M & S Care Limited

Seven Gables

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service:
Seven Gables is a residential care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Seven Gables is registered to provide care for up to 25 people, including people living with mental health needs and dementia. At the time of the inspection, there were 25 people living at the service.

People's experience of using this service:
• The environment was warm and homely. Communal areas of the home had recently been re-decorated.
• People told us they were happy living at Seven Gables. There was an established staff team that knew people well. One person told us, "I'm quite happy here."
• Individual and environmental risks were managed appropriately. People had access to appropriate equipment where needed, which meant people were safe from harm.
• Medicines were administered safely and as prescribed. This was monitored through an electronic medicine administration system.
• Staff had received appropriate training and support to enable them to carry out their role safely. They received regular supervision to help develop their skills and support them in their role.
• Staff recognised people's individual needs and supported them to make choices in line with legislation.
• People and their families were involved in the development of personalised care plans that were reviewed regularly.
• The registered manager and provider carried out regular checks on the quality and safety of the service.
• The service met the characteristics of Good in all areas. More information is in the full report.

Rating at last inspection:
The service was rated as Good at the last full comprehensive inspection, the report for which was published on 26 July 2016.

Why we inspected:
This was a planned inspection based on the previous inspection rating.

Follow up:
There is no required follow up to this inspection. However, we will continue to monitor the service and will inspect the service again based on the information we receive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our Safe findings below.	Good
Is the service effective? The service was effective Details are in our Effective findings below.	Good
Is the service caring? The service was caring Details are in our Caring findings below.	Good
Is the service responsive? The service was responsive Details are in our Responsive findings below.	Good
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	Good

Seven Gables

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was conducted by two inspectors and an expert by experience [ExE]. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The ExE had experience of care for older people and those living with dementia.

Service and service type:
Seven Gables is a care home registered to accommodate up to 25 people who need support with personal care. 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:
We did not give notice of our inspection.

What we did:
Before the inspection we reviewed the information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we gathered information from:
- Ten people using the service.
- Six people's care records.
- The registered manager.

• The deputy manager.
• Five members of staff.
• Three relatives of people using the service.
• One external healthcare professional.
• Records of accidents, incidents and complaints.
• Audits and quality assurance reports.

Following the inspection, we gathered further information from:
• One external social care professional.

Good

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
• There were appropriate policies and systems in place to protect people from the risk of abuse. Staff had received training in safeguarding adults and knew how to recognise abuse and protect people. One staff member told us that they would, "Go straight to the manager or would call safeguarding or CQC if I was not happy with the response."
• People and their families told us they felt safe. One person said, "One of the reasons for being here is that I feel safe and I am allowed to take my time."
• There were robust processes in place for investigating any safeguarding incidents that had occurred, in liaison with the local safeguarding team.

Assessing risk, safety monitoring and management:
• Risks to people had been assessed as part of the care planning process. These were recorded within an electronic care record for each person and clearly identified how staff should support people and what equipment, if any, was needed. Risks were reviewed regularly and updated when required. An external social care professional told us, "People are safe at Seven Gables and I have no concerns."
• The environment and equipment was safe and well maintained. Risks from the environment had been assessed and each person had a personal emergency evacuation plan (PEEP). These identified what assistance each person would need to safely leave the building, in the event of an emergency.
• Staff had a handover at the start of each shift, which informed them of any important information they needed to meet people's needs. For example, information in relation to people's health, any professional visits and if they had declined care was handed over. This meant that staff were fully up to date with essential information.

Staffing and recruitment:
• There were sufficient staff deployed to meet people's needs and keep them safe. The registered manager told us they used a dependency tool, observed care, reviewed call bell times and spoke to people and staff regularly about the levels of staff available to people. We observed that people were given the time they required and were not rushed by staff. One person, when asked about staff responding to their call bell said, "They [staff] are usually here in a few minutes. They keep dropping by, so I rarely need to use it."
• Recruitment procedures were robust, to help ensure only suitable staff were employed.

