Mr Amin Lakhani

Glen Heathers

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 24, 25 March 2015 and 2 April 2015 and was brought forward in response to concerning information we had received.

Glen Heathers is a registered care home and provides accommodation, support and care, including nursing care, for up to 53 people, some of whom live with dementia. There was a secure area of the home referred to as “The Wing”. Staff told us this locked area supported people who lived with dementia and those who may display behaviours which present a risk to themselves and others. On the 24 and 25 March 2015 there were 42 people living in the home, with eight living in the Wing. On 2 April 2015 there were 41 people living in the home.

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. The registered manager was retiring near the end of April 2015 and the provider was recruiting to this position.

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

Summary of findings

- 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.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. Although people said they felt safe, the registered manager did not always respond appropriately to matters of a safeguarding nature and did not report these to other professionals to ensure effective and appropriate investigation.

Risks associated with medicines were not managed effectively. Prescribed medicines were being used as homely remedies. There were no guidance or care plans in place for staff to follow in the use of 'as required' medicines. The use of medicines given on an as required basis were not reviewed by the GP when the use was regular. We could not be assured medicines were stored at required temperatures to maintain their efficacy as temperatures of storage facilities were not recorded. There were gaps in the recording of medicines with no explanation for these. Some medicines stored were out of date.

Staffing levels were not always sufficient to meet people's needs and people waited extended periods of time to receive support. Staff had not received appropriate training and supervision to ensure they understood their roles and worked within their responsibilities. Moving and handling practices observed were unsafe and as such training may not have been effective.

Risks associated with people's individualised care plans were not always identified and plans were not in place to guide staff about how to minimise these risks. When care plans were in place these were not always followed. People's needs had not always been identified and therefore planning for the delivery of their care was not effective. People were not consistently involved in the planning of their care or in making decisions about how they received their care.

The CQC monitors the operation of the Mental Capacity Act 2005 (MCA 2005) and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The registered manager and staff lacked an understanding of the MCA 2005. We found that whilst applications had been made to deprive some people of their liberty, there was no supporting evidence to suggest an assessment of their capacity had been undertaken and that least restrictive options had been explored.

Whilst no recent complaints about the service had been made, people were not confident that any concerns or complaints would be acted upon promptly. Feedback from people and relatives was sought using surveys however not all comments were acted upon.

Whilst people said staff were kind and supported them well, staff did not consistently demonstrate a caring approach to the people they supported. Staff did not always show respect or consideration of people's right to privacy and dignity. Staff were task orientated in their approach and at times ignored peoples request for support. The manager had not identified this as a concern despite indications of a poor attitude by staff within staff meeting minutes. The registered manager lacked an understanding of their responsibilities and we were not confident they could guide staff appropriately. Audits undertaken to monitor the service were ineffective and had not identified the concerns we had. They were not used to drive improvement. Incidents that the provider was required to inform to CQC of were not being reported. Due to the concerns we identified we made a referral to the Local authority responsible for safeguarding adults at risk.

Summary of findings

We found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

The service did not always take appropriate action when safeguarding concerns arose and the manager did not always report safeguarding concerns appropriately.

Planned action to minimise identified risks associated with peoples care and treatment was not always undertaken. Staffing levels were not sufficient to meet people's needs safely.

Risk associated with medicines were not always managed safely.

Inadequate

Is the service effective?
The service was not effective.

Staff were not effectively supported though supervisions and training to ensure they had the skills to meet people's needs.

The manager and staff did not demonstrate an understanding of the Mental Capacity Act 2005. An area where some people lived in the home was locked with no access outside of this, however the reasons for this were unclear. Least restrictive options had not been considered.

People were not supported to maintain a balanced diet that met their individual needs. They were supported to access services of other health care professionals when this was required.

Inadequate

Is the service caring?
The service was not caring.

People's privacy, dignity and independence were not consistently respected by staff. Staff did not always show respect, consideration and compassion for people.

People were not encouraged to be involved in decisions about their care.

Inadequate

Is the service responsive?
The service was not responsive.

Care plans were not always personalised to meet people's individual needs. Where people needed alternative communication support this had not been considered.

Not everyone was confident any concerns would be addressed promptly by the manager. The provider sought feedback from people and their relatives, but it was not always clear what action they took to address concerns.

Inadequate

Is the service well-led?
The service was not well led.

