Care Quality Commission

Mr & Mrs L Difford
Red Gables
Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
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?	**Requires Improvement**

Overall summary

The inspection took place on 19 August 2015 and was unannounced.

Red Gables provides care and accommodation for up to 32 older people who are living with dementia or who may have physical and mental health needs. The provider also offers a day care facility. On the day of the inspection 22 people were living at the care home.

The home was on two floors, with access to the upper floor via stairs or a passenger lift. Some rooms have en-suite facilities. There were shared bathrooms, shower facilities and toilets. Communal areas included two lounges, a dining room, a conservatory and outside seating area.

The service had a registered manager in post. 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.

Summary of findings

After our last inspection in September 2014 we told the provider to take action to make improvements to how the quality of the service was monitored. During this inspection we looked to see if action had been taken and whether improvements had been made. However, we found this had not happened.

People told us staff were kind and caring, and treated them with respect. Relatives told us they were happy with the care their loved ones received. People told us there were not enough staff and because of this, staff did not always have time to talk to them and social activities were limited. People's social life was not promoted, and some people told us they were bored. People felt staff were competent, however, people were not supported by staff who had the knowledge, skills, experience and training to carry out their role.

People were supported to eat and drink enough and maintain a balanced diet. The chef and kitchen assistant were knowledgeable about people's individual nutritional needs. People who required assistance with their meals were supported in a kind and dignified way. People told us the food was nice. The design of the menu and the process by which people were asked what they would like to eat, was not reflective of the principles of dementia care. People's care plans did not always provide detail to staff about how to meet people's individual nutritional needs.

People felt safe living at Red Gables. The registered manager understood her safeguarding responsibilities; however, staff did not always understand how to recognise abuse and did not know how to raise a safeguarding alert with external agencies. People did not always have a call bell in reach to alert staff if they needed assistance. Some of the call bells were not working correctly. People were not always protected by safe recruitment procedures as the registered manager could not confirm if all employees were subject to necessary checks which determined they were suitable to work with vulnerable people.

People were not protected from risks associated with their care because staff did not have the correct guidance and direction about how to meet people's individual care needs. People did not have personal evacuation plans in place, which meant people may not be effectively supported in an emergency. The environment was not regularly assessed and monitored to ensure it was safe at all times.

People's mental capacity was not always being assessed which meant care being provided by staff may not always be in line with people's wishes. People who may be deprived of their liberty had not been assessed. Staff did not understand how the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) protected people to ensure their freedom was supported and respected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

People did not always have care plans in place to address their individual health and social care needs. People were not involved in the creation of their care plan. People's care plans were not always legible which meant staff may not always be able to read or understand them. External health professionals did not have any concerns and explained they were contacted appropriately when required.

People's end of life wishes were not documented and communicated. This meant people's end of life wishes were not known to staff. People's medicines were not managed safely. Staff were not always trained to administer medicines, and documentation was inaccurate which meant it was not always clear if people had received their medicines.

People's confidential and personal information was not always stored securely and the registered manager and staff were not always mindful of the importance of confidentiality when speaking about people's care and support needs in front of others. People did not always have a lock on their bedroom door and had not been asked if they would like a lock.

People who were living with dementia were not always appropriately supported in a person centred way. People's care plans did not address dementia care needs and demonstrate how they would like to be supported.

Summary of findings

The environment was not designed to empower people living with dementia, because of poor signage and a lack of colour contrast. People were not always protected by effective infection control procedures; because the ordering of stock meant that at times there were no paper towels in some of the bathrooms.

People did not know about the complaints procedure but told us if they had any concerns or complaints, they felt confident to speak with the staff or registered manager. Staff felt the registered manager was supportive. Staff felt confident about whistleblowing and told us the registered manager would take action to address any concerns.

The registered manager did not have effective systems and processes in place to ensure people received a high quality of care and people's needs were being met. There were no opportunities for people to provide their feedback about the service, to help ensure the service was meeting their needs as well as assisting with continuous improvement. The Commission was notified appropriately, for example in the event of a person dying or experiencing injury.