Using medicines safely:
• The provider had implemented a new electronic medicines system since the last inspection. The registered manager and deputy manager carried out spot checks and monitored that people received their medicines as prescribed.
• Medicine administration records (MAR) were completed as required.

• Medicines that required extra control by law, were stored securely and audited each time they were administered.

Preventing and controlling infection:
• The home was clean and well maintained. Staff completed regular cleaning tasks in line with schedules. An external healthcare professional told us, "The home is always clean and smells nice."
• There were systems in place to protect people from the risk of infection. All staff had attended infection control training and had access to personal protective equipment (PPE), which we saw they wore when needed.

Learning lessons when things go wrong:
• Accidents and incidents were recorded, the registered manager had robust procedures in place to investigate the cause, learn lessons and take remedial action to prevent a recurrence. For example, when records showed that people had more than one fall in a three month period, risk assessments were reviewed and contact with external healthcare professionals was made. This meant possible causes could be identified and action taken to reduce the likelihood of further falls.
• Records of any accidents or people's changing health needs were clearly marked on the front page of the electronic care records system. This meant staff were aware of accidents or changing needs as soon as they logged into the system.

Good

Is the service effective?

Our findings

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

People's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience:
• New staff received an induction into their role and shadowed more experienced staff whilst they got to know people.
• Staff received training that enabled them to meet the needs of people living at the service. A staff member told us, "We get a lot of training, its good."
• Staff received regular supervision which enabled the registered manager and deputy manager to monitor and support staff in their role and to identify any training opportunities. Staff were kept up to date through handover meetings between shifts.
• Staff told us they felt supported in their roles by the registered manager and the provider. One staff member said, "We are very well supported [by the management]; they are very supportive."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Comprehensive assessments had been completed and electronically stored care plans clearly identified people's needs and the choices they had made about the care and support they received.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. People's diverse needs were detailed in their care plans which included people's needs in relation to their culture, religion, diet and gender preferences for staff support.
• Staff completed training in equality and diversity and the registered manager and staff were committed to ensuring people's equality and diversity needs were met.
• Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.

Ensuring consent to care and treatment in line with law and guidance:
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
• Staff were knowledgeable about how to protect people's human rights. Staff told us they sought verbal consent from people before providing care and support. One person, when asked if staff gave them choice said, "Oh yes. I like choosing my meals each morning."
• Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the service's policies and systems supported this practice.
• People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Although there was no one currently under a DoLS, the registered manager had ensured that where needed, authorisations had been applied for.

Supporting people to eat and drink enough to maintain a balanced diet:
• People had choice and access to sufficient food and drink throughout the day; food was well presented and people told us they enjoyed it. One person told us, "They [staff] really know how to make good old fashioned custard. It's always the real thing and hot."
• Where people required their food to be prepared differently because of a medical need or problems with swallowing, staff were aware of the associated risks. Staff followed guidance from healthcare professionals in relation to these.

Staff working with other agencies to provide consistent, effective, timely care:
• Where people required support from external healthcare professionals this was arranged and staff followed guidance provided by professionals. Information was shared with other agencies if people needed to access other services such as hospitals. An external healthcare professional told us, "The manager is very organised and makes sure people receive the support they need."
• When people were admitted to hospital, staff could print information about the person from electronic care records. This could be given to the medical team to help ensure the person's needs were understood.

Supporting people to live healthier lives, access healthcare services and support:
• A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used nationally recognised tools to assess people's pain levels, risks of developing pressure injuries and to monitor their bowel movements.
• In addition, the service used an electronic healthcare monitoring system. This enabled them to carry out health checks on people such as taking blood pressure. The results of the tests were then electronically sent to the local medical centre where it was reviewed by healthcare professionals. If people required further medical intervention, this was arranged promptly.
• Care records confirmed people were regularly seen by doctors, specialist nurses and chiropodists.

