Southampton City Council

Glen Lee

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

When we last inspected Glen Lee on 9 December 2014 we found mmedicines were not always managed safely.

During this inspection on 25 April 2017 we found the provider had made some improvements but we also identified new concerns. Some people had care plans for medicines, but some did not. Records were not always accurate around medicines. New care plans for people's care and support had been introduced but were not completed effectively. Activities did not always meet people's needs. There were systems in place to monitor the quality and safety of the service provided but these were not always effective in identifying areas for improvement.

Glen Lee provides accommodation and personal care for up to 33 people who may be living with dementia. The accommodation is provided over two floors accessed by a passenger lift. There are a number of communal areas where people can sit together or alone if they wish. There is also a garden which is safe for people to access independently. On the day of the inspection there were 24 people living at Glen Lee.

There was a registered manager at the service. 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.

People's needs were met by suitable numbers of staff. Staff had completed training with regard to safeguarding people and were aware of how to use safeguarding procedures. People had risk assessments in place to ensure every day risks were identified and minimised where possible. The provider had taken action to ensure recruitment procedures were safe.

Staff had training in and followed legislation designed to protect people's rights. People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Staff were further supported through supervision, training and appraisal. People could choose what they wanted to eat and drink and the environment, such as the dining room, was decorated with their individual needs in mind. People had access to healthcare services when necessary.

Staff developed caring relationships with people using the service. People were encouraged to express their views and be involved in making decisions about their care and support. Staff were mindful of respecting people's privacy and dignity when supporting them with personal care.

There were some good examples of how staff had considered the needs of people living with dementia within the service and responded to their views and ideas. The provider had a complaints procedure in place which was followed by the registered manager.

The registered manager and provider promoted a positive culture that was open and inclusive. Staff spoke highly of the registered manager. The registered manager ensured the home met registration requirements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some people were at risk of not receiving some of their medicines safely.

The provider had taken action to ensure all of the required pre-employment checks were completed.

People's needs were met by suitable numbers of staff.

Staff had completed training with regard to safeguarding people and were aware of how to use the provider's safeguarding procedures.

People had risk assessments in place to ensure every day risks were identified and minimised where possible.

Is the service effective?

Good

The service was effective.

Staff had training in and followed legislation designed to protect people's rights.

People were supported by staff who were trained and knowledgeable about people living at the service.

People were supported to eat and drink in ways which met their needs.

People had access to healthcare services when necessary.

The environment was decorated with people's needs in mind.

Is the service caring?

Good

The service was caring.

Positive caring relationships were developed with people using

the service.

People made decisions about how and where they spent their time.

People's dignity was respected by staff when supporting them with personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not completed to show individual preferences but staff responded to people as individuals.

There were some good examples of how staff had considered the needs of people living with dementia within the service but improvements could be made with regard to activities.

The provider had a complaints procedure in place and sought peoples' views.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to monitor the quality and safety of the service provided but these were not always effective in identifying areas for improvement.

The registered manager and provider promoted a positive culture that was open and inclusive.

The registered manager ensured the home met registration requirements.

Glen Lee

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.

The inspection took place on 25 April 2017 and was unannounced. The inspection was conducted by two inspectors.

Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. The registered manager 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.

During the inspection we spoke with 11 people, five staff and the registered manager. We could not always directly communicate with people to ask them about their experience of care and support but we observed staff interaction with them and the care and support offered in the communal areas of the home. We looked at a range of records including five care plans, two staff recruitment files and medicines records. After the inspection we received feedback from three relatives and three healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

When we last inspected Glen Lee on 9 December 2014 we found medicines were not always managed safely. There was no system of audit to show how much medicine should be stored at the home. Staff monitored and recorded the temperature of the fridge daily although records showed there were gaps in the recording. Eye drops did not show the date they had been opened. There were no care plans in place for staff to recognise when people needed as required medicine, for pain or agitation. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan which they did. The provider told us an improved booking in and auditing system was to be put in place, care plans for medicines were to be written and daily checks were to be made on recording of medicines. The provider said this would be completed by May 2015.

