Glengariff Company Limited

Glengariff Residential Home

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 27 November 2017, and also incorporated additional evidence collection days where the registered manager was able to provide us with information following concerns found at the inspection.

Glengarrif residential home is a 'care home'. 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.

Glengarrif residential care home accommodates up to 54 people in one adapted building over three floors. On the day of inspection 47 people were living at the home, some of whom were living with dementia.

A long standing registered manager was in place at the home. '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.'

We found that the service required improvement across all domains. All staff observed at this service knew the people living there well. Responses to people receiving care were kind. However, staff did not always demonstrate that engagements with people was meaningful, nor did they demonstrate how people's independence was promoted. We found that care for people living with frailty and older age was good, however, for those living with dementia or receiving end of life care, care needed to be more person centred and based on current best practice.

Systems in place to monitor the safety and quality of the service and the oversight of all these systems was poor. However, the registered manager took actions to address some of the concerns found during the inspection, and consequently we have made recommendations for improvements needed at the service, and we have also breached the provider in four areas. You can see the actions we took at the end of the report.

Following the inspection the registered manager immediately began to address some of the concerns found during the inspection. In addition the registered manager had set up, and was providing good support networks and links with other care managers in the area in order to share good practice and future learning. This should support the service to continue to develop and improve.

We will inspect the service again within 12 months of this reports publication, to assure ourselves that initial improvements made have been sustained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

The provider did not have clear action plans in place to monitor and improve the safety of the environment, even when issues had been identified.

Staff did not always adhere to best practice in prevention of infection.

Staff managed medicines safely.

Staff we spoke to had a good understanding of how to safeguard vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective

The was a poor understanding of Mental Capacity Act throughout all levels of staffing.

The dining experience was positive on the ground floor, but less so in other areas of the home.

Staff ensured that people had regular access to fluids, but people did not get offered choice and recording fluids for people at risk was poor.

The registered manager maintained good links with other services and professionals to maintain the health needs of people.

Is the service caring?

Requires Improvement

The service was not always caring

Staff did not always actively engage people in making choices if they were living with dementia.

Staff were caring and kind when supporting people, although some interactions could be more person centred.

Staff respected people's privacy and dignity during interactions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have care plans that informed staff how best to meet their needs and preferences.

End of life care was not person centred.

Activity staff carried out regular meetings with people living at the home to gain their views.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager and provider did not have full oversight of all the governance systems in place to ensure that the service was being provided safely.

The registered manager had been innovative in engaging with other organisations and other local residential managers.

Glengariff 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.

This comprehensive inspection began in the early morning, prompted in part by notification that people living in the home were being woken early to receive personal care against their wishes and preferences. At the time of inspection we did not find that these practices were occurring at the home.

The information shared with CQC also indicated potential concerns about the nutrition and fluid management for people at risk of dehydration and malnutrition. Concerns also related to staffing and the general state of cleanliness at the home. This unannounced inspection examined those risks and took place on the 27 November. The inspection team consisted of two inspectors and a head of inspection.

Prior to the inspection we reviewed all statutory notifications received from the service since the last inspection. These are notifications that the provider has to submit to the commission to comply with the Health and Social Care Act, 2008; 2015. This including a provider information request form, about the service they are providing.

During the inspection, we spoke with six staff, including the activity lead, the registered manager, and the deputy manager. We spoke to six people living at the service and carried out observations of the care provided to people. We also spoke with three relatives of people living at the home.

We reviewed five staff records, five care plans for people living at the home and carried out an audit of medication management at the home. We looked at the systems and processes employed at the home to manage risks for people living there. This included reviewing a cross section of policies and procedures and the governance systems in place to monitor the quality of the care provided.

We spoke with the local authority about how they found the home and interviewed two health care professionals who regularly visit people living at the home.

Following the first day of inspection the registered manager provided the commission with additional evidence to review, including minutes from meetings with people, environmental information, and information about some people's care and treatment. They were also able to provide us with evidence that where we had raised concerns on the day of inspection, immediate action had been taken to remedy these concerns, including sourcing of additional training for staff in end of life care, and thorough review of care plans where needed.

Requires Improvement

Is the service safe?

