Gabriel Court Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Gabriel Court is a residential care home separated into two units providing personal care to up to 44 people. One unit is the lower dependency unit and the other is the higher dependency unit, where people with more advanced dementia are cared for. At the time of our inspection there were 38 people using the service.

People's experience of using this service and what we found
Medicines were not always safely managed. As a result, three people had not received their medicines as prescribed and stock control systems required improvement.

The provider had quality control systems in place, however they were not always effective as records were not always correct and audits had not always identified errors in records.

There were enough skilled and experienced staff to meet people's needs. Staff were adequately trained and had regular competency checks. Staff told us that they felt supported by the management team.

People's individual risks were managed in a safe way and staff knew how to protect people from the risk of harm and abuse. Risk assessments were completed appropriately, for example around nutrition, pressure sores and mobility.

Care records were person-centred and contained sufficient information about people's preferences, specific routines, their life history and interests.

People and their representatives were involved in the planning of their care and given opportunities to feedback on the service they received. People's views were acted upon.

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

The last rating for this service was inadequate (published 5 June 2020) and there were breaches of nine regulations. We placed conditions on the provider's registration whereby they were required to send monthly reports on the improvements they had made. At this inspection improvements had been made, however the provider was still in breach of regulations so the conditions remain in place.

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines, moving and handling practices and wound care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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

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

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Gabriel Court Limited on our website at www.cqc.org.uk.

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 two breaches in relation to the management of medicines and the accuracy of records at this inspection. We also found that when the provider identified that improvements were needed, action plans were not always created to evidence that the required improvements were being addressed.

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

Follow up
We will continue to receive monthly reports from 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.

Special Measures
The overall rating for this service is 'Requires improvement'. However, the service will remain in 'special measures', as whilst the ratings in the Safe and Well-Led domains have improved from inadequate to requires improvement, the rating in the Effective domain remains as inadequate. This means we will keep the service under review and 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, 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 of 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?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Gabriel Court Limited

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.

Inspection team
The inspection was carried out by two inspectors. An Expert by Experience contacted the relatives of people who use the service via telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Gabriel Court Limited 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
The inspection was unannounced; however, we spoke to the registered manager on the telephone before entering the service. This supported the home and us to manage any potential risks associated with Covid-19.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group. 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 consideration when we inspected the service and made the judgements in this

report. We used all of this information to plan our inspection.

During the inspection
We spoke with five relatives of people who use the service about their experience of the care provided. We spoke with nine members of staff including the provider, the nominated individual, the registered manager, the deputy manager, the compliance officer, the head of care and three care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found and reviewed further evidence that the provider submitted.

Requires Improvement

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 now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At the last inspection we found that the provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to assess the risks to the health and safety of people using the service, or take action to mitigate risks.

Not enough improvement had been made and the provider was still in breach of Regulation 12.

Using medicines safely; Assessing risk, safety monitoring and management

- Improvements were required to medicines management. People did not always receive the medicines they required. We found during the inspection that one person had not been given their medicines five times in one month, and two other people had also not been given their medicines as required. This put people at increased risk from their health conditions.
- Improvements were also required to how medicines were ordered and how stock levels were controlled. People's medicines were not always ordered in sufficient time which resulted in one person not receiving their medicine as prescribed for 3 days. Two people had excess medication stored in the medicine cupboard. This was in addition to significant stock that required disposal but had been delayed due to implications of Covid-19.
- The registered manager was aware of the missed medicines and had taken some action to attempt to remedy this. However, this had not been completed in a timely manner.

The provider failed to ensure people received their medicines as required. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were control measures in place such as weekly and monthly medicines audits. The service had recognised that there were problems with medicines prior to inspection and were working to improve this.
- We observed staff administering medicines in a safe way and staff treated people with dignity and respect. Staff demonstrated knowledge of each individual and were able to describe how each preferred to take their medicines.
- Staff appropriately recorded incidents where people's behaviour could harm themselves or others. Action taken by staff was in line with people's behaviour care plans, which contained detailed information. This meant that staff were assessing risk based on behaviours that could harm people and were monitoring and managing people's safety appropriately.
- Staff promoted independence and encouraged people to use walking aids where they were at risk of falls or were recovering from an injury. One relative told us staff encouraged their spouse to use a walking aid following an injury and said, "It was [staff] who encouraged them to walk independently after the operation

without the support of the zimmer frame".
● When risk was identified, the provider took steps to mitigate this by providing appropriate assistive technology. One relative said, "[My spouse] was found wandering in the corridors at night. [Staff] put a sensor mat by their bed so someone could be alerted if they got up. I was happy with that".

