Gables Care Home (Market Harborough) Limited

The Gables Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected The Gables Residential Home on 28 February and 2 March 2017. The first day of the inspection was unannounced.

We carried out an unannounced focussed inspection of this service on 13 September 2016. Continued breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to a breach of Regulation 18 Staffing.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met legal requirements.

The Gables Residential Home provides accommodation for people who require personal care for up to 10 people and personal care for people living in their own homes. At the time of the inspection six people were living in the residential home and eight people were receiving care in their own home. The home is located on two floors with a stair lift to access both floors. The home had a communal lounge and dining room. Most people who received care in their own homes lived in flats that were on the same grounds of the residential home.

The service had a registered manager who was registered to manager both accommodation for people and personal care. 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.

At the last inspection we carried out on 13 September 2016 we found that the provider had not met the regulations relating to staffing. At this inspection we found the provider had made some of the required improvements.

People were not consistently protected from risks relating to their health and safety. Risk assessments had sometimes been carried out but had not been reviewed or completed when people's needs had changed. Control measures to protect people from risks in the environment had not been put in place. Where people had allergies this had not been recorded consistently to keep them safe.

Staff could identify the potential signs of abuse and knew how to report any concerns. Where accidents and incidents had occurred that may cause concern these had been recorded. However details of actions that had been taken were not always recorded.

People sometimes had to wait for their needs to be met. Staffing levels had been increased since our last visit and there were less people using the service. Staffing levels had not been reviewed to reflect the needs of people using the service.

People did not always receive their medicines safely. Medicine records had not been completed correctly.

Equipment that people used had been checked to make sure that it was safe. However, when it required maintenance this had not always been recorded as being completed in a timely manner.

Staff had not always been recruited safely. Pre-employment checks had not been thoroughly carried out before staff started to work at the service.

Staff received support through an induction to the service and supervision. There was an on-going training programme to provide and update staff on safe ways of working. We found that staff had not been trained fully to meet the needs of people who used the service. Training records showed that staff had not updated their training to make sure that their knowledge was based on current guidance and best practice.

People were supported to access healthcare services. Where people received support in their own homes, referrals to health professionals for assessments were not always made as soon as they were needed. Where people's food intake needed to be monitored to reduce the risk of malnutrition the amount of food people had been given was not recorded.

People were asked to make choices about their care and staff asked people for consent before carrying out personal care.

People told us that staff were kind. Staff members knew people well and were able to tell us about their likes and dislikes. Staff respected people's privacy while they were receiving care. However, the provider did not always respect people's dignity in relation to their personal clothing. People had not always been asked for their opinion on things that were happening in their home.

People took part in some activities to stimulate them. Relatives and friends were able to visit when they wanted to.

People had not been involved in reviews of their care plans to make sure information about them was current. The provider did not always make changes to the service that people received when their needs changed.

The provider had implemented systems and processes to monitor and improve the quality of the service that had been provided. These did not identify concerns that we found during this visit.

The provider had not implemented feedback from relevant person's that had been sought to improve the delivery of the service that had been provided.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying

the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary,another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found two 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.

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 consistently safe.

People were not consistently protected from risks relating to their health and safety. Where people's needs had changed these had not been assessed.

Where incidents had occurred that may cause concern; actions had not always been recorded.

Staff had not always had all pre-employment checks thoroughly completed before they started work. Staffing levels had not been assessed to ensure that they were correct to safely support people using the service.

People did not always receive their medicines safely. Medicine records were not completed correctly.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to access healthcare services. Where people received support in their own homes, referrals to health professionals for assessments were not always made as soon as they were needed. Where people's food intake needed to be monitored to reduce the risk of malnutrition the amount of food people had been given was not recorded.

Staff asked people for consent before supporting them with their care. People were asked to make choices.

Staff received support through an induction to the service and supervision. We found that staff had not been trained fully to meet the needs of people who used the service. Staff training had not been updated to make sure that they were working in line with current best practice.

