Glendale Residential Care Home Limited

Glendale Residential Care Home

Inspection report

14 Station Road
Felsted
Dunmow
Essex
CM6 3HB

Tel: 01371820453
Website: www.glendaleresidential.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced, comprehensive inspection took place on the 17, 25 July and 1 August 2018.

This inspection took place following information of concern we received that people were at risk of not having their needs responded to in a safe and effective way. At this inspection we identified a number of concerns.

Following our inspection, we notified relevant stakeholders such as the local safeguarding authority and Essex Fire service of our findings.

At our previous inspections in March 2017 and February 2018, we found concerns in relation to ineffective governance of the service. This included a lack of effective management of risk to people's health, welfare and safety as well as shortfalls in maintenance and management of the premises. Our inspection in March 2017 found people were not protected from the risks associated with unsuitable staff being employed as the provider did not operate safe recruitment practices, the risk of not receiving their medicines as prescribed, and environmental risks had not been identified and managed. We also found action had not been taken in a timely manner in response to safety concerns highlighted by visits from fire safety officers.

At our inspection in February 2018 inspection we found some improvements had been made. However, there was a continued failure to provide staff with the guidance they needed to provide safe care and treatment to people including insufficient planning and monitoring of people's needs. Following our inspection, we wrote to the provider and requested an action plan which would tell us what they would do to ensure compliance with the law. The registered provider failed to respond to our request.

At this inspection, we found there had been further deterioration in the quality of care which meant the provider continued to be in breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, the need for consent, staffing, fit and proper persons employed, person centred care and good governance.

Glendale Residential Care Home is a 'care home' which accommodates up to 20 people in one adapted building. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection there were 17 people living at the service.

The service had a registered manager who was also the registered provider of Glendale and another registered 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 were not protected from being cared for by unsuitable staff because safe recruitment systems were not in place and operated effectively. There were insufficient numbers of staff available at all times. This meant there weren't enough staff to fully enhance people's quality of life. Whilst some staff were seen to be kind and caring, further work was needed to imbed a culture of caring throughout the service.

There were inadequate numbers of skilled and knowledgeable staff employed and available to meet people's needs at all times. Staffing rotas did not always reflect the actual staff working.

People were not always supported by staff that had the necessary skills and knowledge to meet their health, welfare and safety needs. Staff had received a variety of training relevant to their roles. However, this learning was not always being put into practice, when supporting people living with dementia and when presented with distressed behaviours that were challenging to themselves or others.

Care plans failed to provide staff with guidance and staff were unclear of the strategies in place to support people whose behaviour can be challenging. Staff lacked understanding about the need to assess people's capacity to consent to care and treatment and action they should take when people's freedom of movement was restricted which placed people at the risk of not having their human rights upheld and prevent the risk of harm.

Visits from a fire officer highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm.

There were systems in place to manage people's medicines safely and ensure they received their medicines as prescribed. However, we found staff who administered medicines were not routinely competency assessed and further work was needed to provide protocols to guide staff where people received medicines as and when required, for example, those prescribed for pain relief.

Not all staff were familiar with safeguarding procedures and not all received adequate training on recognising and responding to acts of abuse and keeping people safe.

People had access to some healthcare services. However, they did not have regular access to a dentist. It was not always recorded by staff what action had been taken to support people who had been identified as losing weight.

The registered manager and staff did not have up to date, skills and knowledge as to current good practice in meeting the needs of people with a cognitive disability including those living with dementia.

The leadership, governance arrangements and culture in the service did not always support the delivery of high quality care. There remained an inconsistent approach to assessing risks to people's health, welfare and safety. Internal assurance systems continued not to identify the shortfalls that we identified at this inspection. As a result, people were not provided with care which met their needs and kept them safe. There was a blame culture where the provider did not promote a culture that encouraged openness, transparency and honesty at all levels.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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.

You can see what action we told the provider to take at the back of the full version of the report.

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.

There were insufficient numbers of staff employed to support people safely.

Staff were not recruited safely.

Risks to people's safety and wellbeing were not always identified and actions to reduce risks.

Systems were not in place to ensure that people were protected from harm as not all staff knew how to report, recognise or respond to safeguarding concerns.

There were systems in place to manage people's medicines in a safe way. There were no clear arrangements in place for the use of as and when required (PRN) medicines.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not been provided with regular supervision and had not received all of the relevant training to support them in their roles.

People's capacity to make decisions had not been consistently assessed.

People had access to a range of health care professionals apart from dentists.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff were seen to be kind and caring, further work was needed to imbed a culture of caring throughout the service.

Widespread significant shortfalls in the service meant that people's health, safety and welfare was not upheld.

Care and support plans for people were brief and contained conflicting information to guide staff in meeting their health, welfare and safety needs.

People and their representatives were not consistently involved in the planning and review of their care.

Is the service responsive?

Inadequate

The service was not responsive.

The care provided did not always meet people's individual needs and preferences and activities were limited.

Care records did not provide sufficient guidance to staff to ensure the care provided was safe, effective and personalised.

There was a policy for managing complaints but this was not always followed appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Oversight and management of the service was chaotic and disorganised. Overall governance systems were ineffective and did not ensure the safety and quality of the service was maintained.

The provider did not demonstrate they had systems in place to continuously learn, improve, innovate and ensure sustainability.

