Glynn Court Limited

Glynn Court Residential Home

Inspection report

Fryern Court Road
Burgate
Fordingbridge
SP6 1NG
Tel: 01425652349
Website: www.glynncourt.co.uk

Date of inspection visit: 29 and 30 October 2014
Date of publication: 04/02/2015

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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected Glynn Court Residential Home on 29 and 30 October 2014. This was an unannounced inspection to check they had made improvements to comply with enforcement action. The provider had taken some steps to improve but had not made adequate improvements and had not complied with the warning notices issued to them in September 2014.

At our inspections of the service in November 2012 and August 2013, we found that the provider was not compliant with the regulation about care and welfare of people who use the service. This was because people's needs were not assessed properly and care was not planned to ensure their safety and welfare.

Following our inspection in August 2013, we took enforcement action against Glynn Court Limited and the

Summary of findings

registered manager in respect of this regulation. We carried out a further inspection in October 2013, met with the provider and registered manager in November 2013 and carried out further inspections in January and February 2014. However, we found that not all risks had been assessed appropriately and care plans were not always followed. We also identified other concerns in relation to staff supervision and training, medicines management, and record keeping. We carried out a responsive weekend inspection in April 2014 in response to concerns and found staffing levels.

We inspected Glynn Court Residential Home again in August 2014 and found the provider had made some improvements and had become compliant in relation to staffing levels, staff supervision and training and medicines management. However, we found that there were still risks to people's welfare and safety as record keeping was not always accurate and care plans were not always updated or followed. We also found the provider did not have effective systems in place to monitor and assess improvements that were required.

We took further enforcement action against the provider and the registered manager and issued three warning notices (enforcement notices telling the provider why they had breached regulations and the date by which they must make improvements) in relation to care and welfare of people, record keeping, and monitoring and assessing the quality of the service provided.

At this inspection (October 2014) we found the provider had made some improvements to the monitoring of the environment and identified actions had been completed. However, we found they had not made adequate improvement to care planning, monitoring and record keeping in relation to the care and welfare of people. Some records did not give staff adequate or up to date information and some people were at risk because of this.

Glynn Court Residential Home is a care home for older people, some of whom are living with dementia. The home is registered to provide accommodation for up to 31 people. At the time of this inspection there were 25 people living there. The home is set in well maintained gardens and consists of a main house and a smaller detached house, this being for people with less complex needs.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were needed in relation to the safe management and administration of medicines. There were not effective systems in place to safely record and administer people's medicines.

People who had developed pressure areas or bruising had not had their injuries investigated, recorded or monitored.

The registered manager had not always identified when people's needs had changed. People's care plans and risk assessments were not always updated when their needs had changed. Care was not always provided in line with people's care plans.

People were not supported to take part in a comprehensive range of meaningful activities. We observed that people spent long periods of time without stimulation or meaningful interaction. People often appeared restless. We looked in six people's records and found low numbers of recorded activities.

People and/or their relatives had not always been consulted about how they would like their care to be provided. People told us they hadn't been involved in planning their care and care plans had not been signed by people or the relatives to show they had agreed with their plan of care.

People and their relatives had not been informed of, or consulted about the enforcement action taken against the provider and registered manager, or been given an opportunity to comment about how the required improvements should be achieved.

Improvements were needed in relation to how the provider and registered manager identified, assessed and managed risks relating to the safety of people and of the quality of the service. During the inspection we identified concerns in a number of areas. These included care and welfare, protecting people from harm and medicines

Summary of findings

management. These issues had not been identified by the registered manager before our visit, which showed that there was a lack of robust quality assurance systems in place.

Whilst most people told us they enjoyed their food, we found that the mealtime experience of people who ate in the lounge required improvement. Some people experienced a delay in their meals being served whilst others did not have the support they needed to be able to eat in a dignified manner and lost interest and did not eat anything.

The building was spacious and airy but thought had not been given to how it could be made more appropriate for people living with dementia, such as contrasting colours, good signage and effective lighting.

People were not always given sufficient information to make an informed decision or asked for their consent before care was provided. People's mental capacity had not been assessed appropriately in line with the Mental Capacity Act 2005. People who had capacity had not always been consulted about important decisions that had been made and documented, such as whether or not they wanted to be resuscitated.

