Little Gaynes Rest Home Limited

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Inspection report

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Ratings

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

Overall summary

The inspection was unannounced and took place on 15 May 2015. There were no breaches of any legal requirements at our last inspection on 27 November 2013.

Little Gaynes Rest Home provides services for to up to 21 older people who have physical health care needs and may also have dementia care needs. At the time of our visit there were 14 people using the service.

The service's registered manager had not been at the service since February 2015. 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. We were informed by the provider that an interim manager had been sourced from an agency and was at the service Monday to Friday from 18 May 2015 until the current registered manager returned or a new manager was employed.

Summary of findings

People told us they felt safe and trusted staff. Staff were aware of how to recognise and report abuse .They told us that they were able to raise any concerns with the manager. In the absence of the manager they said they would raise it with senior staff who would in turn notify the local authority and the Care Quality Commission (CQC).

People were not always cared for in a safe environment. Risks related to uncovered heating rails and hot water that rose to 50 degrees were not always assessed and mitigated in order to protect people from scalding.

People's medicines were not always handled, administered and stored safely. Procedures in place to ensure medicines were administered safely were not always followed.

We found that safe recruitment practices were not always followed as there was no evidence that disclosure and barring checks were completed before staff started work. We also saw that one staff had only one reference on file instead of two.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). There had been no applications to lawfully deprive people of their liberty. Staff had an awareness of the Mental Capacity Act 2005 but had out of date Mental Capacity Act training and safeguarding training. Although supervisions were in place there we found no appraisals completed for staff.

People told us that staff were caring and that their privacy and dignity was respected. People on an end of life pathway were supported to be comfortable and pain free.

People's care was delivered according to their preference. People were able to express their concerns. However we found that there was an ineffective system in place to record, acknowledge and respond to complaints.

There was no registered manager in place at the time of our visit. There were ineffective systems to assess, monitor and evaluate the quality of care delivered. Records were inaccessible and some did not reflect the current needs of people who used the service.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

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?

Inadequate

The service was not always safe. People told us they trusted staff who cared for them. We found that medicines were not administered, handled and stored safely.

The premises and some furniture were not always clean. Health and safety risks were not always assessed and mitigated.

Recruitment checks were not always safe as we found no evidence that disclosure and barring checks had been completed before staff started work.

Is the service effective?

Requires improvement

The service was not always effective. People told us that staff were knowledgeable and could do their job well.

There had been no applications made to lawfully deprive people of their liberty. Staff had some awareness of the Mental Capacity Act 2005 but had out of date Mental Capacity Act training.

Although supervisions were in place there were no staff appraisals completed for staff in order to enable staff to develop and learn ways to support people effectively.

Is the service caring?

Good

The service was caring. People told us that staff were caring and compassionate. We observed that staff interacted well with people and responded to their requests in a timely manner.

People's privacy and dignity were respected. Staff addressed people by their own name and told us how they respected people's wishes.

People were supported to be comfortable and pain free when on an end of life pathway. There was support for families during funerals and after when they came to collect their relative's possessions.

Is the service responsive?

Requires improvement

The service was not always responsive. People told us that staff knew them well and attended to their needs.

Care plans were person centred and documented people's preferences. Activities were infrequent but matched peoples hobbies and interests.

People could not remember the exact details of the complaint policy but said they could talk to the staff or the manager.

Though staff knew how to deal with complaints verbally and where to locate the policy we did not see any records to evidence that complaints were logged, acknowledged and responded to.

Summary of findings

Is the service well-led?

The service was not always well-led. People and their relatives told us that the registered manager and deputy were not at the service and that two staff were standing in.

Staff were aware of the values and the vision of the service which were to "create a home away from home".

We had not received any notifications as required by law relating to deaths that had occurred recently at the service.

There were ineffective systems to monitor and evaluate the quality of care that was being delivered.

Requires improvement

Little Gaynes Rest Home

Detailed findings

Background to this inspection

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

The inspection took place on 15 May 2015 and was unannounced.

The inspection was conducted by two inspectors.

