J.M.K Care Services Limited

Three Gables Residential Care Home

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Three Gables is a care home that provides accommodation for up to 19 older people who require a range of care and support related to living with a mental health condition. This includes a dementia type illness and behaviours that may challenge others. On the day of the inspection 17 people lived at the home.

There is a registered manager at the home who is also one of the partners of the business. 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.

This was an unannounced inspection and took place on 24 and 25 April 2017. We returned on 8 May 2017 to meet with the registered manager who had been away at the time of the inspection. This was the first inspection at Three Gables since the new provider had been registered with CQC.

People were supported by staff who knew them well and were committed to providing them with kind and compassionate care. Feedback received from people was positive about the care, the approach of the staff and atmosphere in the home. People and staff had benefitted from an open and positive culture at the home.

There was a quality assurance system in place to help identify areas where improvements were needed. This required more time to become fully embedded into everyday practice to become fully effective.

There were risk assessments in place however; these did not clearly reflect all the risks identified in some people's risk assessments. The information about one person's diet and some information about people's skin integrity was conflicting. There was limited guidance in place for people who needed 'as required' (PRN) medicines, other areas of medicines systems were managed safely.

People were supported by staff who were kind and caring. They had a good understanding of people's individual needs and choices. This enabled them to provide good person-centred care. However people's records did not always reflect the care people required or received.

Staff were busy throughout the day and attentive to people's needs. However, we found at mealtimes there were not enough staff to support people in a timely way.

There was an ongoing training and supervision programme in place. This included observations of staff in practice. Staff told us they felt supported through the supervision process. Appropriate checks were undertaken to ensure suitable staff were employed to work at the service.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards

(DoLS) had been submitted when required. However, there was not always clear information about how people who lacked capacity were supported to make decisions or how restrictions may affect them.

People were supported to eat and drink a variety of food of their choice and nutritional assessments were in place. However, some people did not receive the support they required to eat their meal in a timely and undistracted way.

Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse. They were able to tell us about the types of abuse and actions they would take to protect people.

People were supported to have access to healthcare services this included the GP, district nurse and chiropodist. Feedback from visiting healthcare professionals was positive.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Three Gables was not consistently safe.

Risk management was not always safe. It did not clearly identify risks to people or what steps were required to minimise the risks.

People's medicines were not always managed safely. There was limited guidance in place for people who needed 'as required' (PRN) medicines.

There were not always enough staff deployed to meet people's needs.

Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse.

Appropriate checks were undertaken to ensure suitable staff were employed to work at the service.

Is the service effective?

Requires Improvement

Three Gables was not consistently effective.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been submitted when required. However, there was not always clear information about how people who lacked capacity were enabled to make decisions or how restrictions may affect them

People were supported to eat and drink a variety of food of their choice and nutritional assessments were in place. However, some people did not receive the support they required to eat their meal in a timely and undistracted way.

There was an ongoing training and supervision programme in place. This included observations of staff in practice.

People were supported to have access to healthcare services this included the GP, district nurse and chiropodist.

Is the service caring?

Good

Three Gables was caring.

People were supported by kind and caring staff who knew them well.

People's privacy and dignity were respected.

People were involved in making decisions about their daily care.

Is the service responsive?

Good

Three Gables was responsive.

Staff knew people well and understood their care and support needs.

People's care was planned in a way that reflected their individual needs and
choices.

A complaints policy was in place and complaints were handled appropriately.

Is the service well-led?

Requires Improvement

Three Gables was not consistently well-led.

There was a quality assurance system in place and this was being developed. However, this had not identified all the shortfalls we found. People's records had been reviewed but these did not fully reflect the care they required and received.

There was an open culture at the home. Both the management team and staff were striving to improve and develop the service.

Three Gables Residential Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The inspection took place on 24 and 25 April and 8 May 2017.

Before the inspection we reviewed the information we held about the home. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with people who lived at Three Gables and they told us about the care they received. We spoke with eight people and one visitor. However, some people were unable to verbally share with us their experiences of life at the home because of their dementia. Therefore we spent a time during our inspection observing the interaction between staff and people and watched how people were being cared for by staff in communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff recruitment, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We looked at four care plans and risk assessments along with other relevant documentation to support our

findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with seven staff members including the registered manager and a visiting healthcare professional. Following the inspection we spoke with a further healthcare professional who visited the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "I have felt completely safe here." Another person told us, "I feel safe with all the girls." We observed people approaching staff freely and appeared relaxed in their presence. A visitor told us their relative was safe at the home.