Glendale Residential Care Home

Detailed findings

Background to this inspection

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

This inspection was prompted in part following information of concern received from the public and local authority safeguarding team. At this inspection we identified a number of serious concerns.

This inspection was carried out by two inspectors and one assistant inspector and took place on the 17, 25 July and 1 August 2018 and was unannounced.

We reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who
commissioned the care of people living in the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale.

We spoke with five people who used the service who were able to verbally communicate with us. Others had limited ability to verbally communicate their views of the service to us and therefore, we observed how care and support was provided to some of these people. We also spoke with four relatives and stakeholders including the local safeguarding authority.

We spoke with the registered manager, the office administrator, the company secretary, and six care staff including carers and senior carers.

We carried out a tour of the premises, reviewed records in relation to staff recruitment and training records, staffing rotas, medicines management and records related to the quality and safety monitoring of the

service, including risk management. We also looked at seven people's care records.

Inadequate

Is the service safe?

Our findings

At our previous inspections in March 2017 and February 2018, we found significant shortfalls in the safety of the service provided for people and we rated the service 'Requires Improvement' in 'Safe'. At this inspection we found risks to people's health, welfare and safety continued not to be fully considered. This was compounded by a lack of effective oversight. We found a continued breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and have rated safe as 'Inadequate.

Staff were aware of their responsibilities with regard to safeguarding people from abuse. However, they did not recognise or understand the wider aspects of safeguarding people from the risks we identified at this inspection or the impact of neglect from not having enough staff to meet people's needs. The breaches in this section demonstrate that people were not being safeguarded from the operation of the service overall.

We found within the provider's log of complaints and recorded as a complaint a safeguarding incident where it was alleged a member of staff physically and verbally abused a person using the service. The registered manager had investigated this incident but had failed to report this in the first instance to the police or local safeguarding authority for their investigation as required.

This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a lack of clear assessment of risks associated with individuals and therefore a lack of detailed guidance for staff to follow to mitigate the risk of harm and promote people's safety. Not everyone who needed it had a moving and handling plan in place to guide staff on moving them safely. Using the wrong equipment or using it incorrectly can put people at serious risk injury, it can also be uncomfortable and undignified.

For example, one person's electronic care record showed us that they were at 'very high risk of falls' and risks associated with their moving and handling were assessed as high. These risks were flagged, 'Please link to a care plan need.' The care plan did not contain any specific guidance for preventing or minimising falls. Information about the person's continence and maintaining a safe environment, showed that they were not weight bearing. The guidance for staff was that the person needed assistance of two staff to transfer, for example to and from the toilet and to bed. There was no handling plan with detail as to how staff should do this safely and what equipment they should use. We discussed this with the registered manager who told us that the person, "…may well need hoisting."

The registered manager told us that two staff had been trained and competent to assess people for the equipment suitable and safe to use when transferring people. However, staff had not received training in respect of assessment for moving and handling equipment. We also found where needed, people had not been referred to occupational therapists for specialist advice and support.

The guidance for staff in the safe moving and handling of people, stated that the actions required of staff

were to use either the hoist or another named piece of equipment designed for helping to transfer people. The manufacturer's guidance about the latter piece of equipment 'Sara steady' is that it should only be used for people who are able to stand independently or with minimal assistance. As the person's records stated they were "chair bound" and could not weight bear we concluded that they would be at risk of potential accident if staff used this equipment.

One person identified as 'chair bound', there was an increased risk of their skin breaking down. Their care plan stated that the person was at medium risk of developing pressure ulcers. However, their care plan for skin integrity did not refer to the need for any support from staff or intervention to reduce this risk. It stated that the person had bruising, their skin was thin, that it could bruise or tear easily, and that they had itchy skin they would scratch. The actions required of staff were that they should take care when transferring the person to avoid skin tears and bruises, and to apply cream to alleviate itching. There was nothing in their care plan to indicate any increased monitoring of their skin condition and how to minimise the risk of pressure ulcers themselves developing.

Prior to this inspection staff notified us of one person living with dementia who had went missing from the service, was found by a member of the public and brought back to the service by the police before staff had noticed they had gone. We reviewed this person's care records to see what guidance staff had been provided with to protect this person from the risk of harm. There was no information in the person's care plan to alert staff including agency staff who may not be familiar with the person of the risk. The only information provided on the summary page stated, '[Person] is not to go out without a member of staff.'

There was ineffective oversight and management of the environmental risks. For example, we found that unprotected portable heating equipment, such as oil-filled radiators, were available in some people's rooms. There was no assessment of whether these were safe for people to use, or any assessment of the evident risk from scalding or fire safety. This meant that people who may lack understanding of the risks, or were prone to falls, could sustain serious injuries from scalding if they fell against the radiator, knocked them over, or the risk of tripping on trailing wires.

We noted some uncovered radiators and hot water pipes which could present the risk of scalding to people who used the service. In a bathroom we also found exposed hot water pipes which if someone fell against could pose a serious risk of scalding. If radiators were low surface temperature radiators, they may not have needed covering to prevent burns but we could not tell because as it was summer the heating was not needed.

We found razors and people's personal toiletries, some of these in liquid form in bathrooms. These items presented a hazard in particular to people living with advanced stages of dementia who we observed walking around the service unsupervised.