People were supported to access healthcare services. The provider did not always ensure that advice given by health professionals was followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that the staff were kind. Staff respected people's privacy while they were receiving care. However, the provider had not always respected people's dignity in respect to their personal clothing.

People had not always been asked for their opinion on things that were happening in their home.

Staff members knew people well and were able to tell us about their likes and dislikes. People's friends and relatives were able to visit then they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not had their needs assessed when they had changed. People were not involved in reviews of their needs to make sure that information about them was up to date.

The provider did not always offer to make changes to the service to meet people's needs when they needed more support.

People were able to participate in activities.

People felt they could raise concerns. A complaints procedure was available to tell people how to do this.

Is the service well-led?

Inadequate

The service was not consistently well-led.

We found that actions that had been put in place to improve the governance in the service had not been sustained. Feedback that had been given had not been used to improve the service that was delivered.

The provider had implemented systems and processes to monitor and improve the quality of the service that had been provided. These did not identify concerns that we found during this visit.

Staff usually felt supported in their role and that they could approach the registered manager

The Gables 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 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 Gables Residential Home on 28 February and 2 March 2017. The first day of the inspection was unannounced. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our 13 September 2016 inspection had been made.

This inspection was carried out by two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service. We also contacted Healthwatch (the consumer champion for health and social care) to ask them for their feedback about the service.

We reviewed a range of records about people's care and how the service was managed. This included four people's plans of care and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service and policies and procedures that the provider had in place. We spoke with the registered manager, the provider, a senior care worker, three care staff, and the cook.

We spoke with eight people who used the service. This was to gather their views of the service being provided. We observed staff communicating with people who used the service and supporting them throughout the day. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of

observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our previous inspection carried out on 13 September 2016 we found that there were not enough staff to meet people's needs safely. People had to wait for their needs to be met and staff told us that there were not enough staff to meet people's needs safely.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made some of the required improvements to meet the regulation but further improvements were still required.

During our inspection some people told us that they felt there were not enough staff. One person said, "I honestly don't think that they have enough staff. They have sometimes been abrupt with me for ringing my buzzer." Staff told us that staffing levels had remained at an increased level following the last inspection. However, they told us that other people's needs had changed and they now required more support. One staff member said, "Life has got a little better. The extra member of staff in the evenings has helped. "Another staff member told us, "[Person's name] required three staff over the weekend. That makes it harder." Another staff member commented, "There are times when staffing is still stretched." One staff member explained that one person was in hospital and this meant that staffing levels were more appropriate for the people living in the home. They said, "It is not so bad now that [person's name] is in hospital."

We found that the number of people who received support in their homes and required two staff to help them move had increased from two to three people. Staff also told us that a fourth person sometimes required two staff depending on their health. There was one person who required two staff to assist them to move who lived in the residential home. This meant that there were up to five people who may require two staff to help them with moving. This shows that an assessment of people's needs was very important to make sure that there were enough staff available to meet those people's needs safely. Without the assessment there was a risk that people would not receive the support they needed, and staff would not be able to provide this safely. We saw that an assessment of need had not been completed for people when their needs had changed. We discussed this with the registered manager. They told us that they would complete the assessments.

We observed that people who lived in the residential home were living with dementia and required reassurance and support on a frequent basis. We saw that staff were able to respond to these requests during our visit. There were times when people were left unattended in the lounge, however these were only for short periods of time during our visit. However, the service was not fully occupied at the time of our inspection. Staff told us that one person who was not at the service during our inspection needed significant amounts of support to help them when they were anxious and to reduce their risk of falling. Staffing levels had not been increased to support this person. This meant that staff were able to respond to people's needs during our visit but if the additional person had been receiving support the staffing would not have safely met people's needs.