The registered manager had consistently failed to meet the requirements of the enforcement notices issued to them. They had not demonstrated they had the skills, qualifications and experience to manage the regulated activity of "Accommodation for people who require nursing or personal care" (not nursing).

People spoke positively about the care provided by the staff as did their relatives. One relative said, "The staff here are really caring, they put themselves out and work incredibly hard to make sure they have what they need". A health and social care professional told us they considered the home "To be a good home. Even though I have limited knowledge of them, from my previous experience I found the staff to be caring and kind with a person who had reached the end of their life".

We observed staff speaking to people with patience, warmth and respect. Staff respected people's dignity and privacy. Some staff gave people gentle encouragement to prompt them to eat and drink and promoted their independence where possible.

The provider recruited staff who were suitable for the role and recruitment procedures were robust. Staff recruitment records were in place, such as Disclosure and Barring Service checks, references and proof of identity. Staff received regular training, appraisal and supervision which supported them to carry out their role.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems for the recording and administering of medicines were not effective which meant staff could not assure that people received their medicines safely.

Records of how people's wounds were monitored were inadequate. This meant staff could not ensure people's wounds had been correctly identified, investigated, treated and recorded.

Staff had received safeguarding training. However, one large unexplained bruise had not been investigated or reported to the local safeguarding authority.

There was insufficient guidance for staff in how to identify if people were in pain.

Care plans and risk assessments were not always updated. Risks to people had not always been identified therefore staff did not have appropriate information in how to manage or reduce the risk of harm to people.

Is the service effective?

Requires Improvement

The service was not effective.

New mental capacity assessments were being completed. However, these were for generic areas of decision making and were not completed in line with the Mental Capacity Act 2005 to ensure they were carried out for a specific decision at a specific time.

Some people who ate in the lounge were left to eat by themselves when they could not do so. Some people did not receive a balanced, nutritious diet.

The environment did not reflect best practice or national guidance for people with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not involved in planning their care. This meant the provider could not ensure that people had understood or agreed to their plan of care.

Staff treated people with kindness and compassion. They were aware of what was required to maintain people's dignity and to respect their choices and wishes.

Staff working in the dining room enabled people to retain their independence when eating their meal with minimal support.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not responsive.

People's assessments, care plans and risk assessments were not always updated to reflect people's changing needs. Information was not available about people preferences and life histories.

People did not always receive their care and support when they needed it. Staff responded promptly to requests for assistance on the whole but there were delays of several minutes when staff needed to locate another staff member to help them support people to stand or to mobilise.

Although some people attended external events such as a lunch club, most activities were delivered within the home. These took place within the lounge and excluded a number of people who preferred to stay in their room. There were very few activities for people.

Is the service well-led?

Inadequate 

The service was not well led.

The registered manager had consistently failed to meet the requirements of the Health and Social care Act 2008. They had also failed to make the improvements needed to meet the requirements of enforcement notices issued to them. There were on-going breaches of regulations at this inspection which the registered manager had failed to identify.

The registered manager had delegated tasks, such as carrying out medicines audits, to their staff but had not put effective monitoring systems in place to assure themselves these tasks were carried out satisfactorily. The registered manager was reluctant to take responsibility for delegated tasks.

The culture within the service was not open and transparent. The registered manager had not shared information relating to the enforcement action taken against the home with people who used the service or their relatives. People had not routinely been asked for their views about the service and had not been involved in the improvements to the home.

The registered manager did not have the skills and knowledge required to deliver a safe and effective service. They did not have an understanding of relevant guidance and good practice.

Glynn Court Residential 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.

We inspected Glynn Court Residential Home on 29 and 30 October 2014. This was an unannounced inspection to check that they had made improvements to comply with enforcement action. The provider had taken some steps to improve but had not made adequate improvements and had not complied with the enforcement action (warning notices) taken against them in September 2014.

The inspection team consisted of an inspector and a specialist adviser who had expertise in the care of older people with dementia.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports, enforcement notices and notifications received by the Care Quality Commission. A notification is when the registered manager tells us about important issues and events which have happened at the service. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during inspection.

