Abraham Health Care Limited

Glenkindie Lodge Residential Care Home

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

About the service
Glenkindie Lodge Residential Care Home is a residential care home providing personal and nursing care for up to 33 older people. At the time of the inspection 26 people were residing at the service.

People's experience of using this service and what we found
Records of care tasks were not always completed. We found gaps in the recording of repositioning tasks, oral care records, continence care and health monitoring.

Risk assessments had not always been completed for known risks to people. We found risk associated with legionella, call bells, catheter care, and health conditions that had no risk assessment or strategies implemented to mitigate these risks in place.

Care plans did not consistently have the required information to support staff in understanding a person's needs and ensuring all information was accessible to them.

People who were at risk of dehydration did not have their needs consistently recorded. We found fluid records did not evidence that people were supported to stay hydrated.

Medicine management system needed to be improved. Records did not evidence people received medicines as prescribed. We found gaps in the recording of medicines.

Unexplained injuries had not always been investigated, and injuries had not always been recorded appropriately.

Staff were recruited safely, however not all staff had received up to date training. The service used a high number of agency staff and at times staffing levels fell below the providers recommended levels.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Systems and processes were not effective in ensuring the safety of people or the environment.

Systems and processes to ensure the provider and manager had oversight of the service was not always effective in identifying and improving the quality and safety of the service.

People were supported to access healthcare professionals and attend appointments. Staff referred people to external professionals as required.

People and relatives were positive about how staff treated them. People used words such as kind and caring. People felt their dignity was respected.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 18 March 2020) and there were four breaches of regulation.

At this inspection enough improvement had not been made/sustained, and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to oversight, records, cleaning and medicines. As a result, we undertook a full comprehensive inspection. We also checked whether the Warning Notice we previously served in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively

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

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

We have identified breaches in relation to records, risk assessments, staff training, consent, medicines, safeguarding, and oversight at this inspection.

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

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well led findings below	**Inadequate**

Glenkindie Lodge Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Glenkindie Lodge residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the provider, registered manager, assistant manager, senior care workers, care workers and the chef.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last two inspections the provider had failed to ensure the risks to people and risks in the environment were effectively assessed recorded and mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulation.

- People were at risk of pressure sores. We found people who required repositioning at prescribed times did not have this need met. For example, one person who required repositioning every two hours to support with risks of pressure damage, had gaps of up to 10 hours within their records. Another person who required support with repositioning had no records in place to evidence this task was being completed.
- People were not always protected from the risks associated with diabetes. For example, one person's care plan stated staff were required to check and record their foot care daily to mitigate some of the risks from having diabetes. We found no records to evidence this task had been completed.
- People's continence needs were not always recorded. For example, one person's records evidenced they had not opened their bowels for six days, and another person's records evidenced they had not opened their bowels for eight days. One person who required their catheter to be checked every four hours had no times recorded, and the checks were only recorded approximately four times in 24 hours. This put people at risk of compaction, constipation and urine retention.
- Known risks were not always assessed and mitigated. For example, risk assessments were not in place for people who required catheter care or for people who could not use a call bell. This meant staff did not have all the information to keep people safe.
- People were at risk from legionella. Cold water temperatures had not been taken and descaling was not completed as required in the Legionella risk assessment.
- People were at risk of not receiving their medicines as prescribed. Medication administration records (MAR) evidenced missed signatures. There was no stock check or investigation after these missed signatures to establish if the concern was a missed signature or a missed medicine. Prescribed thickener had not been signed or recorded as given.
- MAR were not always completed appropriately. For example, when a 'as required' (PRN) medicine was administered staff had not always recorded the reason why. This meant the effectiveness of the medicine could not always be established.
- Injuries to people had not always been recorded appropriately. For example, the size and location of the injury was not consistently recorded and follow up information had not been recorded to evidence how or if

the injury was healing. This information would support staff in identifying when a person may need additional health support.
● Unexplained injuries were not always investigated. For example, we observed one person had a bruise on their hand, this had not been recorded or investigated to identify the cause.
● Accidents and incidents were not recorded and reviewed to identify trends or patterns. This meant that lessons could not be learnt when these things occurred.

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks, and to ensure the safe administration of medicines had been completed. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had policies and procedures in place regarding safeguarding and recognising the signs of abuse. Not all staff had received safeguarding training. The registered manager allocated training to these staff immediately after inspection.