Our findings

The flooring in the main entrance was damaged in two places and the maintenance manager used tape as a temporary cover for this. However, on the day of our inspection the tape had curled and was not flush with the floor. This presented an infection control risk as there was a clear build-up of dirt where the tape had peeled away from the floor. It also presented a trip hazard for people with reduced mobility. We saw staff noted this in the maintenance log but the senior team had not found a permanent solution. The registered manager informed us that they were replacing the floor as a priority.

Advice obtained from service and maintenance contractors was not always followed putting people at risk of potential harm. For example, in November 2016 a water safety risk assessment found 15 areas of non-compliance with safety standards and best practice. It was not clear who was responsible for these issues and whether they had been rectified. Lift inspections carried out in June 2016 and June 2017 identified signs of rusting on a cable. No action had been taken in respect of this.

Staff were due to complete weekly infection control audits however, an audit had not been documented for the last three months. In this audit staff had marked several areas as 'not being applicable in relation to being free from clutter and in good decorative order. However, observations during inspection demonstrated this was not the case as these processes had not identified the issues found.

Staff had not locked sluice rooms as required. Sluice rooms are areas where used disposables such as incontinence pads and bedpans are cleaned, and disinfected and where hazardous cleaning materials can be kept. We found in once sluice room dirty soiled clothes had been left for more than 2 hours on the floor. They had not been placed in special bags meant for soiled clothes. This increased risk of poor hygiene and infection. The registered manager later informed us that a person living at the home had placed the soiled clothes in the room. This presented as a risk of people entering these areas and exposing themselves to risk of infection or injury.

Staff did not maintain all areas of the home environment in a safe, clean, and hygienic condition. For example, a bathroom on the first floor of the home was partially used for the storage of equipment. The area under the windows was visibly dirty and dusty and there were cobwebs on the window frames. This suggested cleaning staff did not routinely clean or monitor this room. In a bathroom used regularly by people at the service, we observed dirt and human hair around bath hoist rims fitted to the bath. This was not exclusive to one bathroom.

A dedicated maintenance manager worked in the home five days per week and provided out of hours cover. Staff used a maintenance log to identify areas that required attention, such as damage or repairs. We saw the maintenance manager signed off repairs when complete, which was usually within 24 hours. In addition, the maintenance manager completed a weekly walk around of the building and grounds to identify repair needs. Although this system meant care staff could report urgent repair needs, there was not being consistently managed. For example, a bathroom on the first floor had missing and cracked tiles and damaged wall covering at the entrance. A bath panel in a first floor bathroom was broken with two nails

exposed close to floor level. In addition, a hoist partially blocked the entrance, which meant there was limited space for people to use the facility. On the second floor, we found a wire casing had become detached from the wall and was on the floor exposing loose wires and two sharp nails. All of these issues presented a health and safety and/or an infection control risk. There was no record of these things in the maintenance log. It was not evident from these records that an effective preventative programme of maintenance was in place. We discussed these issues with the registered manager who was unaware of the problems. They had not made it a priority to have their own oversight of what areas of the environment needed improvement, to ensure that issues were identified and action taken when needed.

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

Incident and accident forms demonstrated that staff provided appropriate care to people following falls, such as hourly observations after a fall and use of a body map to record bruising. Although staff had completed one accident record fully there was no indication the registered manager had reviewed or audited it. However, falls highlighted within incident and accident forms were not recorded in the homes falls analysis sheet where we observed that there had been no entries between May 2017 and October 2017. Falls analysis is an important tool that can identify if there are recurrent factors leading to falls that can be preventable. Without any analysis, the service could not demonstrate that the service was identifying and mitigating risks of falls from people.
We did not find evidence of learning from incident forms and other documents. However, we did observe that the registered manager took immediate action to rectify the problems we found on inspection in the safe domain. This demonstrates that the service is willing to listen to and learn from feedback, and take appropriate actions when areas of concern are identified. Because of this quick response we have issued recommendations rather than to issue a formal breach of regulation.

The senior team maintained comprehensive health and safety records. However, there was no auditing system to ensure required improvements were tracked and completed. For example, we saw in the maintenance log that smoke seals on some doors on the first floor needed replacing. This was not reflected in the latest fire safety inspection in the fire log although staff told us the fire service had noted the failed seals in a recent inspection. Following inspection we received confirmation that these had been fixed.