During this inspection we found some improvements in the way medicines were managed, however, improvements were not consistent or embedded. Some people were prescribed medicines "when required", (PRN). For medicines prescribed as PRN, there should be a care plan in place. This type of care plan should include information regarding: what the medicine is used for; dosage, including maximum dosage in a specified time period; when it is to be offered; and what strategies should be tried before offering the medicine. Without these care plans people may be at risk of not receiving their medicines safely. We asked for this care plan for five people who were prescribed PRN medicines and found three people did not have a care plan in place. People were prescribed these medicines for agitation or if they started to bleed.

Of the two who did have a care plan, one showed the person was prescribed half to one tablet when required and that staff were to offer half a tablet first, then another half if agitation continued, but did not detail how long staff should wait before offering another half. Additionally, the person had been given a whole tablet straight away which was contrary to the care plan stating to give half first. Daily recordings leading up to the administration of the medicine gave no indication as to why the decision was made to give the tablets. For this person, the medicines administration record (MAR) chart did not show how many of the PRN tablets had been received into the home, or carried over from previous months. The MAR showed two whole tablets had been administered and another entry did not identify whether the person had received a half or whole tablet. This meant it was not possible to know whether the number of tablets in stock was correct. Medicines belong to the person they are prescribed for and where staff take responsibility for looking after them, they know how much each person should have in the home. However, the MAR charts did record the number of tablets coming into the home, or carried forward for other medicines which were not PRN. There was a system in place to complete a stock take of PRN medicines in the home. However, the system in use doubled the paperwork and did not identify how many tablets there should be, instead, the system recorded how many tablets there were which meant discrepancies would not be picked up. For one person, stocks of their PRN medicine had run out ten days previously. We were told some was expected the following day but that the person had not needed any of the medicine since not being available. However, the medicine was to be offered to the person when they became agitated and therefore meant stock was not available should the person have needed it and could have put them at risk.

Staff checked the temperature of the fridge where some medicines were stored and this was within the recommended temperature range. However, there were still a few gaps in the recording which meant staff could not evidence the temperature had been checked on those days. This meant that medicines may not have been stored at the right temperature which could have affected the way they worked when people needed them.

By not ensuring 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.

We saw that eye drops had been labelled with the date they had been opened so they could be disposed of within the correct timeframe, where necessary. A relative confirmed to us that their relative received their medicines and another said their relative was "more settled now their medication was sorted."

People were supported with their medicines by staff who were trained to do so. Their competency was formally assessed twice a year. When medicines errors were identified, this was addressed through the use of supervision, extra training, or competency re-assessment. The issue was discussed at care co–coordinator meetings so that learning could be shared.

The provider had recruited new staff since the last inspection. Recruitment procedures were in place which included seeking references and checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, we looked at two recruitment files and for one staff member, whilst there were two references in place, neither was from the staff member's current employer, who was also a care provider. It was therefore not clear how the provider had satisfied themselves that this staff member's conduct in their previous employment had been satisfactory. The registered manager undertook to investigate how this happened as the staff member had started work in 2016, which was before the registered manager was in post. The registered manager subsequently sent us confirmation that a satisfactory reference had now been sought and received.

One person told us they felt safe living at Glen Lee. Comments from relatives included, "I wanted [my relative] to be safe [and they are]", "[My relative] is looked after well" and "[I have] real peace of mind." The provider had policies and procedures in place designed to protect people from abuse. Staff had completed training in safeguarding adults and were aware of the different types of abuse and what they would do if they suspected or witnessed abuse. A staff member confirmed, "We [staff] have a responsibility to keep people safe, follow the training we have had and report when anyone has come to harm." The registered manager had made appropriate safeguarding referrals to the local authority in order to keep people safe.

Risk assessments identified when people were at risk and action was taken to minimise the risks. Where incidents had occurred, these were recorded appropriately and the incident reviewed to understand how the situation had occurred. For example, several related incidents had occurred in a short space of time and staffing levels were temporarily increased to enable the situation to be closely monitored and reviewed. The situation had been resolved. Each person had a risk assessment around malnutrition, moving and handling and whether they could use a call bell in their room. If people could not use call bells to access help, then hourly checks were in place to monitor people's welfare.