We spoke with four people who use the service, four relatives and a district nurse who was visiting. We spoke with six staff as well as the registered manager. We spoke with the maintenance contractor who had been employed on a regular basis to repair and maintain the premises. We carried out observations throughout the day in the lounge and dining room. We reviewed nine people's care records and pathway tracked six people's care to check that they had received the care they needed (We did this by looking at care documents to show what actions staff had taken, who else they had involved such as a GP, and the outcome for the person). We looked at other records relating to the management of the service, such as staff files and health and safety records. Following the inspection we spoke to two social care professionals from the local authority.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Glynn Court Residential Home. One person told us "I feel safe here. The staff are marvellous and kind". Another person told us they thought the staff were "Very, very good" and that they always made sure their call bell was close by. They also told us staff attended to them quickly if they used their call bell. A relative told us "the staff here are so kind, they work really hard to make sure [my relative] has everything she needs, and I have no complaints".

Whilst people told us they felt safe, we found a number of concerns which might have put people at the risk of harm. There were not adequate arrangements in place for the safe administration of medicines. We reviewed 31 medicine administration charts (MAR) and found that 25 contained errors. 19 people had been prescribed PRN medication (this is medication to take as and when required, such as Paracetamol for pain relief) without an appropriate care plan to provide guidance for staff about when these should be used.

One person had a blood clotting monitoring chart in their care plan because they were taking a blood thinning medication, but the most recent entry was dated 6 August 2014. At the inspection, we spoke with the manager about this who told us the person "Is able to keep it [the record] herself and keeps it in her bag". This meant staff were unable to monitor the person's blood clotting ability directly. Depending on the results of regular blood tests the amount of this medication may need to be amended. Staff did not have an overview of the person's medicines records. This meant the person may have been at risk of receiving an inappropriate dose of medication. Following the inspection, the registered manager told us we had misunderstood their comments. They told us that the person used to keep their chart in their bag when they were at home. They told us when the district nurse attended to test the person's blood they asked the person in charge for the medication monitoring chart which they then took away and returned later by post. This was then attached to the MAR chart. However, up to date information about the person's blood tests was not available to us on the day of inspection, and when questioned at the time, the registered manager gave a different response.

Four people had been prescribed a specific medicine to help prevent and/or treat osteoporosis. There are special conditions governing the use of this medicine. It should not be taken by people with swallowing difficulties because it has the ability to irritate and damage the throat. Staff supporting people with conditions such as dementia and Parkinson's disease must be particularly aware of, and monitor a person's swallowing ability (which can become compromised in these conditions in the later stages). There was no reference made to this in people's records or any risk assessment for this medication so that staff would be aware of this risk. The dose prescribed for each person was to be given as a weekly dose and this was clearly noted on people's MAR sheets. However, the time at which they were to take it was not clear. This meant there was a risk of them not receiving this at the correct time. We asked the manager about this who referred us to the team leader. They told us that "early morning would be given by the night staff around 07:00" and further said "This is not correct. We need to change this".

Three records included hand written instructions about the dose or frequency of people's medicines. These included changes in the dose of medicines to be given on "the instructions of the GP". These were not signed or dated by a staff member so it was unclear who had made the amendment. We were aware that a GP regularly visited the home and had done so on the morning or our visit. These amendments could have been ratified if appropriate by the GP during one of their routine visits so clarifying verbal instructions.

Another person's care plan stated they were sensitive to penicillin. Their MAR chart showed they had been prescribed and given penicillin. According to the MAR chart the most recent course finished on 13 October 2014. We spoke with the manager and team leader about this. The manager told us "Oh dear, but they have been registered with the GP for 20 odd years so it should be on their record". We pointed out that it was the responsibility of the registered manager to ensure the safe administration of medicines. They both told us they agreed with this point. Following the inspection the registered manager informed us that "when penicillin was prescribed, the doctor was challenged by a senior and the dose was reduced". However, on the day of the inspection the registered manager gave us a different response.