However, we found aspects of the service were not consistently safe and needed to be improved.

There were a range of risk assessments in place to help keep people safe. These included mobility, nutrition and skin integrity. Information from these were used to inform the care plans. However, these did not always reflect the risks associated with supporting people. One person had been identified as requiring a specialised diet. In the kitchen this had been recorded as a liquidised diet, in the care plan it stated pureed diet in one area and soft diet in another. This person had also been prescribed a 'thickener' to assist with swallowing fluids but staff told us this was only given when the person was having difficulty swallowing. At lunchtime we observed the person eating a soft diet. Staff told us they were unsure what diet this person should be having as following discharge from hospital they had not received any written guidance. On the second day of the inspection staff contacted the person's GP to urgently review this person's needs.

There were risk assessments in place to demonstrate if people were at risk of pressure damage. These were reviewed monthly, one risk assessment had been calculated wrongly, the next month it had been recalculated and showed the person was at risk of pressure damage. However, the care plan had not been updated to reflect this increased risk and there was no information about pressure relieving equipment that should be used. One person was a diabetic and required their blood sugar levels to be checked regularly. There was no information about what the normal blood sugar levels were for that person or what staff should do if blood sugars were low or high. The risks to people were mitigated because staff had a good understanding of the support people needed. These were areas that need to be improved.

People had not been protected against all the risks associated with the unsafe management of medicines. Some of these medicines were 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. Where people received PRN medicines there were individual protocols in place to show why the medicine had been prescribed. However, there was no detailed guidance about when these should be given. Protocols stated, 'when in pain' or 'when constipated' but there was no information about how people, who were less able to communicate verbally, would be assessed as in pain or constipated. Another person had been prescribed a PRN medicine for agitation and again there was no detailed information about when this should be given. When PRN medicines had been given staff had not recorded the reason why or whether the medicine had been effective. The medicine care plans did not include current information about people's medicines which would help to guide staff. Staff were able to tell us when and why people may require PRN medicines. They told us what actions they would take to support the person if they were agitated prior to giving the medicine. We discussed this with the registered manager as an area that needs to be improved. However, the lack of clear guidance leaves people at risk of receiving care that is inconsistent or inappropriate. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a system in place to order, store, administer and dispose of people's medicines. Medicines Administration Records (MAR) charts had been completed fully and signed by staff and medicines had been administered as prescribed. Only staff who had received training and had their competencies checked administered medicines. People we spoke with told us they received their medicines when they needed them. One person said, "We get our medication on a regular basis."

People had mixed views about whether there was enough staff. One person said, "There seems to be enough staff. They responded quickly when I rang the bell." However, another person told us, "There could be a few more staff about from time to time." We found there were not always enough staff deployed to look after people and meet their individual needs. Staff were busy throughout the day and attentive to people's needs. However, we found at mealtimes there were not enough staff to support people in a timely way. The registered manager was not at work the first two days of our inspection and this had not been accounted for in staffing numbers. We spoke with the registered manager on the third day of our inspection, she told us this would be addressed through deployment of staff to ensure people were attended to in a timely way.

The rota showed there were regular staff working at the home each shift. On occasions agency staff would be used but staff told us this was usually at night and staff covered each other during the day. This happened the first two days of the inspection when staff not scheduled to work came into work to cover colleague's sickness. There were housekeeping staff, a cook and an activities co-ordinator working at the home. Staff told us if people's needs increased then extra staff would be asked to work to help ensure people received the required support.

People were protected from the risks of abuse and harm because staff had a good understanding of the safeguarding process. They had received safeguarding training and updates. They were able to talk to us about abuse and what actions they would take if they believed someone was at risk. They told us they had been provided with safeguarding information when they started work and this included guidance about who to contact both inside and outside the home. One staff member said, "I'd always report to the senior or manager but I do have a flow chart that tells me who to contact if I needed to go outside the home." There was a policy in place and this included a copy of the flow chart with contact numbers. The registered manager had introduced an audit which would help to identify if there were any safeguarding themes or trends.

Appropriate recruitment checks had taken place prior to staff commencing work at the home. This included references and criminal record checks with the Disclosure and Barring Service (DBS). This helped ensure, as far as possible, staff were of suitable character to work at the home.