A member of staff completed a monthly medicines audit on each floor of the home. We saw each audit resulted in an action plan. For example, in November 2017 the action plan for the second floor of the home was to improve documentation of topical medicines and to ensure medicines were always counted as part of the stock check. Other action plans for November related to missing signatures and a discrepancy between medicines in stock and those signed for. In October 2017 an action plan identified a missing staff signature for the administration of a medicine to one person. However the member of staff had noted on the person's individual audit that there were no errors in administration. Although the audit system was in place to improve safety, there was no indication that actions were followed up or resolved. In addition, the member of staff completing the audit had not always signed it, which meant it was not possible to identify if they followed it up.

Overall action plans lacked attention to detail, including some important information. For example one document from October 2017 asked, "Are there any [medicine] available for [person]?" The same action plan stated for one patient "Will run out today if not ordered." The action plan did not state what the medicine in question was or if the ordering system was improved following this. However, we found a system was in place for the documentation of topical and PRN (as required) medicines. This suggested although action plans were incomplete, staff had made changes to improve medicines management.

We looked at the medication administration records (MARs) of every person who lived on the first and second floor of the home. In each case we saw documentation was fully completed and matched the stock of medicines available. This included PRN medicine, topical creams and spacers and inhalers.

Medicines were stored in line with guidance. A medicines room on the second floor contained two medicines trollies. Both trollies were locked and stored in a locked room. We looked at the management processes for controlled drugs (CDs) and PRN medicines. In each case we found staff had signed appropriate documentation, including double signatures for CDs and for returned medicines. Staff had signed a daily temperature log of the medicines room temperature and the fridge used for chilled medicines. This meant medicines were stored within the safe temperature range identified by manufacturers.

Staff files were inconsistent regarding the usual safety checks carried out on potential staff before commencement of a post. We looked at six personnel files as part of our inspection. All members of staff had a documented identification check on file as well as a record of a candidate assessment to identify if they were a suitable candidate for the post. However, of those six files, two members of staff had only one reference and another individual had no photograph on file. This was contrary to the services own recruitment policy where two references are required.

Staff had a good understanding of safeguarding vulnerable adults. We spoke to six members of staff and in each case they could articulate the principles of safeguarding and how to escalate concerns about neglect or abuse.

The manager told us that people residing at the home were people without behaviours that challenge as the home was not equipped to care for people with complex mental health needs. However, we observed one person shouting in a distressed manner for over 10 minutes. Staff did not engage with the person to see if they were okay. When we spoke to staff they told us, "They are usually like that."

Staff did not demonstrate an understanding of how they could ensure the person was kept safe. Other people in the home were shouting at the person to be quiet, and we observed one person approach to express their annoyance, to which the distressed person reacted with increased agitation. We discussed this with the registered manager who informed us that the person usually stayed in their bedroom. Relatives for the person who visited regularly told us that the person preferred to remain in their bedroom." But there was no understanding from the manager or staff of how to best support this person when distressed.

The home did have positive behaviour charts, a tool used to monitor a person's distressed behaviour to identify triggers to behaviour and what actions staff took to alleviate distress. However, the registered manager told us they rarely used them.

We recommend that where people demonstrate behaviours that challenge, that they have a robust risk assessment and care plan in place which includes the monitoring of the behaviour in line with NICE guidelines. Staff should be supported to gain the skills necessary to identify people in distress and how best to support them to minimise risk to themselves and others.

Staff had access to moving and handling equipment and all staff had been trained and updated yearly on moving and handling practices. However, we observed a moving and handling procedure where two members of staff placed their hands under a person's arm to support them into a standing position. One member of staff had been using a under arm lift. As the person was unsteady on their feet, had they lost balance a full under arm lift would have taken place due to the support holds in use. This type of moving and handling technique is poor practice and risks injury to a person.

We observed a number of different sized hoist slings kept in communal corridors. These were for communal use. It was evident that some had been previously individually used as room numbers had been recorded and crossed out. The registered manager told us that people had their own individual hoist slings, but this was not always observed and staff we spoke to told us the slings we observed were communal, although some people had their own. It is important that people have access to their own individual slings to reduce the risk of infection and cross contamination. One person did have their own slide sheet (a specialist sheet to help move a person in bed), and their own hoist sling and this was good practice.