Before the inspection we gathered information from safeguarding notifications and previous inspections. We also contacted the local authority to find out information about the service.

We spoke to five people who used the service and two relatives. We observed people during breakfast, lunch and supper. We spoke with staff including the provider, the cook, and three care staff. We observed care interactions in the main lounge, the conservatory, the small lounge and people's rooms. We reviewed five staff files, staff training and supervision logs. We also reviewed records relating to falls, and fire risk assessments. We looked at eight medicine administration records (MARS) and minutes of staff and "residents" meetings.

We also spoke to health care professionals, which included a district nurse. After the inspection we requested for the provider to supply us with the information relating to complaints, incidents and disclosure and barring checks (DBS). We received confirmation of the incidents but the provider was unable to locate complaints and DBS. We were sent information to confirm that an interim manager was now in place and that DBS checks applications had been submitted for all staff.

Inadequate

Is the service safe?

Our findings

People told us that they were supported to take their medicines. One person said, "The staff sort out my tablets as I don't always remember what to take." Another person said, "I get my tablets with my breakfast."

We found that medicines were not administered safely. The medicine trolley was left open and unattended at times during the time medicine was being administered and the person giving medicine was being interrupted by other staff. We saw that staff signed for medicines before administering them and that they did not always wait until people had taken the medicines before moving on to the next person. Some medicine was stored in a box in a fridge that was unlocked and could easily be accessed by people using the service. Similarly, a person's insulin was stored in a room that was very hot and whose temperatures were not monitored to ensure that the temperature did not rise above 25 degrees so as not to interfere with the potency of the medicine. We also found that six people's medicine administration records (MARS) had errors on them. For some the dose was not always written, and for one we found that a medicine that had been discontinued by the GP had been signed for as administered for two consecutive days despite the a note on the administration chart saying to stop the medicine. Staff told us they had not administered the medicine but could not explain why the MARS were signed. Another medicine was prescribed in a misleading way that could result in a person having two doses when they only required one. All the above did not ensure that people received the appropriate medicine as prescribed and left them at risk of receiving the wrong amount of medicine putting their health at risk.

We also saw that during the morning, afternoon and evening medicine administration time, one care staff went round administering the medicines. However when we checked the MARS we saw that they were two signatures which implied that two staff had checked medicines before administering to ensure that the correct person received the correct medicine.

Care and treatment was not always provided in a safe way. We found some risks such as falls and nutritional assessments were completed. However, other risks to the health and safety of people were not always assessed or mitigated. For example the hot water temperatures went up to 50 degrees in communal bathrooms and people's rooms and the heating rails in communal bathrooms were very hot and therefore put people at risk of scalding.

The premises and some furniture were not always clean. We found cobwebs in some rooms and a dirty chair in another room on the ground floor. We also found a dirty ensuite and two dirty toilets. In addition the cooker extractor fan and the floor near the cooker was visibly dirty. Although there was a cleaner employed they only worked from 10:00-14:00 Monday to Friday. This left the toilets dirty especially in the evening. The only shower room available had a shower head that was not working properly. People were not cared for in a clean and hygienic environment and equipment such as the shower was not always in good working order. This meant that people were left to use dirty toilets and could not have a shower if they chose.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment checks in place were not always safe and we found no evidence that disclosure and barring checks had been completed before staff started employment in order to safeguard people from staff who were not suitable to work with people in need of support. We also saw that one staff member had only one reference on file instead of two as outlined in the service's policy.

People told us that they felt there were enough staff most times with the exception of night time and some occasions where staff took longer to respond. Staff told us that there were a few shifts in the last two months where they had been short staffed but felt that they could cope with the needs of people with the current staffing levels. We reviewed the staffing rotas that were made available to us on the day and found some discrepancies. One staff member was on the rota as working Monday to Friday and every other weekend. This meant that they worked 12 consecutive days at times. This could impact on the quality of care delivered. We saw that on 11 May the service had been short staffed and no replacement staff had come to cover. Staff and the provider told us that absences were covered by other staff but saw that this arrangement meant that some shifts went unfilled as there were no temporary staffing arrangements in place.

