Premedic Limited

Glenkindie Lodge Residential Care Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on the 27 and 31 March 2015.

Glenkindie Lodge Residential Care Home provides accommodation for people requiring personal care. The service can accommodate up to 33 people. At the time of our inspection there were 16 people using the service. The service provides care to people that are living with dementia.

There was a registered manager in post. However, they were not present during the inspection visit. A deputy manager was in post and they provided managerial support in the registered manager's absence. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At the last inspection in July 2014, we asked the provider to make improvements to the management of medicines, the safety and suitability of premises and to the arrangements for assessing and monitoring the quality of the service. We found that suitable improvements had been made.

Improvements had been made to the management of people's medicines. Staffing levels required review to provide a consistently good standard of care. People received an assessment of any risks relating to their care and staff were knowledgeable about measures in place to reduce these risks. People were safeguarded from the risk of abuse and there were clear safeguarding procedures in place. The provider had appropriate staff recruitment systems to protect people from the risk of unsafe staffing.

Significant improvements had been made to the provider's premises. There were systems in place to monitor people at risk of not eating and drinking enough; however people's weight assessments were not always recorded. There was a basic system of training and development. People did not always receive effective support to access a range of health and welfare services. People gave consent for their care and the registered manager was aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People did not always experience respectful and considerate care. The systems for supporting people to make choices required further improvement. People did not always receive care that was mindful of their need for privacy and dignity.

The provider had a complaints system; however people's verbal complaints were not always recorded. There were some arrangements in place to support people to undertake a range of social activities and pastimes. There was a responsive system of care planning in place and this took into account people's physical and mental health needs.

The systems for measuring the quality of the service had been improved; however further improvements were required to ensure people's feedback was taken into account. There was a stable management team in place and the provider was informed of any concerns relating to the service to ensure action was taken.

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 always safe.

Improvements had been made to the management of people's medicines.

Staffing levels were not calculated based on people's need for care.

People received an assessment of any risks relating to their care.

People were safeguarded from the risk of abuse.

There were appropriate recruitment systems in place.

Requires Improvement

Is the service effective?
The service was not always effective.

The provider had made improvements to the safety and suitability of the premises.

People were not always protected from the risk of not eating and drinking enough.

There was a basic system of staff training and development in place.

The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People were not always supported to access health and wellbeing services.

Requires Improvement

Is the service caring?
The service was not always caring.

People did not always receive care that was respectful and mindful of their need for privacy and dignity.

People were not always supported to make decisions about their daily care.

Is the service responsive?
The service was not always responsive.

People's complaints were not always recorded appropriately.

People did not always receive support to undertake social activities and pastimes.

There was a system of care planning which met people's individual needs.

Requires Improvement

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

Requires Improvement

Summary of findings

Improvements had been made the systems for monitoring the quality of the service.

People were not always involved in making changes about the service.

There was an open culture at the home and staff were aware of whistleblowing procedures.

Glenkindie Lodge Residential Care Home

Detailed findings

Background to this inspection

At our last inspection visit the provider was not meeting standards in regards to the management of medicines. At this inspection visit we saw that improvements had been made to the management of medicines and this included keeping accurate medicine administration records (MAR) and accurate stock levels. We also saw that medicines were stored safely and procedures were in place to obtain, administer and dispose of people's medicines.

Staffing levels were not calculated based on people's need for care. One relative said "If they had more staff then more one to one care could be given and they would have more time to spend talking to people". Another relative said "There is no manager at the weekend and sometimes there are no staff about". We observed that while staff were able to provide a basic level of care; they had little time to spend interacting and talking with people to provide an improved level of care. The deputy manager told us that staffing levels had recently been reduced to reflect the number of people living at the home. They were unable to demonstrate how the staffing levels had been calculated. The staff reflected the difficulty in providing care with the current staffing levels. One staff said "The staffing levels have been adjusted and we only have two care staff and a senior care staff on duty. We still give people the care but it takes longer to get round to everyone". Another staff said "We are managing with the current staffing levels; but it is very tight and there is not time to interact with people".

The provider had systems in place to safeguard people from the risk of abuse and people told us they felt safe living at the home. The staff told us they understood the safeguarding procedures in place and were able to demonstrate an understanding of different types of abuse and the actions they needed to take. One staff said "If we have any concerns we report to a senior or the manager and they report to the local authority". Another staff said "I've had safeguarding training and would report anything to the manager". We saw that when safeguarding concerns were identified that appropriate referrals and notifications had been made to agencies such as the Local Authority and the Care Quality Commission (CQC). We saw that safeguarding investigations had been taken seriously by the registered manager who had investigated safeguarding concerns appropriately.

People received an assessment of any risks relating to their care and measures were in place to reduce the risk of unsafe care. For example a range of risk assessments such as risk of developing pressure ulceration, of not eating and drinking enough, of sustaining a fall and a fracture were in place. Individualised measures were also in place to reduce the risk of providing care. For example, one person was at risk of developing pressure ulceration and we saw measures such as pressure reliving equipment, regular assistance to move position and a plan to help them eat and drink enough were in all in place and minimised the risk of unsafe care. The staff were able to demonstrate an understanding of the risks relating to each person's care and could discuss risks such as risks of pressure ulceration and not eating and drinking enough.

