Dr E U M Minhas and Dr H A Minhas

The Gables Nursing Home

Inspection report

231 Swinnow Road
Pudsey
West Yorkshire
LS28 9AP
Tel: 0113 257 0123
Website: thegablespudsey.com

Date of inspection visit: 7 November 2014
Date of publication: 20/02/2015

Ratings

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

Overall summary

This was an unannounced inspection carried out on 7 November 2014. We last inspected the service in November 2013 and found they were meeting the Regulations we looked at.

The Gables Nursing Home is located in a residential area of Pudsey in Leeds and provides care, support and treatment to a maximum of 23 older people, some who are living with dementia. Most bedrooms are single but there are some shared rooms. Some bedrooms have en-suite facilities.

There is a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People told us they felt safe living in The Gable. We found staff were aware of their roles and responsibilities to keep people safe at all times. There were procedures to follow if staff had any concerns about the safety of people they supported.

The requirements of the Mental capacity Act 2005 were in place to protect people who may not have the capacity to make decisions for themselves. The registered manager was aware of the new guidance and was reviewing people who used the service to ensure new guidance was being followed. However we found a number of methods used by the service which may constitute a deprivation of liberty.

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

Some people were involved in planning their care and support and this was reflected in the care records we looked at. Staff were given sufficient information in each care plan to provide the appropriate level of care. All care plans were kept under constant review in order that changes could be acted upon as soon as they were noted.

People were able to develop friendships and join in activities, although some people told us that they would like more to do during the day. People told us they were happy with the food provided and the menus were varied with plenty of choice.

We observed people were treated with dignity and respect. People who used the service told us they felt staff were always kind and respectful to them.

People were encouraged to give their views about the quality of the care provided and a carers forum had been established to help drive up standards. Quality monitoring systems were in place and the registered manager had overall responsibility to ensure lessons were learned and action was taken to continuously improve the service.

We saw that staffing levels were good throughout all areas of the service. Training in all aspects of care and support was mostly up to date. We found staff were supported by the management team however regular staff supervision and appraisals were not up-to-date.

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

Procedures in relation to recruitment and retention of staff were robust to help ensure only suitable people were employed at the home.

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?

Good

The service was safe.

People told us they felt safe living in The Gables. Staff were aware of their roles and responsibilities to keep people safe and protect them from abuse. All staff had completed safeguarding adults training.

During our visit there were qualified and experienced staff on duty to provide good levels of care and support. Procedures for staff recruitment were robust which helped ensure only suitable people were employed to care and support those that lived in The Gables.

Systems were in place to make sure that managers and staff learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This reduces the risks to people and helps the service to continually improve.

Is the service effective?

Requires Improvement

The service requires improvement to make it effective

People's health and care needs were assessed and care plans were designed to meet the needs of people who used the service. People told us they liked living at The Gables. They said the food was good. Some people we spoke with told us they would like more to do during the day.

The service had procedures in place in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

We found the service had recognised the requirements of the Deprivation of Liberty Safeguards. The manager was aware of the new guidance and was reviewing people who used the service to ensure new guidance was being followed. However we found a number methods used by the service which may constitute a deprivation of liberty.

Each member of staff had a programme of training and were trained to care and support people who used the service. An on-going training programme in place, staff were being booked for relevant training. In house moving and handling training was taking place on the day of the inspection.

Staff attended staff meetings and were able to discuss work practice; however formal supervision and annual appraisals were not up to date or carried out regularly.

Is the service caring?

Good

The service was caring.

Summary of findings

People told us they were happy with the care they received. We saw staff had a warm rapport with the people they cared for. Relatives spoke in glowing terms about the care staff at all levels and were happy with the care.

We saw all people at the home appeared at ease and relaxed in their environment. We saw that people responded positively to staff with smiles when they spoke with them.

People had been involved in deciding how they wanted their care to be given and they told us they discussed this before they moved in.

The service had procedures in place to ensure an appropriate level of support for people living with dementia.

Is the service responsive?

Good

The service was responsive

Staff we spoke with knew the needs of people they were supporting. We saw there were some activities and events which people took part in. However people told us they would like more to do.

People told us that they knew how to raise concerns and records showed that complaints were dealt with appropriately. This meant people were supported to raise concerns and knew they would be acted on.

Is the service well-led?

Good

The service was well led.

People were not put at risk because systems for monitoring quality were effective. Where improvements were needed, these were addressed and followed up to ensure continuous improvement.