Staffing and recruitment
●Staffing levels required monitoring. Some staff felt there were not enough 'Glenkindie' staff on each shift, as the provider used a lot of agency staff to fill vacancies. Staff told us this impacted on people. For example, staff not having the time to chat to people as they had tasks to do. However, staff stated this did not affect how staff completed tasks required to keep people safe.
● We reviewed rotas which showed that staffing was supported by a large number of agency workers and on eight shifts over a three-week period reviewed, numbers of staff fell below that reported as being the required level.
● Safe recruitment practices were in place and the provider used references and the Disclosure and Barring service (DBS) to ensure no staff had any criminal convictions and were suitable to provide support for the people living at the service. However, interview questions were missing.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

At our last inspection the provider did not have the deprivation of liberty safeguards (DoLs) legal authorisations to deprive people of their liberty or they had not applied for DoLs for people who they were depriving of their liberty. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulation.

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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- The provider had not ensured the MCA had been followed appropriately. For example, four relatives had consented on behalf of a person when they had no legal powers to do so. The provider should have ensured a mental capacity assessment and best interest meeting had been completed before the decision was made.
- Not all mental capacity assessments had been completed as required. For example, closed circuit television (CCTV) was in use in the service. However, there was no evidence of mental capacity assessments being completed. We found when people were unable to consent to share information with others, a capacity assessment or best interest meeting had not been completed.

The provider had failed to ensure consent has been obtained in line with legal frameworks. This was a continued breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Staff support: induction, training, skills and experience; Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Staff did not always have the required skills or training to support people residing at Glenkindie Lodge safely. For example, training records evidenced; four staff were not up to date on first aid training, two staff were not up to date on food safety training, five staff were not up to date on infection prevention and control training, three staff were not up to date on dementia training and 11 staff were not up to date on safeguarding training.
● People did not consistently meet their fluid target. Some people required their fluids to be monitored to reduce the risk of dehydration. Records evidenced that when people had not met the required fluid target no actions had been recorded. This put people at risk of dehydration.
● Records were not consistently completed to evidence care had been delivered. For example, when people required support with oral care tasks, we found records were not in place to evidence this need had been met.
● Staff did not always have the required information to keep people safe. Care plans did not always contain enough detail. For example, catheter care planning did not record the normal outputs expected and diabetes information lacked detail about what to do and how to recognise if blood sugars are low (hypoglycaemia) or high (hyperglycaemia). There were no details around the support stretches/movement required for one person's mobility and no description of what was normal for bowel monitoring. This put people at risk of not receiving the care they required to keep them safe.

The provider had failed to ensure all staff were equipped with training necessary to provide people with safe care and treatment. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People were supported with a choice of meals. People were positive about the food offered and some told us the food was "wonderful". One person told us, "I love salads, so they make me a lovely salad when I ask."
● Staff told us they felt supported by the management team. One staff member said, "I have regular supervisions, it is a confidential conversation about how you feel and what you need. The home runs an open office policy as well."

Adapting service, design, decoration to meet people's needs
●Areas of the home required updating. Staff also told us they felt the environment was 'tired' and in need of refurbishment.
● People living with dementia did not always have the necessary prompts to navigate the home. For example, we did not see any dementia friendly signs or memory boxes used. These would help people orientate themselves within the building.
● We saw people using the well-maintained enclosed garden.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access healthcare as required. For example, we saw evidence of referrals being made to speech and language therapists, GP's and dietitians.
● People were supported to attend healthcare appointments as required.

● Significant people were kept up to date with their loved ones needs. For example, relatives told us the staff contacted them to tell them about a change in need or an incident that occurred.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us that staff were not always able to respond to call bells promptly. One person said, "I use mine [call bell] if I need the toilet, sometimes I have to wait."
- People told us that although most staff knew them well, not all agency staff were aware of their individual needs. One person said, "Agency staff don't know me."
- Care plans were not always reflective of people's needs. We found missing information, which meant staff did not always have all the information required to ensure people's holistic needs were met.
- People told us that staff were, "Kind, friendly and gentle."
- Staff told us they read people's care plans and get to know them, to ensure they understood the person's needs.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People and staff told us how staff respected people's privacy and dignity. We were told of examples such as, knocking on doors, closing curtains and leaving the room if a person was completing their own personal care.
- People and staff told us that staff would ask people for consent before completing a task. A staff member said, "I always go in and explain exactly what I am doing before I do it and ask them if that is OK." A person told us, "staff always ask me before doing anything."
- Staff understood they needed to support people's independence. One staff member told us, "I encourage people to be as independent as possible with all aspects of daily like. I will help if needed but I will try to encourage them to do it themselves." Another staff member said, "We get them [a person] to work with us, we might turn around and say "I'm going to give out the tea now, do you want to help me do the tea?"