Prior to the inspection we had concerns raised with us about staff access to protective equipment (PPE) such as gloves and aprons. Staff told us they were able to access PPE whenever they needed it. They told us where spare supplies were kept and how they could access this in the absence of the registered manager. During the inspection we observed supplies of PPE throughout the home which staff were using appropriately.

The home was clean and tidy throughout. There was a maintenance programme in place and the provider was aware of areas around the home which required updating. Regular health and safety risk assessments and checks had been completed. There were servicing contracts in place for example the boiler and passenger lift. There were systems in place to deal with an emergency which meant people would be protected. There was guidance for staff on what action to take and each person had their own personal evacuation and emergency plan. The home was staffed 24 hours a day and there were local arrangements in the event the home had to be evacuated.

Requires Improvement

Is the service effective?

Our findings

People told us they were provided with a choice of food and drink throughout the day. One person said, "The food's not bad, you can ask for something different." Another person told us, "I find the food very good" and the choice seems OK, I've no complaints." They told us their health needs were met, one person said "If you aren't well, they would get the doctor in." People told us staff were good and had a good understanding of their roles. One person said, "Staff are good at doing their jobs." A visitor told us, "The staff are brilliant my relative is very well looked after."

Despite this positive feedback we found aspects of the service were not consistently effective.

Before the inspection concerns were raised with us that there was not enough food available for people. We looked in the kitchen and saw well-stocked shelves. The cook told us they ordered the food they required each week, they said there was no barriers or limits to what they could order. Staff supported this however, they told us on occasions there had not been enough food to offer people a choice of meals at lunchtime. They said this was due to poor stock control and ordering and not due to people's food being limited. Staff told us this had recently been raised with a director and was being addressed. Staff also said they were able to buy extra food for people at any time. This was confirmed by the registered manager and director.

At lunchtime people were able to choose where to eat their meals. One person remained in their room others ate in the main dining room and those who required more support ate in the small lounge. In the main dining room people sat at tables within their friendship groups. The mealtime here was relaxed and people chatted with each other and staff as their meals were served. In the small lounge there was one large dining table, four people sat at this and three other people sat in the lounge area with individual tables. There was one member of care staff serving meals, one supporting the person in their room and one in the small lounge where people required more support. This staff member sat at the table and supported one person and encouraged others. However, we observed other people did not get the support or encouragement they needed in a timely way. One person who sat at an individual table struggled to eat their meal as they did not have the appropriate equipment. We identified this to a staff member who provided the person with a plate guard and more appropriate cutlery. They were then able to enjoy their meal independently. A second person required prompting and reminding to eat their meal otherwise they would leave and return to their bedroom. When staff were with this person they were able to encourage them to eat more of their meal. On occasions the staff member at the table offered help and support to these two people but this was distracting for all those who needed support. Staff told us usually the registered manager also supported people at mealtimes but there was no replacement available in her absence. This is an area that needs to be improved.

There were nutritional assessments in place and people were weighed regularly to identify if they were at risk of malnutrition or dehydration. Some people who were at risk of losing weight had been prescribed fortified drinks. However their food was not fortified which would help promote and maintain weight by adding extra calories to their food. Care staff understood the importance of ensuring people had enough to eat and drink and action was taken when people were losing weight. They told us they had identified that

food was not being fortified and had recently raised this with the director. The registered manager told us this was an area that she planned to develop through training and supervision.

Despite these concerns people were supported to have enough to eat and drink throughout the day. They were given a choice of meals and individual preferences were respected. One person told us, "If you don't like the choice, you can ask for something different." Another person said, "There's lots to drink." The cook and staff had a good understanding of people's individual likes and dislikes. There was a menu displayed on the wall and people who were able could access this throughout the day. The operations manager told us this was an area they wished to develop. The registered manager had introduced pictorial support to help people chose their meals but this had not been effective. This was going to be further developed so that written menus with appropriate photographic menus would be displayed on each dining table. This would help people who were less able to choose their meals and would act as a reminder as to what they were eating that day. At lunchtime we saw people eating a choice of meals and one person had chosen to have an alternative meal. Staff had a good understanding of what people liked to eat and drink. They told us how they supported people who were less able to communicate to maintain their likes and dislikes. One staff member told us about a person who no longer lived at the home. They said, "I remember when she was well, she never wanted milk in her hot drinks, when she couldn't tell us what she wanted I always remember that and made sure she had what she enjoyed." Another staff member told us how by getting to know people they identified their food choices. They said, "When one person pushed broccoli out of their mouth we knew they didn't like it. They're not given that anymore." This demonstrated staff were aware of the importance of ensuring people were provided with a choice of food that they enjoyed.

