Saffron Care Ltd

Glenkealey

Inspection report

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Ratings

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

Overall summary

Glenkealey is registered to provide accommodation and personal care for up to 15 older people living with dementia. Nursing care is provided by the local community nursing team.

This inspection took place on 4 and 8 June 2015 and was unannounced. There were 15 people living in the home at the time of the inspection. The service was last inspected on 16 December 2014 when it met the regulations we looked at.

At the time of the inspection, the location did not have a registered manager. This location has a condition of registration that it must have 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. The provider had employed a manager who was in the process of applying to register with the Care Quality Commission.

Summary of findings

The Provider Information Return (PIR) was submitted in December 2014. We asked the provider to give us evidence on how their service was safe, effective, caring, responsive, and well-led. However, the PIR contained limited information and evidence. This meant the PIR was not helpful when we planned this inspection.

People's medicines were not always managed safely. Records relating to medicines were not completed correctly. The service could not evidence whether people had received their medicines as they had been prescribed by their doctor to promote good health.

Risks to people were not always identified and managed. The manager had reviewed a person's care with the mental health team following an incident of verbal and physical aggression. However, further incidents had occurred which the manager had not been aware of, the person's care plan had not been reviewed or updated.

People's social and emotional needs had not been fully assessed and care plans had not been developed to ensure people's needs were met. Care plans contained information about the person's life, the work they had done and their interests. However, this information had not been used in their day to day lives to develop individual ways of stimulating and occupying people. During our inspection the television was on all day in the lounge but not everyone in the room was watching it.

Staff did not always respond well to people. For example, one person regularly stood by the front door and said they needed to go out. One staff member told the person they couldn't go out and the person became frustrated. The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People's freedom to leave the premises was restricted without the protection of a legal authorisation to do so.

People and their relatives were pleased with the care they received and praised the staff. Comments included "All the staff are very caring" and "The staff are very good". People told us they felt safe. Staff treated people with respect and kindness. People responded to this by smiling and engaging with staff in a friendly way.

Appropriate staff recruitment checks had been undertaken to ensure staff were suitable to work with people. Although staff were busy on the days of our inspection, they attended to people's physical needs. One member of staff was concerned that when staff assisted people to go to bed in the evening, there was no staff member available on the floor for the other people. The manager told us this had been discussed in the team leader's meeting held on the first day of our inspection. They had asked staff for feedback and planned to review staffing levels.

Staff knew the people they supported. They were able to tell us about people's preferences and personal histories. Staff told us people could make their own decisions about their day to day care, but may not be able to consent to more significant decisions. If people were not able to make decisions for themselves staff spoke with relatives and appropriate professionals to make sure people received care that met their needs and was deemed to be in their best interests. For example, one person was not able to consent to take their medicines. The person's family and GP had been involved in the best interest decision making process relating to administering the person's medicines.

The provider had recently employed a training manager. They had a training plan in place to ensure all staff received a two day training update. During our inspection, the training manager delivered dementia training to staff. One member of staff said "We're having more hands on training which will be better".

The provider had painted some doors to aid orientation and some picture signage was in use. However, the environment was not appropriately adapted for people living with dementia. **We recommend the provider takes into account the NICE guidance for supporting people with dementia which states "environments are enabling and aid orientation".**

People's needs had been assessed and care plans developed to ensure people's physical care needs were met. People's care plans were updated when these needs changed. People were supported to access health care services. A visiting healthcare professional who regularly visited the home said the level of care provided was very good.

There was an open culture in the service. People, their relatives, and staff told us they found the manager approachable. The provider had systems in place to assess and monitor the quality of care. For example, the manager had carried out a medicines audit on 1 June

Summary of findings

2015. They identified the errors we found on 4 June 2015. The manager had sent a message to staff after the audit to minimise the risk of these errors happening again. The manager was keen to develop and improve the service. They accessed resources to learn about research and current best practice. The issues we identified in relation to person centred care planning showed that further work was needed.

Feedback was sought from people and their relatives. For example, service satisfaction questionnaires were sent out in May 2015. Comments included “My relative is so well looked after” and “Staff do it with a smile and make the home a happy place”.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?
The service was not always safe.