The service had made fire evacuation plans accessible for staff to read and people had up to date Personal evacuation plans (PEEPS) in place. These plans informed staff how they would move people in an emergency. Staff had been trained in fire marshal training, and a member of staff was assigned to be a fire marshal every shift. We saw that the registered manager tested the fire alarms regularly and these were recorded. However, records in staff notes demonstrated that on one occasion that staff had not acted on the fire test and letters had been sent to staff reminding them of their responsible to respond. The senior team undertook weekly fire drills and the maintenance manager was the designated fire marshal. This individual had completed a fire risk assessment course with the local fire service and care staff had been trained in the use of equipment they could use to help people with limited mobility in an evacuation, such as ski sheets.

The maintenance manager carried out weekly checks on staff call bells. We looked at the records for the previous six months and found them to be consistently documented along with a record of the action taken in response to faults. This member of staff also carried out weekly checks on window restrictors, which we saw were up to date.

The commission had received complaints about poor levels of staffing in the home. We observed that on the day of inspection, there were enough staff to meet people's basic physical health needs. This included staff supporting people with personal care during the morning at a time of people's choosing, and or in line with their documented best interests and preferences.

The registered manager told us that they rarely used agency staff to cover shifts and when they did, they requested agency staff known to the home. All staff worked in pairs whilst providing direct care to people, so if an agency member of staff visited the home they would be paired with a regular member of staff to support them.

Two activity persons were employed by the home who covered activities for people during Monday to Friday. On the day of inspection one of these people was on annual leave. During this time, no cover was in place to provide people with activity. Care staff were busy attending to people's basic needs so we observed that people were sat at the dining table for prolonged periods of time after meals. People received minimal social and engagement time with staff, particularly on the second floor of the home, where people were living with dementia. Supporting a person who has dementia to remain active and still feel involved in life can be the key to maintaining quality of life even into the later stages of the illness.

People told us that they were bored at the weekends. During this time there were no additional staff to carry out activities. One person said about activity, "when [staff name] and [staff name] are here they are brilliant. But when they are not here we get bored and we just sit here. Weekends are boring." We discussed these issues and the Registered manager told us that most people have family relatives that visit at the weekend. However, not all people had visitors over the weekend. This is not in line with best practice guidance, for example; Mental wellbeing of older people in care homes, National Institute for Health and Care excellence (NICE), 2013.

Following the inspection the registered manager took action to improve activity provision, advertising for an additional activity coordinator to cover weekends.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke to at the service, including the registered manager had poor understanding of the Mental Capacity Act, 2005 and Deprivation of Liberty standards. The registered manager had completed a number of Deprivation of Liberty assessments, however they were unaware that they also had to notify the commission of these applications as part of their statutory requirements. They did not understand that they had to complete additional applications for deprivation of liberty for people who were being restricted in some way. For example, for those people where bedrails were used to kept them in bed, but were unable to consent to their use. We immediately brought this to the manager's attention and they took the appropriate action.

The registered manager informed us that when people lacked capacity to consent to care, they often discussed care with families of those people. The registered manager did not know whether members of family had legal power of attorney for health. A Lasting Power of Attorney (LPA) allows you to give someone you trust the legal power to make decisions on your behalf in case you later become unable to make decisions for yourself. Without this information the provider could not ensure that they were making decisions in a person's best interests, as they did not know who had the legal authority to make decisions on a person's behalf.

People residing particularly on the first floor, who lived with dementia, were assisted to bed during the afternoons for bed rest. The registered manager attributed these routines to be the primary reason that no one had a pressure ulcer. However, it was not clear how people had been involved in making the decision as to whether they wanted to have bed rest. We observed a member of staff informing a person that they were now going to have bed rest, without asking them if this was their preference. The registered manager stated that for those who could not consent this routine it had been discussed with families who were happy with the decision. However, no evidence of these routines and discussions were recorded and no best interest discussion's had been completed about this routine, where people lacked capacity to consent.

Staff did not complete capacity assessments in line with best practice under the Mental Capacity Act, 2005. A capacity assessment is used to identify what a persons need is, and then assess with that person if they are able to make a decision about how they receive care to meet the need. These are decision specific, so if a person has multiple needs a separate assessment should be completed for each need. Some assessments documented how staff had engaged with a person to determine the need, but not what the decision was. For example, decisions relating to support required with personal hygiene. "The registered manager acknowledged that this was an area of weakness.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately following inspection, the registered manager demonstrated that they were seeking guidance to improve this area and use a forum that they facilitated for other care managers to review and share best practice and ideas.

