Derbyshire County Council

Gernon Manor Care Home

Inspection report

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Date of inspection visit:
04 July 2018

Date of publication:
31 August 2018

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

We inspected the service on 4 July 2018. The inspection was unannounced. Gernon Manor 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. Gernon Manor accommodates up to 34 people and is designed to meet the needs of people with a range of needs, including some people who are living with dementia. On the day of our inspection 28 people were using the service.

The service did not have registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was recruiting to the vacant position at the time of our inspection.

We last inspected this service in November 2016. At the time we found the provider to be in breach of two regulations. The provider had failed to ensure that equipment used in the home was safe for people and had not updated staff training as needed. At this inspection we found that improvements had been made with the servicing of equipment, however, we did find some equipment which was overdue a service. We raised this with the service manager who immediately took steps to rectify this. We also found on-going issues with staff training and found some gaps in training.

At this inspection we found the provider was in breach of two regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014 and one breach of the 2009 Registration Regulations. Improvements were needed in a number of areas of the service.

There were not sufficient numbers of staff working at the service to safely meet people's needs and staff training was out of date in a number of areas. People were limited in how they spent their time due to low staff numbers and people told us that, at times, they had to wait for care. Staff felt supported, however, an inconsistent management team had meant that staff performance was not always effectively monitored.

Risk assessments and care records were not always up to date and did not contain accurate and up to date information about people's care needs.

Some of the equipment we looked at had been overdue a service although this was rectified following our inspection visit.

The service was unclean and unhygienic in some areas and there was no effective cleaning schedule or infection control auditing process in place. Some areas of the home had malodours and communal bathrooms we looked at were not clean.

People were not given adequate amounts of nutritious food. We observed people waiting for food for long periods of time and the service ran out of the main meal on the day of our inspection. People's nutritional risks were monitored, however, risk assessments were not always accurate and up to date.

There was an inconsistent management team at the service which had resulted in a lack of oversight and effective quality monitoring. Feedback mechanisms were in place to enable people and their relatives and representatives to feedback on the service, however, these had not been used to improve the quality of care delivery at the service.

People were cared for by kind and caring staff but people were limited in what they were able to do with their time due to staffing levels at the service.

People's consent was sought by the service and the principles of the Mental Capacity Act 2005 had been followed.

People had access to various healthcare professionals to maintain their health and well-being.

The service had failed to notify CQC of safeguarding incidents that had occurred at the service.

The service was recording incidents, however, improvement was needed in relation to how these incidents were acted upon.

The service was displaying their rating as required by law.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Some of the equipment had not been serviced as needed.

There were not sufficient numbers of staff working at the service to meet people's needs due to various staff vacancies and issues with recruitment and retention.

Risk assessments did not always reflect people's current care needs.

Infection control was not always safely managed. Some areas of the service were unclean.

Medicines were being safely managed and there were arrangements in place in case of emergencies.

Staff were safely recruited into the service.

Is the service effective?

Requires Improvement

The service was not effective.

People were not given sufficient quantities of nutritious food. There was not an adequate choice of food for people on offer.

We found that staff training was not being updated as needed.

The service was working with the principles of the Mental Capacity Act 20015 (MCA) and Deprivation of Liberty Safeguardings (DoLS) were in place where needed.

People's health and well-being was monitored at the service and appropriate referrals made to health professionals.

The premises were designed to adequately meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff lacked time to spend with people and some people had little to occupy their time.

Staff treated people with kindness and respect and people could express themselves. However, due to some staffing issues, people's support was, at times, lacking focus on people as individuals.

People were involved in the planning and delivery of their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were limited in how they were able to spend their time and there was a lack of activities available to people.

Some improvements were needed in relation to information being made easily accessible for people who used the service.

People's needs were assessed and care records we looked reflected people's personal preferences.

The service respected people's diverse needs and supported people with their lifestyle choices as far as they were able to.

People could raise any complaints or issues they had and end of life plans were in place where these were appropriate.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a lack of consistent management oversight at the service which resulted in poor record keeping and a lack of effective quality monitoring.