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?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs.

People were not protected from risks associated with their care and

documentation relating to this did not reflect people's individual needs.

People were not protected from risks associated with the environment.

People were at risk of not receiving their medicines as prescribed because documentation relating to medicines was inaccurate.

Safe recruitment practices were not always in place as checks were not always carried out to ensure new staff were of good character and safe to work with vulnerable people.

Staff had limited knowledge about external agencies involved in safeguarding procedures, which meant staff may not always make safeguarding alerts when they were concerned people may be subject to abuse or mistreatment.

People told us they felt safe.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

People were supported to eat and drink enough and maintain a balanced

diet. However, people's care plans did not always provide detail to staff about how to meet people's individual needs.

People were not protected by the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) which meant people's freedom was not always supported or respected.

People received support from staff who did not always have the necessary knowledge, skills and training to meet their needs.

People were not always able to maintain their independence, because the environment did not promote the principles of dementia care.

People's changing care needs were referred to relevant health services in a timely manner.

Is the service caring?

Requires Improvement

Aspects of the service were not always caring.

People's confidentiality, privacy and dignity were not always respected.

Summary of findings

People's choices and wishes for the end of their life had not been considered or communicated to staff. This meant staff did not know how to meet people's individual needs.

People told us staff were kind and caring.

Is the service responsive?

Requires Improvement

Aspects of the service were not always responsive.

People were not involved in the design and implementation of their own care plan which meant care planning documentation was not reflective of their wishes.

People's care plans were not individualised and did not always give guidance and direction to staff about how to meet people's care needs.

People's independence and social life were not promoted, which meant people had very little to occupy their time.

People could raise concerns and complaints. People felt confident action would be taken.

Is the service well-led?

Requires Improvement

The service was not well led.

People and staff were not encouraged to provide feedback about the running of the service.

People did not receive a high standard of quality care because the registered manager's systems and processes for quality monitoring were ineffective in ensuring people's needs were met and the environment was safe.

There was a management structure in place and staff were well supported by the registered manager.

Red Gables

Detailed findings

Background to this inspection

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

We visited the home unannounced on 19 August 2015. The inspection team consisted of two inspectors and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection, we spoke with 17 people living at the home, four relatives, seven members of care staff, the chef, a kitchen assistant, the registered manager and a chiropodist. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how people were supported at lunch, and watched how staff interacted with people during this time.

We observed care and support in communal areas, spoke with people in private and looked at five care plans and associated care documentation. We also looked at records that related to medicines as well as documentation relating to the management of the service. These included policies and procedures, staffing rotas, three staff recruitment files, training records and quality assurance and monitoring paperwork.

Before our inspection we reviewed the information we held about the home and spoke with the local authority. We reviewed notifications of incidents that the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law.

After the inspection we contacted local commissioners of the service who funded people who lived at Red Gables to obtain their views and the local authority service improvement team. We also made contact with two GP practices, one psychiatric nurse, and the community district nursing team.

Inadequate

Is the service safe?

Our findings

People told us there were not always enough staff to meet their needs, "no one comes to chat…only when they bring the laundry", "sometimes I feel like a blooming nuisance…I wanted to go to bed early but I had to wait" and "no one comes in to have a chat. They only come in to clear up or bring the laundry" and "staff call in now and again but they have their job to do and don't have a lot of time to sit and chat. A relative told us, "staff always seem so busy…there are not enough staff here".

Staff also told us staffing levels were insufficient to meet people's needs, comments included, "residents who are in their rooms all day need company. We just don't have the time", "the care is good, but there is just no time for a chat" and "the cleaners spend more time with the residents than the care staff do. Residents in rooms all day need company. Routines are poor, sometimes they don't eat breakfast until 11am and then they are not hungry for lunch". The registered manager explained care staff had a dual role; as well as caring and facilitating social activities, they were expected to work in the laundry. During our inspection staff spent time carrying out personal care and domestic tasks and had limited time to spend with people.

