Caring Homes Healthcare Group Limited

Gildawood Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Gildawood Court is a care home, providing personal care and accommodation for up to 60 people. It provides care to older people, some of whom are living with dementia. Care is provided in five separate units; with the fifth unit on the first floor. Each unit has their own lounge, dining area with a kitchenette. At the time of our inspection visit 56 people lived at the home.

What life is like for people using this service:
• People's risks to safety and well-being were assessed, recorded and reviewed. However, actions to mitigate risks of harm or injury to people had not always gone far enough to ensure people's safety was maintained.
• Staffing levels at night were insufficient and meant people were, at times, left unattended on units. Staffing deployment during daytime shifts meant people's safety was not consistently maintained because communal areas were left unobserved by staff.
• People had their prescribed medicines available to them. However, there had been incidents when people ran out of their medicines because staff had not taken action to ensure there was sufficient stock.
• Overall, staff followed the training they had been given. However, this was inconsistent in, for example, staff's hand hygiene practices.
• Improvement was required in the overall cleanliness of the home.
• People had individual plans of care, so staff had the information they needed to care for them.
• Staff received training, and most were suitably skilled to meet people's day to day physical needs and protected people from the risks of abuse.
• People, especially those living with advanced dementia, experienced minimal activities and social interaction.
• People had access to healthcare when required.
• Overall, people received enough food and drink to meet their dietary requirements.
• People's dignity was not consistently promoted by staff.
• People made decisions about their care and were supported by staff who worked within the principles of the Mental Capacity Act 2005.
• The provider's quality assurance system did not always ensure quality and safety and actions were not always taken to make improvements where needed.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment
Regulation 17 Regulated Activities Regulations 2014 - Governance

Rating at last inspection: At the last inspection the service was rated as Good. (The last report was published on 9 May 2016.

Why we inspected: This was a planned inspection based on the rating of the last inspection. The service is

not rated as 'Requires Improvement' overall.
Enforcement: Action provider needs to take (refer to end of report).

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 consistently safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Details are in our Well Led findings below.

Gildawood Court

Detailed findings

Background to this inspection

The 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.

Inspection Team: One inspector and two experts by experience carried out this inspection on 7 May 2019. The experts by experience had personal experience of caring for older people. Two inspectors returned to complete the inspection on 8 May 2019.

Service and service type: Gildawood Court is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did have a manager registered with the Care Quality Commission (CQC). A registered manager, as well as the owner and provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection visit took place on 7 and 8 May 2019 and was unannounced.

What we did when preparing for and carrying out this inspection:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We also sought feedback from the local authority and professionals who work with the service. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During our inspection we spoke with 15 people and 12 relatives. We spent time with people, who due to living with dementia could not give us their feedback, to see how staff supported them. We spoke with 12 care staff, the cook and kitchen assistant, the registered manager and regional manager.

We reviewed a range of records. This included five people's care records and multiple medication records. We also looked at records relating to the management of the home. These included systems for managing complaints, checks undertaken on the health and safety of the home and staff training records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Requires Improvement: People were not consistently safe and were placed at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong:
• Some risks were well managed, such as a person at risk of choking, but other risks were not well managed. People identified as being at 'very high risk of falls' did not have their risks of injury effectively mitigated. A number of people consistently experienced multiple falls each month. For example, one person had six recorded falls in March and seven in April. Another person had seven falls in March and four in April 2019. One relative told us, "[Name] moved to live here because they'd had a bad fall, we thought they would be safer with staff about, but most days staff inform me [name] has fallen. Sometimes they have no injury but other times it's been a serious injury, It's a big worry."
• People were able to walk freely about the home, however, not all those identified as at risk of falls were wearing appropriate footwear. Some people were wearing only socks on their feet on a laminate wooden floor and staff told us they could not find another person's slippers. Action had not been taken by the registered manager to ensure these people were supported to mitigate their risks of falls.
• Overall, staff supported people using safe moving and handling techniques. However, we observed one incident of an unsafe moving and handling, when staff supported a person to transfer by lifting the person under their armpits. This illegal move posed risks of injury to the person. The registered manager assured us staff would be re-trained and increased emphasis put on manager's observations of staff practices to ensure people's safety was maintained.
• Staff told us they completed a first aid awareness course but senior staff who had completed a full day first aid training course were responsible for administering first aid to people if needed. However, senior staff were not always immediately available as they maybe elsewhere in the home and staff told us they did not always use the emergency call bell to gain their attention but ran to find them. We were concerned that this may cause an unnecessary delay and discussed this with the registered manager. They told us they would remind staff of the expected practice to use the emergency call bell system to gain senior staff support with first aid whenever needed.