The provider's mission statement was not supported by observations of staff practice and the registered manager did not fully understand their responsibilities. Not all staff felt listened to.

Inadequate

Summary of findings

Required notifications to CQC were not submitted and audits of the service were not effective in ensuring good quality monitoring and driving improvement.

Glen Heathers

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 unannounced inspection took place on 24, 25 March and 2 April 2015. The inspection team consisted of two inspectors, a specialist advisor in nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of supporting the elderly and people with mental health conditions.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 17 people and three relatives. It was not always possible to establish some people's views due to the nature of their conditions. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We spoke with the director of operations, the registered manager and the deputy manager. We also spoke with eight staff including nurses, care staff, ancillary staff and agency workers. Prior to the inspection we spoke with an external social care professional.

We looked at the records for 11 people in relation to their care and treatment. We reviewed the medicines administration records for 19 people, staff duty records, staff recruitment information, supervision and training records. We also reviewed accidents and incidents records, policies and procedures, records of complaints and quality assurance records.

The last inspection of this home was in September 2013 where we found our standards were being met.

Inadequate

Is the service safe?

Our findings

Although people told us they felt safe in the home, concerns of a safeguarding nature were not always appropriately reported.

Staff demonstrated an understanding of safeguarding adults at risk and said they would report any concerns they had to the registered manager. We saw records of investigations by the home into safeguarding allegations where the Local Authority had been involved. These included action plans to prevent reoccurrence. For example, retraining on medicines administration for nurses which had been completed. Safeguarding concerns and learning points were shared with staff in team meetings. The provider's director of operations had reviewed all the safeguarding issues that had been raised within the last six months and produced a record of the themes and actions taken to support their monitoring. However, we had been made aware, prior to our inspection, of allegations of a safeguarding matter which we referred to the Local Authority Safeguarding team. The local authority advised us they had not been made aware of concerns of this nature by the registered manager. The local authority instructed the provider's senior manager to undertake an investigation. The provider's senior manager provided us with a copy of their investigation which showed nine people had made allegations of a safeguarding nature. Whilst the service had taken action internally, these incidents had not been reported to the local authority, CQC or other external professional bodies The provider policy stated they should always seek advice from other professional bodies. They were not adhering to their own systems and process or to the local authority "Safeguarding Guidance for Provider Services". This meant there was a risk appropriate investigations might not be undertaken and safeguards put in place to protect people. The director of operations advised all incidents would be reported to other professionals in the future.

This failure to manage safeguarding concerns appropriately is was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Risks were not managed effectively. For one person with regard to their nutrition and hydration we saw their fluids were required to be thickened. Thickening fluids supports people who may have difficulties with swallowing. We observed staff supporting this person with fluids in an inappropriate seating position. This person had been assessed as being at risk of choking. The member of staff told us they would normally do this with this person sitting up, however they would need the help of another staff member to raise the person and no one was available at that time. Care had been planned for this person to reduce this risk, however whilst staff demonstrated an understanding of the need for this person to be sat upright, they did not ensure this happened. This placed this person at risk. Where bed rails were in use for another person, appropriate assessment and monitoring of the risks associated with these were not taken. It was unclear how the risks associated with other health conditions were understood and monitored by staff.

Staff had completed moving and handling training, however poor moving and handling practices were observed which placed people at risk of injury. For example, on two occasions we observed people being lifted from their wheelchair by two carers. The staff stood either side of the person and used an underarm lift. The staff pulled the person from their wheelchair whilst also holding onto their clothing. They then lifted the person to manoeuvre them to a chair. On the third day of our visit the director of operations told us discussions had taken place with staff who had been reminded of appropriate moving and handling practice.

This failure to manage risks safely was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines Administration Records (MAR) contained information about people including photographs, dates of birth, allergy information and any specific guidance. However we found that medicines were not managed safely. There were gaps in the recording of medicines administered and no explanation had been recorded in line with the provider's policy. A registered nurse was not able to tell us if these medicines had been administered or why they had not been recorded. We could not be assured people were administered their medicines as prescribed.