There had been no qualified manager since April 2015 and the deputy manager who was acting up since February

Inadequate

Is the service safe?

2015 had left. The staff in charge of the service at the time of the inspection were not qualified or experienced, or registered as managers, and did not have adequate support from an experienced manager. As a result day-to-day management such as notifications and quality checks were not being completed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and trusted staff. Staff were aware of how to recognise and report abuse. They told us that they were able to raise any concerns with the manager. In the absence of the manager they said they would raise it with senior staff who would in turn notify the local authority and the Care Quality Commission (CQC). People were cared for by staff who were aware of the systems to prevent abuse from happening.

Staff were aware of the procedure to follow in the event of a fire and or a medical emergency. They had attended first aid training and completed regular fire drills. We saw evidence that each person had a fire risk assessment which showed the level of support they would require in the event of a fire. There were procedures to ensure staff responded appropriately in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

People told us that staff were knowledgeable and could do their job well. One person said, "It's the same people on duty most of the time and they know what I like." Another said, "Staff know I love a good laugh." Relatives told us that the staff were very helpful and treated people well.

People were cared for by staff who were experienced. However we found shortfalls in the training and understanding of staff in some areas. These included training and understanding of the Mental Capacity Act 2005 (MCA), medicines, infection control and safeguarding. We also found that staff had not had any appraisals in order to identify and plan for any training and development needs. This resulted in poor medicines management practices and a lack of awareness of the Deprivation of Liberty Safeguards (DoLS) in place which resulted in poor quality care given to people.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were communicated with effectively in a way they could understand. Staff described how they communicated with people who were slightly deaf and people who had lost their sight. We saw that staff had an induction when they began to work for the service in order to orientate them to the people and the environment. Staff attended supervision twice a year where privacy and dignity and safeguarding understanding were reinforced. We also saw that meetings took place where discussions about activities and care given were held. Staff said they felt supported by the manager who was currently off sick.

Staff told us how they would gain consent before delivering personal care. However we found shortfalls in staff's understanding of the MCA and how to obtain authorisation to lawfully deprive people of their liberty when it was in their best interests to do so. We saw four people being deprived of their liberty by use of bedrails and by keeping the door locked to prevent people from leaving the service. Towards the end of the day we saw staff constantly trying to stop a person from leaving for their own protection. However staff told us that there had been no deprivation of liberty applications. We checked people files and found no record mental capacity assessments or DoLS authorisations. Staff were unaware of how and when DoLS authorisations were required. We found risk assessments in people's files for the bed rails, and the behaviours and tendencies of people wanting to leave were documented, but staff did not know that DoLS were required. We found that staff had last attended training on the MCA in March 2013. There was no MCA training scheduled to update staff in line with changes made in 2014. Although staff had an awareness of the MCA, their knowledge was limited as they had out of date training and were unaware that they were unlawfully depriving people of their liberty.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain a balanced diet. We saw that people were given two options of a main course and desert at lunch time. Although the portions were small, people told us they were sufficient. There were regular hot and cold drinks offered to people throughout the day. People were offered assistance to cut up their food where required. Staff were aware of people on diabetic diets. We found that monthly weights and nutritional risk assessments were completed. There were systems to ensure that people found at risk of malnutrition were referred to a dietician and speech and language therapy.

People had access to other healthcare professionals. One person said, "I see the nurse every day." Another person said, "The doctor visits quite often." A relative said, "Staff call the GP who is only next door if anything changes." We saw that the GP came every Wednesday and reviewed people's health. People also had access to chiropody and dental services when they were required. People with long term conditions such as diabetes and people with venous leg ulcer had access to a district nurse. People were supported to maintain their health.

Good

Is the service caring?

Our findings

People told us that staff were polite and kind. One person said, “Staff are very good to me. They help me a lot.” Another person said staff were “Respectful and courteous.” Relatives told us that they were happy with the way staff interacted with people. One relative said, “It has been a huge relief knowing that someone is there to look after mum 24/7.” Another relative said, “Staff are kind and keep me updated on mum’s progress.”