The service had a trainer employed to oversee staff training and induction to the service. We saw that a high percentage of staff had received all mandatory training such as moving and handling, safeguarding vulnerable adults, health a safety and mental capacity act. In addition, they had been supported to undertake some virtual dementia training and Parkinson's, and diabetes training. Most training took place via e-learning, and some was delivered face to face. However, as explored in this report, some interactions observed and care provided did not reflect that staff had sufficient knowledge in some areas.

We recommend that the providers carry out a quality review of training to assure themselves that learning has taken place.

Staff used the malnutrition universal scoring tool (MUST) to identify when people may have been at risk of malnutrition. We looked at all of the MUST records for people who lived on the second floor of the home and found staff updated them at least monthly. However, it was not always evident staff acted consistently on changes in weight. For example, we saw between January 2017 and October 2017 three people had a change in weight of 10kg or more. Staff had highlighted this in only one case, which meant it was not clear if the weight monitoring system was effective in enabling staff to identify risk.

The catering manager had completed specialist dietary training that enabled them to prepare meals suitable for people who were lactose intolerant, diabetic, or living with coeliac disease. They had changed the menu rotation from a four-week cycle to a five-week cycle to ensure people had more choice. Each hot meal service included a vegetarian, meat or fish option. In addition, the catering manager ensured a steamed fish option was available on a Sunday as an alternative to a traditional roast meal. A range of snacks was available to people 24-hours, seven days a week including mousse, jellies, and fruit.

We spoke with the catering manager and found homemade snacks were provided wherever possible, including homemade soup. The catering team was trained in providing fortified and modified diets such as for people who needed extra calories. In summer months during nice weather the catering manager arranged BBQ's, adapting menus to suit people's needs and preferences.

Catering staff made sure that the dining experience was enjoyable and encouraged people to eat seated in the downstairs dining room. Tables were laid nicely with napkins and flowers. People were encouraged to sit with others who they enjoyed spending time with to encourage the social event. The catering staff regularly checked that people were okay and enjoying their food. For people with mobility difficulties, waits to be re-seated in lounge areas following meals were long. However, during that time catering staff would offer people drinks, for example a cup of tea whilst they waited.

We observed that people felt safe to complain about the food and that catering staff were responsive. One person informed staff that their egg was overcooked and they immediately apologised and replaced the meal.

However, on the first floor which was home to people living with dementia, the experience of meal times were different. We reviewed records of meals given to people, given from a hot trolley in the upstairs kitchen. There was no evidence of choice being offered. One person told us, "I don't like meat anymore, I find it hard to chew, so I just was given the vegetable's during the Sunday roast." Another person told us of meals, "sometimes they are a bit cold."

One person had been identified as having a very poor diet and the care plan recorded that staff had to encourage them to eat. Whilst they had not lost significant weight, we observed that the person sat for extensive periods of time in front of their meal without staff engagement. Staff told us, "[person's name] they

never eat, but they don't lose weight either."

People had access to fluids should they want it, with juice dispensers in each lounge area. However, there was no choice of what fluids they would like. In the first floor lounge the fluid dispenser had one choice and staff just placed drinks in front of people. One person said, "I have enough to drink but it's not always what I want. I don't always want a cold drink but they don't ask me. I love coffee. When [staff name] is here they know I love coffee and bring me one, otherwise if I have a hot drink they just bring me tea."

Staff did not keep adequate fluid records for people who have been identified as being at risk of dehydration. Charts informed staff to ensure that people had between 6 and 8 cups of fluid a day and that they should report concerns. Staff also completed these forms retrospectively, so it would be difficult to assure themselves what the person had had to drink. For example, if someone cleared away their empty cup or another member of staff had given them another drink in between. We reviewed fluid charts over a period of four weeks and found numerous cases where people had received less than 6 to 8 cups of fluid but no evidence that this had been reported or any action taken.

Staff had suspected that one person had had a urinary tract infection (UTI) which had resulted in some delusional behaviours over a period of three days. However, they had not begun a fluid monitoring chart for this person which would be considered as best practice. Care plans did not inform staff what to do if someone was identified at risk of poor hydration or UTI's. This is important as older people are vulnerable to infection and poor physical health due to dehydration. In spite of this we did observe that people did not go without fluids.

