The Glynn Residential Home Limited

# The Glynn Residential Home

## Inspection report

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10 July 2017
13 July 2017
03 August 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This inspection took place on 10 and 13 July and 3 August 2017 and was unannounced.

At the last inspection in April 2016 we rated the service as 'Requires Improvement'. We identified three breaches in the regulations and issued requirement notices in relation to people's mental capacity and assurance about the quality of the service. We issued a warning notice because medicines were not always administered in a safe way. This inspection was to check improvements had been made and to review the ratings. However, we found although there had been improvements to the management of medicines, there were continued breaches in the regulations and three new breaches. Continued breaches were in regulation 11 need for consent, regulation 12 safe care and treatment and regulation 17 good governance. Further breaches were in regulation 9 person centred care, regulation 10 dignity and respect and regulation 18 staffing.

The Glynn Residential Home provides accommodation and personal care for up to 38 older people, some of who are living with dementia. Accommodation is provided over two floors with communal areas, including three lounges and a dining room, on the ground floor. There were 31 people using the service when we visited.

The home had a registered manager. 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.

Staff understood how to follow safeguarding and whistleblowing procedures to keep people safe from abuse. People's individual risks were not always known or recognised by staff, and there was missing information in care records about how to care for people safely.

Staffing did not meet people's needs; lounges were unattended for long periods of time as staff were attending to others.

Induction for new staff did not include moving and handling training and staff lacked knowledge of how to assist people safely with moving and handling.

Medicines management had improved but not all matters identified in the warning notice were actioned by the first day of the inspection, although had been addressed by the third day we visited.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible, in line with the policies and systems in the service. Mental capacity assessments were not always clear.

People had access to other professionals to support their care needs. People's food and drink needs were suitably met overall.

Staff spoke kindly with people but did not always use respectful language when speaking about people. People were not always sufficiently supported to go to the toilet in spite of their repeated requests for help.

There were very few activities taking place, particularly for people who could not walk or communicate verbally. Some people spent much of their day in their chairs with little interaction other than when staff carried out personal care tasks.

Care records, particularly information about people upon admission to the home lacked detail and did not correspond with care practice.

Complaints and compliments were recorded and responded to appropriately, although not everyone knew the complaints process..

Staff reported effective teamwork and praise for the way the home was run.

We found poor governance and lack of management oversight of practice and documentation. Records showed the premises and equipment were maintained. Some audits were in place, although the findings of the inspection showed these were not robust or accurate.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

Risks to people were not assessed or understood.

Staffing levels were not appropriate to meet the needs of people living at The Glynn.

Medicines management had improved since the last inspection, although there was further improvement required.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The provider was not working in accordance with the Mental Capacity Act (2005) to ensure people's rights were promoted.

Not all staff completing moving and handling had been adequately trained.

People enjoyed the meals, although they were not always served in a timely way.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People did not receive sufficient attention to support their well-being in a meaningful, caring way and practical action was not always taken to meet people's needs, such as for continence care.

Staff spoke kindly to people although some terminology when speaking about people was not always respectful.

People spent long periods of time in their chairs with little interaction.

### Is the service responsive?

**Inadequate**

The service was not responsive.

There was a lack of adequate information about people new or temporary to enable staff to respond to their needs.

People were not meaningfully engaged in activities and some people were at risk of social isolation.

People and their relatives did not know the complaints procedure, although they thought complaints would be responded to appropriately.

## Is the service well-led?

**Inadequate**

The service was not well led.

The registered manager was not very visible in the home and lacked insight into their responsibilities for managing risks.

Audits were in place, although these were not robust or accurately completed to assure the quality of the service.

The service was not always working in line with their policies and procedures and these were generic and not all tailored to meet the requirements of the home.