Information about medicines to be given 'as required' was not available which contravened the provider's policy. A

registered nurse told us there were no care plans for 'as required' medicines. Where people were prescribed medicines on an 'as required' (PRN) basis we could not see that the use of these was reviewed. For example, one person had taken a prescribed as required medicine every night since 9 March 2015. There was no evidence this had been reviewed and a registered nurse told us they had not considered discussing this with the persons GP. The provider's medicines management policies stated 'if PRN medicine is given on a regular basis the GP needs to be informed and the prescription changed to accommodate the new requirements of the service user.' The policy had not been adhered to.

Receipt of medicines into the home was not always recorded in line with the provider's policy. Of the 19 peoples MAR we reviewed this had not been done and we could not be assured of the amount of medicines received by the home. No temperature checks were under taken of the rooms used to store medicines. Both rooms appeared very hot on the last day of our inspection. We asked the registered nurses to check the room temperatures and they were unable to find a working thermometer. We could not be assured medicines were stored at the correct temperatures. Appropriate arrangements were not in place to check the expiry dates of medicines and dispose of them safely. When bottles of liquid medicines were opened they were not always dated. A registered nurse told us these were being used but couldn't tell us when they should be discontinued. We could not be assured these were within the timescale for use. Other medicines were out of date. For example, seven boxes of nebulisers (this is a medicine used to support people who may have difficulties with breathing) were being stored for one person but expired in December 2014.

Homely remedies were not managed effectively. The home held a list of homely remedies however this was a general list and not personalised to individual people. Professional guidance states a record should be kept of which people should not be given certain medicines or products and how long the medicine or product should be used before referring the person to a GP. This information was not recorded in people's care records. Some medicines stored within the homely remedies cupboard had previously been prescribed for individuals. The label with the name of the person had been removed and the nurse told us they were being used as homely remedies. The director of operations told us this should not happen and medicines would be audited again. Medicines were not being administered as prescribed.

This failure to manage medicines appropriately was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where covert administration of medicines was taking place, an assessment of the person's capacity and best interests decision had been made. Records of this were in place and reflected in the care plans. Pharmacist advice on how to administer the medicines covertly had been documented for one person. One person was on medicines which required monitoring and this was being completed

There were not always enough staff on duty to meet the needs of people. The registered manager could not demonstrate effectively how they identified the number of staff required to meet the needs of people. Staff rotas confirmed consistent staffing levels however we were not assured the number of staff available could meet the needs of people. The registered manager told us that staffing levels would not decrease but it would be "unlikely" they would increase if people's needs changed

Prior to our inspection we received concerns that people were woken up early because there were not enough staff during the day. Most staff we spoke with told us people only got up if they chose to do so. However, one told us 12 people had to be washed and dressed before day staff came on shift. One person we spoke with told us they had got up at 06:30. They said they didn't want to but this happened most days. They said, "I could say [something about it] but it's a case of doing what you are asked".

Staff said they did not feel there was always enough staff to meet people's needs. Observations throughout the inspection demonstrated there were not always enough staff available to meet people's needs. For example, four people living in "The Wing" (a secure area of the home) required full support from staff to eat their meals. Only two staff were available to provide this support, meaning that two people had to wait for their meals. One observation showed two people waited for their meals for 50 minutes while others were receiving support. A second observation showed two people waited for 20 minutes before receiving

Inadequate

Is the service safe?

support with their meal. We were told "The Wing" always had two staff present during the day however we saw that this did not always happen. On one occasion we saw this area of the home only had one staff member for a period of 10 minutes as the second staff member had taken a break. On another occasion we saw this area had one staff member for approximately 20 minutes while the other staff member took a break. A relative told us that there were not enough staff at the weekends and people had to stay in bed as a result. They also said that they had not seen a member of staff for at least 30 minutes in "The Wing" and this was usual.

This failure to ensure sufficient staffing levels was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pre-employment checks included two references of conduct in previous employment, a full employment history and qualifications. Criminal Record Bureau (CRB) or Disclosure and Baring Service (DBS) checks had been undertaken. These checks help employers make safer recruitment decisions and help prevent unsuitable people from working with people who use care and support services. Prior to registered nurses commencing work the provider obtained proof of their professional registration.

Inadequate

Is the service effective?

Our findings

People expressed satisfaction with the care they received. One person said they were well looked after, whilst others told us they liked it in the home and staff supported them as they needed.