Following the inspection the registered manager was able to demonstrate that they were taking action to investigating underlying causes of frequency of infection

Following inspection the registered manager was able to supply us with evidence that when concerns were identified regarding nutritional and hydration needs, they contacted the relevant health care professionals for support. This included dietitians and speech and language therapists (SALT), particularly when people were experiencing difficulty swallowing.

We recommend that the provider reviews their hydration protocols to ensure that there are clear systems in place for staff to monitor, alert and support people who are not achieving the recommended daily fluid levels. Particularly those people who have been identified as being at risk of dehydration and urinary tract infections, in line with current national guidance.

We also recommend that staff review their understanding of people's nutritional and fluid preferences and how to best support people with these needs who are living with dementia.

The registered manager had developed good links with the local health and social care communities. They were able to access quick support and advice from an independent nurse practitioner, who had oversight of a number of homes in the area. People's care records recorded that they had regular optician and dental appointments if these were needed.

Staff were also able to access a Parkinson's nurse specialist to support people who had this condition. We saw evidence in notes that staff had understood that a person's health had deteriorated and not waited for the six monthly appointment scheduled, requesting to bring it forward. If people required hospital appointments then staff would liaise with the activity leads to see if this could be incorporated as a 1:1 activity for that person, or whether family members could accompany them.

Staff regularly checked people's weight to monitor if additional dietary support was needed. We saw evidence in care plans where staff had sought advice from dietitians. Good processes were in place for monitoring the use of supplementary drinks. Each person had their drinks marked with the day and time they were due. This extra measure meant that people did not miss these prescribed drinks unless they refused them.

The environment of the home was tired and worn in places, there was evidence that staff had made the effort to make areas of the home inviting, adapting it to the needs of people. For example, the downstairs dining room was particularly pleasant and offered up a good social opportunity for people using it.

There was a large light room at the back of the home where the activity lead had previously facilitated a gentleman's club and film nights. However, this had not been used for some time due to staffing issues. The activity lead informed us that this was about to be up and running again, and that they had offered the same opportunities for woman, however there had not been the same uptake.

People's bedroom areas were decorated nicely and personalised, including people's soft and hard furnishings. This made people feel more at home, and we saw that people's bedroom spaces had been kept clean and tidy. However, lounge areas were not always inviting. In the large lounge area chairs were sat in a waiting room style around the walls. This is not best practice for an environment for people living with dementia as it does not encourage social interaction with others, or opportunities for different people to use the communal area for different ways. We did however, see a number of dementia friendly activities around the home, including sensor blankets and boards, and that some people had their own dolls and enjoyed hugging them and caring for them.

We recommend that the service seek advice and guidance from a reputable source about the design of dementia specific settings to enhance the safety and suitability of the environment for the benefit of people with dementia using the service.

Requires Improvement

Is the service caring?

Our findings

Whilst people and relatives told us that staff were caring, we found that this area required improvement. Staff spoke to people respectfully and maintained people's dignity, however interactions observed needed some improvement to ensure that they were person centred and meaningful.

People living at the home told us that "most" care staff were kind and caring. However, one person told us, "It's okay here, some staff are nice, I like it when people stop and take time to speak to me, but many walk up and down this corridor with their heads in the air like I don't exist." Another person said, "They are lovely [staff], very kind, just very busy."

Staff were observed supporting two people who were unable to verbally communicate to eat their meals. They gave frequent reassurance such as, "that's good," "here you go," but they did not actually tell the person what they were being given to eat. There was little meaningful interaction. After we left the room we heard care staff talking to each about their own lives, rather than to the people they were helping. This is not a respectful approach.

We observed numerous positive interactions between catering staff and care staff towards people living at the home. For example, staff getting down to a person's level and asking them if they would like anything or if they were comfortable. Care staff spoke in a caring manner towards people. However, interactions were limited for those who had poor verbal communication skills. When staff used moving and handling equipment, we saw they constantly gave reassurance to the person being moved, for example in a hoist (a machine that can lift people in a sling from a chair or bed), but they did not explain to people what they were doing with them. For example, asking permission to move them, informing them why they were being put into a sling, when they would be lifted into the air and what they would be doing next.

We spoke to a person in distress who told us they felt low in mood due to poor mobility and memory problems. A member of staff demonstrated a kind approach to the person, demonstrating they knew the person well and was able to engage them in conversation encouraging the person to explain to inspectors a shared positive life experience. However, the subject of the distress was not revisited. The member of staff told inspectors, "[name] is often like that because they can't walk anymore," but this had not been explored to see if any additional support could be given to the person. It had just been accepted that this was the way it was and not if there were any additional measures that could be taken to manage the person's emotional distress and care note entries did not reflect the person's low moods.