We reviewed risk assessments in people's care plans and found that risk assessments were not updated to reflect people's changing needs. For example, we saw that one person had a fall on November 2016. Their risk assessment had been reviewed before the fall but had not been updated to reflect the fall and resulting injury. We also saw that the falls management plan that was in place had not been updated since June 2016. The person had fallen more than once since that time and plans to reduce the risk had not been reviewed. We saw that another person did not have a risk assessment in place around helping them to move. This was important as the person's needs in this area had changed significantly and risks to them and the staff were evident. We discussed this with the registered manager. They told us that the care plans were being updated to reflect this person's current needs. They agreed that an assessment was necessary to identify risks to the person and to staff and what needed to be done to reduce these. This meant that risk assessments had not been completed and reviewed regularly. These assessments help to ensure that risks to people while they are receiving care, and to staff who are providing care are minimised. As the assessments had not been completed people could not be sure that the care they received was being provided safely.

We found that people who received care in their own home had not had assessments of their needs completed when their needs had changed. At the previous inspection in September 2016 we asked the provider to ensure that assessments were completed for two people whose needs had changed significantly to make sure that there was a record of what the person's current needs were and how to meet these safely. This was an outstanding action from the inspection in December 2015. We found that a social worker had assessed both of these people's needs. However, the provider had still not carried out their own assessment. At this inspection we identified that two other people needed an assessment of their needs due to significant changes in their needs and these had not been completed by the provider. We saw that one person's needs had been recorded as starting to change in July 2016. This meant that the provider had not responded in good time to people's changing needs to ensure that the assessment, planning and delivery of their care met people's needs safely. The registered manager told us that care plans were being updated to reflect changes in needs but an assessment had not been completed to identify all needs that each person had.

Where people had been identified as being at high risk of malnutrition or at risk of developing pressure areas assessments to review the risk had not been carried out. For example, where a person is shown to be at high risk of malnutrition their risk assessment should be reviewed monthly or when their needs changed. The guidance on the assessment tool that had been used identified that if someone was at a high risk of malnutrition their needs should be assessed monthly. This is important so that there is an accurate record of what has been done to reduce the risk and if this is effective. These reviews had not been completed. This meant that people were being put at risk of developing malnutrition or pressure areas.

We found that control measures that had been identified to reduce risks in the environment had not been followed. For example, at a previous inspection in December 2015 we found that radiators were very hot and presented a risk of burns to people. The provider took action to ensure that covers that were in place were not broken and provided protection. Where it was not possible to cover the radiators it had been agreed that the temperature would be reduced and this would be monitored. At this inspection we found four radiators that were very hot to touch and painfully hot to hold. This presented a risk to people, particularly those at risk of falling and who would have been unable to recognise or respond to the danger of the temperature. We discussed this with the registered manager. They were unaware that the radiators were at a high temperature. They agreed to reduce the temperature and monitor this on a daily basis.

Where people had allergies this information had not been recorded consistently. We found that one person was allergic to two medicines and this had not been recorded on their emergency grab sheet. A grab sheet is used to record key information about a person so that staff can give this to paramedics or staff in hospital if

there is an emergency admission to hospital. This is important to make sure that health professionals have access to key information to be able to provide safe care. Without this information being recorded there was a risk that it would not be shared with health professionals.

These matters were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

People did not always receive their medicines safely. One person told us, "They leave my medication on my tray and I take it myself. They don't leave until I have taken it." We found that medication administration records (MAR charts) had been handwritten and these had only been completed by one member of staff. It is good practice that two staff sign the entry to confirm that it is correct in line with the guidance on the medicine label. We also found that one person's medication had been written down as being administered three times a day. However, this was only recorded as being given twice a day. This meant that medicine was not being given in line with the prescribers instructions. We found that there were times when staff had not signed to say that they had administered medicine to each person. The registered manager told us that they would follow up with staff where signatures had been missed and make sure that two staff checked any MAR charts that had been handwritten.

People had medicines that were taken as required and guidance was in place to explain when this should be used. However, this guidance had a review date in September and this had not been completed. The guidance had been written in June 2016 so was less than 12 months old. This meant that the guidance had not been reviewed to make sure it was current and met people's needs. This is important as medicines that are taken as and when required need to be carefully administered to see if they are effective. This information needs to be reviewed to make sure that people are not receiving too much medicine which may be bad for their health or not enough medicine which means that it may not be working the way it is meant too and providing relief to people.