Staff training and performance was not being adequately monitored and care records were not up to date.

Audits were not regularly completed and feedback to improve the service had not been acted upon.

There were regular checks on the premises but improvement was needed in relation to the reporting of incidents.

The service was displaying their rating as required by law.

Gernon Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspected the service on 4 July 2018. The inspection was unannounced. The inspection team consisted of an inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with 16 people who used the service and the friends and relatives of two people who used the service. We spoke with the relief deputy unit manager, the deputy manager, a service manager, two senior care staff and three care workers. We also spoke with a district nurse who was visiting the service on the day of our inspection. We spoke with the deputy manager and the service manager in the absence of a registered manager being in post.

We looked at the care records of five people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the management and running of the service including audits carried out by the registered manager.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in November 2016 we found that equipment within the service was not safe and it was not being regularly serviced or maintained. This posed a risk to people who used the service. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan following the inspection telling us how they intended to improve this. At this inspection we checked the equipment used at the service and found that some of the equipment was being adequately maintained to ensure it was safe for people to use. We checked all of the moving and handling equipment in various parts of the home and checked the maintenance records held for equipment. We found that a hoist and a riser recliner were past their date for a service. We raised this with the service manager who immediately acted on this and provided evidence that the service had set up a monitoring system to ensure this didn't happen again. We were satisfied that following our inspection all equipment used at the service was safe and fit for people to use.

There were several staff vacancies at the service at the time of our inspection. This was due to a number of staff leaving the service following a change in shift patterns imposed by the provider. Staff had been asked to work night shifts on a rolling basis and this had resulted in staff not wishing to continue their employment at the service. The service was struggling to recruit and retain staff because of this and we found the service to be short staffed when we arrived. It took over ten minutes for the staff to answer the door to us and we observed communal areas with lots of people in them and no staff for some time on our arrival. When we raised this with the relief manager they told us that the service was currently short staffed. They explained that the service was actively recruiting but that this was proving challenging due to the geographical area and the shift patterns being offered.

Throughout our inspection we found that staff were task focussed and that they lacked time to spend with people in any meaningful activities. There was no laundry staff on shift on the day we inspected and no cook. This meant that care staff had to step into these roles. Improvement was needed in how the provider recruited their staff to ensure that there were sufficient staff to meet people's needs.

Some of the people we spoke with described a lack of staff. One person said, "There are not as many [staff] on duty now." Another person told us that things had not been the same since the long standing manager of the home had left. Another person said that, "Breakfast could be up to an hour late" and "you have to wait for food." We saw during our inspection that staff shortages were impacting on meal-times as staff were rushed and people were left waiting for long periods of time. We raised this with the service manager who acknowledged that there were staff recruitment and retention issues at the service. They described the area as being, "Notoriously difficult to recruit to."

There were 11 care worker vacancies at the time of our inspection and as a number of staff were away from work on the day of our inspection, this was impacting on the care people received.

Staff we spoke with described staff leaving the service and inconsistency in care delivery due to temporary staff being brought in to cover staff vacancies. One staff member said, "You've not got that consistency

because people come in and out." The activities co-ordinator had recently left the service which had impacted on how people were able to spend their time. This staff member had not been replaced. One staff member commented, "That would help us massively, if people could be entertained." Another staff member said, "We've not got the staff. It comes back to staffing levels again that things haven't been maintained."

There were not sufficient numbers of staff employed at the service to meet people's needs safely. The above evidence is a breach of Regulation 18 (1) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The service was unclean in areas such the communal bathrooms and the cleaning arrangements were not being effectively carried out. Two toilets we looked at were unhygienic and posed a risk to people. There had not been an infection control audit at the service since July 2017 and this lack of monitoring had left the service unclean and unhygienic. We found areas of the home where there was no hand gel available to prevent the spread of infection, such as some of the communal bathrooms and toilets.