Systems were in place to reduce the risk of unsafe staffing. For example, we saw that staff had submitted an application form and had an interview to assess their suitability for the role applied for. The provider had obtained references from the staff member's previous employers and had obtained checks such as a disclosure and baring service check (DBS). A DBS checks helps

employers make safer recruitment decisions. Staff told us they had been through a recruitment process before starting work at the home. One staff said "I had a DBS check before I started here and a reference from [care home's name]. Another staff said "Yes, I worked in care before and had a reference from my employer; I also had a police check and an interview before I started work".

Is the service safe?

Our findings

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Is the service effective?

Our findings

At our last inspection visit the provider was not meeting standards in regards to the safety and suitability of the premises. At this inspection visit the provider had made several improvements to the premises. This included new hard surface flooring in communal living rooms and in people's bedrooms, repairs to a hole in the roof and improvements to the safety of external doors to the property. We also found that the provider had maintained accurate records in regards to the safety of the premises including that of maintenance records for the passenger lift and fire prevention systems.

People received a range of nutritious foods and drinks; however some feedback indicated the need to improve. We observed that a hot meal was served at lunch time and while we saw some people enjoyed their meal other people told us they did not like it. One person said "It's not brilliant, but it's not so bad". Another person said "The chips today were dry". The interim manager told us they were trying to improve the meals served and had appointed a new cook to prepare a range of home cooked meals. We observed that meals were being prepared from a range of fresh ingredients and there was a high focus upon fortifying meals to improve the nutritious value of food. We saw that two choices were available each meal time and a range of fresh sandwiches were prepared at tea time. Staff told us they tried to give people different choices. One staff said "We go round and ask people what they want each day and there are fresh fruits such as oranges and bananas in between meals".

The staff monitored people at risk of not eating and drinking enough; however the arrangements for identifying or approximating people's weights required strengthening. For example one person had not been weighed for several months due to a declining health condition. While staff had monitored their eating and drinking, there had been no formal way to approximate their weight as the person could not be weighed. We also saw that no alternative method was used such as measuring the mid upper arm circumference (MUAC). In general we saw that staff monitored people at risk of not eating and drinking enough each day and appropriate action was taken to fortify meals and contact the GP or dietician for further advice as required.

The arrangements for supporting people to access health services required some improvement. For example people told us they saw their G.P when they needed to; however did not always see health professionals such as the dentist or optician. Other people's feedback was more positive about accessing healthcare services. For example one person said "I used to have blackouts and have seen a doctor about it". Another person said "Yes, the staff have taken me to the dentist several times over the past month". Staff told us and people's records confirmed that several health professionals were involved in people's care and this included the dentist, G.P and the district nursing team. The staff generally monitored people's wellbeing each day and completed a range of monitoring reports such as daily care records and food and fluid monitoring charts.

There was a system of staff training and development in place; however staff required further training to improve the care given. We observed that staff provided a basic level of care; however there was a lack of emphasis upon caring interactions to improve the level of service given. For example, one member of staff was observed trying to rush a person to sit down and there was little attention to caring interactions or thought to work at the person's own pace. The staff reflected on the need for an improved level of training to support their understanding of care. One member of staff said "I have asked for dementia training but have not had it yet. I have done my own research about dementia care and this has helped me. Another staff said "I have done fire safety, manual handling and infection control but the trainings a bit basic". Staff training records showed that there was a system of staff training in place and staff had training in subjects such as the management of medicines, manual handling and safeguarding adults. We also saw that staff had regular one to one supervision with their manager and there was a system of competency based assessments for administering people's medicines and for moving and handling people safely.

The provider acted in accordance to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We saw that the registered manager had submitted DoLS applications to the local authority where people were unable to consent for constant supervision while living at the home. We also saw that when people were unable to provide consent for specific aspects of their care; mental capacity assessments had been undertaken and best interest decisions had been made with people's families and health professionals involved in their care.

Is the service caring?

Our findings

People did not always receive respectful or considerate care. A relative told us "Sometimes the staff's attitude is like 'I don't want to be bothered'; they are not nasty but not really helpful. We also observed a situation where a person living with dementia had mistakenly gone into another person's bedroom. The member of staff dealt with this situation by 'telling the person off' and we saw they 'ushered' the person back to their bedroom with a hurried approach. The member of staff also gave the person little re-assurance or kindness to help them settle down and we observed that they looked confused and anxious. We also observed some really caring interactions between people and staff and saw that some staff were warm and compassionate in their approach. For example, several members of staff were observed assisting people to eat their meals in a sensitive and encouraging way. We also observed that people enjoyed having a laugh and a joke with the staff and some members of staff had clearly developed positive and caring relationships with people.

People were not always supported to make choices about their care. One person told us there was a lack of food choices on offer. They said "It's more about get what you are given rather than choices. I don't remember having a choice". Another person told us that they did not always get a choice about when they had a shower and found it difficult to ask the staff for more frequent showering arrangements. The deputy manager told us that there was a structured approach to providing care and staff did work from a list of people to bath and shower; however they also promoted the need to offer people daily choices about their care. We observed generally that staff gave people choices such as a choice of two meals at lunchtime and choices about drinks and snacks served throughout the day.