The above evidence shows there was a breach of regulations 13 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

Four people's records included a "Wound Identification Form". This included a body map, the size of the wound and any treatment applied. There was no wound care plan attached to these which meant whilst wounds may have been initially identified, there was no record that staff were provided with instructions for appropriate care and treatment of these. There was also no way in which wounds could be monitored and evaluated to ensure they were healing or otherwise. One person's records documented that they had an unexplained '4 – 5 inch bruise' on their arm. There was no record of this being reported to the Local Authority safeguarding team. We spoke to the manager about this and showed them the record. They were not aware of this injury but they confirmed this had not been reported. Staff had received training in safeguarding adults. Staff told us they knew what signs to look out for when identifying abuse and were able to explain the process for reporting abuse or suspected abuse, including the whistleblowing policy. There was a safeguarding policy in place and the procedure for reporting abuse or suspected abuse was clearly available on the noticeboard in reception. This meant that whilst staff told us they had received training in safeguarding adults and explained how they would identify and report abuse or potential abuse, the procedure was not always being followed.

The above evidence shows there was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Whilst most people had risk assessments in place this was not always the case. Three people's records showed they became agitated, distressed and aggressive during personal care. In one person's case this was a regular daily event which resulted in staff being struck on several occasions. Staff should have specific guidelines to help reduce and prevent these risks, however, their records did not include these. Instead the records focused on "talking calmly to the person and leaving them for a short time". This was insufficient information for staff to be able to provide safe care.

There were no pain assessments in use at the home. We verified this with the manager and the team leader who told us they knew people well and knew when they were in pain. This knowledge may be variable from staff member to staff member and may be absent when agency staff were on duty. We spoke with an agency staff member who was not able to tell us what arrangements were in place to monitor a person's pain.

The above evidence shows there was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements were needed in relation to how staff were deployed at busy times. Staff told us there were normally six staff on in the mornings and 3 or 4 staff on in the afternoons. They told us this was because it was "Not as hectic" in the afternoons. In addition there were housekeeping staff and catering staff. However, one member of staff said they thought there needed to be more staff. They told us that staff were "Dealing with multiple dementia. The home is EMI [Elderly mentally infirm] registered. I'd like to see levels up, not less". We asked if people's needs were being met and were told they were not always being met "at the moment". One person told us "I have my call bell by my bed. They come straight away at night. In the day time they're not so quick but they know I'm here waiting". We observed at times during the day, such as lunchtime, people had to wait for support to eat their meal or go to the toilet. We spoke to the manager about staffing and they told us they had reduced staffing as the number of people living in the home had dropped but staffing had now increased again as there had been new admissions to the home. Night staffing had increased from two staff up to three to take account of two people moving back into the detached house in the grounds.

Recruitment procedures were in place to ensure that only suitable staff were employed. Records showed staff had completed an application form and interview and the provider had obtained written references from previous employers. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff.

At our previous inspection in August 2014 we identified failings in relation to infection control within the home. At this inspection, we spoke with domestic staff who told us they had recently reviewed their monitoring systems to ensure the cleaning was completed effectively. An infection control audit had been carried out since our previous inspection, to identify areas which required improvement but it was too early to follow up on actions identified. We looked at records to do with the maintenance of the

Inadequate

Is the service safe?

building which showed regular checks were carried out to monitor the environment and equipment, such as emergency lighting and the fire alarm. The manager had put in place an arrangement with a part time maintenance contractor to manage this. They told us there was a maintenance book which staff would fill in if they found any issues that needed rectifying. They told us the provider was responsive and funding was available to complete any work required.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they were happy with the care and support they received at Glynn Court Care Home. One person told us they were worried about their health and that staff "Are going to take me for a check- up. I don't know when yet but they're doing their best to re-assure me. I can't ask for more".

However, we observed lunch being served in the lounge and saw that not everyone enjoyed their meal and there were not enough staff to support people to eat their meal in a timely way.

One person was given their meal without explanation about what it was. The person was left for ten minutes before a staff member returned. The person rejected the meal saying "I don't know what it is, what is it? I am not going to eat that rubbish". The staff member said "It is what you asked for, steak and potato". The meal was pureed which meant it was not easy to identify the food. The staff member was patient and offered the person an alternative of soup with bread in it. The soup was delivered but the person rejected it again saying "it is too salty, I cannot eat that". Another staff member came by after another five minutes and encouraged the person to have their soup. They ate some soup with the bread but about one third was left. The person was then given ice cream which they seemed to enjoy. We spoke with a staff member about this because we were concerned that the person was not eating or drinking a great deal. A senior member of staff told us "they are always like this. They say they do not like the food so we always get them some soup and bread for lunch". When we looked in the person's record there was no reference to their food preferences such as soup. Their food chart showed they mostly ate biscuits, soup and bread on a daily basis. When we asked a member of staff about this they told us the person was not losing weight. However, action had not been taken to try to improve the person's nutrition.