Preventing and controlling infection:
•There were systems to prevent and control the risk of infection and staff had completed infection control training. However, we saw inconsistency in good hand hygiene practice. The registered manager confirmed they had also observed what we had seen and would address hygiene practices with staff.
• The provider had a refurbishment programme, but this had not consistently ensured the environment was pleasant for people or risks of infection were minimised.

Using medicines safely:
• On the day of our inspection visit, people had their prescribed medicines available to them and trained staff followed safe medicines management when supporting people to take their medicines. We found

where GPs prescribed short term courses of medicines, staff made sure they were available.
• However, medicine records from March to May 2019 noted a total of four incidents when people had run out of their medicines and senior care staff, or managers had not ensured new stock was received. We discussed this with the registered manager who took immediate action to have managerial oversight of the 'medicines issues' diary and told us, "From now on I will personally be checking this everyday."

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Some people had been identified as at risk of having or developing sore skin. Special equipment, such as airflow mattresses were used to relieve pressure and reduce risks of skin damage.
• People had Personal Emergency Evacuation Plans (PEEPS) so staff and emergency services knew what level of support people required in the event of an emergency evacuation.

Staffing and recruitment:
• Staffing levels at night were not always sufficient to ensure people's safety was maintained. The registered manager told us that at night the staffing level was five care staff to cover all five units. This meant that where people required two members of staff, one unit was left unattended. We discussed our concerns about this and during our inspection visit, the provider agreed for night time staffing levels to be increased to six staff with immediate effect.

• Staff deployment, on day shifts, did not consistently ensure people's safety. Staff told us communal areas were, at times, left unobserved as 28 of the 56 people required support from two staff, which took them away from communal areas. Following our inspection feedback, the registered manager told us they would undertake an immediate review of how they deployed senior staff and ensure specific allocation was made to units so that areas were not left unattended.
• The provider's system for recruiting staff ensured staff's suitability. Newly appointed staff confirmed checks had been undertaken before they started working at the service.

Systems and processes to safeguard people from the risk of abuse:
• Care staff had received training in how to safeguard people from the risk of abuse and demonstrated an understanding of safeguarding principles. Staff told us they would report any concerns to the registered manager.
• The registered manager understood their responsibilities in reporting specific incidents to us and the local authority.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People had pre-admission assessments completed before they moved in. This included their medical history, mobility and nutritional needs.
• People had individual plans of care. However, after their initial assessment, people and their relatives did not always feel involved in their plan of care. Care reviews did not show how people, or their relatives had been involved.

Staff support: induction, training, skills and experience:
• Staff received training, however, they did not consistently put into practice what they had been taught or follow the provider's policies. For example, when we discussed an observed unsafe moving and handling technique, the registered manager assured us this was not acceptable practice and they would investigate.
• Staff said they had regular training and opportunities to discuss their practice during supervision and team meetings. They told us managers did observations of practice as well. One staff member described the training as "good".
• Staff had opportunities to obtain nationally recognised vocational qualifications.