Risk assessments for people did not always reflect their current needs. For example, we found that one person had suffered a fall. This had not formed part of a revised risk assessment to accurately assess the person's risk of falling. We found that some nutritional risk assessments did not reflect the frequency at which people should be weighed. Staff we spoke with knew people's risks and current care needs, however, their plans of care and risk assessments did not always provide accurate guidance for new or temporary staff to ensure they delivered care to people safely. We discussed this with the service manager at the service who acknowledged that the care records were not up-to-date due to management changes within the service and a lack of consistent management oversight.

Safeguarding incidents which took place at the service had been reported to the local authority and the service had responded to these in a timely and appropriate manner. However, we found gaps in staff training in relation to protecting people from the risk of abuse and some staff told us that they had not had any recent training in this area. We discussed this with the service manager who told us that this would be looked into immediately. Staff we spoke with could describe how they would recognise potential abuse and knew how to report it.

The provider followed safe staff recruitment procedures. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained from previous employers. The provider had taken appropriate action to ensure staff at the service were suitable to provide care to people.

There were systems and plans in place to ensure people were safe in potential emergency scenarios. We found detailed plans in place to provide guidance to people and staff in the event of any emergency affecting the service. There were also grab sheets in place should people need an emergency hospital admission.

There were arrangements in place for the safe management of medicines. Staff who administered medicines had received training and demonstrated they were knowledgeable about how to safely administer medicines to people. Records showed that people received their medicines at the prescribed times. There was guidance in place for those as and when needed medicines which clearly outlined for staff when people may need this type of medication. Medicine administration records clearly indicated that people were given their medicines on time and these records were regularly checked by management at the service to monitor for any discrepancies. We looked at the storage of medicines and found this was being done safely.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found gaps in staff training. We found that staff training wasn't being adequately monitored and that, as a result, staff had not had up-to-date training in key areas. At this inspection we found that there was still an issue with staff training. We identified some gaps in the training records we were shown. There were gaps in training for staff in areas such as safeguarding, mental capacity and pressure area care. Staff we spoke with told us they felt adequately trained and that they could approach the management at the service should they need any further training. However, we found that there continued to be gaps in training for staff in relation to the safe delivery of care. We discussed this with the service manager who told us that there had been a lack of monitoring of staff training needs and that some training was overdue.

Staff received an induction when they began working at the service and we saw there was a system in place to ensure staff had regular meetings with a manager at the service. Staff told us they felt supported and described an open door policy which meant that issues were discussed continuously through dialogue between staff and management.

During our inspection we found that people were not given adequate amounts of food and drink. We observed people waiting for meals for long periods of time and during the course of lunch-time, the service ran out of the main meal which meant that people lacked a choice in what they were given to eat. We observed three people being given small portions of food due to the lack of food available. Although the service provided a menu for people, this was not what people were given or offered during the course of our inspection. When we raised this, we were told that due to staff shortages there had been some changes made to the menu on offer. People lacked choice and were not given sufficient quantities of food.

People's nutritional risk was being monitored, however, risk assessments did not always reflect their current nutritional needs. For example, one person's care records stipulated that they should be given supplements, however, staff told us that this was no longer needed. We were not confident that people's nutritional needs were being met at the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found where needed people's capacity to make decisions in relation to their care and treatment had been assessed. We saw that best interest decisions were documented and made in consultation with people's representatives where needed.

The provider had made suitable DoLS applications to the relevant authorities and these had been authorised where necessary. People told us they were asked about consent to care and treatment where they were able to give this and we observed people being given choice and staff asking for consent during our inspection.

Staff working at the service had a good understanding of people's conditions and any health-related implications of these. Staff ensured that people maintained their health and well-being. For example, people experiencing weight loss had been referred to health professionals and their was guidance and screening in place for people living with diabetes. People with more complex medical needs were treated by staff who had been trained in specific health tasks and signed off by the appropriate health professional to ensure this was being done safely.

The premises were designed to meet the needs of people currently using the service. Bedrooms and people's personal living spaces reflected their individual needs and preferences and provided warm and comfortable spaces for people. Communal areas were designed to provide a pleasant and welcoming environment for people and we observed people using communal areas of the home as they chose to. There were pleasant outside spaces which people could access and enjoy.