The registered manager listens to suggestions made by people who used the service and their relatives. For example, the registered manager had taken the suggestion to improve the gardens at the rear of the home to make it more accessible to people who used the service.

Accidents and incidents were monitored monthly by a designated nurse to ensure any triggers or trends were identified and acted upon.

The Gables Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 November 2014 and was unannounced.

The inspection team consisted of a lead inspector, a second inspector with specialist experience in dementia and mental health care and an expert by experience with expertise in care of older people in particular dementia care. 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 the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. Prior to our visit we had received a provider information return (PIR) from the provider which helped us to focus on the areas of the inspection we wished to look at in detail. 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.

We spoke with two registered nurses and five care staff. We also interviewed key staff for example the cook, to help us understand how people were involved in decisions about the choice of meals. We also spoke with ten people who used the service and two visitors who came into the home during our inspection.

We conducted a Short Observational Framework for Inspection (SOFI) during the breakfast period. SOFI is a specific way of observing care to help us understand the experiences of people who could not easily communicate with us during our visit. It also helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at five people's written records, including the plans of their care. As part of the inspection process we also contacted three health care professionals to gain their views about the quality of the service provided.

Good

Is the service safe?

Our findings

We asked people whether they felt safe in the home. Everyone we spoke with were clear that they did feel safe. This was also reflected in responses from visitors to the home when we asked about their relative. People told us they were not aware that any bullying had occurred and had not witnessed any instances of poor practice.

People told us that they would tell the staff if they were worried about anything. One person said "I would speak to my relative and ask them to tell the staff." Relatives we spoke with were also confident that the registered manager would act swiftly to protect people from abuse. One relative said, "I have no doubt action would be taken if there was an allegation of abuse."

Nursing staff we spoke with told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact to report any concerns or incidents of abuse. They told us they knew how to contact the local authority Adult Protection Unit and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the manager knowing that they would be taken seriously.

The care staff we spoke with were able to demonstrate a good understanding of safeguarding vulnerable adults and were able to give examples of what constituted abuse and how they may recognise it. Staff also knew the principles of whistleblowing and told us they would make use of whistleblowing if necessary. They were however keen to assure us that the manager had an open approach and they had confidence that any concerns they had would be dealt with.

The provider had a safeguarding vulnerable adults' policy dated July 2014 based on the Department of Health Statement of Government Policy on Adult Safeguarding. They also used the local councils procedures for reporting allegations of abuse

We found that the recruitment of staff was robust and thorough. We looked at six staff files and found they contained all of the required information had been obtained which included application forms detailing their previous employment, two references and evidence that formal interviews had taken place.

The registered manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This ensured only suitable people were employed by this service. We confirmed this when we looked in the staff records. All new staff completed a full induction programme that when completed, was signed off by their line manager.

We looked at the number of staff that were on duty and checked the staff rosters to confirm the number were correct. The registered manager told us they had a flexible approach to ensure sufficient staff with the right skills and competencies were on duty to meet people's needs. He told us that walkie-talkies had been introduced to staff to ensure they could be contacted quickly. This enabled them to respond to calls for assistance without any delay. The responses we received from people who used the services indicted there were sufficient staff on duty. One person said, "If I need someone when I'm in my room they're there, almost right away. I've never had a problem with that."

People's risks were appropriately assessed, managed and reviewed. We looked at five people's care records and saw that they had individual risk assessments had been undertaken with care and support planned to ensure their safety. For example, we saw one person being moved and repositioned with a hoist as described in their care plan. This demonstrated that care staff were aware of care planning needs and were translating this into safe practice.

Systems were in place to make sure that managers and staff learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This reduced the risks to people and helped the service to continually improve.

There were appropriate arrangements in place to ensure that people's medicines were safely managed, and our observations showed that these arrangements were being adhered to. Medication was securely stored. Drug refrigerator temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures. We checked records of medication administration and saw that these were appropriately kept.

Good

Is the service safe?

There were systems in place for stock checking medication, and for keeping records of medication which had been destroyed or returned to the pharmacy. Again, these records were clear and up to date.

Medication was only handled by staff who had received training in relation to medication. This included checking stock, signing for the receipt of medication, overseeing the disposal of any un-needed medication and administering medication to people.

There were up to date policies and procedures relating to the handling, storage, acquisition, disposal and administration of medicines. People's care records contained details of the medication they were prescribed, any side effects, and how they should be supported in relation to medication. We asked a staff member whether any people using the service were allergic to any medication, and they were able to tell us without checking.

