Harmony Care Enterprise LTD

Glencoe Care Home

Inspection report

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10 November 2020
20 November 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Glencoe Care Home is a residential care home providing personal care to people aged 65 and over, some of whom were living with dementia. The service has three floors. Glencoe Care Home can accommodate up to 19 people. At the time of this inspection, 13 people lived at the service.

People's experience of using this service and what we found
People were not safe. Risks to people were not appropriately managed or recorded. There was an insufficient number of suitably qualified staff on duty and robust recruitment processes had not been followed. Staff were unfamiliar with people's care and support needs.

Staff had not been provided with sufficient training or induction to their role. Medicines had not been managed safely. People had not always received their medicines as prescribed.

People's nutritional needs were not being met. Guidance from professionals in relation to special diets and fluid monitoring had not been followed. The provider failed to provide a balanced and varied diet.

Appropriate records were not kept in relation to people who used the service. Care plans, risk assessments, monitoring documents and accidents and incidents could not be located at the time of the inspection.

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 and in their best interests; the policies and systems in the service did not support this practice.

There was a clear lack of systems and processes in place to monitor the quality and safety of the service. The provider had failed to take action following the last inspection to address areas of concern.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 26 November 2020) and there were multiple breaches of regulation. The provider completed an action and improvement plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations and significant concerns remained.

Why we inspected
We received significant concerns in relation to infection control, staffing and the safety of people who used

the service. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has not changed. This is based on the findings at this inspection.

We have found evidence that the provider needs to make significant improvements. Please see the Safe, Effective and Well-led sections of this full report.

Following the inspection site visit on 10 November 2020, the service was provided with additional support from the local authority and the clinical commissioning group. They implemented support with staffing levels, meals, medicine management, infection control as well as completing clinical assessments for each person who used the service. Despite this input, the provider failed to respond accordingly to implement the recommendations made, therefore, significant risks remained.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Glencoe Care Home on our website at www.cqc.org.uk.

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

We have identified breaches in relation to infection prevention and control, medicines, environmental safety and risk assessing, staff recruitment, staffing levels, safeguarding and governance of the service at this inspection.

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

Follow up
We will continue to monitor information we receive about the service and we will continue to work with partner agencies. We will also request a specific action plan to understand what the provider will do immediately to ensure the service is safe. We will work alongside the provider and the local authority to closely monitor the service. We will return to visit in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

This will usually lead to cancellation of their registration or to varying the conditions of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Glencoe Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager was no longer employed at the service. We are taking action, to address this, outside of the inspection process.

A new manager was in post, but they were not yet registered with CQC. We have referred to them as the 'manager' throughout this report.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the nominated individual, manager, one care worker and two agency staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with three people who used the service. We looked at two staff recruitment and induction files. We also looked at medicine records, health & safety checks and servicing, as well as staff training records.

We conducted a walk around of the service and spent time observing staffs' interactions with people as well as staffs' infection prevention and control practice.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested additional documentation that was unavailable during the inspection site visit. We visited the service for a second day to collect these documents. We also had contact with a number of professionals who provided feedback on the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

At our last inspection the provider failed to ensure guidance was implemented in relation to the prevention and controlling of the spread of infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- People were placed at significant risk of contracting infections due to poor practices in place.
- Clinical waste was not disposed of as required. Full, open clinical waste bags were found in a number of communal areas.
- Infection prevention and control guidance was not followed. Personnel, protective equipment (PPE) was not stored or use appropriately by staff. Gloves, aprons and visors were found uncovered in communal areas of the home. No infection control audits had been completed.
- Staff did not change their PPE as and when required. We observed staff assisting people with personal care and then entering the kitchen area of the service without changing their PPE.
- Government guidance in relation to Covid-19 management had not been implemented or followed.

Failure to ensure guidance was implemented in relation to the prevention and controlling of the spread of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At the last inspection the provider failed to assess the risk to the health & safety of service users and do all that is reasonably practicable to mitigate such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- Risks to people were not monitored or managed, which placed them at significant risk.
- Staff on duty did not have access to people's care and support records, including risk assessments.
- Due to staffs' lack of knowledge and access to records, people's basic care needs were not being met. For

example, staff did not know who required hoisting which place people at increased risk of injury. Information recorded in relation to people's nutritional needs was incorrect, which increased the risk of unsuitable foods being provided.
● Risks to people in relation to contaminated waste and risk of infection were not considered.

Failure to assess the risk to the health & safety of people and do all that is reasonably practicable to mitigate such risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made at this inspection and the provider was still in breach of Regulation 12.

● Medicines were not managed safely.
● People did not receive their pain medication when required during the night due to insufficient staff.
● There were discrepancies with the count of a number of medicines including controlled drugs; we could not be assured people had received their medicines as prescribed.
● People did not receive their medicines at appropriate times. For example, staff were still administering prescribed morning medicines at 11.30am on the day of the inspection.

Failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider had not acted accordingly to learn lessons when things had gone wrong.
● The provider and staff had received support from other professionals in relation to IPC, the use of PPE and Covid-19 management but had failed to act on the advice provided.
● A number of shortfalls had been highlighted to the provider following the last inspection; they had not taken action to address any of the issues raised and the quality and safety of the service had further deteriorated.

The provider failed to follow guidance and do all that is reasonably practicable to mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not safeguarded from the risk of abuse.
● Staff on duty did not have appropriate training and did not know the process to follow if they had any safeguarding concerns.
● Visiting professionals had raised a number of safeguarding concerns in relation to the care people were receiving. This included professionals observing staff using inappropriate moving and handling techniques.

