Heritage Care Limited

Gardenia House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

We carried out an unannounced inspection on the 5 January 2017. At our last inspection all of the standards we inspected were met.

Gardenia House provides residential care and accommodation for up to 25 older people. On the day of the inspection there were 23 people using the service.

There was a registered manager in place at the time of the inspection. 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.

From our observations of staffing levels on the day of the inspection, feedback from people and staff and from reviewing the rotas, we established that staff were often rushed in delivering care to people. Some people said that they had to wait to receive personal care. Action had been taken to increase staffing levels, although this was not always consistently achieved.

Risk assessments formed part of the person's agreed care plan and covered risks that staff needed to be aware of to keep people safe. However on one record we saw, it was recorded that a person had four falls over a twelve month period. Despite there being a risk assessment undertaken after each incident, there was no strategy in place to reduce further falls. After the inspection the registered manager issued guidance for the senior staff team to follow.

Medicines were stored, administered and recorded appropriately by staff who had undertaken relevant training. However, there were no protocols in place for people using 'as required' known as PRN medicines. Immediate steps were taken by the manager to discuss this with the GP's that supported the home. Also staff were instructed via written guidance, of the procedures for the use of PRN medicines.

There were systems in place to safeguard people from abuse and staff had a good understanding of the different types of abuse and how they would look out for signs.

People had a Personal Emergency Evacuation Plan (PEEP) on their record. Their PEEP identified the level of support they needed to evacuate the building safely in the event of an emergency.

Recruitment practices ensured staff were appropriately checked prior to employment to ensure they were suitable to work with the people using the service.

Staff received inductions, training and supervision to assist them to carry out their work role effectively.

The registered manager and staff understood the principles of the Mental Capacity Act and supported

people to make choices for themselves. People were included in any decisions about how they were supported.

People were supported to eat drink and maintain a balanced diet and they were supported appropriately during meal times.

Staff interacted with people who used the service in a kind and respectful way. They took time to engage with people and responded appropriately to any questions asked.

Equality and diversity was an integral part of people's care plans and staff were aware of how to ensure peoples differences were respected, valued and upheld.

Pre-admission assessments informed how a person was supported and formed the basis of the person's care plan. Care plans were detailed; person centred and provided guidance for staff to ensure peoples care needs were met.

There was a log that recorded complaints as well as outcomes of the complaint. We also saw that any learning from complaints was used to improve the service provided for people.

People we spoke with told us they thought the home was well-run the management team were accessible.

There were mechanisms in place to ensure people and their relatives had regular feedback, which included regular residents meetings and resident and relatives surveys.

Regular audits were undertaken, including checks of care records and practices within the home to ensure people were receiving high quality care.

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. Individual risk assessments were prepared for people and measures were put in place to minimise the risks of harm. However, there were no strategies in place to reduce further falls on the records we looked at.

From our observations of staffing levels on the day of the inspection, feedback from people and staff and from reviewing the rotas, we established that staff were often rushed in delivering care to people. Some people said that they had to wait to receive personal care. Action had been taken to increase staffing levels, although this was not always consistently achieved.

Arrangements were in place for safe administration and storage of medicines. However there were no protocols for people using 'when required', known as PRN medicines.

Staff knew how to report concerns or allegations of abuse and appropriate procedures were used to keep people safe.

Is the service effective?

Good

The service was effective. The registered manager and staff understood the principles of the Mental Capacity Act and worked within the framework of the act.

Staff received regular supervision as well as annual appraisals.

People had access to healthcare professionals and were assisted to receive on-going healthcare support.

People were supported safely at meal times and were able to indicate their preferences regarding food and drink to maintain a balanced diet.

Is the service caring?

Good

The service was caring. Staff understood people's individual needs and supported people in a dignified way.

Staff understood the importance of promoting independence

and this was reinforced in people's care plans.

Equality and diversity was an integral part of people's care plans and staff were aware of how to ensure peoples differences were respected, valued and upheld.

Is the service responsive?

Good

The service was responsive. People received personalised care that met their needs.

Care plans included people's unique information, including choices and preferences and how they wished to be supported.

Information regarding how to make complaints was available to people using the service and their relatives.

Is the service well-led?

Good

The service was well-led. The home was well run and management were accessible.

People and their relatives were consulted and encouraged to be involved in the service development via regular resident meetings, as well as resident and relative surveys.

There were effective audits and checks to assure a high quality service and identify any potential improvements to the service being provided.