We observed one person with a long, trailing hose connected to their oxygen unit. This allowed the person to move from their chair in the communal living area to the dining room and bathroom. We asked the registered manager for environmental risk assessments which would guide staff with actions they should take in response to any identified risks. They told us they could not provide us with this information.

The fire officer had visited the service in March 2018 and had written to the provider informing them that they were not fully complying with fire safety regulations. The fire officer's inspection identified the provider's fire risk assessment did not adequately assess all requirements necessary to ensure the building was safe and effective action taken to mitigate the risk of harm to people in the event of a fire. The registered manager told us they had not taken any action to rectify the identified shortfalls in response to the notice

issued by the fire service.

The fire risk assessment completed in January 2018 highlighted risks regarding the integrity of people's bedroom doors. These were fire doors designed to protect people from the spread of fire. The safety of these doors had been compromised because "star locks" had been fitted, creating a hole in the doors which rendered intumescent smoke seal strips ineffective. It referred to doors on the ground floor. However, we also found doors on the first floor that were similarly compromised.

We also noted that the fire risk assessment did not take proper account of oxygen being used in the communal area of the home and in a bedroom. The presence of oxygen presents an increased risk of rapid burning in the event that a fire breaks out.

In a communal room used for the morning's prayer meeting on the second day of our visit, the side door was labelled as a fire exit with appropriate emergency lighting above it. This was obstructed by an armchair placed across it, compromising how quickly it could be used for people to leave the area if a fire broke out. We also noted that one bedroom door, fitted with both a magnetic closer and a "Dorguard" device, was wedged open with a commode chair. This was because both devices were faulty and not working. This prevented the door, designed to protect the room's occupant, or to contain any fire that might break out in that area, from closing as required when the fire alarm activated. These faults had not been identified in any of the provider's audits.

We asked staff including senior and night on call staff what procedures were in place and how would they respond in the event of the fire alarm going off during the night time period. It was evident from their responses that they did not know what steps they should take to ensure people's safety. For example, one member of staff told us they would check each room and only if they found a fire and then would call the fire brigade. Another told us they would evacuate everyone to the communal lounge. These staff had not attended fire drills. There was no emergency plan made available to staff to guide them of any planned strategies in the event of a fire.

Immediately following our inspection, we contacted Essex Fire service to inform them of our findings. They followed up with a visit to the service where they confirmed our findings and identified further work was required. For example, to install detectors to alert staff on call at night needing to be linked into the main fire-alarm system

There were restrictors in place to prevent windows opening too far and people being able to fall or climb out. However, one of these gave access on to a flat roof and the key was available hanging on a nail by the frame. This presented a potential risk for people who may confused and anxious about getting outside.

People's safety was not assured against the risks associated with unsecured furniture. We found free standing wardrobes in people's rooms which were not fixed to the wall and were being used to store heavy items. We expressed concerns that people could inadvertently pull the wardrobes over. The risks relating to this had not been identified in any risk assessment, audits or action taken to mitigate the risk of harm.

The passenger lift used to enable people to move between different floors was faulty. We saw that the lift stopped some way below the floor level creating a lip and potential trip hazard. This had not been identified by any audits and no action taken to address this shortfall.

Safety concerns were not consistently identified or addressed. There was limited use of systems to record and report safety concerns and near misses. For example, we looked at the oversight systems that were in

place to review accidents and incidents including the monitoring of falls. We saw accident forms completed by staff whereby the registered manager was also required to record their review and analysis of the event. However, these had not always been completed. There was no system in place to identify trends and patterns with analysis or action taken to look at other contributory factors. This meant there was no system which would initiate further risk assessment and guidance for staff with preventative measures to mitigate the risk of further harm.

The shortfalls we found demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Prior to our inspection we received information of concern which told us there were insufficient staff available to meet people's needs at all times and that the registered provider did not follow safe recruitment procedures.

People who used the service told us when asked about call bell response times, "Sometimes they come quickly but they tell me if I use the bell at night I will wake every one else up." Other people told us, "Lots of the girls have left. I don't like that they give other people my clothes." And "I ask the staff to trim my beard and they say they will come back but then they don't. They are busy running around but don't always have time to talk to you." Another told us, "I sometimes have to wait when I call for help. The staff are always going somewhere and rush past you." One relative told us, "The staff work jolly hard and are rushed off their feet. It wouldn't go amiss if they had an extra one or two."

The registered manager told us they were in the process of advertising for new staff as a number of staff had recently left without giving notice. Night staff numbers had recently been reduced from two awake staff to one with no decrease in the numbers of people living in the service. The registered manager told us they did not have any dependency tool which would enable them to determine the numbers of staff required to meet people's needs and were unable to give us a reason for the reduction in staff available to people at night.

The staffing rota did not always reflect the actual staff working and did not always correctly record the roles for which they were employed to perform. For example, we saw one under age member of staff was employed at weekends and listed as a carer when we were informed they were only employed to provide activities.

Staff including senior staff confirmed rotas did not always reflect the actual staff on duty. One told us when asked was there anything they would want to see improve the smooth running of the service? "I would like to see the rota have the correct number and names of people on duty. I have been put on the rota before as working when I was not here. When you are the senior on duty this is frustrating as you are not sure if you have enough staff and who will be on duty with you."