The activity lead carried out monthly resident meetings to see what type of activities people liked, whether they wanted changes to activities and whether they would like changes to food menus. The registered manager told us that they did not attend these meetings, however, were able to provide us with minutes from these meetings which demonstrated when people wanted some changes to activities or food menus these were made.
The activity coordinator fed back any concerns to the manager who would support staff to make necessary changes.

Staff respected people's right to privacy in all interactions we observed. For example, staff demonstrated discretion when supporting people to a private area when they required personal care. We observed staff moving people with a hoist, ensuring that clothing was straightened and people's dignity was not exposed. Staff were observed providing care to a person at the end of their life. Interactions were gentle and kind as they made the person comfortable at regular intervals.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not include information of how to support people to be independent. For example, health and well-being care plans and person care plans gave an overall description of what care was needed, but not what a person could do for themselves. We observed that this area had been highlighted in April by the local authority quality team, however there had been no changes reflecting recommendations at the time of inspection.

The registered manager told us that they had not cared for many people requiring end of life care at the home. However, many people at the home had been resident there for a number of years and the home would experience an increase in this type of care provision, as the population of the home aged. Care plans for a person nursed on end of life care had not been updated to reflect in end of life needs. It is important that these are urgently completed once end of life care has begun so that clear instructions are given to staff supporting people with these needs. Best practice would be to consider people's end of life preferences and needs on admission to the home and at regular reviews.

However, whilst staff had not updated the care plan, we did see that staff regularly checked and cared for the person. We saw that interactions of personal care were gentle and caring and ensured that the person was kept comfortable and pain free. We discussed the issues around the lack of instructions for staff with the registered manager, who immediately addressed these concerns to ensure that staff had the information needed. The new plans were thorough, but lacked information about how the persons emotional needs could be met. For example, would sounds from the environment around them offer comfort, or did they had favourite music they would like playing in the background, should staff should spend time sitting with them in the absence of family to offer some comfort.

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

We had received intelligence that people were being woken very early to get up for the day due to lack of staff. Due to these concern's we visited the service at 06:30hrs and found that people were being supported to sleep and wake at times that met their individual needs and preferences.

The registered manager and senior staff completed people's care plans and these were reviewed monthly. However, care plans did not always reflect people's preferences and needs and did not provide staff with the information they needed to carry out certain tasks. For example, communication care plans contained generic statements and did not explore whether there were any barriers to communication or if staff needed to use different techniques or additional resources to support people to communicate.

Details of how to complain were displayed in the entrance of the home. This information was also contained in the service user guide given to each person when they arrived at the home. People told us, "I feel able to tell staff if I am not happy with something and they listen." We spoke to relatives who told us, "I have not really had to make a complaint, although have complained about [name] wheelchair being dirty. It still is

dirty though. Although I have no other complaints, they are all very good."

We had received some complaints from relatives of loved ones who lived at the home about feeling unable to raise concerns and complaints with the registered manager. These concerns included having to make an appointment to speak to the manager and the manager not being approachable. We did observe that a sign was placed on the manager's door which stated, "Do not disturb if the door is closed."

We recommend that the registered manager reviews signs in place to support people to come forward with concerns about care.

We recommend that the provider access some end of life training for staff and review current National Guidance for end of life care provision. This will support staff to provide care for people nearing the end of the lives, focusing on not only the physical aspects of care, but also how to ensure that interactions and support are provided in a person centred way.

Requires Improvement

Is the service well-led?

Our findings

The provider had a clear visions and values which were activity based and aimed at supporting people to remain independent. However they did not measure how they were achieving this and in evidence previously referred to in this report, it was difficult to demonstrate how staff would know how to support individuals to remain independent. In spite of this we did observe that staff knew people well and had developed good relationships with them and their families.

The registered manager did not have systems in place to ensure information and confidential data was stored securely. For example, a file containing personal information had been left on top of a filing cabinet in a bathroom on the first floor of the home.