The provider failed to establish and operate systems and processes to ensure people were protected from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Staffing and recruitment

At our last inspection the provider failed to operate effective recruitment procedures. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 19.

- Safe recruitment processes were not followed.
- Staff on duty at the time of the inspection did not have full pre-employment checks completed prior to commencing working at the service.
- The provider had not completed any recruitment checks for agency staff working in the service.
- There was insufficient numbers of staff on duty who had the appropriate skills and knowledge to provide safe care and support to people. For example, one employed member of staff on duty had not completed any training or an induction. They were supported by two agency staff who were unfamiliar with people and their care and support needs.
- People's basic care and support needs were not being met due to insufficient staffing numbers.

Failure to operate effective recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

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

At the last inspection where we inspected and rated this domain, the service was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At the last inspection the provider failed to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reported on these shortfalls within the Safe domain of the report.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● Staff did not receive an appropriate induction to their role. New staff were unfamiliar with systems and processes in place, such as action to take in the event of a fire.
● Staff had not been provided with sufficient training. One staff member told us, "I have not received any training since I started working here."
● There was not enough staff appropriately trained to provide medicine support to people.
● Due to the lack of induction and training provided, we observed poor staff practice in relation to moving & handling, IPC and food and fluid management.

Failure to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff are deployed was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not supported to maintain a balanced diet.
● People had been provided with insufficient meals. For example, sandwiches and soup had been provided as main meals for four consecutive days.
● People had poor fluid intake. Suitable drinking aids were not available to people who needed them.
● Due to low staffing numbers, the support people required with food and fluid was not being provided, which placed them at increased risk of malnutrition.
● Suitable meals were not provided to people who required a special diet due to specific medical conditions. Staff were unaware of people specific requirements in relation to consistency of food and drinks. This placed people at risk of choking.

Failure to meet the nutritional and hydration needs of people who use the service is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Professionals raised concerns about the care and support being provided to people.
● Guidance provided by other professionals had not always been followed. For example, a professional had requested a person was weighed weekly. This had not taken place.

Failure to follow guidance and take action in relation to service users nutritional and hydration needs was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

At the last inspection where we reviewed the Effective domain, we made a recommendation in relation to MCA. Improvements have not been made.

● Where people lacked capacity and decisions had been made in their best interests, this had not been recorded. For example, a number of people required the use of bed rails and sensor mats but there was no recorded information in place to evidence the use of bedrails and sensor mats were the least restrictive options and, in the persons' best interest.
● We found examples where people had Lasting Power of Attorneys or advocates in place and appropriate processes had not been followed to ensure they were consulted when decisions for people who lacked capacity were being made.

Failure to follow best interest processes in accordance with the Mental Capacity Act 2005 is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support needs had not been assessed prior to admission to the service.
● Poor record keeping meant that people's needs, and choices were not recorded or being met. Staff on duty were unfamiliar with people's preferred routines.
● Best practice tools had not been used to assess and monitor people's needs. For example, those at risk of poor food and fluid intake.

Failure to keep maintain accurate, complete and contemporaneous records in relation to each service user is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● Risks to people in relation to some areas of the service had not been considered. People had access to high risk areas such as staircases. Inappropriate items that were accessible to people were stored inappropriately.

● Redecoration had been completed in some areas of the service; other areas needed addressing as they were old and worn and presented an infection control risk.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to establish and operate effective systems and processes to monitor and improve the service and failed to keep complete, accurate, contemporaneous records. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Following the last inspection in October 2020 the provider was requested to submit an improvement plan to say what they would do, and by when, to improve the quality and safety of the service. During this inspection we found they had not followed their improvement plan and risks remained. For example, fire safety, IPC, recruitment and medicines management.
- Since the last inspection, the provider had been provided with support from the local authority and the clinical commissioning group to further drive improvements. Advice and guidance, they had provided had not been fully implemented or followed.
- Effective quality assurance processes were still not in place. Significant risks to people's safety were identified at this inspection that the provider was unaware of and therefore, had not taken action to address
- No audits had been completed since the last inspection to monitor the quality and safety of the service.

Failure to establish and operate effective systems and processes to monitor and improve the service was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

At the last inspection the provider failed to seek and act on feedback from people and staff. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There was a clear lack of effective oversight from the provider which impacted on the outcomes for people. A person-centred service was not provided.
● Staff were not supported within their roles. They had not been provided with sufficient training to ensure they had the skills and knowledge they needed to enable them to provide person-centred care and support.
● Guidance from other professionals in relation to Covid-19 had not been followed, which put people at increased risk of harm.

Failure to seek and act on feedback from people and staff was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection the provider failed to assess, monitor and improve the quality and safety of the service provided. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had not been open and honest. They had failed to inform people and relatives of the significant concerns found at the last inspection or any action they planned to take to address this.
● The provider did not have effective systems in place to allow them to identified concerns and shortfalls. This meant issues and concerns were not responded to in an open and honest way.

Failure to assess, monitor and improve the quality and safety of the service provided was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● The provider had failed to learn from mistakes. They had not taken action following the last inspection to improve their practice and they failed to address shortfalls.
● The provider was unable to locate the accident and incident records during the inspection. They were unable to confirm if anyone had suffered any accidents or action they had taken following accidents occurring to mitigate risks.

Failure to establish and operate effective systems and processes to monitor and improve the service and failure to assess, monitor and improve the quality and safety of the service provided was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.