The registered manager told us she was not able to increase staffing when people's needs increased, for example if someone required end of life care, because her manager had overall responsibility for decisions relating to staffing requirements. There was no staffing dependency tool used to help ensure the correct numbers of staff were on each shift.

There were staffing vacancies at the care home, and on the day of our inspection the registered manager told us the staffing in the afternoon was reduced by one person because of the vacancies.

The provider was providing a day care service and on the day of our inspection there was one person attending Red Gables. However, it was not clear how staffing levels were being considered in relation to this, and the impact that additional people coming into the home may have on others.

We found people's social and, at times, their individual needs were not always being met because the staff were not deployed in sufficient numbers. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People explained how they used their call bell to alert staff if they needed any help, one person told us, "If I need help I press the alarm button and staff come running". However, not everyone knew about their call bell, one person told us, "I don't know anything about a call button. If I had an emergency I would have to shout loudly". People did not always have a call bell in reach should they require immediate support, for example, people who spent the day in the dining room or lounges did not have access to a call bell. People who finished their breakfast had to wait for staff to return to assist them, because there was not a call bell available to them to call for assistance. This meant people experienced a delay in their support.

The call bell system was not effectively working on the day of our inspection, and it was in need of repair. For one person who had recently moved, they were unable to have a call bell because it had been given to someone else, this meant staff had to regularly check this person throughout the night to help ensure their safety. The registered manager showed us emails to evidence they had frequently spoken to their manager about the call bell system and had asked for it to be repaired.

People lived in an environment which had not been assessed to ensure its safety, for example hot water was not regulated to ensure that it did not scald people, radiators were not always covered, windows on the upper floor were not always restricted and a carpet on the ground floor was rippled and was a trip hazard. Doors which should have been locked to stop people from entering them because of risks were not always locked, for example the laundry room and a person's bathroom which was under construction with electrical wiring in progress. There were no environmental risk assessments in place to assess these risks and to identify the necessary action to minimise the risks for people. People's bedroom doors were manually propped open with door wedges, and this had not been considered in line with fire regulations and the home's fire risk assessment. We referred our concerns to the fire authority.

Some relatives were concerned about the security of the home and told us "I just walk in. Anyone can just walk in.

Inadequate

Is the service safe?

My husband could just go out by himself if he felt like it. It needs to be more secure", and "My […] has dementia and it does worry me that if there was no one around to keep an eye on him, that he could wander off. That front door is not secure". The registered manager explained people were free to come and go as they pleased, but the door was locked at 4pm because of staffing, however, this had not been risk assessed in line with people's individual needs.

People did not have personal evacuation plans (PEPs) in place which meant, in an evacuation, emergency services would not know what level of care and support people may need.

We found risks had not always been assessed and monitored in respect of the environment. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's risk assessments, that give guidance to staff about how to minimise associated risks related to people's individual care needs, were not always in place. For example, some people had bed rails to protect them from falling out of their bed. However, there were no risk assessments to help staff ensure risks relating to the rails were minimised, for example to eliminate the risk of entrapment.

People who were at risk of pressure damage did not always have risk assessments in place to help minimise the risk of skin and pressure sore damage. For one person who remained seated for the majority of the day, they did not have a risk assessment in place.

Risk assessments had not always been regularly reviewed, as some were dated February 2015 and when they had been reviewed the information was not always accurate. For example, a falls risk assessment which had been reviewed contained incorrect information, as it stated the person used a stand aid to assist with mobility, but they were currently using a hoist.

We found risk assessments were not always in place as necessary, updated, and reviewed. Risk assessments were not always reflective of people's individual needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not record falls to help identify any themes and trends in relation to staffing.

People were not always protected by effective infection control procedures, because in some bathrooms there were no paper towels available for people and staff. The registered manager explained this was because they were not always ordered by their manager.