The registered manager told us that staff believed in positive risk taking and ensuring that people were supported in the least restrictive way. To that end, people were involved in risk assessments and their capacity to make decisions was taken into account. Risks from the environment had been considered, for example, posters printed on yellow card were displayed throughout the home on what to do if the building

needed to be evacuated. The fire alarm test was undertaken weekly to ensure the system worked. There were plans in place should an emergency arise. Each person had a personal evacuation plan and these had been recently updated.

People's needs were met by suitable numbers of staff. Relatives told us, "If there are any issues, staff deal with it, rather than calling me to help [my relative] settle", "Staff are always sat with someone, or involved in doing something. I never see staff sat around doing nothing." This view was echoed by another relative who said staff were "always chatting with people." One relative compared the current staffing with previously and said, "Now I know who [my relative's] key worker is. The staff are lovely, very pleasant. The staff used to change but now there are familiar faces." We observed people being supported in an unhurried, considerate manner.

At our last inspection we made a recommendation regarding how staffing levels were determined. During this inspection the registered manager told us the staffing levels were determined by identifying the level of need for individuals and that they kept this under review. For example, there was a time when an extra member of care staff was rostered on duty as one person needed some one to one support. Conversely, staffing numbers on shifts had gone down as fewer people were currently using the service. Another example was that staff had expressed concerns that mealtimes had become difficult due to the number of people who needed support to eat. The registered manager therefore ensured extra staffing between 11am and 6pm which covered meal times. We observed a visible staff presence in communal areas throughout the day and staff were available to support people with personal care when required.

Good

Is the service effective?

Our findings

People were supported by staff who had received relevant induction and training to enable them to support people they worked with. New staff also studied for the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. It provides assurance that care workers have the skills, knowledge and behaviours to provide compassionate, safe, high quality care and support.

Staff completed training in a range of subjects which the provider considered mandatory, including moving and handling and infection control. Other training was available to meet people's individual needs such as diabetes and continence care.

The provider commissioned an external provider for training and support which specialised in supporting people living with dementia. Management and staff had completed training courses entitled, "Dementia Awareness; Person Centred Approach to the care and support of a person with Dementia; Managing Medications for people with Dementia; Responding to Challenging Behaviour in Dementia care for Leaders and Managers; Understanding Challenging Behaviour in Dementia Care for Care Workers; End of Life Care and Dementia and Creative Approaches in Life History work and communication. Coaching and mentoring sessions had also been provided based on supporting people living with dementia.

Staff were further supported through the use of regular supervision and annual appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

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. We saw that people had had their mental capacity assessed, for example, to determine whether people could choose to live at Glen Lee.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements and a DoLS authorisation had been approved for most people. The registered manager had applied for others but was waiting for the local authority to consider the application. The registered manager was aware of expiry dates and put an entry in their diary in good time to apply for a renewal, where necessary. One person had a mental capacity assessment which concluded that they did have capacity to make a decision over their accommodation, and they had chosen to live at the home which meant they did not need a Deprivation of Liberty Safeguard in place.

People were supported to eat and drink in line with their preferences and dietary requirements. Comments

from relatives included, "Everything is liquidised [for my relative], the staff cope well" and when people changed their minds about what they wanted to eat, a relative told us "staff take time, they don't get irritated. Staff understand [people]." People were offered choices at meal times and the menu was presented in a pictorial format so that people living with dementia were more able to understand their choices. There was also a picture book just for breakfast so people could flick through and choose items, including a cooked breakfast. Menus were linked to specific dates in the calendar, such as St George's day and St Patrick's day. One person confirmed they had a choice at lunchtime and said, "I hate curry so am having this." We observed lunchtime and found people were supported in a relaxed, calm and unhurried atmosphere.

Staff were aware of people's needs and preferences around food and drink. One staff member said, "Some people need to have their fluid intake monitored. This is because they are at risk and may not drink themselves. Some people may be reluctant so, we monitor them to ensure they have had enough to drink." People were frequently offered drinks and snacks throughout the day, both in communal areas and bedrooms. Appropriate records were kept, when necessary, to show how much liquid people had drunk during the day.