Records relating to medicines were not completed correctly. Therefore, it was not possible for staff to evidence whether people had received their medicines as they had been prescribed by their doctor to promote good health.

Risks associated with people's dementia were not always identified and managed. Action was not taken to minimise the risk of incidents of aggression.

Safe staff recruitment procedures were in place. Appropriate checks had been undertaken to ensure staff were suitable to work with people.

Requires improvement

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

People were being deprived of their liberty without the protection of a legal authorisation to do so.

The provider had painted some doors to aid orientation and some picture signage was in use. However, the environment was not appropriately adapted for people living with dementia.

The provider had recently employed a training manager. They had a training plan in place to ensure all staff received a two day training update.

Requires improvement

Is the service caring?
The service was caring.

Staff knew people well and treated them with respect and kindness. Staff and people interacted in a friendly way.

People made choices about their day to day life.

Relatives could visit the home at any time and were always made welcome.

Good

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

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing.

People's physical needs had been assessed and care plans developed to ensure people's needs were met. People's care plans were updated when these needs changed.

Requires improvement

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

Requires improvement

Summary of findings

There was a manager at the location. However, the manager was not registered to ensure the condition of registration was met.

The Provider Information Return (PIR) was not helpful when we planned this inspection as it contained limited information and evidence.

The provider had systems in place to assess and monitor the quality of care and the manager was keen to develop the service.

Issues we have identified in relation to person centred care planning showed that further work was needed.

Glenkealey

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

One adult social care inspector carried out this unannounced inspection visit on 4 June and 8 June 2015.

Before the inspection, the provider completed a Provider Information Return (PIR). This was a form that asked the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of our visit, 15 people were using the service. We used a range of different methods to help us understand people's experience. We spoke with six people and three relatives. We spoke with the provider, manager, six staff, and one visiting healthcare professional.

We looked at three care plans, medication records, staff files, audits, policies and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People's medicines were not always managed safely. The Medication Administration Record (MAR) sheets were not completed correctly. For example, one person's medicines had been signed as having been given. However, the medicine was still within the monitored dosage system 'blister' pack. Entries on the MAR sheet which had been hand written were not always signed by two members of staff to ensure the correct information had been recorded. When medicines had been carried forward from the previous month, these had not been recorded. It was not possible to evidence whether people had received their medicines as they had been prescribed by their doctor to promote good health which may have placed them at risk of harm.

This was a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could display behaviours that may put themselves or others at risk. Risks to individuals were not always well managed. For example, the manager had sought advice from the mental health team for one person due to incidents of verbal and physical aggression. The person's medicines had been reviewed. The person had been involved in further incidents after this review. Staff had recorded in the daily records that this person had been verbally and physically aggressive towards them. The incidents had not been recorded on behaviour charts and the behaviour management plan had not been updated. Care plans did not include up to date information about the person's behaviour, triggers that may result in the behaviour, warning signs to look out for, or steps on how to manage the situation. Staff had not completed training in managing behaviours that challenge and managing aggression. The manager was not aware of the incidents and the service had not sought further advice, or made a referral to the mental health team..

This was a breach of Regulation 12 (1) (2) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the home and their relatives told us they felt safe. Staff knew how to raise concerns about abuse and poor practice with the manager. Staff told us they had received training to recognise harm or abuse and felt the manager would listen to their concerns and respond to these. The safeguarding policies did not contain information about who staff could go to outside of the home. Two members of staff did not know about the external agencies they could contact with their concerns.

Although staff were busy on the days of our inspection, they attended to people's physical care needs. People received care and support in a timely manner. The manager was on duty with one team leader, and two care staff. There was also one domestic staff and a cook. There were two waking care staff overnight. One member of staff was concerned that when staff assisted people to go to bed in the evening, there was no staff member available on the floor for the other people. The manager told us this had been discussed in the team leader's meeting held on the first day of our inspection. They had asked staff for feedback and planned to review staffing levels.

Safe staff recruitment procedures were in place. Appropriate checks had been undertaken to ensure staff were suitable to work with people.