The registered manager and staff told us that two staff who lived at the service were on call at night to respond and support the one awake member of staff in the event of any emergency. These staff were not recorded on any staffing rotas and so it was not clear who was on duty and would take the lead in responding to calls at night.

We observed throughout our two day inspection staff providing care, administering medicines, attending to laundry, as well as being involved in the preparation and cooking of meals. We noted that staff did not always have time to spend engaging with people.

On the second day of our inspection visit the staffing rota stated an agency cook was employed to cook.

There was no agency cook on duty and the senior carer took responsibility for cooking the midday meal as well as their other duties such as the administration of people's medicines and providing personal care. Between 2pm and 6pm the same day there were only two staff on duty. Again, there were no catering staff available. This meant that, during the afternoon, one staff member was in the kitchen preparing tea while the other had to attend to the needs of people. Staff were observed to be rushed and people were observed asking when their food would arrive. The office administrator provided additional support in preparing and serving food, but only worked at the service three days each week. The registered manager was present and administered medicines. Later a senior member of staff not listed on the rota to be working and who having worked the night before attended and told us they were scheduled to start work again at 6pm.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not protected from being cared for by unsuitable staff because robust recruitment procedures were not in place. We found staff had not been employed in line with the providers own policy and procedure and systems in place were not sufficiently robust. For example, where there were application forms in place we found gaps in employment had not been investigated. There was a lack of evidence of interviews that interviews had been conducted and if so in line with the provider's procedural guidance. References from the most recent employer had not always been obtained and those received not always confirmed as authentic. We found a number of staff where their character references had been written by a member of staff employed at the service. Disclosure and Barring checks had not been carried out on all staff employed. The DBS helps employers to make safer recruitment decisions by providing information to establish if a potential employee has a criminal record and whether they are barred from working in adult social care settings. We were therefore not assured people were protected from the risk of inappropriate staff being employed.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Infection prevention and control systems did not always protect people from the risk of acquiring infections. Policies were in place. However, these policies were not always implemented and
essential elements of general cleaning were not always carried out. We noted variable practice in standards of cleanliness around the home and how risks of infection were minimised as far as possible and how any outbreak of infection might be contained.

We noted several occasions when care staff came to and from the kitchen wearing the same uniforms as those they wore when delivering personal care, without covering them up with any disposable aprons to minimise the risk of contamination. Care and admin staff all involved in the preparation of food wore protective gloves when preparing food. However, we also saw these staff whilst wearing the same gloves they had used to prepare food carrying out other tasks. For example, one staff member went into a bedroom looking for items in a wardrobe, also observed touching their hair and other items and then going back into the kitchen without disposing of the gloves worn or washing their hands. We also noted from a review of the staff training records that not all staff involved in the preparation and cooking of food had been provided with food hygiene and safety training as required.

We found one room with a significant odour associated with difficulties managing continence and where the bed had been made with a brown stain on top of the duvet cover. We also identified that some covers for radiator heaters were of a metal grill type with plastic covering. However, the plastic covering had flaked away in some cases, leaving bare metal exposed. An oil-filled radiator was located in one person's bedroom

near their bed, also had damaged and flaking paintwork on the surfaces and feet. This compromised how easily they could be cleaned.

In other areas, paintwork was dusty or stained. For example, there was a spillage on the paintwork under the first floor bannisters that had not been cleaned. A radiator cover outside the kitchen was splashed and marked with brown stains.

In one person's ensuite toilet facility, their skirting boards were dusty and, although pipes were boxed in, the paint to the top was damaged exposing bare wood. This meant it was not impervious and could not be easily cleaned to prevent the risk of cross infection.

In one first floor communal shower, a container of antibacterial wipes had dried up due to the cover missing and so would not be effective in use. There were no disposable gloves available in the room for staff to quickly and easily access when they assisted people with their personal care.

In the laundry room, there was guidance about infection prevention and control. This stated that staff were encouraged to attend training. The guidance also stated that soiled clothing or bedding was to be washed on a sluice cycle immediately but was not clear how it was to be handled when it was being carried through the home or if the machine was already in use. We observed that there was a trolley with an open linen bag labelled as for "wet nightwear, bedding, and towels." There was no lid on it and it was located close to shelves of clean linen. We were concerned about this as suggesting items affected by continence difficulties could be placed in the bag, risking cross infection.

We saw from a review of the staff training matrix; Infection control audits had not been carried out on a regular basis. Only four of the 13 staff listed on the provider's staff training matrix had been provided with infection control training.

This demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines when they needed them. We carried out an audit of stock against administration records and found that these tallied. We observed people prescribed as and when required medicines (PRN) for example, pain relief. These medicines were not routinely offered during the medicines administration round observed on day one of our visit.

There were no clear arrangements in place for the use of, PRN medicines. This meant that there were no guidance for staff which would set out how the individual may show signs of, for example pain or distress and the circumstances that these medicines should be administered. Where PRN medicines were prescribed as one or two to be taken, staff were not routinely recording the number of tablets given which impacted on the ability to audit accurately. This also presented a risk to people in calculating correctly the number of tablets given in a 24-hour period. For example, in relation to the administration of Paracetamol, a pain reliving medicine which if more than the recommended dose is given in a 24-hour period could pose a serious risk of harm.