Another person was seated in the conservatory on their own. They were given their food and staff left. The person did not appear to understand what they were meant to do with the spoon they had been given because they were unable to manage to get food onto it. A member of staff returned after ten minutes and placed the spoon the correct way in the person's hand and showed them how to get food onto it. The staff member then left. The person attempted to get the food into their mouth but mainly failed to do so. After five minutes the person became distracted and started putting the spoon through the window blinds. The bowl was upturned and when staff returned in a further five minutes, the bowl was taken away. It would have been very difficult for the staff to estimate how much the person had eaten for lunch. We looked at this person's care record which stated "I have a good appetite. I like to have lunch in the dining room with other residents" which is not what we observed. We observed people in the lounge during lunch time and when beverages were provided. The staff involved in this had a good knowledge of what people liked to drink but three people had the same drink in front of them for three hours without drinking them completely.

The above evidence shows there was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked to see consent forms for people who had bed rails in place to check that they were not being unlawfully restrained. One person had bedrails in place but there was no record to show they had agreed to this or that a risk assessment had been carried out. People were not supported to make decisions relating to care and treatment. For example one person told us they had recently had a blood test, but they did not know what this was for. Other people told us that they did not know why they were taking their medicines. One person told us "I don't know what it's for or why I'm taking it but I trust them". Another person told us "I had a tablet this morning and another one at night. I don't know exactly what for." This meant the provider could not evidence that people had made informed decisions about taking their medicines or that they had given informed consent for this.

The registered manager had recently introduced a new mental capacity assessment and staff were in the process of completing this for each person. We were told these would be reviewed every three to six months or when changes to people's capacity occurred. Whilst this was an attempt to make improvements to assessing people's capacity, it was not in line with the Mental Capacity Act 2005 which states a mental capacity assessment should be undertaken at a specific time for a specific decision.

The above evidence shows there was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service effective?

The home was not well designed to meet the needs of people living with dementia. For example, there was a lack of appropriate signage to help people orientate themselves around the home. People were sat around the outside of a large 'L' shaped room. Older people often have difficulty in looking to left and right which means they are most comfortable looking straight ahead. Sitting people around the side of a room means that their visual capacity, if not already limited, is reduced to that which is straight in front of them. In a person with cognitive impairment, this can significantly impact on their ability to understand and participate in their environment. There are clear guidelines for care homes in terms of things they can do to make the home's environment more supportive for people with cognitive impairment which had not been implemented at Glynn Court. When we discussed this with the registered manager, they demonstrated that they did not understand good practice in relation to the environment for people living with dementia. Following the inspection the registered manager informed us that "Residents prefer the layout of the room and this was their choice."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards ensure that any restrictions on people's liberty have been appropriately authorised by the local authority. The registered manager told us there were no applications for DoLS at the time of our inspection. It was not clear that the registered manager understood what might constitute a restriction on a person's liberty which meant that relevant applications may not have been submitted. For example, one person had bedrails on both sides of their bed which had not been identified as a possible restriction to the person's freedom of movement.

The registered manager told us new staff completed an induction programme during the first few months of their employment to ensure they had the basic skills and knowledge required. Staff told us they received regular training and could ask for additional training if they felt they needed it. We checked staff training records and noted that most staff were up to date with training such as safeguarding, fire safety, moving and handling and first aid. Staff told us they received regular supervision and appraisal and records confirmed this to be the case.

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind and they were happy living at Glynn Court. One person told us "The staff here are really caring, they put themselves out and work incredibly hard to make sure they have what we need". Another person said "It was my birthday a few weeks ago and they made me a big cake with candles". A relative told us "We are absolutely delighted with the care they receive, nothing is too much trouble for the staff, they are so kind, we cannot fault them".

However, from our review of records we did not find evidence of the involvement of families and people in care planning and evaluation. The people we spoke with could not recall any involvement in care reviews, planning or evaluation. One member of staff told us they reviewed care plans "At the end of every month. It's not a big job. I do it at home on my laptop (which is just for work)". This meant the provider could not ensure that people had been involved in planning their care, or understood or agreed to their plan of care.