Gardenia House

Detailed findings

Background to this inspection

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

This inspection took place on 5 January 2017 and was unannounced. The inspection team included one 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 care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service including people's feedback and notifications of significant events affecting the service.

During the inspection we spoke with nine people who used the service and one relative. We spoke with five members of staff including the registered manager and deputy manager. We also gained feedback from local commissioners.

We reviewed five care records, four staff records as well as policies and procedures relating to the service. We observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said, "I feel safe, there's always someone on call, I have the buzzer." Another person said, "Since the day I walked in seventeen years ago. There's always someone here who will help you."

Three people out of the nine we spoke with said they thought there needed to be more staff to support them. One said, "Not enough staff, one leader and one staff at night. It's slow if they are agency staff." Another person said, "Not enough. The girls are pushed; they don't do it properly, rushing too much." Another said, "I use the buzzer, sometimes I have to wait – they are very busy." Other comments included, "I don't know about staff, whether there are enough. They come quite quickly." "It seems as if it varies a lot, depends on how many people they have to deal with. I don't usually have to wait long for them to come." One person told us that before they came to the home they were used to having a shower every morning and that this had not been possible at the home as there were not enough staff.

Staff we spoke with told us that after raising concerns about needing more staff in the mornings with the registered manager, he had arranged for a night staff member to work two extra hours in the mornings to support the day staff with assisting people with personal care. This worked well most of the time but on occasion's staff were not available to stay on to assist after working the night shift.

On the day of the inspection there were two care workers, a team leader, the deputy manager and registered manager on duty. This meant that the two care workers were assisting people with personal care and the team leader was responsible for administering medicines and assisting with visiting professionals, for example the practice nurse who was visiting people. Given there were two floors, this meant that the two care staff were very busy providing support across both floors.

We discussed our observations regarding the staffing numbers with the registered manager and although we had seen that he had made attempts to provide extra cover in the mornings, this did not always work, as it was not a permanent solution. He told us that staffing numbers were established based on individual assessments and level of support needs. He told us that staffing numbers were also reviewed when residents were unwell and extra support was arranged, on an as and when needed basis, in consultation with the regional manager. This was confirmed in the records we saw.

However, in light of our observations and the feedback from people using the service and staff about the staffing levels, he had agreed with the regional manager that a new approach would be taken to ensure there were enough staff to meet people needs. We were informed after the inspection that an established dependency level tool would be used to reassess people's needs at the home to ensure adequate staffing numbers were available and address any shortfalls identified.

There were comprehensive risk assessments on each of the care records we looked at. These assessments were specific to the individual. For example, we saw that where a person had a diagnosis of diabetes, there was a record of daily blood sugar tests being carried out and the risk assessment gave staff clear instructions

as to what to do if the blood sugar reading was high or low. However, on one care record we noted that a person had fallen four times in the past year and although the risk assessment had been reviewed after each incident there was no strategy in place to reduce further falls. This was discussed with the registered manager, who told us that generally where people had fallen three times in a short period; staff would be required to refer them to the GP in the first instance. However, this had not happened in this case and there were no instructions on the person's records for staff to follow. He stated that he would be reminding staff of what specific action could be considered for people who were prone to falling and that prompts would be added to the recording process. He also confirmed after the inspection that the senior team had been advised to seek GP intervention and where necessary, request a referral to the local falls team after three or more falls especially if they followed in quick succession.

Risk assessments were reviewed monthly, or when there had been a change in a person's condition, in line with the policies and procedures at the service. Each person had a Personal Emergency Evacuation Plan (PEEP) which detailed how they would be evacuated in the event of a fire or other emergency.

We observed a member of staff whilst they administered medicines to people. This process was carried out safely and carefully by a team leader who wore a tabard that stated she should not be disturbed as she was administering medicines. Each person using the service had a Medicines Administration Record (MAR) which was up to date, accurate and there were no gaps evident.

Staff we spoke with could describe how to administer medicines safely and understood what it was for. We saw from training records that senior staff who administered medicines had undertaken the appropriate training. We also saw that each staff member had an up to date annual 'Medication Administration Competency Assessment' completed to ensure they remained competent to undertake the task.

The majority of medicines were administered to people using a monitored dosage system supplied by a local pharmacist. Medicines that needed to be kept cool were kept in a locked fridge at the recommended temperature, which was recorded daily, as was the temperature of the medicine room.