Supporting people to eat and drink enough with choice in a balanced diet:
• Records showed some people ate very little and had a recorded low weight. Whilst finger food, such as jam sandwiches, were offered to one person as an alternative, staff missed opportunities to offer additional high calorie snacks, such as within drinks. Dementia care research had not been used to explore options, such as special crockery, for people living with advanced dementia.
• Another person appeared to be struggling with solid items of food which they consistently spat out onto their plate, and therefore they ate very little. The person had eaten a big bowl of porridge in the morning, however, staff had not recognised the possible link to the consistently of food items might be the issue for this person. We discussed this with the registered manager who confirmed the person appeared to prefer softer food options, but no action had been taken to ensure they received this. They told us they would investigate this further.
• Overall, choices of meals and drinks were offered to people. One person indicated they did not like the meal they had been provided with and a staff member immediately offered them an alternative option. However, some staff felt more could be done to meet people's individual preferences and choices at meal times. One staff member told us, "I sometimes feel it is inadequate for the needs of people." They told us one person did not like dark meat which was regularly served in the home. They said this person regularly only ate the vegetables because there was not another option more to their liking. We shared this with the registered manager who told us they would investigate why staff were not ensuring this person was offered

an alternative.
• People's experience of staff support during lunchtime was mixed. One staff member assisted a person to eat and sat with them, going at the person's pace, explaining the individual food items on the plate. However, this was not everyone's experience. One person was not offered support from staff, who were focused on cleaning the kithchenette, whilst the person ate mashed potatoes with their fingers.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
•Records showed people were supported to attend regular appointments with their dentist, optician and chiropodist to maintain their health.
•Where a need was identified, people were referred to other healthcare professionals such as the dietician or speech and language therapy for further advice about how risks to their health could be reduced to promote their wellbeing.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•People's care plans identified whether they had the capacity to consent to living at the home and to specific aspects of their care. People's care plans were clear when people lacked capacity to make decisions in certain areas of their life, so staff understood when they had to make day to day decisions in people's best interests.
•Staff worked within the principles of the MCA and sought people's consent before providing them with personal care and assistance. However, we found staff did not always recognise when they needed to make a best interest decision because people who consistently declined support with personal care were at risk of neglect, poor health or their dignity was compromised. Care plans did not provide enough information to explain the steps staff needed to take to minimise the need to restrict the person's liberty and minimise the risks of harm to the person and staff.
•Where restrictions were placed on people's care, the provider had made appropriate DoLS applications for authority.

Adapting service, design, decoration to meet people's needs:
•The purpose-built premises were spacious enough to accommodate people's needs for mobility equipment and allowed easy access to all the rooms.
•People were able to move freely between units which enabled them to go out of their usual environment. This was particularly beneficial for people who liked to explore their surroundings and walk around the home. However, for people living with dementia, no assessments had been carried out to assess what adaptations, including suitable use of signage and decoration, were required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect. Regulations were met.

Ensuring people are well treated and supported; equality and diversity
• We saw some positive and caring interactions between people and staff. One member of staff was assisting a person to eat and had to temporarily leave the person to provide urgent assistance to another. The staff member apologised to the person when they sat down with them again and explained what had happened.
• One staff member helped a person whose spectacles were slipping down and then asked another person if they would like some fresh tissues before removing their dirty tissue. Another staff member gently wiped a person's eyes after they had a coughing episode.
• However, some staff did not take opportunities to engage with people and did not consistently demonstrate a caring approach. For example, one person was shouting out and a staff member walked past them. When we asked this staff member about this, they told us, "[Name] will just stop soon."

Supporting people to express their views and be involved in making decisions about their care:
• Relatives told us staff had involved them in their family member's initial assessment to inform their plan of care. However, did not always feel involved in plans of care or reviews with their family member once they had moved in and lived at the home.
• People had some opportunities to make independent choices. Some people chose to spend time in their bedrooms. One person told us, "I've got my key to my bedroom so I can come and go and I want to."