On day two of our visit we saw that, when staff assisted people with their medicines, they explained what they were for. One care plan we reviewed described how the person liked to take their medicines, and the action needed to prompt or guide the person with their inhalers.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2018 this domain was rated as Good. At this inspection we found a deterioration and have rated this domain as requires improvement.

We found from a review of the staff training matrix, staff training files and discussions with staff they had not been provided with regular planned, supervision and had not received all the relevant training to support them in their roles. For example, robust induction for new staff, training in understanding their roles and responsibilities in relation to the Mental Capacity Act 2005, understanding the needs of people living with dementia, pressure ulcer prevention, food safety and hygiene, infection control and meeting the needs of people at risk of inadequate food and fluid intake.

Staff received training in the main from e-learning and workbooks. Some staff had obtained qualifications in vocational qualifications to level two and three. However, the number of concerns identified regarding the care and support provided throughout our inspection meant that the training provided was effective, took in to account best practice, and was imbedded into staff practice. Poor practice in assessment of safe moving and handling, risk assessment, responding to the needs of people living with dementia, mental capacity impacted on the quality of care being provided and a learning culture was not being promoted.

Staff told us and we observed from a review of records that they did not always receive regular supervision support and annual appraisals to enable them to discuss their performance and plan for their training and development needs. Reviews of rotas showed newly appointed staff had been placed on the rota without opportunities to shadow other more experienced staff. The registered manager could not demonstrate that the new staff member had the competence to carry out their role unsupervised and safely. Staff who administered medicines did not receive regular competency assessment to confirm they were safe to competently administer people's medicines as is recognised good practice to do so.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met.

We noted that plans of care contained some reflections of people's ability to understand and make decisions about their care. For example, in one we reviewed, this stated that the person lacked capacity to make complex decisions. It went on to explain who else would support the person and was actively involved in decisions about their care. For the same person, their plan for personal care showed that staff needed to ensure they explained clearly what needed to happen and ensure they obtained the person's consent.

For another person, their care records showed who had a lasting power of attorney (LPA) to legally make decisions in the best interests of a person, both in relation to their finances and health and welfare.

However, we were not assured from discussions with staff, our observations and a review of care records that staff and the registered manager fully understood their roles and responsibilities in relation to the Mental Capacity Act 2005. One senior member of staff told us, "No one here has capacity to talk to you. You can try but you won't get anywhere. They wouldn't be able to tell you what happened five minutes ago." When asked if any assessment had been carried out to assess people's capacity they told us they, "I wouldn't know."

Where some care plans recorded that people lacked capacity to make decisions, it was not always clear how this conclusion had been reached. People's capacity to make decisions had not been consistently assessed. People's assessment of need did not always explain what decisions the person required support with, and how. For example, in relation to personal care, medicines administration and any restriction on their freedom of movement. We were therefore not assured that people had been given the opportunity to make some decisions for themselves, and what they were if they were able. Therefore, people's consent to care was not always determined and best interest decisions were not always made properly.

Staff were not provided with effective behavioural management plans and strategies based on best practice guidance. For example, one person's care plan stated they '[Person] can be rude and verbally aggressive to others. They are unable to make decisions of what they would like to wear and choose from the daily menu, is unable to make decisions regarding their wellbeing and safety.' Actions described for staff in how to respond were brief and stated, 'ensure [person's] anxiety and confusion is managed and concerns are reported and documented, seek professional help [no record of who] if there are any concerns.'

This demonstrated a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent.

People had access to health care professionals such as GP's and community nurses, people did not had access to dentists to ensure their oral health was maintained. Of all the care plans we reviewed there was no reference to or guidance provided to staff as to how they should care and support people with their oral health care. NICE guidance available for registered managers states that, 'Care should be planned and everyone admitted to a care home should have their oral health care needs assessed according to their needs and preferences. Planning should include action to enable people to regular access to specialist dentist to support to maintain their health and wellbeing.'

Some people had access to advice from health professionals to help promote their wellbeing. For example, district nurses attended the home to provide advice and treatment. We also noted that a referral to the dietitian had been made for one person where they were not eating well. For another person who had lost a significant amount of weight in a short space of time there was a lack of action taken to refer for specialist advice or to increase the regularity of monitoring their weight.

One person's care plan stated the person was at risk of not eating enough and flagged up the need to "treat" the person because of their weight loss. The care plan for both skin integrity and nutrition and hydration stated, having been reviewed on 16 July 2018, that, "[Person's] weight is currently stable." Their care plan for mobility, reviewed on the same date, stated that, "[Person] has recently had a decline in [person's] health and lost weight." Information about their medical needs within the plan also showed, "[Person] has lost a lot of weight and has a loss of [person's] appetite." This was confusing for staff, and presented a risk that prompt action would not be taken to ensure the person received adequate support and intervention with their diet and unplanned weight loss, because the information was contradictory.

The actions staff should take in relation to the person's nutrition did not contain detail about how the person's calorie intake could be increased, for example by fortifying food, offering finger food or frequent snacks. However, it did show a referral to the dietitian was made and identified the person liked to have small portions of food on their plate. It also showed that the person may need reminding to eat and would sometimes ask for another meal because they had forgotten they had eaten.