However, we saw that a person, who had come to the home recently, had missed their medicines for one day due to a problem obtaining them from the pharmacy. We discussed this with the registered manager who was aware of the missed dosage and told us of the problems obtaining medicines in some cases for people when they first come to the home. This was because of difficulties the pharmacy had providing medicines mid-way through the monthly cycle. This had been an on-going problem the registered manager had been trying to address for some time. He confirmed after the inspection that a new procedure would start immediately. This would be included as part of the process for when new residents plan to move into Gardenia House. They would request a full month's supply of medicines from people, which would provide staff with sufficient time to arrange the next cycles of medicines from the pharmacy, without the need to seek 'interim' supplies which could cause delay.

We saw that where "as required", known as PRN medicines had been administered, there were instructions written on them as to when they should be given. However, there were no PRN protocols in place that provided clear instructions for staff administering these types of medicines. There were no instructions detailing how it should be given, the dose, reason for administration, the frequency and the duration. Staff were also not recording on the back of MAR sheets to confirm why a dose had been given. This was discussed this with the registered manager who took immediate steps to clearly instruct staff, via written guidance, of the procedures for the use of PRN medicines. He also confirmed that he had been discussing with the four GP's that supported people at the home about the need for individual protocols for people using PRN medicines.

The service had no current homely remedies in use. There were safe systems for storing, administering and monitoring of controlled drugs. Medicine audits were carried out by the area manager on a quarterly basis. The pharmacy which supplied the medicines for the home carried out audits on a six monthly basis. We saw from records that any recommendations identified were followed through.

Staff had received training in safeguarding adults. They were able to describe the process for identifying and reporting concerns and were able to give example of the types of abuse that may occur. One care worker said, "When it comes to the residents, I would not hesitate reporting my concerns to a manager." The registered manager understood the process with regards to reporting safeguarding adults concerns to the local authority and also notifying the Care Quality Commission.

There were safe systems in place for recruitment and checks were carried out before staff started working at the home. Staff files contained completed application forms which included their employment history. Records contained Disclosure and Barring Service checks (DBS), two employment references, and proof of identification. In addition, where relevant, records contained evidence of a person's right to work in the UK.

The home was clean and we saw it being cleaned throughout the day by dedicated staff. Infection control measures were in place and staff used gloves and protective clothing appropriately.

Good

Is the service effective?

Our findings

People told us they thought staff were well trained and had the necessary skills to support them effectively.

Training records showed that staff had completed an induction programme as well as mandatory training in line with the provider's policy. Training included health and safety, fire safety, nutrition, medication awareness and dementia. Most staff had completed a national vocational qualification and managers were arranging for new staff to undertake the new care certificate.

Documentation showed that care staff received regular supervision as well as annual appraisals. Staff we spoke with was happy with the support they were given and one said, "I have supervision regularly and it is helpful." Team meetings were also held regularly and minutes were made available to staff after the meeting. We saw that a process was in place to ensure actions from meetings were addressed and implemented where appropriate.

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.

The registered manager and staff understood the principles of MCA and told us people they supported were presumed to have the mental capacity to make decisions unless there were indications that it was not the case. People told us they were able to make choices and were included in any decisions about how they were supported. We observed staff asking people what they wanted in terms of their support, for example, what they would like to eat and drink and if they needed assistance with personal care. Each care record had relevant consent forms, which were signed by the person to agree the support to be provided.

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).

No applications had been made to legally deprive people of their liberty. From observation made during the inspection, we were satisfied that there were no restrictions in place for people. People and relatives we spoke with confirmed this was the case. The registered manager and deputy manager were clear about the process to follow should the need arise to apply for a DoLS for a person staying at the home and they told us this was under constant review. Staff had received up to date training on the MCA and DoLS.

Where appropriate, care records contained Do Not Attempt Resuscitation (DNAR) forms to record people's wishes on this matter. These were completed by the GP and we saw records of discussions had with the person and their relatives depending on the circumstances.

People were receiving a balanced diet and had a choice of food from the menus provided. Menus were displayed on notice boards in the entrance hall and dining room.

We observed lunchtime and saw that people did not require support to eat and drink. One person who had a persistent cough said she did not feel well. She was offered a number of alternatives and accepted some ice cream. One person said about the food, "It's not deluxe, it's presentable. We have a choice, two or three choices. I enjoy it." Another person said "I'm eating more, hope I'm putting on weight. I prefer afters, there's a choice. It's quite nice."