Medication was audited regularly by the nursing staff, this included checking stock and ensuring records were accurately kept. We asked the nurse in charge about the systems in place for managing and handling medication and they gave us a clear, knowledgeable account of this.

Requires Improvement

Is the service effective?

Our findings

We found that staff did not receive regular supervision (one to one meetings with their manager) and an annual appraisal. These provide a framework to monitor performance, practice and to identify any areas for development and training to support staff to fulfil their roles and responsibilities. Staff we spoke with said they had not received formal supervision, but had attended staff meetings to discuss work practice. The staff did say that they were able to discuss any concerns they might have had with the registered nurses or the registered manager.

We looked at five staff files and found supervision and yearly appraisals had not taken place. The training plan showed most staff had not received formal supervision since December 2013. Only seven of the twenty-eight staff had received their yearly appraisal. We also found qualified staff had not received clinical supervision. This is required by relevant professional bodies to ensure their continued fitness to practice. This meant staff were not appropriately supported in relation to their roles and responsibilities which may affect the delivery of care.

We asked the administrator to send us their policy on the frequency of supervisions, but we were sent the guidelines for appraisals.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities)

Staff we spoke with said they had received training in the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards. Staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes balancing autonomy and protection in relation to consent or refusal of care or treatment.

Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS ensures where someone may be deprived of their liberty, the least restrictive option is taken. Decisions about depriving people of their liberty should only be made so that people get the care and treatment they needed where there was no less restrictive way of achieving this. The registered manager told us that five people using the service were subject to authorised deprivation of liberty. However when we looked at the documents to support the applications made to the supervisory body only one could be found. The registered manager confirmed copies of the other four applications had been sent by post. We were later informed that the applications had not been received by the supervisory body and the registered manager would need to resend them, to ensure the provider was acting within the law.

We looked at the files of seven people who had been diagnosed with dementia who demonstrated a significant degree of cognitive impairment. We spoke with the registered manager and established a common understanding that up to 20 people at the home may require assessment and application for the supervisory body to issue standard authorisation to permit lawful deprivation of liberty.

We noted that the provider utilised a number of methods to ensure the safety of people who used the service. The front door was locked and some internal doors were also locked. Twelve people had sensitivity mats in or beside their beds to alert staff if the person was vacating their bed. In addition two people had “baby alarms” in their rooms, monitored by staff at another location in the home. In addition the provider had installed overt close circuit cameras in communal areas of the home as a means of increasing observation and safety of people. Whilst these systems were put in place to protect people, the registered manager had not considered if these constituted a deprivation of peoples liberties.

We judged that the provider may be exercising complete and effective control over some people’s care and movements. It may also be the case that people were under continuous supervision and control and may not be free to leave. However there was no evidence to suggest people would be stopped from leaving should they choose to do so. The registered manager told us that urgent attention would be given to completing the necessary applications where required.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities)

We observed lunch being served, which was a limited choice of fish and chips or fish cake and chips. We saw that only four people were sitting in the dining room for their lunch. Most people ate at a single table positioned at their

Is the service effective?

chair where we saw many had been sat in for the whole morning. This approach to care did not maximise benefits to people in a number of ways. For example, it did not encourage mobilisation.

There was also no opportunity to increase social interaction that sitting together for a meal can provide which can reduce isolation. Furthermore engaging people in tasks such as laying a table can help people with dementia by keeping them connected to daily routines and fulfilling tasks that was once an everyday matter. The act of laying a table can also promote a feeling of belonging to the home and not just being a receiver of care. We discussed this issue with the registered manager at the end of our visit.

We saw staff were patient when serving the meal and gave people choice about what was put onto their plate and where parsley sauce was placed. The food looked appetising and people were positive about their meal. One person told us "This is very nice, lovely and hot too." During the meal a staff member noticed that a person had not eaten very much. She offered to get the person the alternative choice if they had changed their mind or did not like what they had chosen.

We spoke with the cook whose main role was as a care assistant. She told us she often covered in the kitchen when the main cook was off. The menus were well balanced and showed an alternative choice was available at each meal except for Fridays. The cook told us people's likes and dislikes were documented to ensure people received the food of their choice.