# The Glynn Residential Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 10 and 13 July 2017 and 3 August 2017 and was unannounced. The inspection was carried out by two adult social care inspectors on 10 and 13 July 2017. An expert by experience with experience of services for older people supported the inspection on 10 July 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A medicines inspector returned on 3 August 2017 to complete the inspection.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding adult board quality intelligence group.

We had not sent the provider a recent Provider Information Return (PIR) prior to the first day of the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spent time observing the care and support delivered in communal areas. We spoke with nine people who were using the service, four relatives, three care staff, the cook, a member of domestic staff and the registered manager. We also spoke with visiting professionals, such as a physiotherapist and an occupational therapist. We reviewed five people's care records, two staff files and documentation to show how the service was run.

Inadequate

# Is the service safe?

## Our findings

We found people's care was not always provided in a safe way. One of the reasons for this was staff obtained little information about people before they came to stay at The Glynn. This meant they were not aware of individual risks associated with people's care and support needs, or how to minimise those risks.

For example, one person had been in the home just over a week and there was little information in their care plan for staff to know their needs or identify concerns about the person's safety. Another person arrived for a temporary stay on the first day of the inspection and within a few hours had left the premises unnoticed, crossed a busy main road and was waiting at a bus stop before staff located them. The home had no prior information the person was at risk of absconding and there was no information about this on their pre-admission assessment. However, after the event, the registered manager obtained further information from another professional associated with this person and this showed the person had a significant history of absconding from care settings.

We found people had personal emergency evacuation plans (PEEPs) in their care files, but these were not adequate for use and staff lacked knowledge of how to support individual people safely. For example, one person needed special equipment to for emergency evacuation, yet this was not in place and the PEEP referred to the person using standard equipment which would not be suitable for the individual.

Another person had a PEEP in place but it was for a different named person, and it was evident this information had been incorrectly cut and pasted because it had the wrong name on and there was identical information in the other file. This meant there was no accurate information to show how the person would be supported.

Staff made sure people had access to their walking frames if needed and people's frames were individually named. However, individual equipment to support people's moving and handling was not all in place; for example, slings used to hoist people were shared, not individual. Care records did not detail the type of sling to be used for each person. Where people had bedrails, we saw there was no information in the care records to show how risks associated with the use of this equipment were assessed, or how the provider ensured the correct use of bedrails. One person did not have bumpers and the registered manager told us the district nurse would have assessed the risk. However, there was no evidence of any risk assessment having been done.

One person's care plan stated they used the shower chair, yet we saw there was no assessment as to if this equipment was suitable. We saw the person's physical condition meant they would have difficulty with their sitting balance. Their moving and handling plan stated 'transfers with two carers, techniques as trained,' yet when we spoke with staff they were not clear about the techniques which were needed to assist this person safely.

This meant the provider was in breach of in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12 safe care and treatment.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. Appropriate checks were undertaken before staff began work; these included employment references and Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

Staff we spoke with told us people were safe .They said, and training records confirmed, they had received training around keeping people safe and protecting people from abuse. Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. Staff showed they were aware of the action to take should they suspect that someone was being abused, and they were aware of the provider's whistleblowing policy. One member of staff told us, "I would not hesitate to report any safeguarding concerns to a senior member of staff."

People and their relatives told us they felt safe staying at The Glynn. One person said, "Yes, I do feel safe here". One relative said, "Yes, I feel [they] are safe, nothing has made me feel uncertain". Everybody felt that they would have no concerns about raising issues with members of staff. One relative said, "The girls are smashing and easy to talk to". The majority of people felt the staffing levels were adequate. One relative said, "There always seem to be plenty [of staff] when I've come". Another relative expressed some concerns about the level of staffing. They told us, "There is a shortage, they don't have enough for one just to keep an eye".