People were supported to access health care services when they needed to. We saw that district nurses visited the home regularly and on the day of the inspection a practice nurse from one of the local GP surgeries was offering people registered at the surgery a flu jab. One person when asked about the support they receive with health care needs told us, "A chiropodist, you can have your own or the home's one. It's very good it is. You can keep your own doctor, you tell them [you need to see a doctor] and the doctor comes"

People were registered with local GP surgeries and were able to attend the surgery as and when they needed. GP's did however did come to the home if it was appropriate and a person was too ill to attend the surgery. Outcomes of GP consultations were recorded in people's individual records.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person said, "They're easy-going. Not too strict, give and take not regimented like in the army. I don't think you can get much better, they are very kind." Another person said, "I had a lovely Christmas here, they entertained us, dancing and a nice Christmas dinner. They are so friendly. I can't ask for more. I'm well looked after. I would recommend it." A relative told us they thought it was a great place.

Throughout the day of our inspection, we saw how staff interacted with people who used the service in a kind and respectful way. They took time to engage with people and responded appropriately to any questions asked. It was clear that they knew people very well and they had built strong relationships with them.

Staff gave us examples of how they respected people's dignity by making sure they were covered during personal care activities, and all doors and curtains were closed. People told us they were actively involved in decisions around the care and support they received at the home and staff tried hard to involve them as much as possible. One person said, "I have to be dressed now, I can't wash and dress myself. Most of them are very good". A relative told us their family member was a representative at the residents meetings, despite being nearly 100 years old.

Staff understood the importance of promoting independence and this was reinforced in people's care plans. Plans outlined clearly what level of support was required by a person and how it should be delivered. One person told us when asked about independence, "Yes I'm supported to be independent, for example with my medication. I'm happy here, I have a nice room, own bathroom, personal stuff and I watch football." We saw that this person was managing most aspects of their medicines for themselves and this was encouraged by the staff team.

We saw there was advance care information on some records and people were encouraged to complete an advance care plan booklet in conjunction with their relatives and friends. This included instructions by the person as to how and where they wished to be treated at the end of their life. The registered manager acknowledge that staff often found discussions around end of life care difficult but that they were introducing advance care plans for all residents and said this was something that was now discussed as a matter of course when people came to the home.

Equality and diversity was an integral part of people's care plans and staff were aware of how to ensure peoples differences were respected, valued and upheld. They received training on equal opportunities and diversity and were able to tell us how they put what they had learnt into practice. They told us that the support they provided was person centred and based on people's preferences and beliefs. They went to tell us how life histories and understanding more about people's lives helped them to support them accordingly. There were equality and diversity procedures in place that provided guidance for staff as required.

Good

Is the service responsive?

Our findings

People and their relatives told us they felt the care and support provided was responsive to people's needs. A relative told us how responsive staff had been in regards to their family member. They explained that her relative had been in and out of hospital and the care from the staff had been above and beyond what was expected in order to meet their needs.

Pre-admission assessments informed how a person was supported and formed the basis of the person's care plan. Care plans were detailed, person centred and provided good information for staff to follow. The information was easy to locate, as the files were separated into individual sections for ease of access. Records also included a section relating to people's life history which was added to over the course of people's stay at the home and when staff gained more knowledge about them.

Records contained a summary of a person's support plan, called 'My Support Plan at a Glance', and we saw a copy was discreetly kept in people's bedrooms as well as on file. Care plans included people's unique information, including choices and preferences and how they wished to be supported. We were told by the registered manager that the information in the care plan was used by care workers to ensure people were supported in a safe, effective, person centred way. It was especially useful for people with communication difficulties as it minimised the risk of people receiving inappropriate or non-person centred care. Daytime care workers and night duty care workers wrote an update on each person in a daily record in order to ensure continuity. This included an account of a person's mood, diet, general well-being and sleep pattern. Staff told us about the importance of care plans to ensure peoples care was person centred and delivered in the way they wanted.

We saw evidence on care records of multi-disciplinary work with other professionals including GPs, district nurses and chiropodists. People had a one page hospital admission form that was kept on file should a person be taken to hospital. This contained detailed information about them, including, their means of communication and all of their medical history to pass on to the hospital staff.

People were encouraged to personalise their rooms we saw that photos and memorabilia were well positioned so that people could see them easily. Most people we spoke with referred us to their photos at some point during our discussions. In the communal lounge there were comfortable seats and armchairs organised in two sitting areas with an additional area with tables and an area where people and their relatives could make a hot drink with and help themselves to biscuits.