We saw that all the care plans we looked at contained a nutritional assessment and a weekly or monthly check on peoples' weight was recorded. We noted that people who were in danger of losing weight and becoming malnourished were given meals with a higher calorific value and fortified drinks. The cook gave us examples of using full fat milk and cream as a way of increasing calories into people's diet. We saw the cook preparing smoothies that were also used as a way of boosting people's nutritional intake.

All new staff were subjected to a probationary period where they were expected to complete the provider's induction training which included a mixture of internal and external training. The registered manager told us that staff would shadow experienced staff until they were competent to work unsupervised with people who used the service. We looked at the training provided to staff which confirmed most staff had attended appropriate training to ensure they had the skills and competencies to meet the needs of people who used the service. We looked at the training plan and found most staff had received training in food hygiene, fire and health and safety. Staff were also receiving updated moving and handling training on the day of the inspection.

Most of the staff who worked at the home had completed a nationally recognised qualification in care to level two. Staff also told us they could access training in specific areas for example nursing staff told us they had attended training in palliative care. They told us this ensured they were able to meet people's end of life care needs.

We saw that care plans clearly recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed recording the person's name, an assessment of capacity for this element of care, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff all of whom knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

At the point of admission we saw a list of health care professional who had recently been engaged in delivering care, these included dieticians, tissue viability nurses, community psychiatric nurses and hospital consultants. The inclusion of this information ensured a continuance of health care when a person was transferring their social care to the home. We spoke with people about their access to health professionals from outside the home. One person said, "If I need a doctor they get me one, no problem." Another person said, "The doctor is only next door so I can get help quickly if needed."

Good

Is the service caring?

Our findings

We saw that staff respected and involved people who were receiving care. For example by addressing people by their preferred name and supporting people to be as independent as possible. Each room visited showed signs of individual choice and personal touches such as photographs, prized possessions and personal furniture.

People at the home appeared at ease and relaxed in their environment. We saw that people responded positively to staff with smiles when they spoke with them. We observed that staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. We saw staff helping and encouraging people to eat and sitting beside them at a suitable height. This was done at the person's pace and was unhurried by staff.

Staff were observed regularly asking people who used the service whether they wanted or needed anything. For example, one person became distressed about wanting to go home. A staff member took control of the conversation and moved it on to reminisce about a place that the person had lived in younger life. The person became calmer immediately and enjoyed the conversation from there.

Staff took opportunities to speak to people wherever they could and appeared to respond to their needs quickly and discretely. One person mentioned that they could have a blanket around them if they felt cold. A member of staff heard this, came to ask the person if they needed the blanket and went to collect it for them.

People we spoke with and their visitors confirmed that there were no rules about the timing or duration of visits. A lack of space meant that there was nowhere other than a person's room to gain any privacy for a visit. One visitor told us, "We always come to the conservatory to visit our relative. There's not much quiet space."

Care plans had been reviewed monthly as a minimum to ensure that there was up-to-date information on the person's needs and how support was to be provided to ensure these were met. Additional reviews were undertaken in response to such matters as visits to hospital consultants or other healthcare professionals.

We found close relatives had been engaged in care planning However, a small number of people did not appear to have regular access to family. The registered manager had not considered if people who did not have regular contact with family should have access to an advocate. This would assist them in understanding their options and enable them to make informed decisions.

We saw staff respected the privacy and dignity of the people who were using this service; for example by knocking on bedroom doors before entering and allowing people time to respond.

We saw that the provider had installed close circuit television cameras in communal areas of the home. The registered manager told us the installation had been carried out to enhance the safety of people living at The Gables.

A risk assessment had been carried out prior to installation which demonstrated the benefits that would accrue. The risk assessment included the need to reassess the risks and benefits in December 2014. We saw evidence in care files which suggested all people at the home and their relatives had been made aware of the proposed installation before it took place. Our discussions with some people who were able to voice an opinion demonstrated that they were aware of the cameras. The viewing of the images was secure with only two viewing points with only relevant staff having access. Nurses we spoke with told us the system had improved observation within the home which helped to keep people safe. We found there were little signage both outside and inside of the building to inform people who used the service and their visitors that CCTV was in operation at the home.

Good

Is the service responsive?

Our findings

When people who used the service spoke with us about staff they used phrases such as “lovely,” “very nice” and “friendly” to describe them. One person pointed out a member of staff to us. They said, “See her, she’s lovely. All the staff are lovely.” No one told us about any staff that they did not have a good relationship with, and all the people we spoke with felt that they only saw regular staff and did not have much experience of high turnover of staff or agency employees being used to cover shifts.