People were happy about the response to their buzzers. One person said [about waiting times when they pressed their buzzer] "Not long, I have never had to wait a long time". Everybody felt regular staff on duty was good. One person said, "You see the same ones usually, I call them a team".
However, we had concerns about the level of staffing available to meet people's needs. We looked at the staffing rotas for the four week period before the inspection and these indicated the provider's minimum staffing requirements were met. Throughout the inspection we saw many instances of people asking for support and other people sat for long periods of time with minimal interaction. Staff we spoke with told us they felt there were enough staff, however one member of staff said, "When we are supporting new staff it would be better to have another member of staff on shift to help us."

We saw, particularly in the morning and lunchtime, staff had little time to interact with the residents. For people who were dependent on staff to bring their meals to them there was a delay whilst staff served others. We saw staff did not have always have time to sit and encourage people to eat, and at times food was taken away uneaten where people had made little attempt to eat it or fell asleep.

We saw lounges were unattended for long periods of time at different times of the day as staff were attending to other people. For example, when we arrived at 8.15 on the first morning of the inspection, we observed there were six people in one lounge area for more than 25 minutes with no visible staff available to support them. During this time two people asked for the toilet and another person repeatedly asked for something to eat and drink. Another person complained they felt cold. However, staff were busy attending to others; one member of staff told us they were, 'busy helping people to get up'. When staff came into the lounge area they told people, "We are coming, won't be long," yet we saw people continued to wait some time before staff were able to return.

We spoke with the registered manager about staffing in the home. The registered manager told us, "We do not use a dependency tool, we look at the pre assessment information to establish what staffing needs are for the home." We expressed concern that the care plans we looked at during the inspection had insufficient pre-assessment information in them for the service to be sure staffing levels were adequate.

This meant the provider was in breach of in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18 staffing

People and their relatives told us they felt safe staying at The Glynn. One person said, "Yes, I do feel safe here". One relative said, "Yes, I feel [they] are safe, nothing has made me feel uncertain". Everybody felt that they would have no concerns about raising issues with members of staff. One relative said, "The girls are smashing and easy to talk to". The majority of people felt the staffing levels were adequate. One relative said, "There always seem to be plenty [of staff] when I've come". Another relative expressed some concerns about the level of staffing. They told us, "There is a shortage, they don't have enough for one just to keep an eye".

We saw premises and equipment had regular safety checks, although some areas of the premises needed attention. For example, some window restrictors were broken in top opening windows. Some people had names on their bedroom doors, whilst others did not and there were no blinds on the bathroom windows.

People said their medicine was given in a timely manner. One person said, "I get my medicines at the right times, they look after my inhaler". However, we saw on the first day of the inspection, the morning medicine round was not completed until almost lunchtime, and we saw the member of staff responsible for medicines was distracted several times with various other tasks.

We identified concerns relating to the safe handling of medicines on our previous inspection in April 2016. During this inspection, we checked to see what improvements had been made. We looked at 13 Medicines Administration Records (MARs) and spoke with the care manager responsible for medicines.

Medicines were stored securely in a locked treatment room, and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the provider's policy.

Room temperatures where medicines were stored were recorded daily, and these were within recommended limits. We checked medicines which required cold storage and found temperature records were completed in accordance with national guidance.

MARs contained photographs of service users to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduces the chance of someone receiving a medicine they are allergic to. Documentation was available to support staff to give people their medicines according to their preferences. Administration records had been completed fully to show the treatment people had received.

Handwritten MARs were now signed by two members of staff to confirm dosage instructions had been transcribed accurately. However,we found that MARs were not always completed with the same instructions as stated on the label attached to the medicines: one person who was prescribed an antipsychotic medicine to be taken each morning had been incorrectly re-written on the MAR with instructions to be taken daily. Another person was prescribed an antibiotic to be given with or after food. However, the instructions had not been transcribed onto the MAR. This meant there was a risk that people were not receiving their medicines as prescribed. We recommend the provider ensures that instructions for administration of medicines on handwritten MARs are transcribed accurately.

We checked the quantities and stocks of medicines supplied outside of the monitored dosage of system for 13 people and found the stock balances to be correct. This meant that medicines had been given as signed by staff.