Staff told us that they felt confident with the tasks related to medicines that they were being asked to complete and that they had been trained to administer medicines. One staff member said, "My training is in date." Records confirmed that staff had completed training and were assessed to make sure that they were competent to administer medicines. Each person who required support with their medicine had a support plan around medicines to determine the support they needed and a medication administration record (MAR) to record what medicine they had taken. The service had a policy and procedure in place which covered the administration and recording of medicines. This meant that the staff had appropriate guidance in place but this was not consistently being followed.

Where accidents or incidents had occurred these had been documented. It was not always recorded that follow up actions had taken place. For example, we saw that three people had fallen on more than one occasion. This was despite them having aids in place to reduce falls. We found that advice had not been sought to see if the equipment was working correctly or if an alternative form of monitoring was needed. We saw that the registered manager monitored accidents and incidents on a monthly basis. However, this audit had not identified concerns due to actions not always being recorded. We found that where people had sustained a very high number of falls this had not been raised as a concern with the relevant health professionals to review measures in place and their effectiveness.

The provider had not consistently followed safe recruitment procedures. We looked at the files of four staff members and found that most pre-employment checks had been carried out before they started work. These records included evidence of a Disclosure and Barring Service (DBS) Check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work

with people who used care services. However, the provider had not always sought evidence of good conduct from previous employers before staff had started work. We found that two staff had started work before references had been received. It is important that all checks are completed before staff start to work in the service to make sure that the provider is confident that the member of staff is suitable for the role. The provider had not completed a risk assessment to show that they had considered that staff starting work before all checks had been completed may present a risk to people. We discussed this with the registered manager. They told us that they would make sure that all checks had been completed before staff started their employment.

People told us that they felt safe while receiving care and support from the staff. One person said, "I feel safe here." Another person commented, "I'm very safe here. I am able to lock my door." One person told us, "I wear a call alarm on my wrist so that I can call them if I want to. They check on me." Staff members we spoke with knew and understood their responsibilities to keep people safe and protect them from harm. They were aware of the signs to look out for that might mean a person was at risk. Staff knew the procedure to follow if they identified any concerns, or if information of concern was disclosed to them. One member of staff told us, "I would report any concerns to the manager. If nothing is done I would report to safeguarding and CQC." Staff we spoke with confirmed that they had received training to support their knowledge and understanding on how to keep people safe and recognise abuse. However, some staff told us that this had been with a previous employer and they had not completed this training recently. Policies and procedures in relation to the safeguarding of adults were in place and the actions staff described were in line with the policy.

Where people required the use of specialist equipment to support them, for example, a hoist, assessments were in place regarding the safe use and maintenance of this. Checks were carried out on equipment to make sure that it was safe to use. However, we saw that when maintenance was required this had not always been recorded as being completed in a timely manner. For example, we saw that two people had sensor mats that would alert staff if they got out of bed. These had been reported as not working in the maintenance records. Work to address this had not been recorded as being completed. We found that the sensor mats had been repaired. However, it was not possible to show how long people had been without this important equipment. The sensor mats are important to alert staff if people got out of bed so that they can respond. The registered manager told us that the council repaired the mats and this would usually be completed within 24 hours of the fault being reported.

We saw that there were emergency plans in place to keep people safe should there be an emergency such as a fire. These plans detailed the support each person would require to help them to leave the building should it be necessary. We saw that the provider had identified alternative accommodation to be used in an emergency. This meant that should an emergency occur staff had guidance to follow to keep people safe and to continue to provide the service. We saw that the checks were carried out on the environment and equipment to minimise risks to people's health and well-being. Records showed that fire drills had taken place and that people had been involved so they knew what to do in case of an emergency.

Requires Improvement

Is the service effective?