Adapting service, design, decoration to meet people's needs:
• The building had been adapted to meet the needs of the people living there. The dining room and lounge had recently been re-decorated and had been designed to be a relaxing, homely and comfortable space.
• A passenger lift gave access to the first floor of the home; lighting levels were good in all areas.
• People's bedrooms contained personalised items and they were involved in decisions about the premises and environment; for example, the recent re-decoration of communal areas.
• The premises had sufficient amenities such as bathrooms and communal areas to ensure people were supported well. We saw people using a 'sun lounge' throughout our visit, which was a quieter space for those that wanted it.

Good

Is the service caring?

Our findings

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• Care plans identified people's preferences and protected characteristics.
• We observed people were supported by staff who knew them well and treated them with kindness and compassion. Relatives of people were positive about the staff. One relative told us, "Residents are treated like people, not patients, they [staff] are committed to care."
• Staff were knowledgeable about, and sensitive to how people preferred to be cared for and we saw that they demonstrated this in practice. For example, we saw that one person had chosen not to have lunch and to stay in their bedroom. A staff member knocked on their door and said, "Hi [person's name] are you sure you don't want lunch, would you like something else like a sandwich?" The person replied, "No thank you, I am not hungry." The staff member then said, "Ok how about a nice cup of tea?" The person accepted this and staff were heard making plans to check and offer food again later. A social care professional told us, "All the staff have been caring and [person's name] is always pleased to see them and holds their hands. [Person's name] has dementia and touch is very important to them."
• Each person had their life history recorded, which staff used to get to know people and to build positive relationships with them.
• Staff told us they enjoyed working at the home and supporting people to receive the care and support they needed. One staff member said, "I would recommend the home and wouldn't mind a family member coming here."
• We observed staff who knew people well and had built positive relationships. During a music sing-a-long session, a staff member said to one person, "I thought you would be singing, you have a lovely voice." The person smiled and agreed to sing the next song. Another staff member was supporting people in the lounge and we observed them bending down to each person individually and asking them if they were ok or if they needed anything, or would like a drink.

Supporting people to express their views and be involved in making decisions about their care:
• The registered manager spoke to people daily about all aspects of the care they received and gave them an opportunity to discuss their care or the staff that supported them. The registered manager said, "If the residents are happy, then we are happy."
• Staff spoke to people in a way they could understand and showed patience when supporting people living with dementia. Where people had limited ability to verbally communicate, staff observed people's body language and general presentation to interpret what they needed. One staff member told us, "I like it here, I like how it is run, we have time for people."
• Staff described to us how they supported people to be involved in decisions about their care. A staff member said, "If someone wanted to go out we would try and accommodate, it is their life." People told us they felt involved and could speak to staff if they wanted to do something. One person told us, "There is

always somebody popping in to say, 'how are you?'"

Respecting and promoting people's privacy, dignity and independence:
• Staff understood their responsibilities when respecting people's privacy. Staff recognised when people wanted to spend time on their own and always knocked before entering rooms.
• People were supported to receive visitors in a way they chose. We observed a visitor arriving at the home and being greeted nicely by staff; "Can I get you a drink or anything?" The staff member then asked the person if they would like their bedroom door closed while they had their visitor.
• The service had clear systems in place to ensure confidentiality, which staff were aware of and adhered to.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People's likes, dislikes and preferences were recorded in electronic person-centred care plans that were reviewed and updated every month or more frequently, when needed.
• Staff were responsive to people's changing needs. Technology was used to monitor people's health and seek prompt support from healthcare professionals when needed.
• Some people at the service were living with dementia. Care plans contained detailed information about people's specific needs. For example, one person's care plan recognised that their ability to engage with others changed in the late afternoons and evenings. Staff understood that at these times the person needed a calmer, quieter environment with less communication demands.
• People were provided with opportunities to participate in activities. There was an activities coordinator that visited three afternoons a week. Their role included providing people with one to one support; such as reading to people, painting nails or an activity of the person's choice. The activities coordinator also completed small group sessions including; reminiscence sessions and making cakes. During times when the activities coordinator was not available, care staff provided activities such as singing, puzzles and looking at newspapers with people. In addition, the registered manager arranged for external visitors to provide activities such as art and music.