Where concerns had been identified around people's eating and drinking, this had been referred to the Speech and Language Therapist (SALT). Where the SALT had advised food additives, such as a thickener for fluids, staff followed these guidelines. We also saw that one person whose care plan stated they required pureed food and assistance from staff was appropriately supported. There were specific risk assessments in place around eating and drinking for those who required assistance or specialist diet so that staff were clear how to support people.

People had access to healthcare services when necessary. Staff knew people well enough to know when they may be unwell which meant healthcare professionals could intervene before their health deteriorated further. We saw staff recorded information about healthcare visits from doctors, district nurses, opticians, chiropodists and so on. An example of this was seen regarding a person who had developed red skin on a pressure area and the district nurse visited the next day after being contacted by staff.

The registered manager and provider had made changes to the environment which they felt were better for people living with dementia. An example of this was opening doors between the lounge and dining room to make a bigger space. This resulted in the dining room being bright with natural light. The dining room had been painted a colour which enhanced the size of the room and a staff member had made new curtains. Wide and unobstructed walkways, with handrails, meant it was easier for people to navigate around the home. Walls were used to their best advantage. Some displayed posters of celebrities and films which were relevant to the age of people living there. Others had colourful murals, painted by staff, which gave people a point of interest and helped those who were visually impaired.

Bedroom doors had front door knockers and some had pictures or stickers of interest relevant to the person whose room it was. This meant people were more likely to find their bedroom independently. Toilets doors were painted a different colour to the walls and the doors were painted the same colour throughout the home. This, alongside pictorial signs on the doors meant it was easier for people to find the toilet independently.

Outside, there was an enclosed garden, with a ramp for easy access through the conservatory. The door was not locked to enable access to the garden for people, but the door was alarmed to alert staff if people left building.

Good

Is the service caring?

Our findings

Staff developed caring relationships with people using the service. Comments from people included, "I have no problems living here, you know you have your ups and downs, but good overall", "This is a caring home with caring staff", "They [staff] are supportive, we are very lucky" and "Staff always treat you with respect". A staff member told us "It's a relaxed and happy home here".

Relatives echoed these views, saying, "The staff really do care. As soon as somebody [needs support], they are there" and "I am pleased with the commitment of staff [to their job." A healthcare professional told us the staff were "caring and patient" with both the person living there and their relatives.

During the inspection we observed staff interacting positively with people. We saw a person being supported to go outside for a cigarette, staff sitting with people talking about their day or engaging in jokes and repartee and staff crouching down to speak to people at eye level and waiting patiently for a response.

People were supported to express their views and be involved in making daily decisions about their care and support. A staff member said, "We try to give people a choice as much as possible" and another said, "People can walk around as they please. A lot of people follow the same routines they did when they were at home. We try to respect this." The registered manager told us in the Provider Information Return that the staff team were sensitive to the changing needs of the people, they gathered and recorded any changes on their care plan to ensure continuity of their needs and wishes in a confidential way. The staff actively listened to and supported people with the choices and decisions that they make whilst making sure their independence was promoted in a dignified way.

Staff described how they supported people with personal care whilst being mindful of their dignity. One staff member said, "We [staff] always knock on doors before going in [to bedrooms] to protect [people's] privacy." There was a named staff member who had the responsibility of being the dignity champion and took the lead on promoting privacy and dignity within the home. The dignity champion attended the local Dignity Forum to share knowledge and best practice with staff. A dignity audit was completed on a quarterly basis and actions were followed through by the dignity champion and the registered manager. The registered manager told us as part of the audit, the dignity champion actively listened to and monitored interactions between people and staff. A "Dignity in Action" day was held with both staff and people sitting down to an entertainer whilst enjoying a buffet tea and companionship.

Requires Improvement

Is the service responsive?