People were given a chance to speak and were supported where required in a timely manner. One person chose to stay in their room and we saw that as staff went by to the laundry room they made an effort to make contact with the person each time they passed by. We saw staff smiling, laughing and joking with people throughout the day. Staff spoke fondly of people and could tell us about people’s families previous careers and aspirations.

People were supported to be comfortable when on an end of life pathway. There was support for families during funerals and after when they came to collect their relative’s possessions. We saw evidence in staff meeting minutes that care staff went to people’s funerals if the family permitted and also held a luncheon for the family at the service. Staff demonstrated how they showed empathy to families and people during their last stages of life and how people’s last wishes were respected.

People told us that they were treated with dignity and respect. We saw that staff addressed people by their preferred names. We saw that people’s preferences for same gender staff to attend to their personal hygiene needs was honoured where requested. We observed that staff spoke with people before encouraging them to get up and walk to the conservatory for their meals. Staff were aware of people’s religious and cultural preferences and respected their views

People were given information when they first started to use the service. We saw this was kept in people’s folders and explained issues such as fees, complaints and meal times. We saw that people who were expecting health care professional visits were kept informed.

We observed that a list of people’s birthdays was kept in the office in order to enable staff to remember and try to make the day special for people. Staff and relatives told us and we saw evidence that birthdays were celebrated according to people’s individual preferences.

Requires improvement

Is the service responsive?

Our findings

People told us that staff knew them well and attended to their needs. One person said, “They are very good to me and listen.” Another said staff “know what I want and usually come quickly when I call for them”. We observed that staff interacted well with people’s health needs requirements. For example we saw staff respond appropriately to a person when their blood sugar levels were low by offering them a drink and food.

People could not remember the exact details of the complaint policy but said they could talk to the staff or the manager. One person said, “I have had no need to grumble. I would speak out if anything went wrong.” Relatives thought concerns about care were dealt with promptly. However some felt that they had raised the issue of activities and this had not been dealt with. A relative said, “They are quite good at sorting most things out. However activities could be improved.” A second relative said, “I have no major concerns except more could be done to keep [my relative] stimulated. I have asked several times but there is no real change.”

We found that there was an ineffective system to identify, receive, record, handle and respond to complaints. Staff knew how to deal with complaints verbally and where to locate the complaints policy. However, they did not know where the complaints log was. They told us that there were no recent complaints and that the manager usually dealt with complaints. However, prior to our inspection we had received a complaint from a relative which they told us they had reported to the senior staff on duty in April 2015. No one knew if this complaint was logged or if a log of complaints was kept.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were person centred and included people’s likes and dislikes and their life history. For example, one person’s care plan said they liked to read and we saw that on the day our visit someone from the library came to collect and deliver books that this person had requested.

There was evidence that an initial needs assessment was made before a person began to use the service and that this was reviewed every few months when the person’s condition changed.

We saw that activities were very limited. The activities plans we saw scheduled six activities for the month of February and another six for March. There had been a visit to Southend the previous summer, a visit to a pantomime and to the theatre. However the few activities that happened corresponded to what was written in people’s care plans. For example in two care plans we reviewed we saw that people liked to go to the theatre. Minutes from staff meetings, feedback from these people and staff confirmed that they did go to the theatre even though it was not as often as they wanted. During our visit there was no scheduled activity in the morning. The only scheduled activity for the afternoon was pot planting and this was only completed by one person. The rest of the day was mainly people chatting with each other and their relatives or people reading the paper.

People told us that their relatives could visit at anytime during the day and could take them out if they wished. One relative said, “I come every other day. Staff are always welcoming and helped mum settle.” People were encouraged to maintain contact with their relatives or people who mattered to them. We observed several relatives visiting and interacting with people and staff.

Requires improvement

Is the service well-led?

Our findings

People told us that they had not seen the manager in a while. Relatives told us that two senior staff were in charge. They told us that they were happy with the staff. One person said, "Staff are approachable and we can have a good laugh." Another person said, "They try to listen and help as much as they can."