We found guidance was now in place to enable staff to safely administer medicines prescribed to be given only as and when people required them, known as 'when required' or 'PRN'. Some medicines were prescribed with a variable dose, i.e. one or two tablets to be given. We saw the quantity given had been recorded, meaning that records accurately reflected the treatment people had received. On the first day of the inspection we saw there were people who did not have PRN protocols in place to guide staff as to when and how frequently these medicines could be taken. By the time the medicines inspector visited the PRN protocols were in place.

Instructions for medicines which should be given at specific times were now available. For example, one person was prescribed a medicine to be taken 30 minutes before breakfast when the stomach is empty. Another person was prescribed a medicine which should be taken whilst upright and 30 minutes before eating or drinking. Administering medicines as directed by the prescriber reduces the risk of the service user experiencing adverse effects from the medicine, or the medicine not working as intended.

We saw the use of patch charts for people who were prescribed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application. Body maps and topical MARs were also in use, these detailed where creams should be applied and provided clear records of administration.

Improvements to medicines audits (checks) had been made since our last visit. These now included twice weekly and monthly checks by the care manager. These included a review of stock control for PRN medicines and boxed medicines supplied outside of the monitored dosage system. Issues that had been identified had been acted upon and improvements made.

Staff had received medicines handling training and their competencies were assessed regularly to make sure they had the necessary skills.

Some people we spoke with said that the standards of cleanliness and hygiene were good; one resident said, "Marvellous, spotless". We saw staff used protective equipment, such as disposable gloves and aprons. Most areas of the home were visibly clean, although we noticed strong odours of urine in some bedrooms.

Requires Improvement

# Is the service effective?

## Our findings

Staff who were new to their role completed the 'care certificate', which is an identified set of standards that health and social care workers adhere to in their daily working life. The service had an overview of training for staff in the home and these were mostly up to date. These included fire safety, challenging behaviour, infection control and moving and handling.

However, on the first day of inspection we observed two members of staff supporting a person into a hoist. This continuedfor over 10 minutes before an inspector intervened and asked if they would need help. The inspector asked another member of the care staff to support their colleagues. The person being supported was clearly in distress and was shouting out at this time. We looked at the training records for both staff; one of the members of staff had received no training on moving and handling. We asked the registered manager why this was. They told us, "I have just changed all the paperwork and this must have been missed." We told them the member of staff must not support people until trained in using a hoist. The registered manager confirmed after the inspection that training had been arranged for the end of July 2017.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so they can 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had some understanding of the principles of the MCA and DoLS and had made some appropriate applications, although their knowledge was not robust enough to ensure decision making processes were followed accurately. For example, two people, both with mental capacity, were in bed with bedrails yet their consent for this was not sought. The provider said it was the district nurse's decision to provide bedrails and there was some confusion about people's right to choose for themselves when they had mental capacity. The provider obtained consent from one person after the first day of the inspection; the other person had gone into hospital so it was not possible for the provider to seek their consent.

Care plans contained conflicting information about people's ability to make decisions. For example, one person's care record stated they had 'full capacity' to make all decisions, yet would not be able to understand or decide upon the use of their buzzer. Staff told us they would not remember what to do with the buzzer so they made regular checks to the person's room instead. One person who was there for respite care, had no assessment of their capacity, yet staff agreed they were vulnerable and thought they would not be able to make decisions about their care and treatment. There was no evidence of any consultation or best interest decision about the person staying in the home.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 11 because care was not provided with sufficient regard for people's consent or their mental capacity.

Staff confirmed they had received training on mental capacity, and showed a good understanding of how to protect people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions.

One person told us "They [the staff] know what they are doing". They felt they were kept involved in their daily care and told us, "They sit down and have a chat about how we are doing". People told us they were involved in making decisions about their daily care and one person said, "They let you have a lie in if you want".