Our findings

People were sometimes supported to have prompt access to healthcare professionals when they required it. One person said, "A doctor comes to see me when I am ill. A district nurse comes to check my blood." Staff were aware of people's health needs and told us they reported any changes to the registered manager. One staff member told us, "I look out for signs that a person's health has changed. They might be eating less or not eating. It could be something about the way they mobilise. I report concerns to [registered manager]. I did last week and we called a GP." However, staff also felt that people were sometimes waiting for assessments to be completed when their needs had changed. One staff member explained that a person was struggling to move and needed equipment to help them with this. They told us that the health professional who needed to carry out this assessment had not been contacted. We discussed this with the registered manager. They told us that they were waiting for an assessment to be completed so that the correct equipment could be put in place. The registered manager explained that they had waited to seek agreement from family before the person had been assessed; as the person liked their family to be involved. This meant that this person had to wait to have the assessment for equipment that would have made moving around easier and safer for them and for staff.

People received support from staff who had some of the skills to meet their needs. One person told us, "The staff are wonderful. They help me." However, another person said, "I know that the staff go on training courses but I don't think they are well trained enough." Staff told us that they had completed training. One staff member said, "The training I had was good. It covered people's needs." Records showed that staff had completed some training and were booked to attend other courses. We saw that some staff had completed training a long time ago and had not completed updates on this to make sure that their knowledge and practice was based on up to date guidance. For example, staff had completed a course about supporting people who were living with dementia. However some staff had last completed this in 2011. This meant that they did not have access to the most up to date guidance about how to support people living with dementia effectively.

Staff had received an induction to the service when they started work. Records we saw confirmed that staff had completed an induction checklist that included policies and procedures and an introduction to the people who used the service. One staff member said, "I completed an induction. I found it very useful."

Staff told us that they had supervision meetings with their manager. One staff member told us, "Supervision's are helpful. I can raise any concerns about people and discuss their support. I've been supported to improve my record keeping." Another staff member said, "I have had an appraisal. I have not had a supervision meeting. I can talk about things with [registered manager]. " We saw that the registered manager had recorded details of planned supervision meetings for the year so that each staff member had four meetings. They were in the process of completing appraisal meetings with staff. An appraisal reviews a staff member's performance over a 12 month period and identifies plans for the next 12 months.

People had access to a choice of meals, snacks and drinks. They told us that they liked their meals. One person said, "The food is very good." Another person told us, "They get me my breakfast and bring my

lunch." We saw that drinks were available throughout the day. People were asked to choose what they wanted for lunch from a menu that was displayed on the wall. We observed that people ate all of their lunch and told us that they had enjoyed it. We observed that where people needed support at lunchtime this was provided. Staff and the cook were aware of and provided suitable meals for people's specific dietary needs such as food needing to be softened to make it easier to swallow. This meant that people's nutritional needs were met.

We saw that food charts were in place and were being completed where people had been identified as being as risk of malnutrition. However, these did not accurately record what people had to eat as they did not always record the quantities people were given. For example, the record stated, vegetable cobbler ate all. On another occasion staff had been very specific. They had recorded one bowl (300mls) porridge, tablespoon of honey, 50mls semi skimmed milk. This meant that the actual amounts that people were eating was not consistently being effectively monitored.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where people were not able to make their own decisions we saw that mental capacity assessments had been completed and were based on specific decisions. We found that DoLS had been requested for people who may have been at risk of being deprived of their liberty. The registered manager showed an understanding of DoLS which was evidenced through the appropriately submitted applications to the local authority.

Staff were able to demonstrate that they had understanding of the MCA and that they worked in line with the principles of this. One staff member told us, "When a person cannot make their own decisions we make decisions that are in their best interests." Staff told us that they offered people choices and asked for consent before supporting a person. One staff member said, "I always offer choices. First if they want a drink, then what they would like to drink." We saw that care plans identified decisions that people could make for themselves and encouraged staff to prompt people to make these choices. For example, one care plan said the person could choose their own clothes and should be encouraged to do so. Each section of the care plan prompted staff to consider the person's capacity to make decisions relating to their care.

Requires Improvement

Is the service caring?

Our findings

People were mainly positive about the support that they received and the caring nature of the staff. One person told us, "The staff are wonderful." Another person said, "We are all treated really well." One person commented, "Some of the staff are good and some aren't. Some are very contentious." Another person said, "The carers are very good. They are all very pleasant." Staff we spoke with demonstrated that they cared for the people who used the service. One staff member told us, "I care for people the way I would want my family cared for."