The premises and equipment were maintained to ensure people were kept safe. Checks had been carried out in relation to fire, gas, water, and electrical items.

There were arrangements in place to deal with foreseeable emergencies. For example, each person had a personal emergency evacuation plan that told staff how to safely assist them in the event of a fire.

Requires improvement

Is the service effective?

Our findings

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The front door was locked. One person had the door code and was able to open the door. The rest of the people did not have the mental capacity to make the decision about going out and were unable to leave the home. The manager was not aware of changes to DoLS due to the supreme court judgment, or the need to make an application to the local DoLS team. People were being deprived of their liberty without the protection of a legal authorisation to do so.

This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had painted some doors to aid orientation and some picture signage was in use. However, the environment was not appropriately adapted for people living with dementia. For example, there were very few things for people to pick up and handle throughout the home. This type of stimulation can improve mood, encourage people to talk with others and take part in daily activities.

Staff had an understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals, where relevant. Staff told us people could make their own decisions about their day to day care, but may not be able to consent to more significant decisions. If people were not able to make decisions for themselves staff spoke with relatives and appropriate professionals to make sure people received care that met their needs and was deemed to be in their best interests. For example, one person was not able to consent to take their medicines. The person's family and GP had been involved in the best interest decision process.

The home had recently employed a training manager. They had completed a training matrix to show the training each staff member had completed. It was planned that each member of staff would attend a two day training update. During our inspection, the training manager delivered dementia training to staff. The induction for new staff lasted three days and the Care Certificate had been introduced. The training manager planned to deliver more face to face training and practical training to benefit people living in the home. One member of staff said "we're having more hands on training which will be better".

Staff had not received regular supervision or an appraisal over the past year. However, the manager had recognised that more regular supervision was needed. We saw that supervisions had been carried out recently and included observations of staff's care practice.

People were supported to access health care services. People had seen professionals including GP, optician, dentist, and specialists. A healthcare professional who regularly visited the home said the level of care provided was very good.

People told us they enjoyed the food at the home. Staff knew people's likes and dislikes. If people wanted an alternative, these were always available. For example, at lunchtime people were offered ice cream and bananas as they didn't want sponge cake. Information for staff about people's special diets were on a noticeboard in the kitchen for quick reference. People had access to drinks at all times. A choice of cold drinks were available in the lounge, dining room, and people's bedrooms.

We recommend the provider takes into account the NICE guidance for supporting people with dementia which states "environments are enabling and aid orientation".

Good

Is the service caring?

Our findings

People told us they were happy and that staff were kind and caring. Comments included “All the staff are very caring” and “The staff are very good”.

Staff treated people with respect and kindness. For example, staff addressed people with their preferred name and spoke with respect. People responded to this by smiling and engaging with staff in a friendly way.

Interactions showed staff were patient when meeting people’s needs. For example, one person was not sure how to get to the lounge. Staff spent time supporting the person to get to the lounge without rushing them.

When staff administered one person’s medicines, they explained what the medicine was and offered the person a drink. They were patient whilst the person took their medicine, and offered the person another drink afterwards. This showed the staff member respected the person and treated them in a caring way.

Staff demonstrated they knew the people they supported. They were able to tell us about people’s preferences and personal histories.

People were involved in making day to day decisions. For example, staff sat with people in the lounge and offered a choice of foods for tea time.

Staff maintained people's privacy and dignity. For example, staff explained where people were independent in the bathroom, they would get everything ready for the person then wait outside, giving the person the time they needed.

People were supported to be as independent as possible. Staff encouraged people to carry out their own personal care when they were able to. Care plans contained information for staff to follow to ensure people’s independence was promoted. For example, they described how people were able to wash themselves and choose their clothes.

Relatives told us they could visit the home at any time and were always made welcome. They told us the home informed them of any changes to their relative’s care.

Requires improvement

Is the service responsive?

Our findings

People's social and emotional needs had not been fully assessed and care plans had not been developed to ensure people's needs were met.