Staff attended regular team meetings where they had opportunity to discuss their roles and responsibilities. Discussions included activities and what people would like for the home in relation to more external companies coming in. Fire drills were discussed, as were visual aids for meal times for people. The importance of staff completing their online training was also discussed. Staff were supported with supervisions and appraisals in the home. We looked at three staff files which confirmed this.

Handover of information between shifts was done but the documentation was not detailed, although staff told us they understood what was said during handover meetings and made their own notes, but did not keep these from shift to shift.

We observed breakfast and lunch time meals in the home. We saw people had breakfast at varying times depending on when they got up. However, some people had to wait some time from being assisted to get up, to being offered anything to eat or drink. One person told us they had, "Not had a cup of tea or anything," and they had "Been up for ages." Staff told them they would attend to them as soon as they were able, but we saw this was more than 25 minutes. There were some delays for people who were reliant upon staff to support them with their meals.

People made positive comments about the cooking and the quantity of the meals. One person said, "They [the meals] are nice, there is a good choice, two things every day". Staff told us, and records showed people were weighed regularly and people's diets were adapted according to their needs.

There was a new cook in post who was learning their role in the home on the first day of the inspection. We spoke with the cook who told us staff informed them of people's dietary needs, although we saw there was no information available in the kitchen for the cook to refer to in order to know what to provide and for whom

We saw people were offered the choice of meals just before they were served, and the menu was displayed on a whiteboard in the dining room. On occasion, staff gave visual choices to people to help them choose what they wanted. People ate snacks throughout the day, such as biscuits and crisps, and drinks were offered mid- morning and afternoon.

One relative said, "[My family member] gets weighed and has been on a fortified diet in the past". Everybody said that there were snacks and drinks available between mealtimes. Another relative said, "There is tea and biscuits and things all day".

Everyone we spoke with said there was good access to other health care professionals. One person said, "They all come in if we want to see them". Staff told us people had good support with their healthcare, and records confirmed this. One member of staff told us that the physiotherapist and occupational therapy team attended the home regularly for people. We saw evidence in people's care plans which supported this. We also spoke with a district nurse who said the staff were very proactive with managing people's pressure care and seeking routine advice when needed.

The premises were not adapted to assist people living with dementia to recognise their surroundings and be able to find their way around the home. For example, there was little signage to assist people to key areas in the home, such as their own room or toilet areas. We recommend the provider makes suitable adaptations to the home including signage to support people living with dementia.

Requires Improvement

# Is the service caring?

## Our findings

Although we saw staff did not always have time to sit with people and attend to their needs, we saw interactions between members of staff and the people or visitors were professional, warm, friendly and caring. Staff were cheerful and friendly. However, we noticed some terminology staff used was not always respectful. For example, staff referred to people who needed assistance with meals as 'feeders'. Senior staff confirmed this language was used in the home and acknowledged it was unacceptable, although not intentionally meant as disrespectful. This was raised with the registered manager.

Staff we spoke with said people received good care. Staff told us the team worked well together. One member of staff said, "We all work as a team here."

People we spoke with were happy with the quality of the care given by the staff and the manner of their interactions with people. One relative said, "The girls are lovely, they never have an unkind word for anyone". One person said, "They are caring, they sit and chat to make sure you are OK".

People told us they were treated with respect and dignity and said care was taken over ensuring their privacy. One person said, "My privacy and dignity are respected, they talk to me properly". People wore clean and appropriate clothing and if necessary were supported to their rooms for a change of clothes. We heard staff compliment people on their appearance.

We saw people's individual rooms were personalised with their own possessions, such as photographs and ornaments. One person had a picture of their favourite singer in their room. Where people had particular religious preferences we saw they had items to support their faith. For example, one person had a crucifix and photographs of a religious leader, as well as leaflets from the local church.

