The Gables Care Home Ltd

The Gables Care Home

Inspection report

25 Southport Road
Chorley
Lancashire
PR7 1LF

Tel: 01257271299

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Gables is a residential care home providing personal care and accommodation for up to 21 people. At the time of inspection there were 17 people living in the home. There are 18 single rooms and three shared rooms. There is one large communal area downstairs which serves as the lounge, dining area, office space and staff area. There are three floors with lift and stair access.

People's experience of using this service and what we found
People told us they felt safe, however the provider failed to demonstrate that risks were consistently monitored, and they had oversight of people's safety. People lived in a home that did not look visibly clean. Equipment used to support people with their personal care did not look well maintained and hygienic.

Record keeping related to the administration of some medicines was not in place or not consistently completed. Oversight of people did not reflect the care needs identified in people's care plans. The provider failed to deploy sufficient staff while waiting to employ new housekeeping staff.

Audits failed to either identify concerns or drive improvement. Some documents in use had been reviewed as correct when they were not accurate. Systems were not always robust and operated effectively to ensure all regulatory requirements had been fulfilled.

We were not assured the provider always followed current guidance on the testing of staff for COVID-19. We have made a recommendation about this. The provider did not consistently follow robust recruitment procedures. We have made a recommendation about this.

People's dignity and privacy was not consistently upheld. People's personal information was discussed in front of other people. Confidential information was accessible to people in the communal lounge and in a shared bedroom.

People spoke positively about the relationships they had formed with staff. Observations showed people were happy and relaxed in the company of staff. The provider had engaged with people and staff, formally through meetings and through daily interactions. The management team had been working with a range of professionals following the previous inspection in order to meet people's needs.

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

Rating at last inspection and update: The last rating for this service was inadequate (supplementary report published 13 April 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since 14 April 2021 During this inspection the provider failed to demonstrate that improvements have been made. The service remains rated as inadequate overall and is still in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. It was also in part due to concerns received about areas of concern such as good governance, medicines, the management of risk and staffing. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

The provider and registered manager have engaged in the inspection process and taken action to lessen the risks people were exposed to.
The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

We carried out an unannounced comprehensive inspection of this service on 03 February 2021. Breaches of legal requirements were found. We also undertook this inspection to check whether the Warning Notices we previously served in relation to Regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The concerns we had about the provider were, failing to have effective oversight of the quality of care, records and the providers failure to ensure people's dignity and wishes were upheld.

The provider completed an action plan after the last inspection to show what they would do and by when to improve safeguarding, premises and equipment and fit and proper persons employed. The action plan also looked at duty of candour and safe care and treatment.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, caring and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Gables Care Home on our website at www.cqc.org.uk.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering

what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of risk and medicines. The lack of dignity and respect some people experienced and the poor hygiene standards throughout the home. Staffing levels did not reflect the care needs identified and record keeping was not robust or consistent to provide oversight and drive improvement.

We have taken enforcement action. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Gables Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

We checked whether the provider had met the requirements of the Warning Notices in relation to Regulation 10 Dignity and respect and Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to people not having their dignity upheld and the provider failing to have effective oversight of the care and documentation.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors visited on the first day. One inspector returned on the second day.

Service and service type
The Gables Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first day.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection-
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including the provider, registered manager, senior care worker, care workers administration staff and the chef. We observed the care and support people received. This helped us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with professionals who had recently visited the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The provider failed to ensure all care plans had information to guide staff on how to manage people's health conditions.
- Documentation related to nutrition did not reflect what one person had eaten. One person ate very little breakfast and did not receive the support identified as being required within their care plan. Staff had completed paperwork indicating the person had eaten a full breakfast.
- Medicines were not always stored safely. In a shared bedroom prescribed creams were left on the top of a set of drawers, accessible to whoever entered the room. The date they were open had not been recorded.
- The provider failed to ensure that everyone had an up to date personal emergency evacuation plan (PEEP) that reflected their support needs. All the PEEPs looked at stated that, should people refuse to leave, staff should leave them in their room. One person's PEEP talked about evacuation to an adjoining building. There was no access to an adjoining building. One staff member was unaware of where the PEEPs were kept or how to support people in an emergency. A PEEP is a plan for a person who may need assistance, for instance, a person with impaired mobility, to evacuate a building or reach a place of safety in the event of an emergency.
- Water temperatures were not controlled within the home and no risk assessments were in place to determine whether people would be at risk of scalding.
- The provider failed to ensure equipment was properly maintained. Commode pans were extensively stained. One pan did not have a lid between the pan and the chair seat. Shower and bath seats were stained and required cleaning. We made a referral to the Infection Prevention Team. They visited and recommended the home have a deep clean as a matter of priority as one of their recommendations.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed care plans and documentation were being reviewed and additional safeguards were in place to keep the kitchen secure.