Staff did not always respond well to people's needs. For example, one person with dementia regularly stood by the front door and said they needed to go out. One staff member told the person they couldn't go out. The person started to become frustrated and again asked to go. Another member of staff approached the person differently. When the person asked to go out, they reassured the person and told them to come and have some lunch, as it was lunchtime and they must be hungry. The person was satisfied with this response and walked to the dining room with the staff member.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Care plans contained information about the person's life, the work they had done and their interests. However, this information had not been used in their day to day lives to develop individual ways of stimulating and occupying people.

One person had experienced regular falls within the home. The manager had sought advice from the GP and a referral had been made for an x-ray. This person regularly walked back and forth along the hallway with their frame. This person was not offered any meaningful activity. This may have reduced their walking and therefore minimised the risk of further falls.

This was a breach of Regulation 9 (3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The television was on all day in the lounge but not everyone in the room was watching it. On the second day of our inspection, staff did not have time to provide any activities for people during the morning. In the afternoon, some people took part in a ball game. People spent time watching television and listening to music in their bedrooms. One person spent time knitting. Several people read the newspaper. People talked with other people and relatives. One person enjoyed sitting in the garden with the manager and chatting. One person told us they enjoyed helping out in the kitchen at tea time. Activities included regular visits from musicians and a reminiscence group. The Provider Information Return said the provider was looking to offer a better variety of outings and activities that were more individually suited to people.

People's needs had been assessed and care plans developed to ensure people's physical care needs were met. People's care plans were updated when their needs changed. For example, one person had been in hospital. The person returned to the home and arrangements had been made to ensure staff were able to care for them. This included putting appropriate equipment in place. Their relative was happy that staff were coping well with the person's increased needs.

People were confident if they made a complaint this would be dealt with. None of the people or relatives we spoke with had needed to make a complaint. People said "I have no complaints" and "it's perfect, I would have contacted you if it wasn't". Two complaints had been received in the past year. The manager had investigated and responded to these. There was evidence that learning had taken place as a result of the complaints. For example, staff had been reminded of the actions they needed to take in an emergency situation.

We recommend the provider takes into account the College of Occupational Therapists guidance in relation to engaging people with dementia.

Requires improvement

Is the service well-led?

Our findings

This location has a condition of registration that it must have a registered manager. The registered manager was de-registered on 12 December 2014. The provider had employed two managers since this date. At the time of the inspection, the provider had employed a manager who was in the process of applying to register with the Care Quality Commission.

The Provider Information Return (PIR) was submitted in December 2014. This contained limited information and evidence on how the service was safe, effective, caring, responsive, and well-led. This meant the PIR was not helpful when we planned this inspection.

The manager was keen to develop and improve the service. They accessed resources to learn about research and current best practice. For example, they accessed information from Skills for Care and Social Care Institute for Excellence. They received the monthly updates from the CQC and had subscribed to a monthly care magazine. The issues we have identified in relation to care planning showed that further work was needed.

Staff told us they found the manager approachable. Comments included “If I had any problems, I would ask” and “I can talk to the manager”. A visiting healthcare professional commented if they asked the manager for something to be done, they knew it would be followed up.

Systems were in place to monitor the quality of the service. For example, the manager had carried out a medicines audit on 1 June 2015. They identified the errors we found on 4 June 2015. The manager had sent a message to staff after the audit to minimise the risk of this happening again.

Meetings were held with senior staff to plan work and discuss any issues and concerns. Senior staff told us there had been discussion about their role and responsibilities at the meeting which was held on the first day of our inspection. The manager told us this was to ensure issues were identified and dealt with.

The manager monitored the quality of care and support and sought feedback from people on an on-going basis. For example, service satisfaction questionnaires were sent out to people and their relatives. These asked people for their views of the support provided. The last questionnaire had been sent out in May 2015. A total of four completed questionnaires had been received at the time of the inspection. All of the responses were positive and there were no suggestions for improvement. Comments included “My relative is so well looked after” and “Staff do it with a smile and make the home a happy place”.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not always assessed and designed to meet people's needs. Regulation 9(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not assessed risks to people's health and safety or made adjustments to make sure the risks were minimised. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. Regulation 12 (1) (2)(a)(b)(g)

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 People were deprived of their liberty without lawful authority. Regulation 13 (5)

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.