We recommend that the registered manager and provider review how information is stored so that it can be kept confidential in line with the Health and Social Care Act, 2008

The registered manager did not have robust processes in place to follow up staffing concerns. For example, they told us that there had been concerns about some members of night staff not carrying out allocated cleaning duties, such as cleaning moving and handling equipment and wheelchairs. We had observed that moving and handling equipment and wheelchairs were dirty. The registered manager told us that they intended to introduce a new member of night staff to oversee that staff were carrying out the roles correctly. However, this person would be a peer member of staff of equal responsibility. There was no managerial oversight of staff who had refused to carry out cleaning duties. The registered manager had identified there was a certain culture amongst staff but taken no direct measures or action to address these issues. For example, supervision of staff around these issues, night visits, night staff meetings to ascertain if there were any difficulties, or even disciplinary actions. This lack of action whilst acknowledging a poor culture could place people at risk of neglect.

As previously mentioned in the safe domain, we found issues around the general maintenance of the environment. However, the registered manager told us they did not know what these issues were, they did not know work that was needed and did not have recorded action plans and completion dates for works necessary. They informed us that this was the responsibility of the maintenance person. However, as the registered person it is essential that the manager and the provider have a through oversight of all aspects of the service so they can be assured of the safety and quality of the service. In addition, audits in place to monitor the cleanliness of the home, also documented within the safe domain, did not reflect our findings on the day of inspection.

Whilst the provider had a number of processes and systems in place, observations and review of information demonstrated that there was no oversight to ensure these were affective. Consequently, the evidence above supports a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service were encouraged to engage in regular meetings with the activity coordinator to

discuss issues such as the food provision and activities at the home. Feedback for these meetings was positive. However, we noted for those people who were living with dementia, the service had not been able to create ways to support their involvement in the general running of the service. For these people, opportunities to support them to live well with dementia were lacking. For example, seating areas in lounges were arranged in waiting room type format, sat around the edge of the room, instead of being broken up into smaller social spaces.

Whilst the registered manager and senior care team carried out a variety of audits to measure the quality of the service provided, audits did not identify learning objectives when areas needing improvement were found. For example, we had found issues with infection control and cleanliness. Audits in these areas either were ticked or had N/A (non-applicable) written by checks. We had been informed that there was an issue of night staff not carrying out certain activities related to these audits, but this had not been reflected anywhere.

Staff files demonstrated that there was not always a culture of positive and open communication between the senior team and all other staff. For example, four members of staff had notes on their file that were disciplinary in tone, including the failure to act on a fire alarm and a lack of communication when a person's condition deteriorated. The letters contained no action plans or outcomes about how staff would be monitored and managed in relation to concerns, and in some cases it was not clear why they were in individual staff files. Consequently, we could not see how learning had taken place for these identified members of staff.

The registered manager had begun hosting a registered manager meeting, monthly at the service. These had arranged these after identifying that there were limited resources and support available in the local area. Registered managers from across the region attended to discuss best practice and concerns about service provision and how to address these. This was an innovative idea and one that had proved to be popular. The registered manager had even supported other managers to access training for their staff at Glengariff residential home, at no cost. To encourage engagement the registered manager offered a light lunch to those attending at no additional expense, and offered managers an opportunity to make suggestions for the meetings content, example exploring concerns and best practice. This type of networking will support the service to improve going forward and shared learning is excellent practice.

In addition to this the registered manager and staff at the home and built good relationships with other health and social care professionals to ensure that people at the home received timely input for any physical conditions and need. Professionals told us, "The manager is very good, really cares about the people in her care." Another said, "I find that any advice I give is taken and shared with staff, I'm happy with the care that [name] receives."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The services values and visions aligned with the principles of supporting people to be independent. However, care plans were not always person centred, and did not provide the information staff needed to support people to achieve their potential. Personal preferences were not explored. For people living with dementia, care was not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff had a poor understanding of mental capacity and completing assessments. For people lacking mental capacity staff made decisions on how they should be cared for. Staff did not know if people had Last power of attorney to support with decisions over their health and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Whilst processes were in place to monitor good infection control, these were not adhered too and we observed a number of concerns about the cleanliness of the environment. Safety concerns were found with some of the fixtures and fittings that had not been reported in the maintain log. There was no recorded action plan and timeframe to make necessary

improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits in place did not identify the shortfalls found by the inspection team. In some cases incorrect information was documented. This included environmental concerns and medicine errors. The registered manager and provider did not have sufficient oversight of staff completing these audits to ensure that the information gathered to measure of the safety and quality of the environment and care given was of a good standard.