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were not consistently met. For example, one person who spoke another language was observed during the inspection to be distressed, staff did not use any alternative communication methods, or speak to the person in their native language. Staff told us, that not all staff used the translation cards.
- We found limited evidence of AIS. The registered manager told us that information could be put into a different format such as easy read, large print or pictorial. However, we did not see any information that had been put into an accessible format.
- Care plans did not always contain enough information to ensure person centred care could be delivered. For example, if a person had a preference on gender of staff to complete personal care or details of what was 'normal' for a person.
- People's religious/cultural needs were recorded within care plans. However, due to the COVID-19 pandemic we found limited evidence in how these needs were met.

End of life care and support

- End of life care plans did not record the wishes of a person regarding any care leading up to their death, for example, if they wanted a priest or minister to deliver their last rights, if there were any objects or sounds that they wanted played or in their room.
- People had it recorded within their care files, if they had a 'do not attempt cardiopulmonary resuscitation order'
- Staff received training on end of life care and support.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People told us they were offered activities daily. One person said, "I don't like going downstairs to do the activities, so sometime [activity] staff come and talk to me." Staff confirmed that the activities person could spend time with people occasionally.
- People were supported to stay in contact with their loved ones during the COVID-19 pandemic.

Improving care quality in response to complaints or concerns

● People staff and relatives knew how to complain. One person who had complained told us that they felt their complaint had been responded to their satisfaction.

● There were procedures in place for making compliments and complaints about the service. All complaints we saw had been investigated and responded to within the providers specified timeframe.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last two inspections the provider had not maintained effective oversight of the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had not made enough improvement and was still in breach of regulation.

- Audits had not identified the missing information we found in people's care files. For example, healthcare information, preferences and risk assessments. Therefore, the registered manager could not be assured of person-centred care being delivered.
- Systems and processes to ensure equipment within the service was safe and properly maintained were not effective. We found no evidence of thermostatic mixer valves being serviced annually which can put service users at risk of scalding. We found insufficient testing of water temperatures and descaling tasks to mitigate risks of legionella.
- Systems and process to ensure people were protected from harm were not always effective. For example, unexplained bruising had not always investigated to identify the cause and protect the person from this occurring again.
- Systems and process to ensure staff had the correct skills to support people's safety was not effective in identifying when staff training had expired or when staff had not received all the necessary training.
- Systems and processes to ensure people's rights to privacy and care and treatment is only provided with consent of the relevant person was ineffective.
- People were at risk of receiving unsafe care due to the lack of oversight of the service and records. For example, we found gaps in the recording of blood glucose monitoring, repositioning tasks, oral care tasks and catheter checks.
- Processes to ensure medicine administration was completed safely was not effective. Medicines records had not been consistently completed to evidence medicines were given as prescribed. Stock checks or investigations had not been completed to identify if the issue was a missed medicine or a missing signature
- The registered manager had limited oversight of Infection prevention and control [IPC] measures. The registered manager had only started to complete IPC audits and personal protect equipment [PPE] audits in May 2021. During the COVID-19 pandemic we found no evidence that the provider or registered manager had put systems into place to ensure all measures were completed.

The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

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

● The registered manager was clear about their responsibility to be open and transparent in line with their duty or candour responsibility. However, we only saw handwritten notes on telephone calls completed, when the duty of candour was required. The registered manager told us he would send formal duty of candour correspondence soon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Most staff felt supported by the registered manager and felt able to raise any concerns. One staff member said, "Yes, if I have any concerns I go straight to the office." However, another staff member told us, "Sometimes you go in [into the office] and you wonder why you bothered as they [management] don't listen any way."

● People told us they felt comfortable to speak with the management team. One person said, "I feel valued and they [management] listen to me."

● People, staff and relatives were given surveys to complete to feedback on the service. The responses were mostly positive. However, we saw no action plan to address any of the less positive responses.

● People and relatives were involved in care plans. Relatives told us that staff updated them with any changes in need or incidents.

Continuous learning and improving care

● Actions had not always been put into place when an issue was noted. For example, the visiting chiropodist had commented to the registered manager that some people's feet were very dirty. The registered manager discussed this with staff in a staff meeting stating, "Please check people's feet regularly to avoid comments like this in the future." However, we found no oversight of feet being checked and we found multiple gaps in the recording of people's feet being checked.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure consent has been obtained in line with legal frameworks.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. The provider had failed to ensure the safe administration of medicines had been completed. The provider had failed to ensure all staff were equipped with training necessary to provide people with safe care and treatment.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Notice of proposal