We saw staff encouraged people to be independent where possible. Staff patiently spoke with one person who was walking with them and reassured them they could take their time, before gently guiding them to sit in their chair. We saw one member of staff noticed a person could not reach their cutlery when eating, and they made this more accessible. Another member of staff noticed a person was struggling to open a carton of juice and they offered to help them. People and their relatives said independence was encouraged. One relative said, "[My family member] is supported to do as much as they can". Two relatives we spoke with said their family members' end of life care had been discussed and planned with them.

We observed people in the home sat for long periods of time with little stimulation. For example on one day of inspection we saw two people sat with minimal interaction from 10.00am until 12.30pm and their only interaction was through receiving lunch. After lunch had been served there was again minimal interaction throughout the day from 1.30 pm until 4.30 pm.

One person who was reliant on staff to support their mobility, was unable to go to the toilet as staff did not promptly support them in spite of their repeated requests. We saw staff paid no attention to the person or acknowledge their needs. Staff said the person made frequent requests and 'forgot' they had already

been.Inspectors did not see this was written in the care plan although the provider sent this information following the inspection. The care plan showed staff were to reassure and distract the person, although we did not see this happening in practice.

Inadequate

# Is the service responsive?

## Our findings

The care records we looked at did not contain any pre- assessment information of people's needs made before they started to receive care within the service. One person required medical attention on the first day of inspection. A visiting professional was attending the service to review the person's mobility needs and was concerned about the person's health and requested staff seek emergency medical treatment. Staff did not respond promptly to this request and the visiting professional called for an ambulance.

The paramedics asked for any pre-assessment information from the staff team in relation to the person's past medical history. Staff confirmed they had little information, and the paramedics were unable to identify if this was a pre-existing condition or a new concern.

One person came in for respite care on the first day of the inspection but there was minimal information in their care plan, and there were no risk assessments in place. Serious concerns emerged during the inspection in relation to the person's behaviour and them leaving the home unseen. There was no DoLS in place, but the provider said the person lacked capacity and would be vulnerable if they left the home. The person absconded during the first day of the inspection and staff had to carry out a search, before locating the person at a bus stop. It was evident the provider had not fully assessed or mitigated the risks for this person and they were unable to meet their needs. We asked the provider to make a safeguarding referral in respect of this incident. We were present and heard the person's relative complained about this when they had to collect their family member.

We saw one person was seated in a specialist chair which was referred to in their care plan, although we could find no assessment of the person's needs in relation to using the chair. This meant it was not possible to determine if the person was using equipment suitable for their needs.

Some people we spoke with were satisfied with the level and quality of the activities. One person said, "There is singing, plenty to do". People and relatives were happy that there were no restrictions on going out except that some residents needed to be accompanied. One relative said, "[My family member] can go out if [they are] accompanied by staff".

However, we saw during the inspection, there was very little for people to do and many people were not meaningfully engaged throughout the day. One person told us, "This is about as good as it gets," and gestured to the lounge with little going on. On occasion, we saw where people could mobilise themselves, they engaged in meaningful activity on their own initiative, such as setting the table.

We observed people in the home sat in their chairs for long periods of time with only very limited staff attention and interaction. In one lounge there was music playing, but the volume was too low for people to hear. In another lounge the television played but we saw none of the people had been asked if they wanted to watch, and some people were unable to move themselves away.

Two people sat in a small quiet area with only a radio playing all day but a relative told us that this was their

choice. We did not see any activities taking place on the first day, although many people used the services of the hairdresser. This was listed on activity schedule, but this was the only thing happening on Mondays. We questioned whether this was an activity or part of people's personal care and staff said it was included as an activity. On the second day we saw one person attempted a jigsaw puzzle whist another did a word-search puzzle.

The notice boards in the home displayed information about some activities, for example 'sangria Sunday.' We asked staff and the registered manager if there was an activities co-ordinator. There was no activities co-ordinator in post at the time of the inspection.

We concluded the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9 because care was not person centred.

People and relatives said there were no real restrictions on friends and family visiting times. One person said, "Visitors can come any time".

