there was not means of establishing the effectiveness of the action plans. Many of the care plans we looked at did not have dates on so it was hard to know if they were a current reflection of people's needs. The director said they had also noted this. One member of staff said, "I am not sure care plans are used as they should. I would like to see them more goals focused. They are good for reference but not devised for people to achieve realistic goals." Another member of staff said, "I would struggle to follow the care plans and there are bits missing. There may be things identified but not actioned."

Diaries and communication reports were used to record daily events of direct care, meals served and visits from relatives and health care professionals. However, the reports were detailed and used for reference instead of updating care plans. There was a risk that important information would be lost in these books and not managed appropriately. For example, we found incidents of behaviour recorded but no details on if they had been investigated or measures put in place to manage them effectively. A manager from another home had come over to update the care plans. They told us they were transferring information onto a new template and making them more positive "It's been highlighted that there are a few issues with paperwork,

so I have come over to look at this."

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assigned with a key worker. People we spoke with knew who was their keyworker. One person told us their keyworker helped him clean his bedroom. A member of staff said "Keyworker will look through the care plan and go throughout it with people. We go out for one to one time monthly. He will ask for assistance for support with cleaning their room and during these times we spend extra times playing board games."

People we spoke with told us how they spent their day. Some people had paid befrienders who took they went on outings with. One person said, "Every Tuesday I go out for a meal". They attended clubs and every Saturday met with family." Another person said, "not much sit down and have cup of teas. I am saving money to buy bottles." This person also has a paid befriender to go on outings.

The staff told us they found it hard to get people to engage in activities and we observed there was little time available for staff to interact with people. During our inspection the majority of people stayed in their rooms and came down to make a drink or food, have a cigarette or take some medicine. We did not see any attempts made to ask people what they would like to do or offer an activity to join. One staff told us, "People don't have enough activities to do but it all depends on the staffing level." Other staff said, "One person goes out independently each day up town. People do what they want to do, we have tried to do group things but the people here don't want to attend things together, we have a fairly well attended evening meal", and "I have tried to have social activities on a Friday night once a month. It's difficult to motivate people. If people want to go out it has to be planned."

One person told us, "I don't go out, I stay in and watch TV, listen to radio, it's alright. I used to like going out, staff do try and get me too. There are things inside but not very often." We saw that one person had a review completed earlier in the year that stated "[name of person] is spending long periods of time at home doing very little. They recognise they become bored which impacts on how they relate to others. May be useful to be supported to draw up a person-centred plan, a visual timetable." We could not find any evidence of this plan and staff were unsure about this either. The recommendations had not been followed or put in place to reduce this person's social isolation.

There seemed to be an acceptance that people historically did not want to interact and this was no longer promoted as much as it could be, we saw at times people seeking interactions from staff but due to being involved in other tasks these opportunities were sometimes lost and people returned to their rooms. One staff said, "People get the time but it's scheduled not flexible, it couldn't work if someone just wanted to go out for lunch we would have to look in the rota for a few days' time. It does reduce people in what they care able do."

The director told us things had been put on and people from a sister home had visited commenting "We did a fundraising event two years ago to enable us to put more activates in place, ran an art group and a music group, the client group did not engage with this. There have been day trips arranged going back but people don't want to go out together." The director further said, "In some ways the clients are happy enough, but I think a lot more could be put in place for them. We have had really good times and there are still annual get togethers'."

We found that complaints had not always been dealt with effectively. We saw a complaint had been made in

November 2017 from one person about another person living in the home. The action taken had been to speak with people and a verbal apology had been given from the staff team. There were no details on what could be done to prevent the incident from reoccurring or how they were going to support the two people to continue living in the same house. The provider's policy stated that full records of the incident and actions taken should be documented. The policy had been reviewed in August 2018 but had not been followed.

We saw a complaints book was available for people to record any concerns they had. However, this book was left in the lounge and detailed confidential information that people may not want shared with others living in the home. We saw that there was no follow up actions in this book or evidence that the concerns recorded had been viewed or managed. The director informed us that complaints had not always been dealt with appropriately. They had recently found a complaint dating back to April 2018 that had not been investigated by the registered manager.