Our findings

People had care plans in place but a new format had been introduced from other services provided by the provider and had been developed to support people with learning disabilities. Staff did not speak highly of the format and comments included: "The old care plans were much better, they prompt you to say a lot more detail about the person", "None of the staff like the format. It's hard to work with and we struggle to update them", "Other services have used this care plan, but I'm not sure it works here" and "The care plans are not easy to update now they have changed the format." We raised this with the registered manager and subsequently work has begun in changing the format to be more relevant to the people living at Glen Lee.

The concerns raised by staff were reflected in the way the plans were completed. Sections for care plans around personal care entitled, 'How I would like to be supported' were blank. The care plans used tick boxes for tasks such as shaving, but gave no detail about any preferences or routines around personal care such as preferred time, products and routines. There were no specific guidelines around people's communication needs or preferences. One person's care plan stated they were reluctant to accept support with personal care and said staff were to "give lots of encouragement". However, the care plan did not state what sort of encouragement, the possible reasons or triggers around their dislike for personal care and did not have a way of monitoring and reviewing different strategies which may work. Staff who did not know people well might therefore not have all the information they needed to support people's individual needs if they were to rely on the information in people's care plans.

Some care plans contained a document entitled: "Let's look at me". This was completed by people or their families which informed staff of their life history. People's religious beliefs were considered within their care plans. One person's care plan documented that they were a practicing Christian and would like to attend any visiting religious services. A staff member confirmed that care plans were reviewed monthly by staff and added, "We try to get people and families involved as much as possible."

Although the care plans were in a stage of development, people's needs were met by staff who responded to them as individuals. We observed a staff member with a very patient approach when a person was indecisive over their choice of biscuits. The member of staff was upbeat and patient throughout. We also saw staff patiently encouraging people who were reluctant to join in activities to ensure they had opportunity to take part. A staff member told us, "Patience should always be in our practice. We concentrate on making sure we take a patient approach with people." Another staff member said, "We [staff] try our best to accommodate everything people want to give them the best experience of living here."

People's needs were assessed before they moved to the service to ensure staff could meet their needs. People and their families were involved in care planning where possible. The registered manager was aware of the importance of understanding the balance between the needs of people already living in the home and the needs of new people moving in. In view of this, the registered manager was clear that people would not move into the home unless staff had the appropriate skills to meet their needs.

The registered manager told us they were currently looking at activities and social interaction with people,

understanding that this contributed to their wellbeing. They said the staff take time to get to know people, their behaviours, their likes and dislikes and made time to have a "little chat" to build positive relationships. Relatives confirmed this but also said, "There is a lack of stimulation [for my relative]. There are lot of raffles to raise money, they get singers in, there are 'arty crafty' things, but I think it's beyond some of them. [Staff] try to celebrate, for example, the lovely Christmas decorations" and "I don't see a great deal [of activities], they don't have the staff. They do art and crafts, exercises and people can walk around the garden." A healthcare professional told us, "I do sometimes feel that there are not enough staff in relationship to residents as there are a lot of people sitting around, but I suspect this is also due to the nature if the client group." The registered manager was drafting a job description for an activities co-ordinator which would mean activities would not depend on staffing levels for their success.

Management and staff had put a lot of thought into the environment and how it could be improved within a limited budget, in response to the needs of people living with dementia. Alcoves in corridors, which people used to walk past, had been decorated and themed. These alcoves provided people with points of interest, such as a seaside theme and were designed to be areas to relax in. There were boards displayed on the walls which had interesting items, such as bells, zips, keys and locks, which people could handle. One person told us, "I like this room [alcove] as it is nice and quiet".

Following a suggestion made at a "relatives' meeting", one room had been transformed into a bar area, decorated to a 1970's colour scheme to appeal to the age of people visiting the bar and the flooring was wood effect rather than carpet to more accurately reflect a public house. People enjoyed sitting in this room, for example, the men often watched football on the television whilst enjoying a shandy and some people ate fish and chips and drank shandy on a Friday. The room also provided an alternative communal area where rooms were needed for distinct activities, such as on Mother's Day; the women sat in another room and enjoyed afternoon tea whilst the men watched football. The design of the room had been a joint effort involving others besides staff, for example, a staff member's relative provided some objects for the bar and a person's relative made beer mats.