Although there was a lack of comprehensive detail, the registered manager told us how the person would sometimes have several breakfasts. She also explained that they did fortify food using cheese and butter for example, but that the person did not always like this. On 25 July 2018, when we were present, we saw that the person ate both baked beans on toast for tea and sandwiches. However, at lunchtime, they asked for additional food after their main course. We saw that the registered manager suggested perhaps they should have their pudding first and then see if they still wanted more food. This suggested a potential failure to capitalise on the opportunity to increase their calorie intake with a second helping of the main course. However, we observed that they did eat ice cream afterwards, and accepted biscuits with a hot drink in the morning and afternoon.

We noted that the menu board displayed, contained photographs of quiche, and baked potato for lunch. This was inconsistent with the cottage pie followed by ice cream served and so did not remind people what was on offer. The registered manager told us that the pictures were for the day before. We observed that one person was not enjoying their main meal at lunchtime. A staff member intervened saying, "If you don't like it, would you like something else? A sandwich? Salad?" They ensured that the person was provided with their choice so that they would eat.

There were no pictures to remind people what was on offer at teatime. However, we saw that, at teatime, people were offered choices of sandwich fillings or beans on toast.

People were monitored to help ensure they received enough to drink. We saw that the electronic system allowed staff to use "icons" to record how much drink they had offered and what people had accepted. Where targets for fluid intake were met, the system flagged up fluid intake in green to show it was acceptable. The registered manager told us how it would be amber or red if it was not satisfactory so that other staff could offer further encouragement.

People gave mixed feedback about the quality of the food provided. Comments included, "The food is alright, not what you would expect if you cooked it yourself", "It's quite good" and "They do their best." One person pushed their meal of cottage pie away, pointed at the plate and told us, "Just look at that, it is disgusting. I'm not eating that." A member of staff overheard and offered instead a cheese sandwich which was accepted. Another person told us, "You wouldn't feed that to a dog." People also told us they had not been involved in the planning of menus but did say if they did not like what was provided they were offered an alternative.

On the second day of our inspection we observed the lunch and tea time meals. A notice board in the lounge told people the main meal for the day would be quiche and jacket potatoes. However, we saw that cottage pie and vegetables followed by ice-cream was provided. Whilst the menu displayed in the kitchen stated that chicken pie followed by meringue and ice-cream was planned.

People were provided with timely assistance at meal times when needed and provided with cold and hot drinks throughout what was a very hot day. We observed some people who spent time in their rooms had a jug of water beside them but did not always have a glass or cup to drink from.

There were handrails provided in the new extension to the home, in a contrasting colour to the walls, to aid people with a visual impairment would see them. This was also the case with door handles in that area.

There were clear signs showing people where toilets, bathrooms or showers were. The provider's website stated that it caters for people who are living with dementia. However, there were no memory boxes or pictures selected by people to help them easily identify their own rooms for the people we observed who became disorientated.

We noted that, in one part of the home, a bus stop and seat was provided. We observed the registered manager who explained to a visitor that they felt this helped people who were restless to "sit and wait for a bus as they used to do."

Some bedrooms contained lockable drawers whilst others did not. However, there were no assessments within the care plans reviewed, of people's wishes and abilities to hold keys (or have their relatives do so), so they could keep some belongings securely and privately.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in February 2018 this domain was rated as Good. At this inspection we found a deterioration and have rated this domain as requires improvement.

We received mixed views from people about the caring nature of staff. Comments included, "I have never liked it here." And, "Some staff are alright but they can be nice one day and nasty the other."

Care plans were not always written in a caring, compassionate manner. For example, one person's care plan when referring to guidance for staff in the 'management of behaviour' for a person diagnosed with dementia stated, 'Is verbally aggressive and rude to others…[person] has become demanding…[person] often gossips about others and passes derogatory comments about staff and residents.' Actions recorded to guide staff in how to respond stated, 'Ensure that distraction methods are used when being challenging towards others and explain to [person] they cannot get other residents to wait on them as some require helps and support themselves.'

There were widespread serious shortfalls in the service provided to people which meant that their immediate needs, safety and wellbeing did not benefit from a caring culture. Whilst we observed some staff to be kind and caring towards people, further work was needed to imbed a culture of caring throughout the service. Staff were not supported by the management of the service overall to ensure that people were provided with sufficient staff available at all times to provide meaningful activities and time to spend with people.

People's care records reflected how some people could become anxious and worried and the reassurance staff should offer. We saw that staff did intervene when people became distressed and anxious. However, we observed due to the lack of staff available on one occasion this required support from the office administrator, when one staff member was preparing food in the kitchen and only one other carer was busy and unable to provide the emotional support needed.

We also observed one person ask the registered manager for paracetamol, pain relief medicines. The registered manager told the person to look for a named member of staff in the lounge. The person responded to say they could not see the staff member in the lounge area. The registered manager then shut the door without providing any further support.

People's dignity was occasionally compromised. For example, personal toiletries were left accessible to others in shared bathrooms rather than in people's possession. Additionally, we found a letter rack by the front door containing correspondence waiting to be allocated to people. We checked a sample of these at random so see if people's right to confidentiality was compromised. These had not been opened, contributing to people's privacy, but neither had they been delivered to the person or dealt with by appropriate person for a significant period of time.

One of the envelopes was postmarked dating back to 21 March 2018. One looked like a greetings card, being

handwritten and in a red envelope and this was postmarked for April 2018. Others had no clearly distinguishable postmarks but were type written in windowed envelopes and so could represent more formal correspondence about people's finances or health. There was therefore a risk that people, with support from staff or family members if required, were not able to deal with their private correspondence promptly.