Staff recorded what people ate and drank throughout the day which helped identify people who were not eating enough and what people liked to eat. There were a choice of soft drinks provided and hot drinks and snacks were served throughout the day.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people lacked capacity DoLS applications had been made or authorisations were in place.

The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. There was inconsistent information in people's care plans about whether they lacked capacity or how they could make decisions. Not all care plans clearly stated whether people had capacity, they did not reflect the individual and did not contain detailed information about how people could make decisions. There had been some best interest discussions recorded to show how decisions had been made for example in relation to personal care, but for other decisions such as why a person remained in their room there had not taken place. In some care plans there was information about whether someone else could make decisions on a person's behalf such as a power of attorney but this was not consistent across people's care plans. The registered manager had identified this as an area that needed to be improved. She had developed a check list for staff to identify which areas people required support to make decisions. This would then be incorporated into people's care plans. The impact on people was reduced because staff demonstrated an understanding of mental capacity and DoLS. They knew people well and

were able to tell us how people were supported to make their own decisions. Throughout the inspection we observed staff offering people choice and asking consent before they provided care and support.

People told us staff had a good understanding of their needs. One person said, "The staff are well trained." Another told us, "Staff do know what I need" and another added, "Staff are good at doing their jobs." There was a training programme in place this included moving and handling, infection control, safeguarding and dementia. From the training matrix we saw that not all staff had received recent training or updates but we were told this was not correct. The registered manager told us that prior to them taking over the home staff had received training. However, she wanted to know of the quality and content of the training provided. Therefore all staff were to receive refresher training and this was ongoing. She told us this was in place and staff had received the appropriate training. Not all staff gave medicines but those who did had received appropriate training and had their competencies assessed to ensure they had the skills and knowledge required. There were no other formal competency assessments but the registered manager and staff told us she observed staff on a day to day basis and would ask them questions about what they were doing and ask them the rationale. This helped her identify any areas staff may require further training or issues that needed to be discussed during supervision. The registered manager had also introduced 'situational training' where senior care staff with supervisory responsibilities would discuss areas of learning with staff. We saw these discussions had taken place and were signed by all staff involved.

When staff commenced work at the home there was an induction programme in place. This included orientation to home and people. Staff also shadowed more experienced colleagues for a week. Staff who were new to care were required to undertake care certificate, for which there was an arrangement with an external training provider. Care Certificate training which familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. One staff member told us the Care Certificate had "Opened their eyes to their surroundings" and given them insight as to the care they were providing.

The registered manager was passionate about developing and training staff. Staff had the opportunity to complete further diploma level training to enhance their knowledge and skills. Staff told us they were pleased to have this opportunity to develop.

There was a supervision programme in place and we saw staff received this regularly. In addition to regular supervisions these were also completed when areas of concern had been identified for example with staff practice. These were also completed by senior care staff in the absence of the registered manager and fully addressed by her on her return. When issues had been raised we saw these had been addressed through the supervision process and appropriate actions taken where required.

People were supported to have access to healthcare services and maintain good health. One person said, "Staff will call the doctor if needed". Care records showed external healthcare professionals were involved in supporting people to maintain their health. This included GP, district nurses, optician and chiropodist. Healthcare professionals told us the staff referred concerns to them appropriately when a need was identified.

Good

Is the service caring?

Our findings

People were treated with kindness, understanding and respect. People spoke positively about the kindness of staff. One person told us, "Staff are very nice, kind to all of us." Another person said, "The staff are nice people, kind and caring." A healthcare professional told us staff knew people well and treated them with kindness.

There was a warm and friendly atmosphere at the home. Staff were observant and attentive to people's needs. The SOFI and general observations showed interactions between staff and people were caring and professional. We observed one staff member approaching a person and asking if they were alright. The staff member said, "Are you cold, come and sit here by the fire, you'll soon warm up." When staff approached people they did so respectfully and spoke to them using their chosen name and made time to speak with them throughout the day. Staff complimented people on their appearances which demonstrated they took an interest in people.

People told us staff were respectful. One person said, "The staff are respectful, like making sure it's private when looking after me." We saw staff spoke discreetly with people, when for example supporting them to use the toilet or offering personal care. Bedroom doors remained closed when staff were supporting people and people told us staff respected their privacy. One person said, "They (staff) always knock before coming into my room" and this is what we observed during the inspection. People's bedrooms were personalised with their belongings such as photographs and mementos.