People spoke positively about staff's knowledge of people. One person said, "They [staff] know them all". We found through speaking with staff they knew people's personalities and preferences well, although there was a difference in staff's knowledge of people's care needs.

All people and relatives we spoke with said that they did not know the formal complaints procedure but this was not an issue as they did not want to make any complaints. One person said, "I have no complaints, none whatsoever". There was a generally positive feeling about how the staff and management would respond to issues being raised outside of formal meetings. One relative told us, "Yes, if we said something they would act on it if they could". We saw complaints and compliments were recorded and responded to. One visiting entertainer had written to CQC before the inspection, expressing compliments for the quality of care.

Inadequate

# Is the service well-led?

## Our findings

There was a registered manager in post who had been in charge of the home for 32 years. However, we found poor governance and lack of management oversight of practice and documentation. The registered manager had difficulty finding information for us and said it would be the care manager's responsibility to know where this was, but they were on leave during the inspection. The registered manager lacked insight into the risks within the home.

We found the registered manager was not very visible in the service and some people and visitors told us they did not often see them, although knew who they were. One visiting professional told us they had only met the registered manager once and that was during our inspection. One relative said "Yes, I see [registered manager] regularly, [they are] approachable, they all are".

We spoke with staff who told us that the care manager and registered manager were approachable. One member of staff told us, "The [care] manager is lovely. The registered manager is not in much but if I had any concerns I could speak to any of the senior staff or the manager. Another member of staff told us, "We all get on really well. They have said they will help me with my level 3 certificate".

We reviewed documentation for the running of the home, such as for premises and utilities and saw these were checked regularly, but there were limited audits. Where audits/quality checks were in place and the registered manager had signed to say they reviewed, such as care plans, we found they were signing documents we found flaws in, such as the copy and paste/inadequate information in PEEPs. This meant the registered manager's checks were not effective

People and relatives told us the home was well managed. One relative said, "Very efficient." We received a mixed response about how much people and relatives were involved in the running of the home; some said they did not attend meetings and had not been given questionnaires whilst others were more positive. One resident said, "I do questionnaires and we have awareness meetings." We saw evidence of residents' and relatives' awareness meetings, and information about these was pinned on the notice board in the entrance. Few people we spoke with said that were given updates about changes in the home such as new decoration. One said, "We are told that we are getting new carpets and chairs".

We noticed there was a five star food hygiene rating displayed on the front door, yet when we looked at records we saw the home was visited by the environmental health officer in January 2017 and been graded with a one-star rating, requiring 'major improvement'. The registered manager was unable to locate an action plan to show how each point raised by the environmental health officer had been addressed. The registered manager said they had not noticed the previous five star rating was incorrectly displayed. Whilst there is no legal requirement to display food hygiene ratings, it would indicate the provider was sharing information in an open and transparent way and we saw this was not the case. The previous CQC inspection findings were displayed in the home.

There was a detailed set of policies and procedures prepared for The Glynn by an external provider.

However, these were not specific to the needs of the service or the people using it and practice was not always carried out in line with these policies and procedures. For example, the pre-admission policy and procedure made reference to nursing care, for which the provider is not registered and stated there would be thorough assessment of people's needs prior to being resident in the home.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 because there were significant weaknesses in the systems and processes in place to assess, monitor and improve the quality of the service.

We saw the provider had carried out quality assurance surveys based around the five key questions we ask at our inspections. These sought the views of staff, people, relatives and other professionals and we saw there were positive results received.

Everyone we spoke with said they would recommend the home. Four members of care staff we spoke with said they had been in post for a number of years, liked working in the Glynn Residential Home and had no plans to move on.

People and relatives reported that there was good contact with the local community with groups coming into the home one relative said, "The local community comes in for special events, like the school singing carols". Everybody said there was a good atmosphere in the home, one relative described it as "Very, very homely and friendly," and everybody said that they would recommend it to others. Two relatives said "Yes, we already have".