Ms Margaret Morris

The Gables Private Residential Home

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
The Gables Private Residential Care Home is a care home providing personal care for up to 28 people aged 65 and over. At the time of the inspection there were 15 people using the service. The service is provided over two floors, with communal facilities being provided on the ground floor.

People's experience of using this service and what we found
The provider had not developed effective systems to monitor and manage the service, nor were there effective systems to gather and analyse information. This has restricted the overall monitoring of the service and ineffective governance meant there was a lack of management oversight of the service.

Staff were not always encouraged to give feedback at team meetings. This meant that the service lacked different perspectives from staff who provide care and support.

At our last inspection we identified the need for a robust system for the assessment and reviewing of potential risks, and through the analysis of accidents and incidents within the service to ensure lessons are learnt. At this inspection we found that this had not been implemented.

Medicines weren't always managed and monitored effectively. There was no audit system for weekly and monthly checks and no protocols for medication which was given 'when required'. This posed a risk to medicine errors not being identified and addressed in a timely manner.

Rating at last inspection
The last rating for this service was requires improvement (published 31 December 2019)

Why we inspected
At our last inspection the service was rated as requires improvement so the inspection took place to ensure that improvements had been made from the action plans provided.

Enforcement
At our last inspection we identified breaches in relation to the assessment and review of potential risks to people, poor leadership oversight and governance of the service to monitor the quality of care being provided. At this inspection we found that there was not enough improvement made to mitigate the concerns and therefore the breaches in regulation have not been met. A warning notice was issued after our previous inspection and at this inspections we found that the actions had not been met.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

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

The Gables Private Residential Home

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.

This was a focussed inspection to check whether the provider had met the requirements of the warning notice in relation to Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance) Of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
The Gables Private Residential Home is a '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.

Notice of inspection
This inspection was unannounced. However, due to the restrictions of Covid-19 we did phone the home prior to entering to check that there were no new cases.

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 who commission some people's care at the service. We used this information to plan our inspection.

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 account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with the provider's representative, three members of care staff, the cook, the providers representative and deputy manager.

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

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 requires improvement. At this inspection this key question has remained the same. 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- There was a lack of oversight with regard to managing and monitoring risk. Servicing and maintenance of electrical equipment risk assessment expired in January 2019. The fire risk assessment had expired in July 2020. This meant that people were at risk and the environment was not kept safe.
- There had been an audit of all fire doors carried out in March 2020. The audit highlighted that the majority of the fire doors did not pass regulation. At the time of our inspection, none of the fire doors had been repaired or replaced.
- We found that checks on fridge and freezer temperatures in the kitchen were not consistently recorded, entries were missed on a Wednesday and Sunday and some bank holidays. There was no management oversight to check that this was carried out consistently.
- Staff were knowledgeable about the action to be taken in the event of a fire, however, the last fire drill had taken place in February 2020 and there was no information on how frequently drills should take place.
- We could find no evidence of regular checks required for legionella. Staff were requested to carry out regular flushing in rooms, however, we could not find evidence of this being documented. There were logs for water flushing and temperature checks of water, but they were blank, and no entries had been made.
- Systems and equipment in the service were maintained by external contractors. These included gas and electrical appliances, the passenger lift and equipment used by staff to move people safely, such as stand aids. The fire safety systems were not effectively maintained, a company had been employed to carry out checks, but improvements had not been carried out from their recommendations.

At our last inspection people were placed at risk as systems were not in place to assess, monitor and review risk. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that not enough had been done to mitigate this risk and they had not acted proactively on actions from professionals within fire safety, therefore they remain in breach of Regulation 12.

Preventing and controlling infection

- Policies and procedures were in place for infection control and hygiene and were implemented. However, we could see no evidence of cleaning schedules being in place. This is especially important with regard to having the Covid-19 pandemic as we were unable to see how cleaning had been increased to prevent the spread of infection.
- We observed that the home was clean and free from malodour, however we were unable to see any evidence of how this was achieved on a daily basis.

Using medicines safely

● We identified improvements were needed to medicine management. There were no protocols for medicine which was given 'as required' this meant that there was no instruction regarding when the medication should be given.

● Medicines were not always disposed of in a timely manner. We found medicine in the fridge which was prescribed in April 2020 and the person had passed away.

● Staff responsible for the administration of medicine had undertaken training in the safe handling of medicine and had been assessed as competent.

● The temperature in the medicine's fridge was not consistently taken. This meant that people who had medication stored in the fridge, may be at risk if not stored at the temperature advised.

Systems and processes to safeguard people from the risk of abuse.

● Staff were aware of external stakeholders they could contact about safeguarding concerns, which included the local authority, the police and the Care Quality Commission (CQC).

● People told us they felt safe, staff were kind and caring and looked after them.

● The providers policies and procedures and local safeguarding protocols were followed.

Staffing and recruitment

● We saw evidence of safe recruitment taking place. We checked staff files and there were appropriate checks carried out prior to staff starting in their role. However, staff who had been working at the service for many years had not had their criminal record checked frequently, good practice guidance states that this should be refreshed every three years. The Disclosure and Barring Service (DBS) assists employers to make safe recruitment decisions by ensuring the suitability of individuals to care for people.

● Staff told us that they felt supported and received good support and training.

● People told us that there were enough staff on duty and one person said "I don't have to wait long if I need something.'

● Staff told us they had more time now that there were less people living at the home. They helped with activities and could talk to people more.

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 requires improvement. At this inspection this key question has remained the same. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- The provider did not have in place a system to enable to monitor and manage the quality of the service in order to identify issues and make improvements. We were informed some audits did take place, for example medicine audits. However, there were no records to support this.
- The provider did not have a system to identify any themes or trends occurring within the service, for example learning from accidents and incidents through analysis and review.
- The provider's representative who facilitated the inspection was aware of the improvements required from the previous inspection. There had been improvements made to care planning but other improvements outlined in the warning notice had not been addressed.

At our last inspection provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that there had been no change and therefore the provider remained in breach of Regulation17.

- The provider had implemented a mobile chat group for the staff. The chat application is a facility on a mobile phone which allows people to share information and there is the facility to have large groups. This was used to keep staff updated regarding the changing legislation during the Coronavirus outbreak.
- Staff told us that they were consulted on issues regarding the home and they felt that their opinions were valued.

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

- There had been a death at the service several weeks prior to the inspection and we had not received a notification to inform us. However, this was an isolated incident and we had been informed of all other incidents and the manager told us that this would be addressed moving forwards.
- The manager was aware of compliance with duty of candour, however this was not always adhered to. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's feedback on the service was sought twice a year, however, this information was not collated and shared with people.

● People spoke favourably of the management of the service, they told us members of the management team were approachable, and that staff were kind and caring.

● The provider encouraged people to feedback on aspects of the service and staff, relatives and residents were comfortable to approach management.

Working in partnership with others

● The provider worked with commissioners of local authorities when people's needs changed and their package of care needed reviewing.

● The service had forged good relationships with health professionals who they consulted and referred people on as required.