Staff supported people with care and kindness. There were conversations between staff and people, these were positive and there was friendly chat and good humour between them. People were genuinely pleased to see staff and staff greeted people with smiles. We observed one person trying to teach a staff member to knit, this resulted in fun and laughter and lots of good hearted banter between people and staff. This demonstrated there was a relaxed and friendly relationship between people and staff. One person liked to hold a soft toy for comfort and reassurance. Staff ensured these were always available to the person and we heard staff engaging with the person and discussing the toys.

People were involved in decisions about their day to day care and support and were supported to spend their day as they chose. Staff offered people choices throughout the day and supported to spend their time where they wished. One person said, "I am able to do what I want" and person told us, "No one bothers me, I am left to get up when I like."

Staff knew people well and they were able to tell us about people's personal histories, care needs, likes, dislikes, individual choices and preferences. Most people spent the day in the lounges but they were able to return to their rooms as they wished. People had their own routines, staff knew what these were and supported people to maintain them. They told us about one person who didn't come into the lounge until 10am, this person said, "Staff have just helped me and now it's time to go to the lounge for a cup of tea." People had developed their own friendship groups and were supported to continue these. They spent time together in the lounge and in the garden chatting and enjoying each other's company. Visitors were always

welcomed at the home. One person told us, "There are no restrictions on family visiting."

People were supported to maintain and develop their independence as far as possible. One person said, "I am encouraged to be as independent as I can be." We saw staff supporting people to stand and walk, they worked at the person's own pace and guided them with patience and encouragement. People were reminded and supported to go to the toilet to help them maintain their continence and dignity.

Good

Is the service responsive?

Our findings

People received the care and support they needed and chose and care was personalised to people's individual preferences. People chose how to spend their day and were able to move freely around the home. A visitor told us they were kept updated about their relatives care. People told us they had not been involved in developing their care plans. One person said, "I haven't spoken to anyone about my care plan." However, people told us they were involved in their care decisions on a day to day basis. People told us they had no cause to complain but if they did they would talk to staff. We were told, "I know the staff and I can go to them."

Before people moved into the home the registered manager undertook a pre-admission assessment to ensure their needs and choices could be met. This was completed with the person and where appropriate their representative. This information was used to develop care plans and included information about their needs in relation to personal care, mobility, skin integrity, nutrition, health and personal preferences. Care plans and risk assessments were reviewed regularly. Care plans did not always reflect people's current needs however this did not impact on people. People received care that was person centred because staff knew them well and had a good understanding of their needs and were able to tell us about it in detail.

There was a mixed response from people about whether they had enough to do during the day. One person said, "There's not much to do here," another, "There is a bit going on sometimes. We get involved in decorating the place for Christmas and Easter" and also, "We do exercises, music for health, once a month, we get pets coming in and we get out into the garden in good weather." Another person told us they were chose what they would like to take part in. They said, "I take part in what I want to, listening to music, watching TV and a singer comes in sometimes to entertain us."

There was an activity programme displayed however this was not followed. Staff told us, "We decide on the day what to do." The registered manager had identified there needed to be improvements to what people did each day to ensure activities were relevant and meaningful. An activities co-ordinator had been employed for a few hours each week and the registered manager had arranged for the local In-reach team to work with staff to develop their understanding of providing good person-centred care. The In-reach team provides a specialist service to support providers to develop their understanding of person-centred care. During the day we saw a variety of activities taking place. People were engaged in a jigsaw puzzle, the activities co-ordinator had supported two people to play a board game. We observed one staff member sitting with people and looking at a magazine prior to lunch, another person was supported to finish their daily crossword puzzle. Staff had also engaged a number of people in a quiz which people clearly enjoyed. This stimulated people's memories and further conversations. The activities co-ordinator had a good understanding of what people liked to do and their abilities and was using this to develop individual activities. We were told about one person who did not like to join in but sat and observed activities. This was recognised as important for this person and the activity co-ordinator supported this involvement. People had taken part in making Easter decorations, this included an Easter tree which was now going to be a memory tree. The activities co-ordinator registered manager and operations manager were enthusiastic about developing the activity programme and involving care staff to embed meaningful activities into

people's daily lives.

There were celebrations and events held in the home which were enjoyed by the people living there. People's birthdays were remembered and celebrated. One person said, "They do a special do for you on your birthday."