At our last inspection the provider had failed to ensure equipment was properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

● Water temperatures were not controlled within the home.
● Fire exits alarms were not set, potentially allowing some people to leave the home unnoticed. The fire exit steps were corroded in parts and covered in algae in other parts presenting as a slip hazard.
● The provider failed to ensure the kitchen was secure. After the previous inspection the provider agreed to lessen risk by ensuring the kitchen door was locked when staff were not present. We observed the kitchen door open and people had unsupervised access to the kitchen.
● The risk of falls from height had not been lessened by using tamper proof window restrictors. People had access to windows large enough to fall through. The restrictors in place were not of a suitable standard and did not require a special tool or key for removal.
● People had the opportunity to leave the home unobserved and unsupported. Fire exits were not alarmed when we first visited. The stairs leading from the fire exits were corroded in some parts and covered in green moss like growths in parts that could cause the steps to become slippery.
● Not all the fire doors were well maintained. Three bedroom fire doors did not close independently into their door frame. This meant the spread of fire or harmful smoke would not have been restricted had there been a fire.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home did not look visibly clean and hygienic. There was a build up of dirt on the floor by the downstairs bathroom. Paintwork in several places throughout the home was chipped and covered in fluid stains. We saw black staining that looked like mould in the dining room and some bedrooms.

We found no evidence that people had been harmed however, systems were either not in place to maintain appropriate standards of hygiene. This placed people at risk of harm. This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed water temperatures had been regulated and tamper proof restrictors had been purchased. Additional cleaning of the home had taken place. New bins and commodes had been purchased to safeguard people. All fire doors were being reviewed to ensure compliance with current guidance.

Preventing and controlling infection
● We were not assured the provider was using PPE effectively and safely. We observed discarded PPE in a bin in the dining room. The bin did not have a lid so did not restrict any potential spread of bacteria. We observed one staff member carry used PPE through the dining room to a clinical bin outside.
● We were not assured the provider was meeting shielding and social distancing rules. People and staff sat together in close proximity when outside smoking. Staff sat together in close proximity when smoking or when on meal breaks.
● We were not assured the provider was promoting effective infection prevention guidance. Staff travelled to

and from work in their uniforms. Wearing their uniforms only at work, lessens the risk of the spread of infection.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was preventing visitors from catching and spreading infections. People were being asked to provide recent evidence of a negative test result before being admitted into the home.

We found no evidence that people had been harmed however, systems were either not in place to promote positive infection prevention practices. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was accessing testing for people using the service and staff. However, the provider was not following current guidance on the frequency of staff testing.

We recommend the provider consider current guidance on the testing of staff for COVID-19 and update their practice accordingly. We have also signposted the provider to resources to develop their approach.

● We noted the latest food hygiene rating from the Food Standards Agency (FSA) was displayed. The home had been awarded a five-star rating following their last inspection by the FSA. This graded the home as 'very good' in relation to meeting food safety standards about cleanliness, food preparation and associated recordkeeping.

Using medicines safely

We made a recommendation at the last inspection that the provider considers current guidance on the recording of medicines.

● Medicines administration records were not always robust. Medicine records were not always fully completed. Staff did not have oversight of how many tablets were stored at the home.
● There was no written guidance on when to administer 'as and when required' medicines.
● Medicine records did not guide staff on how many tablets to administer when they had the option to administer one or two tablets [variable dose]. This meant people could be at risk that medicines were not effective, or they received more than required to manage their health needs.

We found no evidence that people had been harmed however, systems were either not in place or completed consistently to maintain the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People received their medicines when they should. People were given time to take their medicines in a calm and person-centred manner.
● Controlled drugs were stored and recorded correctly. Controlled drugs are medicines that are tightly controlled by the government because they may be abused or cause addiction.
● The provider had medicines management policies and procedures in place which helped ensure people's medicines were managed safely. Staff responsible for administering medicines had received training and competency checks.

Staffing and recruitment

At our last inspection the provider had failed to ensure fit and proper persons had been employed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Oversight of people was inconsistent. At the time of this inspection staff were expected and responsible for cleaning the home and all laundry duties. This limited the time staff had with people.
● There was not enough staff to meet the identified needs of people. One person's care plan stated they needed support with meals. We did not see this happen, and the person did not eat their meal. One person was identified as requiring regular supervision due to their health condition. We did not see this happen, and the person chose to spend a significant period of their day unsupervised.
● There were not enough suitable staff to ensure the home was clean. The provider failed to deploy enough staff while waiting to employ new housekeeping staff. This led to a deterioration in the cleanliness of the home.

We found no evidence that people had been harmed however, sufficient staff had not been deployed to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not consistently follow robust recruitment procedures. Criminal record checks with the Disclosure and Barring Service were carried out and appropriate references were sought. However, not all application forms held a full employment history and there was no evidence this had been discussed with the candidate.