One person had mental capacity to make decisions and it was stated in their care plan that they could make decisions about their end of life care. The person had a 'Do not resuscitate (DNR) form' in their care records but this had only been signed by a relative and a GP. The person themselves had not signed the form and there was no evidence they had been involved in this important decision.

The above evidence shows there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The atmosphere in the home was welcoming and relaxed. People were chatting and joking with staff, and we could see there was a warmth and desire to help people.

Staff were caring and people were trusting of the staff supporting them. We observed good practice in relation to promoting independence. For example, a staff member guided a person with a sight impairment from the dining room. When walking with the person they used phrases such as "90 degrees to the left please [X]" to help them understand what direction they needed to walk in.

Staff were polite and respectful. They were able to explain how they maintained people's privacy, such as knocking on their bedroom door before entering. We saw this in action during our inspection. When staff supported people to stand from a chair we saw that they protected people's dignity by making sure their clothes were not tucked up, and spoke reassuringly to them during the procedures.

Staff were compassionate and we saw some good examples of this. For example, a staff member spoke kindly to, and re-assured a person when they became anxious and worried. The team leader had requested support from the palliative care team for one person. They were due to attend the following day, the second day of our inspection. When we arrived the following day, the team leader told us that the palliative care team had cancelled their visit that day. They were visibly upset about this and told us they had already called to chase them up as it was not acceptable they had cancelled the visit when person was nearing their end of life.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the care they received and had no complaints. One person told us "I would speak to [The manager] if I was unhappy about something". Another person said "I've never had a grumble". Relatives were happy with the care provided. A relative told us "Staff are so good at keeping me informed". However, one relative added "The only thing is they do seem to be pushed for time and this makes it difficult as people try to help others without the staff which is a bit of a worry".

Despite this, we found that people did not always receive their care and support when they needed it and in a manner that was responsive to their individual needs. For example, staff responded promptly to requests for assistance on the whole but there were delays of several minutes when staff needed to locate another staff member to help them support a person to stand or to mobilise.

At lunchtime three people were sitting in the lounge with their clothes protectors around them for 40 minutes before their meal arrived. One person was seated in an armchair and it was some distance between the chair table and the bowl containing their lunch. This meant large volumes of food fell off the spoon into their lap. They struggled with this for ten minutes before a staff member arrived to help them.

People did not have sufficient opportunities to engage in meaningful activities in line with their choices and preferences. We observed that most people spent long periods of time without stimulation or meaningful interaction. Staff were busy supporting people but this was mainly completing tasks rather than engaging people in activities. Although a few people attended an external lunch club, most activities were delivered within the home. In the afternoon, people in the lounge area were provided with a Bingo session. Although some people were engaged with this game others were not able to. In addition, some people were still in their rooms and therefore did not have access to the activity. During the afternoon a member of the team led a game for people sitting in the lounge. The numbers were greater than in the morning but the same people engaged with the activity who had done so during the morning. Staff did not provide individual activities for people who chose to stay in their rooms or who were unable to take part in the group activities. We found a low level of activity was recorded for each person. People's activity was recorded as "phone call from daughter" "and "sat in on activities". This meant some people were not given opportunities for social engagement and stimulation.

The above evidence shows there was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people's MAR charts stated in the 'diagnosis' section that people had "old age". We spoke with the manager and team leader about the use of this term. The team leader told us "That's the truth, what else are we supposed to say". This is not a diagnosis and is unhelpful in the individualised care and support of people.

The records had been changed since our last visit and now included a daily report which described the care and support each person had received. We were told that these were completed daily and were reviewed by the registered manager each day to determine if any action was required in response to changes in people's needs. We spoke with the registered manager about this form in terms of its purpose and design. He told us "the staff were not keeping records properly so I designed this form so that it reminds them what to complete". We saw these forms were introduced on 13 September 14. We found these were not being reviewed daily by the registered manager and did not provide a detailed and personalised record of the care and support provided by staff. This meant staff could not be assured that people had received appropriate care and support.