There was a complaints policy and procedure in place. There were no current complaints. The registered manager had introduced a log where people's concerns had been recorded. This included information about the concern and action taken to resolve it. This prevented concerns being escalated into formal complaints.

People were asked for their feedback through surveys and regular resident meetings. Feedback from people and their relatives was positive. Minutes from the meetings demonstrated the people were asked for their opinion on life at the home. There were discussions about what people liked to do and their meal choices. Not everybody liked to attend the meetings and the registered manager told us she spoke to people individually to gather their feedback. We saw complaints had been investigated and the person responded to appropriately. People told us they would make a complaint if they needed to. A visitor told us they had raised a concern and staff had asked if they wished to make a complaint but they declined. They told us they were happy with the actions taken. There was one complaint that was being addressed at the time of our inspection. People told us they had no complaints but would be happy to raise them and were confident they would be addressed appropriately. One person said, "I've never needed to complain, but I would. No major concerns here."

Requires Improvement

Is the service well-led?

Our findings

People and the visitor were complimentary about the management of the home. Staff told us they were supported by the registered manager. They said she was approachable and they could talk to her about anything. One person told us, "I get on well with the manager, she is approachable and she seems to know everybody's names." A visitor said, "I can't speak highly enough about this home and its management."

We identified that some improvements were required to ensure the changes that had been made were fully embedded into everyday practice.

The registered manager had identified areas that she needed to improve and develop when the home was registered with CQC. There was an action plan in place and we could see a large amount of work had taken place. This included maintenance and redecoration around the home which was on-going, staff training and development and improvements to the medicine system. The registered manager had taken the time to get to know people and staff and introduced a comprehensive audit system. The audits identified areas which needed to be improved and we could see that actions had been taken to address these. When completing audits the registered manager told us she would take a staff member with her to explain what was being done and obtain another opinion. The operations manager also completed monthly audits to ensure appropriate actions had been taken where issues had been identified.

Accident and incident records had been completed. These contained a description of the event and the actions taken following the incident to protect the person. However, they did not always contain information about what had been done to prevent a reoccurrence. There was a lack of analysis to identify any themes and trends. The registered manager told us she had also identified this and had introduced new documentation to help support this.

The medicine audit had identified that staff were working to ensure PRN protocols were in place. However, these had not shown that protocols did not include all the information required. We found people's records did not contain all the information to show the care they required and received. Examples included, one care plan that stated the person liked to watch TV but did not include any information about what programmes. Another person required specific personal care and although staff could tell us about this it had not been recorded. Another person's risk assessment stated to check the person's ability to use the lights but there was no information about what their ability was. Daily records did not fully show what people had done each day and other charts related to continence care had not been fully completed. Some people required support to maintain their continence and good skin condition but there was limited information to demonstrate how this support was provided. Staff knew people well and were able to tell us about the support they provided however, the lack of clear records leaves people at risk of receiving care that is inconsistent or inappropriate. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff told us that staff were being given the responsibility of writing, reviewing and updating people's care plans and risk assessments. Staff had received some training and the registered

manager had planned to work with them to further develop their knowledge and skills. The registered manager told us it was important that staff were supported to develop the knowledge and skills to write care plans and risk assessments that fully reflected people.

Before the inspection concerns had been raised to us that the registered manager did not know people well, did not understand their needs and did not spend much time at the home. This is not what we observed or what we were told during the inspection. The registered manager was a visible presence and worked at the home most days. She had worked hard to develop a positive culture and aimed to provide the best quality of care possible. She was clear about developing and empowering staff to fully understand their roles and responsibilities and help develop the service. Staff told us since they had been more involved in the day to day running of the service they understood what was required of them and the reasons why. One staff member said, "I can see why we do what we do now, being involved helps me make sense of things."

The registered manager knew people well; she had a good understanding of their individual care and support needs, their likes and choices. People told us both the registered manager and staff were approachable. Their comments included, "The service here is very good," "The manager is very busy at running this place." There is a resident's meeting every month and overall, it's very good here."

The registered manager had plans in place to continue to develop and improve the service. This included continuous development for staff and the introduction of 'champions.' She also planned to establish and develop links within the community to enhance the lives of people who lived at Three Gables.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that service users were protected from unsafe care and treatment by the quality assurance systems in place. The provider had failed to ensure people's records were accurate and complete. 17 (1)(2) (a)(b)(c)