The arrangements for maintaining people's privacy and dignity required improvement. We found that people who used mobility aids were unable to close the door of their en-suite toilet facility due to a lack of space. A relative told us "It is a really difficult situation; especially when we are visiting as [person's name] cannot shut the door". Another person told us "I would just like to use the toilet in my bedroom but I can't get in with the hoist". We observed that some people's en-suite toilet facilities were very small and could not easily accommodate people's walking or mobility aids. The deputy manager was aware of this situation and had made alternative arrangements for people where required. This included using a communal bathroom and toilet and were people preferred the use of a commode was made available.

Is the service responsive?

Our findings

The provider's complaints system needed strengthening. One person said "I complained before, but the staff were 'off' with me afterwards and made me feel I couldn't complain". One relative said "I have complained so many times about [person's name] care that I feel guilty complaining. The manager does listen but the same things come up each time". Other relative's told us that their complaints had been dealt with promptly and improvements to the premises had been made. We saw that there was a formal procedure for managing people's written complaints; however verbal complaints were not always logged to ensure they were followed up and investigated appropriately. We saw that one written complaint had been received and this had been investigated and resolved by the registered manager and the local funding authority. We saw that complainant had been given a formal apology and had also been given the opportunity to discuss their concerns further.

There were arrangements in place for supporting people to undertake social activities and pastimes required some improvement. One relative said "They do play skittles now but sometimes I come and they are not doing much. The activities have improved here but they are often sitting around". One person said "There is nothing to do here; I suggested going out for a drive to break the monotony but we haven't done it yet". We found that a new member of staff had been appointed to assist people with social activities; however this had been geared towards group activities such as 'sing songs' rather than tailored to people's individual social needs. The deputy manager told us "We have plans to further improve activities at the home and we are going to develop 'life tree's' so that people's life stories can be displayed around the home. The staff also showed us how they had developed the garden area to attract more birds into the garden as people enjoyed watching and feeding the birds. They also explained their plans to develop a more individualised approach to social activities and pastimes. This included getting people involved with a new 'sensory' area in the garden.

There was a responsive system of care planning in place. For example, one relative told us "There is a bi-annual review of care and the staff have been concerned about [person's name] care and if their appetite is improving". We saw that people and their relatives were routinely invited to attend care reviews every six months to review their care needs and find out their experience of the care received. We also saw that a range of detailed care plans were in place to meet people's physical and mental health needs. A person centred care plan was also in place and this included information about people's likes and dislikes, hobbies and interests. We found that staff did have a good knowledge of people's changing care needs and understood their preferences for care. We saw that care planning information was reviewed regularly by the staff and reflected people's changing needs.

Is the service well-led?

Our findings

At our last inspection visit we found that the provider was not meeting standards in assessing and monitoring the quality of the service. At this inspection visit we found that the provider's systems to assess and monitor the quality of the service had improved. For example, a more through and robust audit had been introduced to check the condition of the premises. The deputy manager also conducted a 'daily walk around' to ensure standards relating to cleanliness and the condition of the premises were being maintained. We saw that when improvements were identified such as painting and decorating or cleaning the flooring; these were made without delay. A new medicines audit had also been introduced to check people's medicines were being handled safely and we saw that generally standards in managing people's medicines had improved. We also saw that systems were in place to check the quality of manual handling procedures and people's care plans. Safety checks were undertaken to check the fire safety systems and temperature of the water to reduce the risk of Legionella's disease in the water system.

However, there was a lack of focus in improving the service based upon people's, relative's and staff's feedback. For example, people and staff told us that while they could raise any concerns they were not always asked for their feedback about the service. People told us that sometimes the level of care was 'variable'. One person said "The manager is very nice and always asks how I am but I'm not asked for my feedback. If there are any residents meetings I have never been told to go". A relative said "I've not been asked for my feedback but there have been some improvements made here as the home used to be really poor". One member of staff said "We don't get involved in audits or improvements. I think the building needs to look a bit more homely and the tables and chairs need replacing". While we saw that people's relatives were sent quality assurance surveys; there was little evidence that this had been analysed to spot trends or to make improvements to the home. The deputy manager acknowledged the need to improve the service based upon people's feedback and had several ideas for putting this into practice.

There was a registered manager in post to provide the service with a stable management. The registered manager was supported by a deputy manager and by the provider. We saw that the registered manager and the provider had regular meetings to discuss the running of the home and to identify improvements to the premises. We also saw that there was a regular system of staff meetings in place and staff had discussed improvements that they needed to make such as to the management of people's medicines.

The registered manager was aware of their regulatory duties and we saw that safeguarding concerns and notifiable events were reported to the appropriate agencies. The provider promoted an open culture at the service and staff were aware of whistleblowing policies and procedures. Whistleblowing is when people make a disclosure in the public interest. One staff said "We know we can go to the Care Quality Commission with any concerns and we can speak to the manager". Another staff said "I am aware of the whistleblowing policy and I can contact the Care Quality Commission and local authority myself".