Staff supervisions were inconsistent and did not take account of staff development. The director of operations told us a yearly supervision record was completed throughout the year and any follow up that may be required took place outside of this and was recorded separately. We looked at the records for 13 staff; six yearly records had not been completed, three had been completed in part and four had been completed in one day, indicating this had not been carried out over a period of a year. There was no evidence of a date when the process started, or any evidence of follow up. It was unclear if concerns had been identified or fed back to the member of staff. For example, one member of staff's booklet identified that dignity, fulfilment and choice was explained to them, however there was no detail of why this needed to be explained, what was discussed and whether further training had been identified. Feedback had only been provided to those members of staff who had completed their booklet, as a result those staff who had partly completed theirs had not been given feedback. Of the 13 staff supervisions records viewed one member of staff had received an appraisal. We spoke with the director of operations and they confirmed they would review the supervision forms and introduce new ones. Throughout our inspection we identified a number of concerns which could have been addressed by the manager and provider through the appropriate use of supervision and appraisal. This meant we were not assured the systems in place to support staff to deliver care were effective.

Staff had not received training which would support them to deliver care based on best practice. A centralised staff training database was in place, which we were told monitored the training undertaken by 46 staff, including the registered manager. Staff told us they found the training to be useful and helped them to learn more about the provision of good care. Mandatory training was identified by the provider however we identified a number of gaps. For example, no registered nurses had completed care planning training, and care plans created by nursing staff lacked clear guidance and did not fully reflect people's needs. The service supports people who live with dementia however no registered nurses and only 10 care staff had completed any training about dementia. People with dementia often have difficulties with communication; however no registered nurses and only 10 care staff had received training in communication. Care plans regarding communication lacked detail and clear guidance and we saw where one person had a specific communication need not training had been delivered to ensure this need could be met. Whilst staff had received moving and handling training, we could not be assured this was effective based on our observation of their practice during the first two days of our inspection.

Future training was not appropriately planned. A training plan for 2015 was in place. This provided a list of dates and topics for training sessions. Staff supervisions did not identify future training requirements and the manager was not able to show us how staff had been allocated to attend any training for 2015 and told us they did this when they planned the rota.

This failure to ensure staff were appropriately supported through effective supervision and training was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff did not demonstrate an understanding of the Mental Capacity Act 2005 (MCA), its associated code of practice and the Deprivation of Liberty Safeguards (DoLS). The MCA 2005 governs decision-making on behalf of adults who may not be able to make particular decisions. DoLS are applied when the person does not have capacity to make a decision about what is being proposed for them. It provides the framework when acting in someone's best interests means they are to be legally deprived of their liberty so that they can get the care and treatment they need.

We asked two registered nurses how they sought peoples consent and how this was evidenced. They told us consent was sought verbally and this was not recorded. We asked what action they would take should the person lack capacity to provide consent. They told us they would gain this consent from family members. In line with the MCA 2005 no one is able to provide consent on behalf of another

person unless they have been given the legal authority to do so. This is an inappropriate method of gaining consent and places people at risk of receiving care and treatment they do not want, or that is not in their best interests.

The registered manager told us one person lacked capacity. We saw they did not have a cognitive impairment and asked the registered manager why they lacked capacity. They told us this was due to their age and a sensory impairment. These two reasons would not necessarily mean a person lacked capacity to make a decision. The MCA two stage test following assessing a person's capacity had not been appropriately applied. This person lived in a locked part of the home, which we were told was for people's safety. An urgent authorisation application had been made to the local authority to deprive this person of their liberty. However there was no evidence that a mental capacity assessment had been completed for this person. The registered manager later told us they believed this person lacked capacity based on a social worker's assessment. A person must be assessed each time a decision needs to be made. This was therefore an inappropriate application of the MCA 2005.

We looked at another three people's care records that resided in the locked area of the home and found urgent authorisations had been made to the local authority to deprive them of their liberty. Mental Capacity assessments had not been completed for these people and when we spoke with the registered manager they advised us mental capacity assessments had been done but they had not written them down.