The complaints policy had incorrect information recorded regarding the role to The Care Quality Commission as an investigator of individual complaints. This was highlighted to the director who took immediate action in revising the complaints policy and sending an amended copy to us following the inspection.

People told us if they had concerns they would approach the staff. A member of staff said they "give people support to document their complaint. There is a complaints book." Another member of staff said, "I ask people if this is to be documented and give it to the manager to investigate. I ask for feedback [from the manager] to make sure it was acted upon."

Inadequate

Is the service well-led?

Our findings

A registered manager was in post at the time of this inspection. The registered manager was on a period of absence from the service and was not available during our inspection. Our inspection was supported by the director of the service and a deputy manager. We have concerns about the provider and management team at this service to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care. The director had implemented some immediate changes to address these concerns by putting in a new temporary management team to oversee the service in an interim period.

Staff did not all speak positively about the leadership within the home commenting, "It has not been good. The manager was not getting things done and it's not really improved. A manager from another home has been trying to help our paperwork" and "For a long time we have said we are due a CQC inspection but it's only gone downhill since."

Some staff spoke about friendships in the home between management which had made it hard to get things addressed quickly. One staff commented, "Hard to take action when staff are friends, it can be a bit cliquey." Another staff told us, "It is being addressed about friendships and family members working together." However, one staff said, "The team is lovely we bring different things to the group we are a small team. There are no cliques, I come here and do my job. We all respect each other and each other's roles. I don't have a problem with anybody. The [registered] manager is supportive but can be short and can be a bit abrupt." The director told us "If the manager is not happy this will effect staff and then the clients and we need to build relationships within."

Services are required by law to send us statutory notifications about incidents and events that have occurred at the service and which may need further investigation. Prior to this inspection the provider failed to notify us of one serious injury incident and delayed to notify in a timely manner, of a second serious injury to a person in the service. At this inspection we found a further incident of physical abuse had not been made to The Care Quality Commission. This had not been picked up through the provider's quality monitoring of the service. The director informed us that they thought because it was reported to the Safeguarding team that was enough.

Quality monitoring at the service was not robust. Effective monitoring or regular quality checks had not been completed by the management team in order to identify shortfalls and take timely action to protect people from receiving unsafe care.

Medicine audits were not robust and were not based on the medicine system. The director could not find any monthly audits other than from April 2018. The outcome for weekly audits for 7,14 and 21 August 2018 were documented as "positive". This did not evidence what had been checked or looked at and was not a reflection of our findings. This audit had not picked up any of the concerns identified.

Incidents, accidents and complaints did not form part of the quality monitoring process in the service. This meant there was no measured approach to consider if full investigations had been completed, if

appropriate action had been taken and what measures could be put in place going forward. When a person had experienced a bruise or a mark this would sometimes be referred to in the communication book but not reflected on a body map to track the progress of the injury. Staff confirmed they should have been doing this.

We were informed that monthly audits should have included infection control, medicines, care plans, health and safety and checks completed on communication books and monitoring forms. The director told us trust was placed in the registered manager to do this and lead the service effectively, however the management checklist audit tool had not been completed since 2013. An observation audit on the communication of staff to people was meant to be in place and completed monthly, however we found that this had not been done. The director told us "We definitely need to overhaul everything, make staff aware of the policies and procedures and refresh the care plans. We have tried to define different staff meetings, such as around being client led so we set a topic."

We saw that environmental risk assessments had not been reviewed since April 2017 and there was not one in place for the pest control incidents the home was having. A health and safety audit had been completed in September 2018. This was very basic and did not pick up the concerns around fire safety, instead it was ticked to confirm that everything was in place. There was no action plan in place or improvement plan to address the concerns that we found. This meant people had been left at risk of an unsafe service operating where concerns were not being picked up or acted upon to reduce the risk of harm.