Respecting and promoting people's privacy, dignity and independence:
•People's appearance was not always indicative of promoting their dignity. We saw several people who looked dishevelled, their hair was un-brushed, and their finger nails were dirty.
• Care supervisors and managers did not consistently take action to ensure people's appearance and dignity was promoted as staff did not support people to change their clothing when it was soiled. Plastic aprons used at mealtimes to protect people's clothing did not have the desired effect, and food and drink spilled onto people's clothing. One relative told us, "My family member's clothing is covered in food, staff don't freshen them up or change their clothing."
• Staff did not consistently use language that showed respect or value toward the people they cared for. For example, one staff member described a key task of their job rile to us as "making sure people were fed and watered." The registered manager assured us this did not meet their expectations or reflect how staff were trained and would be addressed.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations were met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• Care plans were detailed and provided sufficient detail to enable staff to meet people's needs. At the front of the care plans was a profile of people's immediate risks and needs which staff could use to refresh their memory. One staff member told us they used this knowledge to support people at times of anxiety and distress. "If they are having a bad day, we know what to say to calm them down."
• The provider had specific staff to arrange activities for people in the home. However, improvements were required in understanding and responding to people's interests and need for occupation and engagement on the individual units. Staff told us many of the organised activities took place in the day care centre. One staff member said, "You don't see the activities staff coming onto the units." Another staff member said, "Some people are focussed on more because they are easier to focus on."
• In the absence of organised activities on the units, staff said they had little time to engage with people on a one-to-one basis. One staff member told us, "I would love to be able to do more but am held back by tasks." When we asked what impact it would have on people if staff had more time to spend with people, a staff member responded, "People would be a lot less depressed and a lot happier in themselves."
• Staff were task led and care was not person centred, with everyone living at the home having the same activities planner. During our inspection we saw long periods of time when people were sitting around with little to do that might interest them or give them something to look forward to. One person told us, "Not much happens here," and a relative said, "[Name] has an activities planner but nothing on it resembles what they'd enjoy doing and I don't see those things listed happening."
• Staff's monitoring of people's privacy in their bedrooms was not always effective. One person told us, "Staff put that (pressure sensor) door mat there for me, because I don't want other residents coming in, but I want my bedroom door open. Staff are meant to come when it rings but they don't always." Staff, who were within the vicinity of this person's bedroom, did not respond on the two occasions when we activated the pressure sensor door mat. We discussed this with staff who told us the sensor was not linked to the call bell system. We raised this concern with the registered manager and they told us they would look at how an improvement could be made to link the sensor door mats to the call bell system to alert staff so they could respond.

•On the units there was little of interest in the décor, such as pictures, photos or tactile objects people could touch and hold to stimulate their minds, especially those people living with dementia. A relative told us, "Trips out are very rare. There's not a lot going on. I think it's because there aren't enough staff."

Improving care quality in response to complaints or concerns:
• Some people and relatives were satisfied with the services received and told us they had no complaints. However, others had raised concerns and issues were addressed, but sometimes improvements were not

sustained. For example, issues around offensive odour, lost clothing, and a lack of personal care were given to us as examples.
• Most people and relatives felt the registered manager was approachable and felt able to raise concerns following the provider's complaints policy which was displayed. However, a few people living at the home told us they had 'given up' saying something and some relatives felt they had to repeatedly raise an issue, such as lost glasses or hearing aids, before action was taken.

End of life care and support:

• Many people had decisions in place as to whether they should be resuscitated in the event of a cardiac arrest. Staff said this information was kept in care plans, locked in the unit office, which meant there might be a delay in people receiving Cardio Pulmonary Resuscitation (CPR) whilst staff checked the records.
•There was some information in people's care plans about whether they would like to remain at the home if they became very poorly or whether they would prefer to be transferred to hospital for further treatment. However, there was limited information about people's preferences for their final days.

Requires Improvement

Is the service well-led?