Observations throughout the inspection did not reflect consistently that people were supported to make simple decisions. For example, at lunch time in the wing people were not asked first before a tabard was put on them. Comments from staff reflected a lack of understanding, for example one staff member told us "MCA is when the client knows what is right or wrong". A second staff member said "Is that about dementia". One registered nurse could describe in detail the MCA 2005 and what they should do, however when we asked what they would do if they could not gain consent because a person lacked capacity, they told us they would gain consent from a family member. The training matrix showed no registered nurses and only 10 care staff had received training in the MCA. This meant staff were not supported to understand their responsibilities in line with the MCA to ensure people were encouraged to make their own decisions or that these were made in people best interests where required.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The use of restraint was not monitored. The registered manager told us that a DoLS application had been made for all of the people who resided in the locked wing. This area was locked using a key code system that none of the people residing here had access to. A door that lead to the outside area was also locked and people could not go to the garden without staff support. Of the five people's care records that resided in The Wing we found decisions about the use of restraint were not appropriately made for three. Applications to deprive people of their liberty due to the locked door had been made to the local authority; however records indicated that the use of the locked door was not necessary. For example one person's application stated it was unlikely they would attempt to go through an open door. A second person's stated, "[Person] is not mobile and would not be able to walk through the door of the wing." It was unclear why on this basis, they needed to be in a locked wing. Staff told us people were in a locked wing for their safety but records did not reflect what would be unsafe if they didn't and staff were not able to tell us. Some told us that two people resided in this wing due to challenging behaviour, however we found no evidence of this behaviour in records and our observation across the three days of our inspection showed that people appeared to be very settled and mostly stayed in their rooms or in the chairs. Only three care staff had received training in challenging behaviour and when asked a registered nurse told us no form of restraint was used in the home. The use of a locked door was not recognised as a form of restraint by all staff. This meant we could not be assured the least restrictive options had been considered by staff. We spoke with the director of operations and registered manager about why this area was locked. They told us this was implemented when there was a risk. They told us they would review this. This meant action was not taken to minimise the use of restraint on people.

Inadequate

Is the service effective?

This was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People spoke highly of the food provided by the home. They told us they enjoyed it and there was enough. A planned menu was in place and staff told us how people were supported to choose from this. However, one staff member said "diets need re-assessing. Meals get too sameish". They told us people were not spoken to about meal choices. The kitchen held up to date information about people's needs including if they required a high calorie diet, a soft or pureed diet and if they required supplements. They told us this was based on information provided to them by staff. Kitchen staff told us where it was known a person required extra calories they would make milkshakes with full fat milk and additional milk powder, they would add extra cream to potatoes and also to puddings. We saw that the kitchen staff responded quickly to peoples likes and dislikes, one person following lunch had stated they did not like garlic, immediately the cook updated their information and told us they would ensure this person was offered alternatives and their food would not be cooked with garlic.

Planning for people's personalised nutritional needs was inconsistent. For example, for one person a daily record in January 2015 stated they had lost 7lbs in 6 weeks. Whilst a discussion had taken place with the person's GP, there was no evidence of a plan of care to ensure staff could support this person to maintain adequate nutrition and no monitoring of this person's intake was recorded. Whilst we saw this person had gained weight, the history identified a risk that the service had not planned support for. For two people who had been assessed as underweight, their care plans contained very little about their preferences or guidance to ensure staff knew what they should be eating over the course of 24 hours. Where people required supplements to support their nutritional intake we were not assured these were provided. Two people's records reflected that they should be receiving supplements, however one person did not have any stock of this and there was no evidence for the other that this had been prescribed.

Monitoring of food and fluid intake was not effective. For two people the monitoring charts provided no guidance about the person's ideal intake. The completed charts did not contain sufficient information to understand and assess their nutritional intake. They had not been totalled or evaluated and we could not see any action taken by nursing staff when these showed concerns. A lack of guidance and clear monitoring about a person ideal intake means staff would find it difficult to monitor if their nutrition and hydration needs were being met, and identify if further action was required. Approaches to planning for the delivery of care had not been personalised to ensure they met individual needs, likes and wishes.

This was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health and social care services. This included social workers, GPs and chiropodists. Staff supported people to attend hospital and clinic appointments outside of the home. We saw where staff had requested GP's to make referrals to dieticians and when speech and language therapist input was provided.

Inadequate

Is the service caring?

Our findings

People provided mixed comments about the care they received. Some told us this was good and they were supported by kind and caring staff. However, one told us "They don't care as much as I would, never seem to have enough time for you".