Requires Improvement

Is the service caring?

Our findings

During our inspection we observed staff to be busy and lacking time to spend with people. Some people sat for long periods of time engaged in little or no activity. This was due to staff shortages at the service and meant that people did not always get the emotional support they needed. People's living spaces were not always adequately clean and did not always provide a dignified environment for people. There was a lack of attention to people's living environment to ensure that this was clean and comfortable for people.

We observed staff treating people with kindness, patience and respect. One person said, "Staff are very helpful". One staff member told us, "The people here are well loved and looked after". Another staff member said, "Everyone's really friendly and everybody knows everybody. It's very personal. I think it's a lovely home". We observed a staff handover meeting where staff spoke confidentially about people with affection and compassion. "[Person] is in a fantastic mood this afternoon."

Staff that we spoke to demonstrated that they knew people well. One staff member said, "We [staff] know them [people] and their families really well." Another staff member said, "I have a close connection to them [people], they are like family to me". A visiting professional said, "The carers here are on the ball. Very conscientious and caring".

We observed staff interacting with people during lunch, singing with each other whilst the tables were being set. We also observed one staff member discussing the previous evenings football match with a person in their room.

Staff that we spoke to respected people's dignity. A staff member told us, "I asked [person] if they wanted me to leave whilst they had a bath, [person] asked me to stay so I did and we had a chat". Another staff member said, "The bedroom doors are always shut in the morning when supporting someone with personal care. If a person requires personal care support during the day, I would quietly ask them if they would like to go to their room and not say it out loud".

People were encouraged and supported to remain independent. One person regularly accesses the local community to go shopping. A staff member we spoke to said. "They go out as and when they want". However, people who needed staff support to go out were less able to do so due to staffing levels at the service.

Staff that we spoke to respected people's individual choices and people were able to freely express themselves. One staff member said, "If they [people] do not want to have breakfast early in the morning, they [people] can choose to have their breakfast later". Another staff member said, "Choice is always given". One person told us that he was free to get up and go to bed when he wanted. We saw that people had access to a hairdressing service within the home in a separate treatment room.

People could move around the service and spend time in areas of their choice. There was several communal area's in the home including a pleasant garden. One of the communal areas had a lounge with a kitchen

where visitors could make their own drinks and talk to their friends/relatives in private. People's friends and relatives could visit them at any time.

There were systems in place in the laundry room to ensure that people's clothes were returned to them once cleaned. People looked comfortable, clean and well presented. One staff member said, "They [people] wear their own clothes and are always smartly dressed". People's rooms were personalised with photos and pictures of family and friends.

We looked at feedback from people and their relatives and representatives during our inspection. One relative had said, "Excellent, caring and friendly staff". A staff member told us, "We have review meetings with people and their families, these happen yearly or sooner if anything changes". A relative told us, "We are able to approach the staff if we have any problems". We saw evidence that people who used the service took part in meetings with the staff to discuss changes in the home and offer suggestions of improvements however, these meetings had not taken place regularly and the last documented meeting took place in January 2018.

Requires Improvement

Is the service responsive?

Our findings

We found little evidence of people being given the opportunities to spend their time in activities they may have enjoyed. Staff we spoke with told us that there was not a lot for people to do since the activities co-ordinator had stopped working at the service and we found this to be the case. The service was not fully staffed which meant that people did not have meaningful interactions with staff as often as they may have liked and people could not always access the community as they wanted to. For example, one person using the service told us that a staff member had told them they would take them into the town. The person said that they had been waiting for this to happen but that it hadn't due to a lack of staff availability. This had left the person feeling let down. We observed people sat for long period of time with little or nothing to do.

People's needs were assessed before they used the service to ensure that the service could meet them. Staff created people's initial care plans, some of these had not been updated as people's needs changed which meant they were not always accurate and up-to-date. People and their families and friends provided information about their lives which helped staff to relate to them; staff talked to people about their interests and their families.