People and their representatives were not consistently involved in the planning of their care. Care records were brief in detail and did not always reflect people's preferences with regards to how they wanted their care delivered. People and their relatives told us they were not asked for their views in the planning and review of their plan of care. One person told us, "I wouldn't know anything about that." A relative told us, "We are not aware of any written care plan, no we are not asked to be involved in that side of things."

People were supported to bring in personal items such as jewellery, furniture, pictures, ornaments and electrical items. However, personal inventories had not been developed to record items belonging to individuals as is recognised good practice. We noted that not everyone had been provided with lockable spaces in their rooms to protect their personal belongings if they chose to do so. We also found not everyone with capacity had been provided with a key to their door to protect their privacy. One person told us, "I have not ever been offered a key. Is it alright for us to have one? I would like that."

This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection in February 2018 this domain was rated as Good. At this inspection we found a deterioration and have rated this domain as Inadequate as we found people did not always receive personalised care that met their individual needs.

At our last inspection we found people were admitted to the service without effective pre-admission assessments having been carried out. At this inspection we found the registered manager, had visited in their previous home, one person's needs before they moved into the service. Records confirmed from dates given, that information about their needs was gathered before they moved to Glendale. However, we found that the person's care plan contained conflicting information as to their personal care needs, communication needs, their ability to weight bear and the equipment staff should use to move them safely.

People told us care provided was not always responsive to their needs. For example, one person told us, "At night, I am in a cage [referring to bedrails]. I haven't always got a button to get me out of there or call for help. I can't reach my buzzer my arms aren't long enough." And, "Staff are up and down, one minute they are nice and help you and another you can't get their attention. They are under a lot of pressure… you can tell they, they are uptight, say they will come back and help you and then they don't."

We observed one person living with dementia asking if they could, "go home". The senior member of staff appeared rushed and responded by saying, "Now you can go home" and later said when asked again by the person for help to go home, "You've missed the bus. Now let me finish what I have to do." There was no engagement with the person's presenting emotions and neither any comfort or reassurance given.

The content of care plans was confused at times with conflicting information. Care plans contained incorrect and/or lacked relevant information and effective care planning strategies. This included a lack of correct information in relation to people with a diagnosis of dementia, those at risk of malnutrition, risk of absconding, people with an acquired pressure ulcer and people at risk of insufficient nutrition to maintain a healthy weight. Staff therefore did not have sufficient guidance to ensure people's rights were being protected, that their safety and welfare was robustly assessed and monitored to ensure needs were met and changes were recognised, explored and actioned to safeguard the person's wellbeing.

Care records for people who had been at the service for some time, contained information about their strengths and details about the tasks they could do independently. They also took account of people's psychological wellbeing. However, they did not always reflect people's life histories and previous interests so that staff could use these to engage people in meaningful activities they might enjoy, or in meaningful conversation.

Care records did not always include specific information on how to care for people who had diagnosed conditions such as stroke, diabetes and dementia. However, staff told us they knew people well and received updates to changing needs during handover meetings.

There was limited information about people's personal life history and preferences. The care plans reviewed contained very limited information regarding people's personal interests, hobbies and how they wished to spend their day and life at the service. People were not always protected from the risk of social isolation or loneliness. One person who sat alone in their room all day told us, "I like my own company but don't always see much of the staff and I get a bit lonely." Other comments included, "There's nothing much to do." And "We used to have activities but don't do much these days."

People were not fully supported and their needs assessed in supporting their autonomy, independence and involvement in the community, as much or as little as they wished. People told us and the registered manager confirmed people did not have access to community activities other than one person who enjoyed outings organised by their legal representative. The registered manager told us an activities person recently employed did not stay long and they were in the process of recruiting another member of staff. There were no plans for increasing staff or for any arrangements to meet these needs in the interim. Staff and relatives told us there were limited opportunities for people to engage in organised activities. The lack of staffing and recruitment to the activities role did not help limit the impact of this.

The registered manager told us they were in the process of building a log cabin to be used as a coffee shop. They said this was being provided, "Because people keep asking to go out, a visit to the coffee shop will help people think they are going out." We asked both the registered manager and a senior member of staff if opportunities were provided to enable people access to the community. The senior member of staff told us, "It is not safe for people to go out as they do not have capacity." The registered manager told us, "People can't go out they have dementia."

There was variable practice in showing the support people wanted to receive at the end of their lives. We were informed about the involvement of the palliative care team for one person. For another person, their care records showed the arrangement not to resuscitate them if they had a cardiac arrest, and that they were not to go to hospital for their current medical condition. However, despite being admitted to the service in October 2017, nine months before our inspection visits, their care records showed the person and their family had not been spoken to about their wishes and preferences as to their end of life care plan.

A notice displayed in the staff room for actions staff should take in the event of a person dying. These instructed staff with contact details to refer to only one undertaker. There was no reference to checking people's individual preferences if they wanted alternative arrangements made.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was information about how to complain within the service, displayed on a noticeboard in the dining area. However, we noted that the first member of the management team listed for people to contact no longer worked at the service. The information also indicated complaints could be referred to the Care Quality Commission (CQC). CQC has no statutory powers to investigate complaints for individuals. There was no mention of the local authority ombudsman and no contact details for people to refer unresolved complaints to them.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2018 this domain was rated as Requires Improvement as we found continued shortfalls in relation to ineffective governance and oversight of the service. The registered manager who was also the registered provider failed to send us a response to our request for an action plan which would tell us what they would do to ensure compliance with the law.