We did see some examples where the care provided demonstrated respect for the person and was undertaken in a caring manner. However staff did not consistently display these qualities. Staff did not always explain what they were doing when they supported people and did not give them time to decide if they wanted staff involvement or support. We observed a number of occasions when staff acted with no prior discussion with people. For example, on one occasion we saw a person in "the wing" with their eyes closed sat in the chair. Two staff came over to the person, who was still asleep and pulled them into an upright position by putting their arms underneath the person's arm and pulling them upright. The person let out a yelp. The two staff did not offer any reassurance or explanation to the person before they moved them. They did not offer an apology or explanation after they had moved them, despite the loud noise the person had made. This persons eyes remained closed and the carer picked up a spoon with food and pressed the spoon into the person's lips. The person showed surprise and jumped. The staff offered no explanation or reassurance.

On a second occasion we saw a staff member wipe a person's mouth roughly without informing the person first. The person made a loud noise of surprise. The staff offered no explanation or reassurance to the person. This demonstrated a lack of respect and kindness.

On a third occasion a staff member gave lunch to a person. A second staff member told the first staff member this was another person's meal. The staff member leant over the persons shoulder and removed the plate. The person said "that's my dinner, where's my dinner gone." No explanation or reassurance was offered to this person. This demonstrated a lack of respect and consideration for the person.

Other observations demonstrated a lack of care and compassion when supporting people to move. For example, we saw a staff member pushing a person in a wheelchair under a dining table for lunch. The staff recognised the wheelchair wasn't moving but did not check why and continued to push this under the table. The person's leg was trapped between the wheelchair and the table leg. We advised the staff member of this who said "oh", however they made no attempt to move the table or the wheelchair. The staff offered no apology or reassurance to the person. This demonstrated a lack of respect, kindness and consideration for the person.

People's privacy and dignity was not always respected. We heard staff talking about people in front of them as if the person was not present. On one occasion we heard a staff member say "I wasn't sure if she was going to the toilet so I left her plate on the table". This person and four others were in the room. This was said loudly and with no consideration to how the person may feel hearing this. Staff did not always knock on people's doors and wait for their permission before entering. Staff often did not get down to the same level as people and maintain eye contact when talking to them. On one occasion we heard a person make a request and the staff member abruptly responded with "What do you want". Staff did not always show they had a caring attitude towards people and did not recognise when they needed support.

A registered nurse told us that people were not involved in their care plan reviews. They said, "We ask them if they are happy", but said they did not discuss the care plans with them. People were not aware of their care plans and some told us that choices were not always offered. For example, two people told us they had not been offered the option to administer their own medicines, although they were not concerned about this. Two people told us they were not given choices over meals. There was no evidence of people's involvement through resident meetings and whilst the provider had introduced a form whereby people could sign to say they had agreed to their care plans, these were not always signed by the person.

This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People told us they did not know about their care plans. They said staff supported them well and listened but were not confident concerns would be addressed quickly.

Plans of care for people contained very little information about their backgrounds, preferences and personal history. Detail about people's daily routines, how they preferred to be supported and what actions staff should take to meet their individual needs and communicate with them was lacking. One set of care plans for a male person referred to "she" and another male persons care plan referred to a female name. These had not been personalised.

Care plans provided information about some of the person's needs, however we found gaps in some areas where we could not see how the person's needs had been appropriately planned for. One person's pre admission assessment and moving and handling profile indicated they could suffer pain. This person had end stage dementia and therefore pain assessments would be vital in assessing if the person was suffering any pain. There were no pain assessments or plan in place to support staff to recognise if this person was suffering pain. A lack of structured assessment and planning left this area of need open to staff interpretation and personal opinion. This meant pain might not be readily identified so appropriate action could be taken promptly. This person's care plan for elimination and hygiene needs stated they were at risk of skin breakdown. Their assessment identified this as a high risk. Whilst we saw they were being cared for on a mattress that helps reduce the risk of skin damage, there was no clear personalised plan to manage this identified risk.

For another person they were prescribed medication for a health condition however there was no plan of care in place regarding this condition and two staff we spoke with did not know if this person had this health condition. Training had not been provided to staff to ensure they could recognise what actions to take should this person have a seizure. This meant the service had not responded to this persons individual needs.

A folder was kept in the nursing staff office which held records of Do Not Attempt Resuscitation forms (DNAR). The registered manager and two registered nurses told us this folder was up to date and all forms were relevant and valid. They told us that any person who had these forms would not be resuscitated in the event their heart should stop. We found that 11 people's forms contained the wrong address for the person. The provider had not ensured they responded to all needs on admission to the service as these documents had not been reviewed. This placed people at risk of receiving treatment and support that may not want or that was not appropriate to their current needs.