Throughout the day of our inspection visit, we observed that staff interacted with people in a warm and kind manner and took time to talk to people before proceeding with their tasks. They enhanced their verbal communication with touch and altering the tone of their voice appropriately. One staff member was giving someone clear instructions about what they needed to do to sit down safely. The member of staff was patient and pleasant during this interaction. Staff told us that it was important for them to be able to spend time with people and talk with them. They said that they had time to do this sometimes. However, staff told us that this was not always possible due to the support that people needed and staffing levels. One staff member said, "Now [person's name] is not here there are enough staff. Before that we struggled. I told [registered manager] that [person's name] should have been moved before they fell. I was worried about them." Another staff member said, "We are okay with staff today. The other day [person's name] rang their buzzer all day. They needed three staff. we struggled to manage."

People were supported by staff in a dignified and respectful manner when they were receiving care. One person said, "The staff knock before they come into my room." Staff we spoke with were able to give us examples of how they promoted people's dignity when they cared for them. This included ensuring that they knocked and gained permission before they entered people's room and ensuring that people were covered appropriately when they supported them with their personal hygiene or mobility needs. One staff member told us, "I use a towel to cover people's modesty when I support with washing. I close doors in people's rooms." We observed that staff did knock on people's doors. We found that the provider had not always ensured that people were treated with dignity. The tumble dryer in The Gables Residential Home had not been working. During this time a person who received support in their own home was asked if their dryer could be used. One member of staff said they were not comfortable with this action. They told us, "I try to use the radiator's instead where possible. It is people's underwear and clothing. I wouldn't like it." This meant that people's clothing was being dried in someone's personal home and people had not been asked if they were happy with this arrangement. This did not promote dignity for people.

People felt that they were not always asked for their opinion about things that were happening in their home. One person said, "I have not been asked for my opinion." The registered manager told us that people were asked for their opinion at residents meetings. We saw minutes from these and saw that people were asked about food, activities and for feedback on the service. There was no other way such as individual meetings or reviews where people who did not attend the meetings were asked for their opinion.

People told us that staff respected their independence. One person said, "I do all of my own personal care."

We saw that where people were able to do things themselves they were encouraged to do them. Staff told us that they tried to encourage people to do things for themselves. One staff member told us, "I encourage each person to do as much for themselves as they can. It is different for each person."

People told us that they made their own decisions about their care on a day to day basis. One person said, "I can do what I want to do." Another person told us, "I get up and go to bed when I want to." The staff told us that people were asked about how they wanted their care and were given choices. One staff member said, "We ask people every day what they would like to do." We saw that people's preferences and wishes were taken into account in how their care was delivered. For example routines that they wanted to follow were recorded.

People had information within their care plans that provided details about their life histories and events of importance to them. Staff knew this information about people and used it to start conversations with people. We saw one staff member sit down with someone and talk to them about holidays they had been on.

People's visitors were made welcome and were free to see them as they wished. One person commented, "I have visitors come to see me." We saw from the signing in book and relatives communication records that visitors came regularly.

People's sensitive written information was usually being handled carefully. We saw that the provider kept people's care records in a locked room or in their own flat. However, we saw that some records which were waiting to be reviewed were stored in the office near to a window and were visible to people walking past, although this was at the back of the property. The registered manager told us that she thought people could not see through the window and the documents would be moved.

Requires Improvement

Is the service responsive?

Our findings

People had not always received care that was responsive to their needs when these had changed. Staff told us that people's needs had increased and they would benefit from being in a bedroom downstairs so that they were closer to staff. One staff member said, "It is better for people to be down here. If they have high needs." They explained that one person had moved downstairs shortly before they had died to enable staff to care for them. However, another person had not been able to do this. Staff told us that one person was at high risk of falling and they were concerned about them having a bedroom upstairs when there was a bedroom available downstairs that would be safer for the person. We discussed this with the provider. They told us that it was a business decision and it would be considered if the person could move to a different bedroom downstairs.