People's medicines were not safely managed; the door to the medicine room was unlocked throughout the duration of our inspection as it was also being used as a staff room. The temperature of the room was not being recorded and monitored to ensure medicines were being stored correctly. The recording and documentation relating to people's medicines was inaccurate, for example, medicine administration records (MARS) were not consistently signed to show people had received their medicines. The storage and recording of controlled medicines was not accurate.

We spoke with the registered manager about our concerns; we were told there was no system in place to ensure medicines were being managed safely.

People did not have care plans in place to provide guidance and direction to staff about how they would like to be assisted with medicines, for example one person was given four tablets to take at once, as a result of this the medicine got stuck in the person's throat and the person began to cough. Staff were not always trained to administer medicines, so the registered manager was sometimes contacted on her day off and out of hours. This meant people may not always get their medicines when requested or required.

We found the management of medicines was unsafe and ineffective. Documentation relating to medicine management was not being completed accurately. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by safe recruitment procedures. Staff recruitment files did not always demonstrate the provider was following safe recruitment practices to ensure all employees were subject to necessary checks to determine they were suitable to work with vulnerable people. For example, disclosing and barring service checks [DBS] were not always in place and references had not always been applied for. The registered manager told us, "I know the files are not up to date".

Inadequate

Is the service safe?

Recruitment procedures did not always ensure people who were employed were suitable to work with vulnerable people. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of her safeguarding responsibilities. Staff had received training in safeguarding; however, staff had a limited understanding of safeguarding procedures. For example staff did not always understand how to recognise abuse or who to contact if they had suspected someone was being abused or mistreated, other than the registered manager.

People told us they felt safe living at Red Gables, comments included, “I feel safe here”, “I feel safe here, if I need help I’ve got it” and “I feel safe here, very safe”. A relative told us, “She’s happy here and the family are satisfied that she is safe”.

Requires Improvement

Is the service effective?

Our findings

People's mental capacity was not always being assessed which meant care being provided by staff may not always be in line with people's wishes. The legislative framework of the Mental Capacity Act 2005 (MCA) was not always being followed. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. For example, for one person their care plan stated they relied on others to make decisions for them, however, there was no evidence of how this person's mental capacity had been assessed to make this decision. There was no record of "best interest" meetings.

Some of the people who lived at Red Gables were living with dementia. People's care plans did not always contain guidance and directions for staff about how to support people when they did not have the capacity to make decisions for themselves.

People who may be deprived of their liberty had not been assessed. The deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. One person sat in a recliner chair with their legs up for the duration of our inspection and spent time alone in a lounge, with little interaction from staff. The person was unable to independently leave the chair without staff assistance. The registered manager told us this person became anxious around others, so it was appropriate she spent time alone. There was no information in this person's care plan about the chair and the implication of the restriction in respect of this decision. The person's care plan showed no evidence of mental health professionals to help ensure the person's needs were being met. The registered manager told us the person had been discharged from the mental health service, however, no action had been taken by staff to contact the mental health service to review the person's care needs. We were concerned about the care and support this person was receiving so we informed the local authority safeguarding team.

Staff had a limited understanding about the principles of the MCA and DoLS and we were unable to confirm if all staff had received training because the training records were not up to date. Staff however told us, "I do not know anything about DoLS and MCA" and another staff member told us they had completed their training so long ago, they could no longer remember what it entailed.

The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received regular supervision or appraisals because the registered manager explained she had also been working as a member of the care team to cover shifts. However, staff we spoke with said they felt well supported. The registered manager told us staff had not received regular training because the responsibility for booking training was with their line manager. We were unable to determine what training staff had completed, because staff files were disorganized and the registered manager's spreadsheet to record what training staff had completed and when had not been updated. Training certificates for some staff had expired and there was no evidence to show staff had been trained in courses relating to the people they supported, for example in diabetes or pressure area care. One member of staff told us "we don't have enough training". The registered manager confirmed some staff had not received manual handling training for over two years, and was concerned some bruising to people's skin was as a result of this.