Our findings

Well Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires Improvement: Service management and leadership was inconsistent. Management and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:

• The registered manager did not have effective oversight of checks and audits they had delegated to staff. For example, people's medicines were not always in stock and the registered manager had missed opportunities to make improvement to the system to ensure people did not run out of their medicines.

• The registered manager and provider were responsible for analysis of accidents and incidents to identify patterns and trends and prevent risks of reoccurrence. Whilst some actions had been taken, including a referral to the falls clinic for guidance, the provider and registered manager had not done all that was possible to mitigate risks and reduce reoccurrence. For example, where one person reached out to hold items, additional grab rails had not been considered.

• Where night time falls had been recorded, this had not prompted a review of night-time staffing review to ensure staff were available to support someone when needed.

• The registered manager used the provider's 'dependency rating scale', but this was not used effectively to determine safe staffing levels. They told us, "Staffing levels are set by the provider and have, overall, been the same since I've worked here." We discussed our concerns with the registered manager about the existing arrangements of five night staff in total covering all five units. The registered manager told us they also had concerns. However, they had not ensured action had been taken to address this.

• The registered manager's oversight of staff deployment and care practices was not consistently effective in ensuring people received safe care. For example, care supervisors did not lead by example in putting people's needs before tasks.

• The effectiveness of staff training was not effectively monitored by the provider or registered manager. For example, people's dignity was compromised by their unkempt appearance and soiled clothing.

• Improvements needed to the home were not always identified or acted on. There were unpleasant stale odours in areas of the home which indicated deep cleaning, or replacement flooring, was required in some rooms. One staff member told us, "Some carpets have not been replaced in the twenty years I've worked here, they are sticky and can't be cleaned properly."

• People and their relatives were invited to attend 'resident and relative' meetings. Information was shared with people during the February 2019 meeting about new menus and that pictorial menus were being updated and would be ready for the end of March 2019. However, we were told pictorial menus were still being updated and were not yet available to people, which meant actions to make improvements did not always happen in a timely way.

The above concerns demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our inspection feedback, the registered manager and regional manager submitted an action plan to us telling us about immediate actions they had taken, such as mitigating risks of potential injury to people and a review of staffing levels and deployment of staff on shifts. Further training had been arranged for staff to address areas where development was needed.

• Staff spoke positively of the registered manager. "She is very understanding and very down to earth and helpful." When we asked one member of staff if they felt supported, they responded, "Very much so."
• However, some staff felt the registered manager could be "stricter" with some staff colleagues who they described to us as "laxidaisical".
• Some relatives and staff felt that when they did raise issues with the registered manager, they were not always given feedback about any actions taken.

Continuous learning and improving care:
• The provider's regional manager completed compliance assessment visits and told us, "The registered manager and I know improvements are needed. Your feedback is also showing us areas we need to focus on, work will be done to improve." The registered manager and regional manager agreed improvements were needed to be embedded into the culture of the home and sustained to ensure people received a good service.
• The registered manager attended local provider forums where learning was shared. The registered manager had appointed a skin care staff 'champion' who attended local hospital events on preventing skin damage and good practices were shared with staff at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The provider offered opportunities to people and their relatives to give feedback and some positive feedback had been received from the December 2018 feedback survey. An action plan had been implemented to address some of the negative comments received and some actions had been implemented, such as replacement corridor flooring. However, some issues raised in December 2018 were the same as those we found or received negative comments about, which meant actions taken had not been sustained or were yet to be implemented.
• Staff told us they had staff meetings, and these were used as an opportunity to share their thoughts and views whilst receiving feedback and updates about the service.
• The rating from the provider's last inspection was displayed, as required, in the entrance area of the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not consistently taken reasonably practicable action to mitigate risks to the health and safety of service users. The provider had not consistently ensured the safe management of medicines to ensure people did not run out of stock.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not effectively assess, monitor and improve the quality and safety of the service and did not always mitigate risks relating to the health, safety and welfare of service users.