People were not always involved in reviews of their care and these had not always recorded changes in their needs. For example, we saw that one person had fallen and broken their hip. Their care plan had been reviewed twice following this and said that there was no changes to the care that the person needed. However, we saw that the person's needs had changed following the fall and subsequent injury. This was not identified during the review. People and their relatives had not been asked for their feedback as part of the review to gather their views. This meant that care plans were being reviewed but not meaningfully to make sure that they were continuing to meet people's needs and preferences.

People had not always had an assessment of their needs when they started to use the service. Staff told us that one person had moved to the service and they did not fully understand their needs when they moved in. They explained that the person had received support from staff during the day in their own home but this was different to the support they needed when they required 24 hour care. The staff told us that this person had fallen out of bed as an assessment had not been carried out to identify if they had needs in this area. We also found that when people's needs changed assessments had not been completed to determine what their needs were and how to meet these.

People were offered activities to provide them with stimulation. One person said, "Every Friday two or three women come to sing. They sing country and western and old time music." Another person told us, "We do go on outing's sometimes. We went to the local church when they had a concert on. At Christmas we all went out for lunch." Staff told us that they tried to offer people activities that they enjoyed. They explained that they tried to take time to sit with people one to one and paint their nails, or talk with them when they could. One staff member said, "It is important that we get time with people. We don't always get that." We saw a newsletter that identified activities that were available. These included arm chair exercises and entertainment. On the day of our visit the planned activity did take place. Trips were arranged so that people could go shopping or to a local group called the Dementia café. The hairdresser visited on the first day of our inspection. They told us that they visited each week and appeared to know people using the service well.

People had attended residents meetings. We saw the minutes from the last meeting that had been held in January 2017. These showed that people had been asked for their opinion on the service, cleanliness, meals and activities. This meant that people had an opportunity to give their feedback on the service that had

been provided.

All of the people we spoke with told us they would raise any concerns with the staff or the manager. One person said, "I have not got any complaints about living here. I would tell them if I had a complaint." There were procedures for making compliments and complaints about the service. These were displayed on the wall and included timescales for responses and who the complainant could approach if they were unhappy with the outcome. The manager told us that they had not received any complaints in the last 12 months.

Inadequate

Is the service well-led?

Our findings

At our previous inspection carried out on 10 December 2015, we found that the systems and processes in place were failing to assess, monitor and improve the quality of the service.

These matters were a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At our inspection on 13 September 2016 we found that most of the requirements had been made. However, at this inspection we found that these had not been sustained.

Audits that had been introduced at the service to ensure that the environment was safe had been carried out. These had not identified areas of concern that we found during this inspection. For example, radiators were not always covered and were very hot to touch. At our inspection in December 2015 we identified that this presented a risk to people. Control measures that had been put in place following the previous inspection to turn radiators down to a lower level were not being followed. We found four radiators that were uncovered and very hot to touch. Medicines audits that had been completed had not identified the areas of concern that we found during our inspection. These included MAR charts being handwritten by only one member of staff, MAR charts not being completed correctly and changes to the instructions from the prescriber of the medicines. Audits had not been completed on records or the quality of the information that was in them. For example, reviews had identified no change in needs, despite the person having sustained a serious injury

We also found that timescales had been set for reviews to take place by the provider and these had not been met. For example, medication protocols had a date for review set at every three months. We found they had not been reviewed for the last six months. We also found that assessments and care plans had dates set for review by the provider that had not been met. For example, a falls management plan had a review date in September 2016. This had not been completed at the time of our inspection which was five months later.

Systems and processes in place were not being completed effectively. Where they were being completed they were failing to assess, monitor and improve the quality of the service.

At our previous inspections on 10 December 2015 and 13 September 2016 we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing. This was because suitable staff had not been deployed to meet the needs of people who used the service. At this inspection we found that there were enough staff deployed. However, this was because the home was not full. There were four vacancies in the residential service and two in the flats where people received support in their own homes. Despite the provider being in breach of this regulation at the previous two inspections they had not determined how many staff were required to safely meet the needs of people using the service based on their assessed needs.