There was a programme of group activities provided for people at the home that included bingo, quizzes as well as regular outings to the theatre and celebrations to mark events like Chinese New Year and Christmas. Some people who had sight impairments accessed the talking book service. One person said, "I'm involved in quizzes and bingo" and another person said, "Bingo, quizzes, raffles. Whatever's doing here, I get involved." An activity co-ordinator was employed at the home who arranged most of the activities on offer. During our inspection the activity coordinator was on annual leave after providing a full programme of activities over the Christmas period, which people commented positively on during our discussions with

them. We did not see any group activities taking place, although some people were pursuing individual activities, like reading, watching the television and some went out of the home to access community resources. Some of the activities outside of the home included church visits, meals at local restaurants, shopping and attendance at lunch clubs. One person used a mobility scooter to get out and about in the warmer months.

We saw staff interacting with people as they were supporting them but they were not involved in providing group activities. We discussed this with the registered manager who explained that there had been discussions with staff recently around their role in activities and they had been asked as part of their key worker role to initially find out from people what they liked to do with a view of encouraging people themselves to facilitate an activity or a group. We saw this had been discussed at a recent team meeting and residents meeting and it was work in progress.

A copy of the complaints leaflet was available at the service. People told us they knew how to make a complaint. One person said when asked what they would do if they had a problem, "I'd go and see [registered managers name] or [deputy managers name]. They're in charge. You can speak to them." Another said, "There's a suggestion box but I usually tell them direct." Staff were able to tell us how they supported people to make a complaint and ensure that any issues or concerns were reported to management promptly. The complaint records showed that there had been two complaints in the past year. There was a log that recorded the nature of the complaint as well as an outcome to be fed back to the complainant. We also saw that any learning from complaints was used to improve the service provided for people.

There had been several compliments received from people and their relatives, praising the staff and the managers for the care and support provided at the home.

Good

Is the service well-led?

Our findings

People we spoke with told us they thought the home was well- run and the management team were accessible. One person said when asked about the management of the home, "It's well managed. Another person said, "I've met the manager and would feel comfortable talking to [manager's name], I think he would listen. So far I haven't had any complaints. They treat us all alike"

Staff were complimentary about the management and told us they felt well supported. One staff member stated "I feel supported and I would always speak to [managers name] if I had concerns". As well as one to one supervision, staff meetings were held monthly and included topics such as, residents, staff recruitment, fire risk assessments and health and safety. Meeting minutes demonstrated that previous issues were addressed and followed through. We saw that up to date policies and procedures were available for staff to refer to for guidance.

Regular resident committee meetings took place with people in the form of a 'surgery' that offered an opportunity for people to discuss any issues and feedback to a member of staff about the running of the home as well as suggestions for change. Feedback would then go to the registered manager for consideration and action. It was felt by the registered manager and deputy manager that this type of session would give people an opportunity to open up to staff about any aspects of the home including the management in a more relaxed way, therefore encouraging people to talk frankly. People were reassured that this was a trial and if they wanted to revert to old style meetings this would be done. We saw from recent minutes of meetings that areas of discussion included menus, and outings, the garden and staff recruitment. The registered manager responded to each item raised with an action for improvement and update. For example, we saw that he had responded with an up to date overview about how many applications had been received for current staff vacancies, how many people had been interviewed and whether they had been successful.

Regular audits were undertaken, including checks of care records and practices within the home to ensure people were receiving high quality care. Outcomes and learning from audits as well as incidents and investigations were shared with the staff team in one to one supervision and team meetings. Regular checks were carried out by the area manager which included, person centred care and support, nutrition and hydration, risk assessments and safeguarding and safety. The last check was completed in October 2016 and a review date was set for July 2017.

Local commissioners carried out two monitoring visits to the home in February and April 2016. Actions were identified by commissioners in relation to safeguarding, whistleblowing and medicines management. We saw that actions agreed at the February visit were checked at the visit in April to ensure they had been undertaken by the registered manager. We noted that all identified actions had been completed.

Separate service user and relative surveys were undertaken annually, the last being completed in December 2016. Feedback from surveys was positive, one relative said, "My mother is provided with all opportunities to enjoy her days, it is up to her to join in. She is encouraged by the staff". One person stated, when asked

about three things they liked about the home, "The friendship, the kindness of the staff and being able to talk to the girls". There were also some suggestions for improvements, including needing more permanent carers, door security and improvements to the garden. The registered manager told us they were in the process of analysing the feedback and told us that as in previous years an action plan would be formulated to ensure feedback was considered and changes implemented.