One person was receiving end of life care. A general care plan had been written by the registered manager when the person had returned from hospital the day before our inspection. However, the care plan did not include guidance for staff in relation to end of life care. There was no pain assessment and there was no information informing staff what signs to look for that might mean the person had pain or what arrangements were in place to summon a district nurse from the community to administer pain relief in a timely way. This meant people may have been in pain without the appropriate support from staff. Good pain management technique involves looking at a comprehensive picture of the person on admission to a home and then following this up with pain assessment on a regular basis. Studies have shown that at least one third of people living in care environments have pain with no

Requires Improvement

Is the service responsive?

treatment for it (Social Care Institute for Excellence (SCIE), 2012) and people with dementia are at greater risk because of their difficulty in expressing this to staff (Dementia UK, 2014).

The above evidence shows there was a breach of regulations 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spent some time in the dining room during lunch and saw people there had a different experience to those people having lunch in the lounge. The atmosphere was relaxed and people were chatting together. Staff were attentive and had time to sit with people to support them. One person had a sight impairment and was unable to see the food on their plate. Staff were aware of the person's needs and observed discretely in order to help them promptly. For example, a staff member walked over and said they had come to help and placed their hand gently on top of the person's hand and moved it to different areas of the plate. They explained "There are green beans at 3 o'clock and on this side of the plate is the mash". They then told the person "I'm not far away if you need help".

Inadequate

Is the service well-led?

Our findings

People told us the manager at Glynn Court was "Very helpful" and "Marvellous". One person told us they had asked for additional facilities and that the manager "Got it all done. Did everything". A relative told us Glynn Court was "Perfect. I would recommend it". Staff told us the manager's door was "Always open" and that he was "Approachable". However we found that the service was not well led and there were systematic failures within the service.

People or their relatives had not been given regular opportunities to give feedback about the service, the concerns raised by the Commission or improvements that could be made. There had been only one 'Residents meeting' which had been implemented since our inspection in August 2014. The minutes from this meeting had not yet been shared with people. Topics discussed were around food and activities and did not include an opportunity to discuss the enforcement action we had taken and what action was being taken to make the improvements required. Records of what had been discussed lacked detail and there were no action points. It was not therefore clear what had been agreed. The staff member who wrote the minutes told us they had the information in their head and would include more detail in the typed minutes. The registered manager had not kept relatives informed of concerns raised by the Commission, despite receiving three warning notices [enforcement action] in September.

The arrangements to encourage open communication with people, those that matter to them and staff were inadequate. The registered manager had not informed people and relatives about the enforcement action we had taken and the actions required to make the improvements needed. This meant that most people who lived at the home and their relatives had not been told about our concerns or been given the opportunity to discuss this. We asked them why they had not ensured people or relatives knew about our concerns and the enforcement action we had taken but they were not able to give us a reason.

Meetings were held between the registered manager and team leader every week to discuss people's needs. However, the manager did not provide regular opportunities for all staff to meet. One staff member told us "We rarely have staff meetings. I would like to see more".

Minutes showed staff meetings had taken place on 3 March 2014 and 19 June 2014 so there had not been a general staff meeting following the warning notices [enforcement action] issued in September 2014.

The registered manager did not adequately learn from incidents and accidents. There were poor monitoring systems in place to identify issues, and failings we had identified in previous inspections were still happening. We spoke with the registered manager and the team leader about the errors in people's records and pointed out the inconsistencies and inaccuracies we had identified including the lack of care planning. They told us they accepted these but could not offer reasons why these had occurred. At previous inspections, in previous action plans and in the Pre Inspection Information Pack, the registered manager informed us they undertook all audits of care plans. They told us they would alter the manner in which they conducted their audits in future. However, they had been telling us this since we first identified non-compliance in November 2012 and found the on-going issues in relation to care planning continued to put people at risk of harm.

There are guidelines, research and polices that provide information to providers about the care and support needs of older people. For example, there is clear guidance about the use of routine pain assessments to identify changing needs. This applies in particular in people who may be unable to express their pain. This evidence was not apparent in the provision at the home.

People's records showed they were weighed each month and a nutrition assessment carried out at the same time. The records were up to date. However the system the provider used to identify if people were losing weight and at risk of malnutrition was not clear. We asked the registered manager and team leader about this who told us they thought it was the "Braden" System, however, this is a method of predicting pressure sore risk. We explained the importance of records containing their source so that we could be sure a scientifically validated system was in use.