People expressed their likes, dislikes and preferences in their care and support plans. Staff told us this enabled them to provide care that met people's preferences. For example, the plans we looked at described what time people liked to get up in the morning, whether they liked a regular routine and the kind of ways they liked to spend their time. Each person's care plan reflected their individual needs and preferences which staff followed. This supported staff to provide personalised care.

Processes were in place to identify people's diverse needs, and ensure that no discrimination took place. One person using the service had recently wanted to make some changes to how they identified themselves. This had been compassionately and considerately managed by the service who had fully supported the person in how they chose to live their life. This person told us how supported they felt by staff during this transitional period for them.

We observed a handover of staff shift during our inspection and found that people's health and well-being was discussed in detail and that staff were able to demonstrate that they knew people well. Despite records not always reflecting people's current health and care needs, staff were knowledgeable and thorough in relation to responding people's care needs.

The service needed to improve in order to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. We found that people were not always given information in ways they could easily understand, for example the food menus were not easily accessible for people and may have been difficult to read and understand for people who used the service.

People felt confident that they could make a complaint or raise any issues should they need to. The provider had procedures in place to record and respond to people's concerns. We found that complaints had been adequately responded to and in line with the policy in place at the service.

People had the opportunity to discuss with staff what it meant to be at the end of life. People could express their own preferences in how they wanted their care to be provided when they were at end of life and we saw evidence from family members and health professionals that the service had respected these.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the service in May 2018 and a new manager had not yet been appointed. The service was actively recruiting to this post at the time of our inspection.

We spoke with the deputy manager who was new in post and also to the service manager. They described some inconsistency with the management team since the registered manager had left the service which had resulted in a lack of effective oversight throughout the service. We found this to be the case during our inspection. There was a lack of planned improvements at the service and some of the areas identified for improvement at our last inspection had not been fully addressed.

There were staff shortages and challenges with recruiting and retaining which had not been adequately addressed by the provider. This had left the service short staffed and staff were struggling to meet people's personal needs as well as their care needs. Staff performance was not being adequately monitored and there was not consistent oversight of staff training, despite us raising this issue at our last inspection. Although staff felt supported by the deputy manager, we found that staff performance and training was not being adequately monitored by the provider.

Infection control audits had not been completed since July 2017 and this was impacting on the environment people lived in. We found some areas of the home to be unclean and this wasn't dignified for people. Risk assessments didn't contain up-to-date information which put people at risk of unsafe care. When we raised this we were told that this was due to a lack of effective auditing of care plans.

Systems were in place to obtain feedback from people using the service and their relatives. We looked through feedback received following a relatives survey in November 2017. We found comments around staffing levels which were, "Better staffing with more people on the rota would give carers more time." We did not find any evidence that the feedback had been reviewed and acted upon to improve the service.

Systems to quality monitor the service were not effective and there was a lack of oversight which was impacting on people's care. The above evidence is a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider had not made the required statutory notifications to CQC in relation to safeguarding incidents which had taken place at the service. During our inspection we identified safeguarding incidents which had taken place at the service and not been notified to CQC. We discussed this with the service manager who acknowledged that this had been an oversight of the part of the service. There was a lack of oversight in relation to incidents and how they were reported.

This is a breach of Regulation 18 of the 2009 Registration Regulations, Notification of Other Incidents.

Regular staff meetings were held and it was clear from staff meeting minutes that staff would be able to raise any issues they may have.

Regular checks were carried out on the premises and we saw evidence of fire tests as well as tests on the gas and electrics. We found that the monitoring of incidents was not being done effectively and that further improvement was needed in the recording, reporting and monitoring on incidents which took place at the service.

The provider was displaying their rating at the service which is required by law.

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 18 Registration Regulations 2009 Notifications of other incidents The service had failed to notify CQC of safeguarding incidents which had taken place at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of consistent management oversight and a lack of effective quality monitoring which was impacting on the quality of care delivery at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably trained, qualified staff working at the service to safely meet the needs of people using the service.