After the inspection the director sent us monthly house reports that they completed. These were based on observations of what people and staff were doing, and verbal reports about the staff training undertaken and the health and safety of the building. There was no action plan from this and very few of the concerns we identified were mentioned. The director explained that they had been doing these regularly but said "I do understand that they need to be far more robust with much more information on including my audits, and they most certainly will be from now on."

We were informed that people had the opportunity to provide feedback about the service through an annual survey. However there had not been a survey offered since March 2017 and the one before that was from 2013. We saw that positive responses had been received in 2017 but there had been no analysis of the information and the results and any actions were not shared with people or their relatives. The director told us that the feedback was meant to be collated and reviewed but no evidence of this could be found.

The director told us they visited the home and on a weekly basis and would discuss the running of the home verbally with the registered manager. There had been an expectation that the registered manager had been completing the necessary monthly audits and checks but this had not been visually checked. There was no monthly report or oversight that was given to senior management to evidence the service was operating as it should be. The director was open and transparent that they were disappointed and "appalled" that the service had not been managed as they trusted and the necessary checks had not been undertaken. Since our inspection the director informed us they would be implementing a quarterly quality audit tool for the service to ensure going forward this process was more robust.

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.

People and their relatives did not raise any concerns around the management of the home with us. People confirmed they saw the registered manager in the home and one relative told us, "I see the [registered] manager a lot. I am quite happy with the home." A health and social care professional also commented "The

[registered] manager is very approachable and spoke to me often." The director told us "They are a good team, they just need to be led well."

Staff said they were able to attend staff meetings. Staff meetings had been weekly but had recently changed to two per month. Staff said the team mostly worked well together. One member of staff said "Staff meetings were weekly and changed to two three-hour meetings to discuss people and health and safety issues. We all get along we can disagree and we work well together. At meetings we are all able to air our differences. The manager is supportive. She is always there to listen." Resident meetings had been held in the home but staff told us the attendance of these had been poor commenting "We have resident's meetings which people do not attend. They will stay for food then drift away. People don't interact with each other." The meetings were now held individually with people and relatives told us the communication they received from the staff was good.

The staff knew about the values of the organisation and how they should implement these into their practice. A member of staff said, "Able actions for a better life. It's to do with enabling our client group to be involved and be part of society, making sure they are involved and are as engaged as possible. Making people feel proud, making them know they are an individual and it's their home." Another member of staff said "Able accommodation for people with mental health to live in the community. The opportunity is here for people. People at times clash and one person doesn't even leave the house. We try." We spoke to the director about if they felt the values of the organisation were followed in the home and they commented "It could be better; the clients could be encouraged more and it evidenced that it has been offered."

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 10 HSCA RA Regulations 2014 Dignity and respect There were inequalities in the way people were treated around the issue of smoking within the service. This had impacted negatively on some people who were being discriminated against. Regulation 10 (2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels in the home were not reflective of the level of needs people had. People were not always supported by staff that had up to date knowledge and skills from up to date training. Regulation 18 (1) (2) (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 12 HSCA RA Regulations 2014 Safe care and treatment The recording of incidents and accidents, subsequent investigations, actions taken and measures to minimise risks had not been safely managed. Risks in the home had not always been safely managed or action taken to prevent harm in a timely manner. People's behaviours that could be challenging were not always supported appropriately. Infection control was not managed safely to reduce the risks of harm. Medicine systems did not protect people from potential harm. Regulation 12 (1) (2) (a) (b) (d) (g) (h).

The enforcement action we took:

Imposed a positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans were not always person centred and were focused from the staff's perception. There was often a lack of guidance on how staff were to support people. We have concerns about the provider and management team at this service to meet the requirements of the regulations placing people at risk of receiving inappropriate and unsafe care

The provider failed to notify us of incidents including serious injuries and physical abuse.

Effective monitoring had not been completed in order to identify shortfalls and take timely action to address these concerns.

Regulation 17 (1) (2) (a) (b) (c) (e) (f).

The enforcement action we took:

Imposed a positive condition