People told us they found the staff friendly and approachable, and this was evident during our SOFI observations during breakfast. Interactions between people who used the service and staff were light-hearted. One person told us, “Staff are cheeky, and I like that.”

People were less positive about how they filled their days. One person said, “We do a lot of sitting.” Another person said, “I just sit here, there’s not much else to do.”

We saw that there was a schedule of planned activities that should take place on a daily basis. However, in the morning of the inspection we did not did not observe any group activities taking place. The activities co-ordinator was going from person to person, spending five to ten minutes with each, talking, reading or playing dominoes. The activities co-ordinator told us “I do some one-to-one with the residents and I also do some group activities.” We did not observe any ‘one to one therapy’ being undertaken in the afternoon of the visit. People appeared to be sitting in the communal rooms; some were chatting to one another and some chatted to staff as they passed.

The memory nurse was involved with four people who used the service, by assisting with assessments for people taking memory medications. She also provided cognitive stimulation activity to monitor if there was a correlation between the activities and the medication. The cognitive stimulation was ad hoc, but it is hoped that it would be rolled out across the home. The activity co-ordinator helped to facilitate the sessions. We spoke with the memory nurse and she told us that staff had responded very well to the assessments and this had benefitted people who used the service.

We saw that life histories were recorded when individuals came to the home. This ensured staff did not see people as a person living with dementia but as a person who had had a rich life. Staff spoken with demonstrated that they were aware of the needs of the people they were supporting and their individual personalities and preferences.

Care plans recorded what the person could do for themselves and identified areas where the person required support. The care plans had sufficient detail to ensure staff were able to provide care consistently. We observed good correlation between what the care plan required and the care given and saw it was consistently recorded. We saw that staff were able to easily access any aspect of defined care need through clearly presented files.

The outcome of risk assessments at the point of admission to the service were used as the foundation to create a safe care plan covering, mobilisation, continence, nutrition, communications, mood, night care and personal hygiene. We saw that staff daily recorded outcomes of the care plan and took steps to modify the plan in light of people’s experiences or changing health care needs.

The service had up to date policies and procedures in place with regards to any complaints people may have. There was a copy of the process to follow on display in the entrance. We asked the registered manager and staff if there had been any complaints to deal with since our last inspection. He told us there had been no formal complaints. He said, “Concerns were dealt with straight away to prevent them from escalating into complaints.” Records confirmed no formal complaints had been received.

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since April 2014

People we spoke with were able to identify the owners of the home when they saw them and were positive about their relationships with them. One of the providers told us, “We keep a very small catchment area, meaning we can preserve a sense of community and make it easier for relatives to visit.” Both providers were observed chatting to people who used the service and visitors.

Staff took accountability for their work within the home. We spoke with a healthcare professional who was part of the care home support service, provided by Leeds City Council. They told us that the service was improving under the current registered manager. We also received positive feedback from the memory nurse who said she was working closely with staff to improve the quality of life for people living with dementia.

We saw that a regular audit took place on the administration and storage of medicines. The audit recorded adverse observations and noted how the issue should be corrected. The registered manager told us that one of the nursing staff had recently been identified to undertake some of the audits in relation to falls analysis and mattress checks. The nurse told us it was a new role and the registered manager was arranging further training to ensure he was competent to undertake the audits effectively. The nurse gave us an example of how they had referred a person to the falls team following several incidents involving the same person. Health professionals had put in equipment to reduce the risk of further falls. The outcome was that the number of falls for the person had been reduced.

Other audits such as infection control, maintenance and a monthly provider audit were also undertaken as part of their quality monitoring of the service provision. Identified areas for improvement were identified and implemented

Incidents, accidents and complaints were also analysed as part of the quality monitoring system to enable them to identify and themes or trends and take action as required

We spoke with staff about staff meetings. We were told these took place regularly. Items for discussion included issues such as staffing and people who used the service related issues such as problems addressing particular people’s needs. We saw minutes from senior managements meeting and full staff meetings.

The registered manager told us that they listened to suggestions made by people who used the service and their relatives. He said, residents and relatives were asked to take part in completing a satisfaction survey and as a result of their comments they were making the rear garden more accessible and user friendly. Relatives had also raised an issue about private space for people to go when they had visitors. He told us this was more difficult due to the layout of the building.

A carers group had also been formed which met every month to discuss any concerns they may have about the home and how the service was run. The registered manager told us the group was established to help drive up improvements in the service.