At this inspection we found a deterioration and have rated this domain as Inadequate. We found risks to people and the registered manager's understanding of action they should take to ensure compliance with regulatory requirements were not fully understood or acted on. We identified some risks within the service for which the registered manager could not locate information about how they assessed environmental and individual risks and mitigated these with guidance provided for staff.

The registered manager, told us they had not completed any recent training in the management of health and safety including risk management. Throughout our inspection they did not demonstrate a clear understanding of their responsibility to monitor the quality and safety of the service with a failure to implement processes for assessing and minimising risks, confusing audits with risk assessments.

Processes to assess and monitor the quality and safety of the service were disorganised and had not consistently been carried out by the registered manager. For example, audits with action taken to address areas of risk including fire safety, safe staff recruitment, care planning and dependency assessment to ensure action was taken to ensure the availability of sufficient numbers of suitably qualified staff. The audits that were in place were not well developed or effective as they had not identified or resolved the issues that we found at the inspection.

Incident and accident reports had not been fully completed as the section of the accident/incident logbook for the provider to assess and review had been left blank. The provider did not have a continuous improvement plan to keep track of progress and ensure accidents including falls analysis and incidents did not reoccur.

Despite repeated efforts to explain what we were doing as the inspection team and why, including sign posting the registered manager to CQC guidance on our website to enable them access to our methodology, there were occasions when they and a representative of the registered manager did not engage positively in the process of the inspection and became confrontational.

Residents meetings were sporadic. However, there were some arrangements in place for seeking the views of people and their relatives through surveys to enable people to have a say in how the service was being provided. However, it was not evident from a review of records, discussions with relatives and people who used the service that feedback received was used to plan further improvements to the service.

The staff supervision process was not fully embedded to ensure all staff received regular, planned and structured supervision to discuss and plan their training needs, review their performance and professional

development. Systems were not in place to check the learning staff had undertaken was effective and to ensure their competency. For example, competency assessment for staff who administered people's medicines and mitigating the risks to people with unsafe moving and handling or to take action where shortfalls had been identified.

Feedback from relatives regarding the leadership of the service was positive. Comments included, "The manager is often around when we visit. We know who they are if we need to speak to them. There have been some recent changes of staff personnel which I think can be unsettling for the staff.", "On the whole I think the place is run ok." And "Apart from the apparent lack of staff on occasions when we visit, we have no concerns about the running of the place."

The culture within the service was task focussed and did not consider the wider rights and experience of those they cared for. Staff did not understand or know what the vision and values were of the provider. The registered manager's response to some of the issues we found was to blame a range of others. They did not always recognise the importance or significance of some of the environmental issues. There was no clear improvement plan, which involved and engaged staff or others in developing the service and the quality of care people received.

We found that the registered manager did not consistently demonstrate a good understanding of their own policies, procedural guidance, and their legal responsibilities for carrying on the regulated activity. For example, their procedural guidance in the management of complaints. We also found the provider's health and safety policy dated 9 January 2018 where it was required the person with overall responsibility for health and safety at Glendale was required to sign to confirm this, was left blank and they had not completed it for this specific service.

The registered manager could not demonstrate they were routinely providing people with opportunities to express their views, or consulted in the planning of their care, menu choices and activities. We were therefore not assured that people's views were listened and responded to and used to improve the quality of care provided.

We reviewed the system for identifying, receiving, recording, handling and responding to complaints by people who used the service. We found the log of complaints included the provider's complaints they made about other clinical professionals, staff disciplinary matters and a complaint made against a person using the service. The complaints log of response about the person living at the service recorded how this person had been called to a meeting to face the office administrator and another senior member of staff without any advocate to support them.

Shortfalls in the governance and oversight of the service demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager displayed the rating of their previous inspection in the service and on their website, which is a legal requirement as part of their registration.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not take proper steps to protect people against the risk of receiving care or treatment that was inappropriate or unsafe by means of the carrying out of an assessment of needs; and the planning of care to ensure the health, welfare and safety of service users.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not fully support and assess all people's needs in relation to access to lockable space, access to door keys inventories of personal items and supported to be involved in their community as much or as little as they wish.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not protected the risks of receiving care and treatment without establishing whether or not they had capacity to consent.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has failed to maintain an

effective system for assessing the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider did not follow local safeguarding arrangements in reporting allegations of abuse and ensure allegations are investigated appropriately.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not kept clean and cleaning done in line with current legislation and guidance. Health and safety audits did not identify that infection prevention and control systems did not always protect people from the risk of acquiring infections. Policies were in place. However, these policies were not always implemented and essential elements of general cleaning were not always carried out. Not all staff involved in the preparation and cooking of food had been provided with food hygiene and safety training as required.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person failed to follow their own recruitment policy and ensure staff safety recruitment checks were carried out before staff started their employment.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not ensure people's needs were met by sufficient numbers of suitably qualified, competent, skilled staff at all times. There was not dependency assessment with staffing levels reviewed to reflect people's changing needs.

The enforcement action we took:

We issued a notice of proposal to impose conditions on the provider's registration.