Systems and processes to safeguard people from the risk of abuse
At the last inspection the provider was in breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to protect people from the risks of abuse as they did not have suitable systems to identify and report incidents of physical and verbal abuse

The provider had made improvements and they were no longer in breach of Regulation 13.

● Staff were trained in safeguarding and knew how to recognise the signs of abuse. The staff that we spoke with said that they know how to report incidents and who to report them to.
● Safeguarding alerts had been raised appropriately and clear records were maintained. When incidents occurred, clear actions were identified and implemented to minimise the risk of re-occurrence.
● One relative told us, "Staff regard the resident's safety as paramount, and I feel they are doing an incredible job. They have worked so hard to keep everyone safe and well".

Staffing and recruitment
At the last inspection the provider was in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have enough skilled and competent staff deployed to meet people's needs.

The provider had made improvements and they were no longer in breach of Regulation 18.

● Staff recruitment was suitable. Pre-employment checks were carried out when appointing a staff member to ensure that they were suitable to work with vulnerable people. For example, a criminal conviction check and previous employer references were obtained. Where people had started prior to a criminal conviction check being obtained, a risk assessment was in place.
● There were enough staff deployed to provide people with their care at regular planned times and to respond to people when they needed care as and when. One relative told us, "I think there are enough staff".

Preventing and controlling infection
● People were protected from the risks of infection as the staff supporting them had undergone training in infection prevention and undertook safe practices when providing care. Staff demonstrated good knowledge of infection prevention and control practices.
● We observed staff using personal protective equipment (PPE) appropriately when providing care for people. There was enough of the right kind of PPE available to staff throughout the home.
● All areas of the home were clean, including communal areas such as the lounges and dining rooms and private areas such as bedrooms and bathrooms. One relative told us, "Staff always clean. They never stop cleaning. [Person's name]'s room was always spotless".

Learning lessons when things go wrong
● Accidents and incidents were recorded, and the information collated and analysed and used to inform measures to prevent incidents reoccurring. For example, following a fall, staff took appropriate measures to reduce the risk of re-occurrence.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection we found that the provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have systems and processes in place to assess, monitor and mitigate the risks relating to health, safety and welfare of service users, or have systems to improve the quality and safety of care.

Not enough improvement had been made and the provider was still in breach of Regulation 17.

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

- Oversight of documentation and records was not always effective. For example, we found several documents were not signed and dated. We found that cleaning schedules were not always fully completed, and this had not been identified during a subsequent audit. We found that one care plan contained the details of two different people who use the service. This meant that staff did not always have the correct information.
- Auditing documentation required better action plans when issues were identified. For example, issues were identified during a medicines competency assessment for a member of staff, but the assessment did not have a section for what action would take place to address the issue, by what date and by whom. The issue was subsequently addressed in a supervision with the staff member and a note added to their staff file.
- Decisions about people's care were not always documented. For example, staff had discontinued daily health checks for one person but had not recorded that this was on the advice of their GP. This meant that there was insufficient documentation to evidence and justify the actions taken.

These issues were a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed the care plan containing details of two different people who used the service had been corrected, they told us they would ensure they report incidents appropriately and that ongoing checks to ensure records were robust were in place.

- The registered manager understood their regulatory requirements to report incidents and events to CQC.

● Information within care plans was very person-centred and included up to date, relevant information around people's needs, their likes and dislikes, their life history and family relationships.
● Staff were knowledgeable about people who used the service and demonstrated that they took a person-centred approach to providing care.

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 provider's website did not display the rating of the service at the last inspection. The provider added this information after the inspection, although the information remained unclear and was not easy to find. However, the provider was displaying the current rating within the service.
● The provider had implemented a whistle blowing policy and had made all staff aware of it. There was also a poster in the reception area advising people of who to contact.

Working in partnership with others; Continuous learning and improving care
● Improvements were required in partnership working with the GP surgery and pharmacy to improve communication. This would reduce the risk of people not receiving their medicines in a timely manner and would allow staff to understand sooner the potential impact of a person not receiving their medicines.
● The provider had worked with a private consultancy firm to improve systems and processes. We saw that the provider had implemented the required policies and procedures and had made improvements to documents such as care plans, audits and risk assessments. However, further improvements were required to these documents and the changes needed to be better embedded within the service.
● The provider had worked with the local authority quality improvement team and we found a number of improvements since the last inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People who use the service had the opportunity to attend regular residents' meetings and issues and suggestions were acted upon. For example, residents were asked about meal and activity choices during these meetings. Those who were unable or did not wish to attend the meetings were given a satisfaction survey.
● The registered manager held regular staff meetings and staff told us that the registered manager was visible throughout the service and was approachable and supportive. One staff member told us, "Managers treat me with respect. They do tell us what we need to know. I feel like I know what's going on".