The registered manager was not aware of what some medicines being administered by their staff were for. A registered manager has responsibility for ensuring people receive their medicines safely. They should therefore know what each medicine is for and if they do not, they should seek advice before administering it. The registered manager told us their team leader undertook audits of

Inadequate

Is the service well-led?

medicines and when they were on duty did the medicines rounds. We spoke with the team leader and registered manager and pointed out some of the errors we had found in our review. They said they accepted our findings. Although the team leader completed the medication audits, the registered manager had overall responsibility to ensure these were checked for effectiveness and identify any action required.

There had been one complaint in the last twelve months which had been responded to by the registered manager by letter. However, there was no information to explain how the complaint had been investigated, or how the outcome had been arrived at. The written response to the complainant did not offer any re-assurance or empathy.

The evidence above shows there was a breach of regulations 6 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We had asked the registered manager about their training in the care and support of people with cognitive impairments such as dementia. They told us "I have attended a course but I cannot be sure when it was, it was a one day course". The home provided care for people with dementia which had resulted from different conditions requiring different approaches to care. We found the RM did not have the necessary skills and knowledge in relation to dementia care.

The registered manager had not kept themselves up to date with training, best practice and national guidance. They had consistently failed to meet compliance since November 2012 and had not met the warning notices issued in August 2013 and September 2014.

We found that the registered manager was reluctant to take responsibility. When we informed the registered manager about our findings, they told us they had delegated the tasks and that staff had not done as they had been asked. For example, when we told them about the MAR chart errors, they told us it was the responsibility of the team leader to do the audits. We reminded the registered manager that it was their overall responsibility to make sure that staff had the necessary skills to carry out the delegated tasks, and that they monitored the work to ensure it was completed properly.

All of the evidence above shows there was a breach of regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Failings identified at our previous inspection in relation to the health and safety within the building and grounds had been rectified. The registered manager had taken on a contractor to oversee weekly health and safety checks, such as fire alarm testing and emergency lighting checks. We heard that resources were made available to ensure work that was required to maintain or repair the premises or equipment could be carried out.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not have suitable arrangements in place to ensure service users were protected against the risk of abuse by taking reasonable steps to identify the possibility of abuse and responding appropriately to the possibility of abuse. Where restraint was used, the registered person did not have suitable arrangements in place to protect service users against the risk of unlawful restraint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had not ensured service users were protected against the risks associated with unsafe use and management of medicines by means of appropriate arrangements for recording, dispensing and administering medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person had not ensured service users were protected from the risk of inadequate hydration and nutrition by means of providing a choice of suitable and nutritious food and hydration, in sufficient quantities to meet their needs, and provide support, where necessary for the purpose of enabling service users to eat and drink sufficient amounts for their needs.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not made suitable arrangements to ensure service users were enabled to make or participate in making decisions in relation to their care and treatment; had not provided service users with appropriate information in relation to their care and treatment; had not encouraged service users to understand the care and treatment choices available to them and balance the risk and benefits involved; or to express their views as to what is important to them in relation to their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of service users in relation to the care and treatment provided for them.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of the carrying out an assessment of needs, planning and delivery of care, and/or treatment to meet the service user's individual needs, ensure the welfare and safety of the service user, and reflect published research and guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users from the risk of inappropriate or unsafe care or treatment by the means of effective systems to regularly asses and monitor the quality of the service; identify, assess and manage risks relating to the health, welfare and safety of service users; had not identified or analysed incidents or near misses that resulted in or had potential to result in harm to service users. The registered person had not regularly sought the views of service users, persons acting on their behalf and staff to enable them to come to an informed view in relation to the standard of care and treatment provided to service users. The registered person had not established mechanisms for ensuring that decisions in relation to the provision of care and treatment for service users were taken at the appropriate level and by the appropriate person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Enforcement actions

The registered person had not ensured service users were protected against the risks of unsafe or inappropriate care or treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user, including appropriate information in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 6 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to registered managers The registered manager did not have the necessary qualifications, skills and experience to manage the carrying on of the regulated activity.

The enforcement action we took:
We have cancelled the registration of this manager.