People's needs had not been assessed when they changed. This was raised with the provider during our

inspection in December 2105 and again in September 2016. We asked that two people were assessed due to changes in their needs. At this inspection we found that assessments had been completed by a social care professional. However, the provider had not completed their own assessment to ensure that they could meet people's needs. We also found that three other people's needs had changed significantly and assessments had not been carried out by the provider to determine what support they required and how many staff were needed to carry this out. This meant that people were at risk of their needs not being met and there not being enough staff available to meet the needs of all people who used the service.

The provider had failed to assess, monitor and mitigate the risks relating to health, safety and welfare of people.

We found that there were no clear boundaries between the two separate services. This was raised at our inspection in December 2015. At this inspection we found that a person who received a service in their own home had been asked if staff could use their tumble dryer when the one in The Gables Residential Home had not been working. This is something that does not promote the dignity of people living at The Gables Residential Home as their washing was dried in someone else's home without their permission. At our previous inspection the registered manager told us they were working to create more boundaries between the services. We found that this had not happened.

We found that records were not being kept securely. Documentation was left by a window where people could see this when they passed by. We also found that a member of staff was on a period of leave and had been asked to complete some paperwork. They had this at home with them and brought it to the service on the day of our inspection.

The provider had failed to maintain securely records that are kept in relation to people employed by the service and the management of the service.

The provider had been advised at both of our previous inspections the importance of completing records fully, and specifically about completing food charts where a person was at risk of malnutrition. The provider had also been advised on how to complete these records by a health professional. We found that the records were not being completed fully and did not provide an accurate reflection of what the person had eaten.

Recruitment procedures were not always robust. This was raised at both of our previous inspections. At this inspection we looked at recruitment files for two new staff. We found that information from previous employers about character had been sought after the member of staff had started work and were also not always sought from the most recent employer.

The provider has failed to seek and act on feedback from relevant persons and other persons on the services provided, for the purpose of continually evaluating and improving such services.

These matters are a breach of Regulation 17 (1) (2) (a) (b) (d) and (e) of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014: Good Governance.

People had been asked for their feedback on the service through resident's meetings. However, most people felt they had not been asked for their opinion. One person said, "I have been asked to make suggestions. I didn't have any to make though." Another person told us, "I've not been asked my opinions or to give any suggestions. I do have some I would like to make." One person commented, "I have not been asked for my opinion or how things could be improved." The registered manager told us that they were going to carry out

a survey to seek feedback from people more formally. They told us that people and their relatives could speak to them at any time with suggestions.

The registered manager carried out checks on the service to monitor the service that people were receiving. These included checks on people having drinks available in their rooms, that people were wearing clean clothes and socks and that they could reach their call bells. These were meant to be completed daily however we found gaps in the records. The checks were important as they considered areas of dignity that are important to people.

We received mixed feedback from staff about the support they received to fulfil their role. One staff member said, "I am supported." Another staff member told us, "[Registered manager] is not always willing to listen." One staff member commented, "[Registered manager] is approachable and will listen to me." The registered manager told us that they worked as part of the team to support the staff. We saw that team meetings had taken place. The frequency of these was variable. Minutes from the meetings showed that areas such as training, good practice and feedback from visits had been discussed. This meant that there were opportunities for staff to reflect on their practice.

The registered manager had notified CQC of events they were required to. It is a requirement that providers tell CQC when certain events happen within the service. This includes allegations of abuse, events that affect the service and when an application to deprive someone of their liberty is approved. We found that the relevant notifications had been made. The provider had displayed the most recent CQC report in the service and on their website. This meant that the provider was giving people the opportunity to see feedback that had been received.

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 Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess risks to the health and safety of service users of receiving the care or treatment. They had not done all that is reasonably practicable to mitigate any such risks.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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
Personal care	The provider did not assess, monitor and improve the quality of the services provided. They did not have systems or processes established and operating effectively. The provider did not seek and act on feedback from relevant persons and other person's on the services provided.

The enforcement action we took:

We also asked the provider to submit an action plan detailing how they would meet this regulation.