Red Gables provided care and support for people who were living with dementia. People were not supported by staff who were all trained in dementia care and did not demonstrate the principles of dementia care.

People did not receive care and support from staff who had the right knowledge, experience and skills to support people. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived with dementia were not supported to remain independent and have their individual needs met because the environment did not promote the principles of dementia care. For example because of poor signage and colour contrast, one person regularly walked around and asked more than once "where do I go". People could not remember what day it was and asked an Inspector. There was a board in the corridor to display this information but it

Requires Improvement

Is the service effective?

was incorrect. The registered manager recognised that changes were needed to the environment and told us she would like to make improvements and had discussed this with her line manager.

People told us the food was nice. People were supported to eat and drink enough and maintain a balanced diet. The chef and kitchen assistant were knowledgeable about people's individual nutritional needs. The kitchen assistant explained about the meals which were prepared carefully for one person who had suffered with a stroke. Nutritional supplements were requested for people when there was a concern about their weight.

People were given a variety of choices from a menu but were also able to request alternatives. The chef explained people were asked the day before what they would like to eat. For people who lived with dementia, this process may not be suited to meeting people's needs, as people may forget what they have ordered. There were no visual prompts for people to remind them of what was for lunch and the menu was not displayed.

People could choose if they wanted to eat their meal in the dining room or elsewhere, one person told us, "I can choose whether I eat meals up here or go down with the others". People who had eaten their breakfast after 10am had their lunch at 12.30pm. Although we were told people could choose to have their lunch later, people were not offered this option.

People were seen to be supported at lunch time in a kind and dignified manner and were given encouragement when they needed it, for example a member of staff was heard to say "if you're struggling, just use your spoon" and people were offered any assistance to cut up their meal. People who were unable to support themselves were assisted by staff in a respectful manner. An explanation was given to the person about what their pureed meal was before the person tasted it, and people were assisted in an unhurried manner.

People's care plans were not always accurate about the support people required with their nutrition and hydration. For example staff were recording the intake of one person's food and drink. However, the reason for this was not recorded in the person's care plan. There was no guidance to show how much the person should be drinking and whether the charts which were being completed by staff were being monitored, so responsive action could be taken when necessary. The registered manager was in the process of updating all the records to ensure accuracy.

People told us they had confidence in the competence of care staff, they explained "the people here look after me well", "the girls know their job" and "staff look after me well".

People confirmed they had access to external health professionals, such as GPs and district nurses and documentation supported this. External health professionals were complimentary of the care and support staff provided, and told us they were contacted in a timely manner. The registered manager explained, "we have a fantastic support from the district nurses….they are always on the end of the phone".

Requires Improvement

Is the service caring?

Our findings

People had not been involved in the creation or review of their care plan to ensure it was reflective of how they wanted their health and social care needs to be met. People's end of life wishes were not care planned. During our inspection end of life care was being delivered and external health professionals were supporting one person. However, the person did not have an end of life care plan in place. This meant the person was at risk of not having their choices and wishes for the end of their life met because there was no written information for staff to follow. The registered manager told us about music this person had enjoyed listening to in the past. However there was no evidence to show that staff knew about this to make sure the person's choices were respected.

People's records were not always kept secure. The office doors which stored people's confidential personal information was left open and unlocked, which meant people's confidential files were accessible to anyone in the home.

People's confidentiality was not always respected, for example the registered manager spoke with a member of staff in the dining room about the care needs of another person. The conversation was held in front of another person who lived at the care home, as well as being able to be overheard by others.

People's dignity and privacy were not always protected as there were no locks on bedroom doors and people had not been asked if they would like a lock. A member of staff explained, "we don't have locks on the doors because of health and safety reasons. If somebody needed help, we wouldn't be able to get into the room to help them".