Improving care quality in response to complaints or concerns:
• The service had a complaints policy and information about how to complain was displayed around the home. The registered manager told us that no formal complaints had that been received since the last inspection. However, the registered manager described what action they would take if a complaint was received.
• The registered manager, deputy manager and staff regularly engaged with people and their families so that any low-level concerns could be addressed quickly. Feedback was sought through formal questionnaires, a comments box, and through daily conversations and observations of people.

End of life care and support:
• Staff were not supporting anyone with end of life care at the time of the inspection. However, people's end of life wishes had been captured within their person-centred care plans. This gave details of people's choices, including considerations to cultural and religious preferences.
• The registered manager told us that they worked closely with external healthcare professionals to respect people's wishes and provide them with the care they required to be pain free and cared for at the end of their life.

Good

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

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• People and their families told us that the service was well run. One relative said, "I've not seen [name of person] so happy and relaxed in years."
• The management team and staff demonstrated a commitment to provide person-centred, high-quality care by engaging with everyone using the service and stakeholders.
• The registered manager felt supported by the provider and told us that they had regular telephone contact. In addition, the provider visited the service weekly.
• The previous performance rating was prominently displayed in the reception area.
• The provider had a duty of candour or policy that required staff to act in an open and transparent way when accidents occurred.
• The registered manager understood their responsibilities and had notified CQC about all incidents, safeguarding concerns and events that were required.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There was a clear management structure in place, consisting of the provider, the registered manager and a deputy manager and they were clear about their roles and responsibilities.
• Staff understood their roles and communicated well between themselves to help ensure people's needs were met. One staff member said, "We all work well as a team, I can talk to management at any time, they will act."
• Extensive policies and procedures were in place to aid the smooth running of the service. For example, there were policies on equality and diversity, safeguarding, whistleblowing, complaints and infection control.
• There were robust quality assurance procedures, which included audits of care plans, cleaning records, medicine administration and stock, environmental audits, training and food safety.
• During the provider's weekly visits, they completed an audit of the home and the service provided. Any areas that required action were discussed with the registered manager and timescales for work to be completed, agreed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• Staff told us they felt listened to and the registered manager was approachable. Staff understood the provider's vision for the service and they told us they worked as a team to deliver support that met the needs

of individual people. Staff comments included, "I'm 100% supported; [registered manager] is the best manager I have worked for, always asking if I need help; They care about the staff and the residents, definitely" and "The registered manager is a terrific manager, very supportive, on the ball, I can't fault the home."
• Staff were kept up to date through handover meetings between shifts. During these meetings they discussed all people living at the home. Discussions included information in relation to people's health, mood, any professional visits and if they had declined care.
• People's individual life choices and preferences were met. The registered manager and deputy were clear how they met people's human rights. People and families were involved in planning care and support and the registered manager regularly spoke to people and involved them in decisions about the home.

Continuous learning and improving care:
• The staff were provided with a weekly newsletter. The newsletter kept them up to date on any changes in policies and procedures and best practice guidance. It also kept them up to date of any changes within the service.
• Feedback was sought from people, staff and professionals through quality assurance questionnaires. In addition, the registered manager spoke to people daily about all aspects of the care they had received to monitor the effectiveness of the service.
• Accident and incident reports were monitored on the electronic care planning system. For example, when people had falls, their mobility assessments were reviewed and updated where needed. Any potential causes were considered and prompt medical intervention, such as a referral to a falls clinic, were completed.

Working in partnership with other:
• The registered manager told us that they had a good local support network. They attended meetings with other residential and nursing home managers in the local area. This enabled managers to share good practice and talk about any issues or concerns they had.
• Healthcare professionals visited the home regularly and the registered manager told us that they felt supported by the local medical centre, where they had access to regular support from GP's and a consultant nurse practitioner.
• Staff had links to other resources in the community to support people's needs and preferences.