People's communication needs had not been considered and adaptations implemented to support these. One person used sign language to communicate, however staff were not trained to use this. A staff member told us this person could lip read, however they were unable to tell us how they ensured they could understand the person. They told us the person made their basic needs known. This person was seated in front of the TV throughout our visit. Subtitles display on the TV had not been considered by staff and when we suggested this, the subtitle function did not work. This meant the provider had not responded fully to the individual needs of this person in ensuring effective communication.

This was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed a lack of confidence that concerns would be dealt with promptly. One told us, "They listen but anything will be when they can fit it in...– not a priority. If I had a complaint I would speak first to the person or direct to (the manager). There would be no hurry". A second person said "The manager is always busy. Listened to, I don't think so, too busy". The provider had a complaints policy and the registered manager told us they had not received any complaints in the last 12 months. The registered manager held a file containing all copies of investigations relating to concerns, complaints and safeguarding raised within the service. As there had been no complaints we reviewed the other information held in the file and saw the provider responded and implemented action plans as a result of investigations into concerns raised.

People and relatives feedback had been sought via surveys. The analysis showed people were generally satisfied with the service, however some comments raised concerns and we could not see that action was always planned to respond to these. For example, one comment made by a

Inadequate

Is the service responsive?

person was that younger staff did not know how to wash people. The analysis dated March 2015 stated under "Actions": "No occasion known to have occurred and no details". This statement did not demonstrate the provider had responded to the concern. Other actions had been identified based on comments such as, "call bell response to be randomly checked". However it was too early for us to review the effectiveness of this response.

This was a breach of Regulation 10 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Staff told us management were always present in the home and were able to talk to them if needed although one expressed they did not feel listened to. Prior to our inspection an external social care professional expressed their concerns about the culture and management within the home.

The Mission Statement for the home stated the core values of the provider were to assure the dignity of service users and to respect their needs and wishes. The attitude and behaviours of staff did not reflect this culture. For example, we informed a staff member that one person required support. They advised us they were on their break and did not offer to provide any solution to meet the person's needs until further prompted. Whilst staff sat within the dining area of the home they told us they were having a break. They did not respond to call alarms where people were requesting support. This did not reflect a respect for people's dignity and needs. Comments in the minutes of staff meetings indicated staff had a poor understanding of their roles and responsibilities in supporting the culture of the home. For example, we saw discussions about staff being "selective" in the people they supported. We could not see how people were consistently supported to express their wishes and be involved in the service or their individual care. This meant we could not be assured people's wishes and needs were being met. The registered manager did not respond when we provided feedback about the concerns we had identified in the home and the director of operations told us they were shocked to hear our feedback. This meant we could not be assured the registered manager and provider were aware and kept under review the day to day culture in the service.

The director of operations told us that staff knew they were available to speak to if they had any concerns. We were told staff were encouraged to raise concerns and make suggestions. Some staff told us they felt listened to and that the registered manager would act on concerns raised. However one also told us that whilst the registered manager was always easy to find, they did not feel concerns about the staffing levels were listened to because no action had been taken. They also said they could make suggestions in team meetings but nothing was done with these. We saw that staffing levels had been discussed in team meetings, however we could see that no action had been taken to review the levels of staffing to check the validity of staff concerns and then take appropriate action to address these.

We were not confident the registered manager was fully aware of their responsibilities. They showed a lack of understanding of the need for robust and clear record keeping and the regulations providers are required to meet. The records kept by the registered manager lacked detail and were not clearly legible. Each time we reviewed the hand written records maintained by the registered manager we had to ask them to read them to us as we could not understand these. We asked three staff to interpret what the registered manager had documented and none could read them. The registered manager's understanding of the requirements of the Mental Capacity Act 2005 was poor. They were unable to evidence best interest and when discussing one person and why they had been assessed as lacking capacity, their response that this was due to a sensory impairment and the persons age, did not reflect an understanding of the Act. If the registered manager lacked this understanding, then we could not be confident they could provide suitable guidance and support to staff.

The director of operations told us of their planned changes to the management structure. They advised that they had recruited an assistant manager whose role would support the training and observation of staff. In addition they would be introducing the role of senior care staff to provide support and supervision to carers. The aim of this was to strengthen the management team in order to provide effective support and develop the service.