At the time of our visit there was no registered manager working at the service. We were informed by the provider that an interim manager had been sourced from an agency and was at the service Monday to Friday from 18 May 2015 until the current registered manager returned or a new manager was employed. Staff were aware of their roles and responsibilities and told us they had an approachable manager. They were aware of the reporting structures in the absence of both the registered manager and their deputy.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. On the day of the inspection we noted that we had not been informed about deaths that had occurred between January and May 2015. We had not been notified of falls that had resulted in injuries. This showed that CQC had not been informed of significant events in a timely way so that we could check that appropriate action had been taken to protect people. This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

We found several shortfalls to the systems to assess, monitor and improve the quality and safety of the services provided including the quality of the experience of people using the service. We asked for any monitoring audits related to the quality of care and were told by staff that these were completed by the provider. When asked, the provider told us these were completed by the manager who was currently off work. We found no documentary evidence to confirm that quality checks were completed in relevant areas such as food, medicines, infection control or records. We also found shortfalls in the training delivered to staff and gaps in the knowledge of staff in relation to the Mental Capacity Act 2005 and medicines management.

We found that the provider did not always seek and act on feedback from people and other persons for the purposes of continually evaluating and improving the service. Staff said annual satisfaction surveys were completed by the manager. However we only saw one questionnaire returned for 2014 and another for 2013's satisfaction survey. We did not see any action plan or any analysis of feedback given. Although we found record of one resident meeting on file dated 2 February 2015, this did not contain any specific feedback from people but focussed on planning activities. We saw no quality audits in order to evaluate and improve practice.

We found that the provider did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. Staff told us they completed checks on people regularly at night and on the environment but these were not recorded.

When we asked for records relating to the management of the service and employment checks we were told there were not at the premises and that the manager may have taken them home. As a result there was no documented evidence on whether staff had undergone disclosure and barring checks as well as other relevant checks. We also did not have access to records relating to complaints and staff rotas for March and April 2015. We found discrepancies in the staff rotas we reviewed dated May 2015 as they did not always show if staff who were off sick were replaced by another member of staff. People's care records were not always accurate. For example one person's records said they could not swallow and needed a pureed diet but we saw that person eating sandwiches at tea and a lamb chop at lunchtime.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of the values of the service which were "a home away from home". Staff told us that they wanted to create a homely environment. This was confirmed by people and their relatives who all said the small size made the atmosphere within the service "friendly and relaxed".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The registered person did not notify the Commission without delay of the death of a service user whilst services were being provided in the carrying on of a regulated activity; or as a consequence of the carrying on of a re The provider had failed to notify us of death that had occurred since our last inspection. Regulation 16 1 (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person did not operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Persons employed by the service provider in the provision of a regulated activity did not always receive appropriate training and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Persons employed for the purposes of carrying on a regulated activity must have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. The staff in charge of the service at the time of the inspection were not qualified or registered as managers and did not have adequate support from an experienced manager. Recruitment procedures were not always operated effectively to ensure that persons employed meet the conditions. Regulation 19 (1) (b) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission without delay of any injury to a service user resulting in the service user experiencing prolonged pain. Regulation 18 (1) (2) a(ii) & 2 a(iii).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 Care and treatment was not always provided in a safe way for service users. Risks to the health and safety of service users were not always assessed and reasonable practical steps to mitigate such risks were not always taken. The premises and equipment was not always clean or used in a safe way. Medicines were not managed safely. We found concerns relating to the storage handling and administration medicines People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 12 (1) (a) (b) (g) (d)

The enforcement action we took:
Issued a Warning Notice

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not operated effectively to ensure that quality of care was assessed, monitored in order to improve the quality and safety of the services provided. Risks relating to the health, safety and welfare of service users and others who may be at risk were not always assessed, monitored and mitigated. Records were not always accurate, complete and contemporaneous record in respect of each service user. Other records were not always accurate or complete.

This section is primarily information for the provider

Enforcement actions

The management did not always seek and act on feedback from relevant persons and for the purposes of continually evaluating and improving such services.

Regulation 17 2 (a) (b) (d) (ii) (e) (f)

The enforcement action we took:
Issued a Warning Notice