People were complimentary of the staff who worked at Red Gables and of the support they received. They told us "the staff are kind, they help me do things, help me get dressed, the attention you get is quite sufficient for what I need", "the staff are very kind to me", "the care here is very good. I'm very happy here. The girls look after us really well and sometimes we are a blooming nuisance" and "they look after me well, I like it here. They are all so nice. Staff are kind and calm. It's nice to know that the people who look after me are always very gentle and very kind".

Staff were kind and caring when they interacted with people. They communicated with people in way which suited their needs and staff demonstrated familiarity and knowledge of people's likes and dislikes. Staff called people by their preferred name.

The registered manager told us "they are all very special people…they should be treated differently, they're all individuals". She told us, "I do have my expectations… I do expect people to be treated with dignity and respect". A member of staff told us, "we treat the residents with respect. I put myself in their shoes…and treat them as I would expect to be treated". People told us they were treated with respect, "the staff are kind to us and treat us as individuals" and a relative told us "My […] is treated well. They treat her with dignity and respect".

We recommend the provider considers research and published guidance in relation to the design of the care home environment and its connection in providing an enhanced level of care for people living with dementia.

Requires Improvement

Is the service responsive?

Our findings

People told us there was not enough to do. Comments included, "I do get a bit bored. Need more things to do. My […] takes me out when he can but he's busy. The staff take me out for a walk sometimes but I spend hours up here on my own and bored", "I can't see very well now. I used to love knitting. Sometimes I get bored stiff. Staff call in from time to time but they have a job to do, no time to sit and chat" and "I get a bit lonely sometimes, my […] comes and takes me out. I would love to go to a football match but that's not possible anymore. I have to watch it on the telly".

Relatives told us, "there are no activities that I've seen, […] just reads his books and watches the TV" and "I visit every day and I've never seen any games going on".

On the day of our inspection, people participated in a game of bingo; however, for the majority of the day, people chose to stay in their bedrooms or were sitting in the lounge with the TV on. People were not given a choice of channel by staff and showed no interest in the programmes. Staff told us, "we try to play bingo once a week. No time for one to one games. There is a need for more activities" and "we care for the residents but we don't have time to do any one to one. We wash and dress and move on".

People did not always have a care plan in place. For one person who had lived at Red Gables for over a month; there was no care plan or risk assessments in place. The registered manager told us this was because she was waiting for a social worker's assessment. This meant staff did not have the necessary information about how to meet this person's health and social care needs.

People's care plans did not guide and direct staff to deliver consistent care. For example, one person's care plan stated they required full assistance to carry out any task; however, there was no information about what these tasks were. Another person experienced anxiety but the care plan did not detail how this person should be supported when this occurred.

Care plans in place to support people with their mobility were not always descriptive, for example they did not detail the equipment a person used, or how many staff were required to assist them. People did not always have medicine care plans in place specifically when they were taking a controlled medicine for pain. People who had diabetic care needs did not always have detailed care plans in place to give guidance and direction to staff about what action to take if the person became unwell.

People's care plans did not always include a personal history so staff were aware of what a person achieved in life prior to getting older and moving into Red Gables. A person's history helps to enable staff to have meaningful conversations with people and tailor social activities to people's past interests and memories. This is particularly important when supporting people who are living with dementia.

Care plans were not regularly reviewed and changes to care plans were not always made. For example, the care plans for two people stated they should be encouraged to socialise, however, one of these people was at the end of their life and we were told the other person became anxious around others. Care plans were not always legible and as a response to this the registered manager was in the process of typing them.

Care plans were not always in place and did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were supported with their personal care and were able to have a bath or shower once a week on their allocated day. They told us their clothes were washed and ironed. People told us, "they look after me well, I like it here", "I need help to stand up and there is never any hurry. They care for me really well, help me onto the walking frame. When I need them, they come; otherwise I don't see anybody till my family visit" and "the girls look after me, help me to dress myself". A relative told us, "they handle her gently, she is comfortable, safe, well fed and her personal hygiene is well taken care of".