Registered providers are required to notify the CQC of a range of significant incidents, which occur within the home. The provider did not ensure they notified CQC of such events. Prior to our inspection we had been made aware of allegations of a safeguarding nature which we had not been notified of. The director of operations provided us with a copy of their investigation report which showed nine people had made allegations of a safeguarding nature. We had not been notified of these. The director of operations and registered manager told us they were not aware they needed to notify us of these.

This was a breach of regulation 18 of the Care Quality Commission (registration) regulations 2009.

Inadequate

Is the service well-led?

Senior managers of the provider and the registered manager undertook several audits of the service. However we were not assured of their effectiveness. Care plan audits were carried out monthly by the registered manager, however they lacked detail and had not identified the concerns we had. The registered manager said these audits involved them reviewing all care plans to ensure they reflected people's needs and were up to date. We found that care plans did not fully reflect people's needs. The registered manager showed us the audits of medicines. They did not provide any information about what was looked at and actions to be taken. They did not identify the concerns we had. The registered manager told us they had written January and February 2015 audits up at the same time. A night audit carried out on 25/1/15 asked "Do staff receive suitable training?" the response stated "Training Matrix". The training matrix reflected several gaps in training for staff. This audit was ineffective as it had not identified the gaps in training and planned any action to address this.

A clinical audit stated a new observation chart was to commence in relation to observing and training staff. The registered manager was not able to show us evidence this had taken place, although they stated they had done these. Observations of staff practice may have identified the concerns we had in relation to staff attitudes and as such action could have been taken to address this. We could not be assured of the effectiveness of these audits in monitoring the service and driving improvement.

On the last day of our inspection we spoke to the director of operations about the quality assurance systems. They told us the processes had not worked in this home. We asked why and they told us "the information we received at head office hasn't been accurate". This meant we could not be confident that senior management were fully testing the information they were provided with.

This was a breach of Regulation 10 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we returned for the third day of our inspection the director of operations told us of the immediate action they had taken following our previous two days of inspection. They told us they had started discussions with staff about our findings and had planned a staff meeting to discuss this further. They had a person external to the service undertaking observations of staff practice and feeding back to the director of operations. They had plans in place to change the management structure within the service and this had already commenced. Following our inspection they advised us of further actions they had taken including a review of the medicines and some of the locked area in the wing. The provider had taken the concerns raised seriously and started to take action to address these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not ensured the systems and processes in place were operated effectively to ensure people were protected against abuse and restriction of their liberty was appropriate to their needs. This was breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 13(1)(2)(3)(5)(7)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered persons had failed to notify the Care Quality Commission of incidents which were reportable under the Health and Social Care Act (2008) Care Quality Commission (Registration) Regulations 2009. Regulation 18 (2)(e)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not ensure Care was planned in a way they was based on the individual person and ensured their preferences and needs were met. This was breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9(1)(a)(b)(c)(3)(a)(b)(d)(d)(f)(h)(I)

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 4 June 2015. A further inspection will be carried out in due course to ensure the provider has met the requirements of this notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not ensured that people were treated with dignity and respect at all times, by all staff. This was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 10(1)(2)(a)

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 4 June 2015. A further inspection will be carried out in due course to ensure the provider has met the requirements of this notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

The registered person did not ensure consent was gained before support was provided and where a person lacked the capacity to make a certain decisions, the Mental Capacity Act 2005 was not understood and applied.

Regulation 11(1)(2)(3)

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 4 June 2015. A further inspection will be carried out in due course to ensure the provider has met the requirements of this notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured appropriate assessment and management of risks associated with peoples care and the management of medicines. This was breach of Regulation 9 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12(1)(2)(a)(b)(f)(g)

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 4 June 2015. A further inspection will be carried out in due course to ensure the provider has met the requirements of this notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured the systems and processes in place to assess, monitor and improve the service were effective in driving improvements. This was breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17(1)(2)(a)(b)(c)(e)(f)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
A Notice of Decision was served restricting the provider from admitting any other person to Glen Heathers without the prior permission of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured there were sufficient numbers of staff who received effective training and supervision were on shift at all times. This was breach of Regulation 22 and Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18(1)(2)(a)

The enforcement action we took:
A Notice of Decision was served restricting the provider from admitting any other person to Glen Heathers without the prior permission of CQC.