We recommend the provider follow best practice guidance on the recruitment of staff.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of regulation 13 ((Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People were safe and protected from abuse and their human rights were respected and upheld. Staff told us they had received relevant training and knew how to recognise potential abuse and report any concerns. Staff said they felt able to challenge poor practice and report their concerns to the registered manager. One person told us, "Yes, I do feel safe. It's a lovely place, I'm very comfortable." A second person said, "I feel very safe living here, they [staff] are nice."

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure people were supported in ways which respected their privacy and dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

- People's privacy was not consistently maintained. The registered manager and staff completed a handover meeting in the lounge. This took place in front of people and identified what support people had received or required.
- People's dignity was not consistently maintained. One staff helped someone with their personal appearance while they were sat in the lounge.
- Personal information was not always kept private. Concerns were raised at the previous inspection that the computer screen was visible to people walking by. This was still the case when we visited six months later, and personal information was visible. The computer was moved to support confidentiality during this inspection.
- Staff talked with each other across the lounge, in front of people, about what personal care named people required and who had already received support.

We found no evidence that people had been harmed however, people were not always treated with dignity and respect. This placed people at risk of harm. This was a continued breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

- People had developed positive, respectful relationships with staff. One person said, "Staff are very good. They are very willing to do anything they can." A second person told us, "You can have a laugh with the staff, it makes a difference."
- People were supported by caring staff. We observed people were comfortable in the company of staff and actively sought them out. People were actively included within conversations taking place. One staff member told us, "The people here are like family to me."

Supporting people to express their views and be involved in making decisions about their care

- People and relatives were consulted about care and made decisions for their wellbeing and support they required.
- Care plans held information on people's preferred ways of communication.
- Staff encouraged people to make daily choices, gave people time to make decisions and actively listened to their responses.

Inadequate

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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to have effective oversight of the, quality of care, risk and governance. There was also the potential for people to experience harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider failed to follow their own governance policies and failed to maintain necessary records to improve the quality and safety of people's lives. The extensive concerns identified related to the lack of risk assessments for people who had access to hot water, for cleanliness of the environment and to fire safety concerns that had not been identified or recorded.
● The provider reviews that had taken place did not always indicate improvements were required. When care plans and PEEPS needed updating or additional information was required, the review process had not recorded any shortfalls and had been marked as no changes required.
● Some documents in use had been reviewed as correct when they were not accurate. For example, one risk assessment document compiled and assessed by the management team as correct at three reviews, identified staff had been trained in the safe storage and disposal of sharps [needles]. This was untrue, no staff member had received this training.
● Systems were not robust and were not operated effectively to ensure all regulatory requirements had been fulfilled. We found one notification had not been submitted to CQC when one person had been injured and admitted to hospital. The registered manager told us they thought the provider had completed this.

We found no evidence that people had been harmed however the registered manager and provider had failed to have effective oversight of the, quality of care, risk and governance. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoke positively about working at The Gables Care Home. One staff member said, "It is relaxed here, family orientated."

● The atmosphere was calm and relaxed. People appeared at ease in each other's company enjoyed chatting and joking with staff. One person told us, "These girls [staff] have been brilliant with me. They have brought me back to life, you can't knock them." A second person said, "[The Gables] it's a lovely place. I am very fortunate to live here."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager and provider have engaged and been frank and co-operative throughout the inspection process.
● The provider had a policy and procedure to guide staff on their responsibilities and action they should take when something went wrong.

Continuous learning and improving care; Working in partnership with others
● The provider had not acted on feedback in a timely manner. Concerns identified at a previous inspection had not been fully addressed. Repeated concerns had been noted at this inspection. Governance processes had not been embedded to support the improvement in people's care.
● The management team had been working with a range of professionals following the last inspection in order to meet people's needs. The provider had taken some action to lessen the risks identified. They had sought advice and guidance to meet people's health and behavioural needs.
● Management staff attended regular calls with the local authority, Lancashire fire and rescue service and us to review the risks within the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider offered formal and informal opportunities for people to be involved in the delivery of their care. Meetings had taken place and we observed people seek out staff when they required guidance and support.
● We saw that staff meetings had taken place and events relating to the service were shared with staff.
● The provider had built a visiting pod to provide people and their loved ones an opportunity for face to face visits. The registered manager engaged with relatives during these visits.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. The provider failed to ensure discussions about care and treatment were not overheard. 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff had not been deployed to meet people's needs. 18(1)

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 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. 12(1)(2)(a)(b)(g)(h)

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people had been harmed however the registered manager and provider had failed to have effective oversight of the, quality of care, risk and governance. This placed people at risk of harm. 17(1)(2)(a)(b)(c)

The enforcement action we took:

Warning notice.