Staff were aware of, and responded to, the changing interests of people currently living at Glen Lee. For example, there was an empty fish tank in the corner of one of the communal rooms and we asked staff about this. They told us that people used to like watching the fish, but people living there now did not enjoy this so the tank had been emptied and was waiting to be removed. One person tended to bang or pat things a lot and so staff got them a "Twiddlemuff." A Twiddlemuff is a knitted muff with bits and bobs attached inside and out and is designed to provide a stimulating experience for people with restless hands.

Some people liked to see the hairdresser who visited the home at least once a week. There was also a kitchenette which some people used because they liked to eat their meal as a small group and do the washing up.

There was a complaints procedure in place and records showed there had been one complaint which had been investigated within the timescales set by the provider. A senior staff member, in the absence of the registered manager, had dealt with the issue the same day the complaint was made and other staff were made aware of the issue and what action was to be taken to reduce the chances of the issue recurring. The registered manager telephoned the complainant on their return to follow up the complaint. People were provided with a copy of the complaints procedure in their bedrooms so that it was easily accessible to them as well as their visitors. A relative told us they had "No complaints at all."

Requires Improvement

Is the service well-led?

Our findings

Following our last inspection in December 2014 we found areas which required improvement regarding medicines auditing. A new manager had been registered with CQC since we last inspected Glen Lee. During this inspection we found the auditing systems which were in place were not always effective for ensuring the requirements of all regulations were met or identifying where improvements could be made. We found concerns with the administration of medicines, care planning and the provision of activities, although the registered manager had identified activities as an area for improvement.

The registered manager completed a number of audits which looked at areas such as health and safety and the environment. However these audits had not always been effective in identifying shortfalls and driving improvements. Whilst a medication audit was undertaken monthly, the format did not identify the concerns we found during the inspection, for example, the gaps in the recording of the fridge temperatures. The provider had not identified that this audit required improvement and that medicine concerns were still continuing prior to our inspection. Other audits were effective in identifying areas for improvement and action was taken and improvements noted. A "Dignity in care" audit was completed quarterly and actions were followed through by the dignity champion and the registered manager. There was an auditing process in place to monitor falls. The registered manager had identified that this audit needed to be more effective. They were making adjustments to make it easier to identify patterns in people's falls and were planning to start completing root cause analyses for falls to ensure injury to people from falls would not reoccur.

The registered manager and provider promoted a positive culture that was open and inclusive and the registered manager said they had an "open door policy". Staff spoke highly of the registered manager and comments included: "[The registered manager] has been supportive in making sure we have the right people come in as new residents. We have to consider the needs of people and the impact of new people coming in", "In all fairness, [the registered manager] is involved and has taken an interest in the day to day running of the home" and "[The registered manager] gives us a lot of training and support."

Family members and staff had confidence in the registered manager and felt they managed the service well. Comments from relatives included: "The home has come on in leaps and bounds, it has improved a lot"; "[the staff] do an amazing job with the budget they've got"; "at the last residents' meetings they wanted ideas on what they could do [for activities]. They were looking for gardening volunteers" and "[The registered manager] went to different homes to seek ideas to brighten [Glen Lee], for example, stencil work on walls and not bare wooden doors but for them to look like front doors." Staff told us they enjoyed working at Glen Lee. One staff member said, "It's a nice place to work" and another said, "I love working here, you get to know all the residents really well." A healthcare professional said "Staff are always welcoming and helpful."

The registered manager ensured the home met registration requirements which included sending notifications of any reportable incidents and when necessary to the Care Quality Commission.

The provider had a management structure throughout the organisation. The registered manager was

supported in their leadership and management role through supervision and training. The registered manager also told us they attended management meetings to share good practice and discuss any concerns or queries. Certain aspects of the running of the home were managed by separate departments, such as recruitment.

Regular meetings were held for staff to be able to share good practice and discuss any concerns and the registered manage had recently sent surveys to staff to gain their views on the quality of the service provided. Meetings with people living at Glen Lee and their relatives were also held throughout the year.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were not robust systems in place to ensure the proper and safe management of medicines.