People did not know about the complaints procedure which was displayed in the entrance of the care home, but told us they were confident the registered manager would listen to their complaints and act upon them, "If I had a complaint I would tell the manager. I've never had a complaint about anything…everything is fine…I've no worries at all", "I'm not aware of a complaints procedure. I

Requires Improvement

Is the service responsive?

would tell one of the seniors if I had a problem and I'm confident it would get sorted out", and "If I had a complaint I would tell the manager but, so far, I have nothing to complain about".

The registered manager told us there had been no complaints although was aware of people's concerns about staffing arrangements. There was a complaints policy which outlined the procedure which was to be followed, the last documented complaint had been in 2014, but we were unable to confirm if the complaints procedure had been followed effectively because documentation was missing.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2014 we found the quality monitoring systems were not effective in identifying areas that required improvement. At this inspection we found that improvements had not been made.

People did not receive a high standard of quality care because the provider did not have systems and processes in place to help ensure the service met regulations in respect of the planning of people's care, meeting people's individual needs, staffing, the management of medicines, the environment and the implementation of the legislative framework the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS).

The registered manager told us every two months she walked around the care home with the maintenance man and created a list of work which was required. This list was then sent off to her line manager for action. However, their observations had failed to pick up on the risks we identified. There was no action plan in place for the ongoing upkeep and maintenance of the building. We found some carpets throughout the building were badly stained and puckered in places increasing the risk of trips and falls.

The registered manager explained a manager of the organisation used to carry out quality audit visits; however, this had not taken place recently. The last recorded visit had taken place in 2013 and reflected previous regulatory legislation.

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a "quality policy" in place which stated that to monitor "client satisfaction" people's views would be obtained by the completion of a questionnaire; however, this had not occurred. There were no current systems in place to obtain people's feedback.

Policies and procedures had not been regularly reviewed and were not always reflective of current legislation which meant staff may not always have the correct information. For example, the mental capacity policy did not reference the changes which came into force in April 2014 and the safeguarding policy did not reflect the recent changes within the local authority. The registered manager told us she was not able to update policies as she did not have the authority to do this.

The registered manager did not receive effective support or supervision; she had not had any opportunity to discuss her training and development with the provider. The registered manager spoke openly about the pressures staffing vacancies had had on her ability to effectively manage the care home, and as a result of this, told us things which should have been in place were not.

People were able to speak with the registered manager at any time, and during our inspection the registered manager made themselves available to people at all times. Staff told us they felt well supported by the registered manager and had confidence in her leadership, "we have every confidence in […]. She is fair to us, and works hard herself. She often works 70 hours a week. She is a brick". A relative told us, "this place is managed really well; it's always clean and fresh in my Mum's room".

Staff had whistle blown in the past about concerns about staffing practice and told us, "we told the manager and she held a meeting with all the staff and explained the jobs to them. They even got a bit of training. It improved after that".

The registered manager had notified the Commission of significant events which had occurred in line with their legal obligations, for example when a person had died, expectedly or unexpectedly.

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 Regulation 9 (1) (a) (b) (c) (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans were not always in place and did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not always being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (a) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments were not always in place as necessary, updated, and reviewed. Risk assessments were not always reflective of people's individual needs. The management of medicines was unsafe and ineffective. Documentation relating to medicine management was not being completed accurately.

Regulated activity	Regulation

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19(1) (a) (2) (a) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment procedures did not always ensure people who were employed were suitable to work with vulnerable people.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's social and, at times, their individual needs were not always being met because there were not sufficient numbers of staff deployed. People did not receive care and support from staff who had the right knowledge, experience and skills to support people.

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 17 HSCA (RA) Regulations 2014 Good governance The systems in place to monitor the quality of service people received were not effective. We found risks had not always been assessed and monitored in respect of the environment. Regulations 17(1) (2) (a), (b), (c), (d) and (e).

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 14 October 2015.