Bupa Care Homes (CFC Homes) Limited

Gable Court Nursing Home

Inspection Report

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Overall summary

Gable Court Nursing Home provides personal care, including nursing care to up to 51 people in a purpose built building located in a residential area. At the time of the inspection, 38 people were using the service, most of them had needs relating to their physical health, and some of them had dementia. The service is arranged over three floors and there are garden and patio areas. Most people's rooms have an attached private bathroom.

The previous registered manager of the home left the service in February 2014. At the time of the inspection, the manager of the home, who had taken up her role in March 2014, had not yet applied to be registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The situation will be kept under review by us to ensure Gable Court has a registered manager.

Most people who used the service and their relatives told us the service was effective in planning and meeting people's needs in relation to their health. A person's relative told us, "one of the staff is brilliant and they knew exactly what to do when [my relative] was going downhill. They made sure they got the treatment they needed." Records showed staff had worked with health professionals to ensure people's complex needs were met effectively.

Staff understood their responsibilities in relation to people who may lack the mental capacity to make decisions about their care and support. People's relatives were involved in making decisions in their best interests. We did not observe any restrictions on people and staff understood their legal responsibilities in relation to the Deprivation of Liberty Safeguards. The service complied with the requirements of the Mental Capacity Act 2005.

People said that staff were kind but very busy. A person's relative told us that, "staff give people the basic care but have not really had time to get to know them or find out anything about their past life or interests." People said there were delays in them receiving their meals in their rooms which meant food was not as hot or appetising as it could have been. They also said that their tea and coffee was sometimes not hot. A person told us, "when you are in your room all day, these little things matter." A person's relative told us that they had noticed that people did not always receive their care promptly whilst in their rooms upstairs. They said this was especially evident when staff were away from the upper floors taking people to and from activities on the ground floor.

Some people attended a range of activities which took place on the ground floor of the home during the week. They told us they enjoyed them. Most people stayed in bed in their rooms on the first and second floor of the home. Some of these people said they preferred to do this, but other people told us that they felt isolated and bored in their rooms. A person's relative told us, "it is very quiet upstairs."

The manager told us that the provider calculated the staffing budget for the home from information she supplied to them on the number of people using the service and their level of need. During the inspection we found that there were insufficient staff to meet people's needs.

The manager told us she anticipated that new people would be moving into the home and staffing levels would be adjusted accordingly. She said she was looking at the arrangements for activities and how people received their meals and drinks in order to improve people's experience of the service.

We checked how people's medicines were managed. We could not be certain that people had consistently received their medicines safely as prescribed. This was because staff had not kept accurate records.

We also spoke with staff and checked the arrangements that were in place to provide them with training and support. Although some staff had received appropriate supervision and training, we found that other staff had not been given all the support they required to deliver people's care to the required standard.

The provider carried out checks on the quality of the service which had identified areas for improvement. However, there were no clear timescales for the

Summary of findings

implementation of these changes. There were breaches of health and social care regulations. The action we have asked the provider to take can be found at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We could not be certain that people consistently received their medicines safely as prescribed. This was because staff had not always made accurate records about this.

People were not cared for safely because there were not enough staff on duty to meet their needs.

Are services effective?

People were at risk of receiving support from staff who did not have the appropriate skills and experience to meet their needs. Some staff had not received the required training and support to develop their skills.

People and their relatives told us that staff had given them good care in relation to their health needs. People had appropriate support with their nutrition and hydration. Staff had ensured that specialist health professionals were contacted to advise them how to meet peoples' needs.

Are services caring?

People and their relatives said staff were kind and polite. They also said staff were very busy and did not have time to get to find out much about their backgrounds or interests.

People had little opportunity to develop trusting relationships with staff. They could not easily ask questions about their care or explain to staff how they were feeling.

Are services responsive to people's needs?

People said they had been involved in planning their care and their needs were regularly reviewed.

Some people told us they were unable to attend the activities which were held on the ground floor and felt bored and isolated from other people.

Are services well-led?

At the time of the inspection the manager, who had taken up her post in March 2014, had not yet applied to the CQC for registration. This is being kept under review by the CQC to ensure this is resolved.

The provider had a system in place to identify areas of the service that required improvement. However, no timescales had been set for the required changes to be made.

Summary of findings

What people who use the service and those that matter to them say

People told us that staff were kind and caring, but seemed very busy. A person's relative said "some of the staff are excellent and they really know what to do." People and their relatives said it took a long time for staff to give them their meals when they were sent up from the kitchen on the ground floor and consequently food was not very hot or appetising. One person told us, "there aren't enough staff to help. I've timed the delay based on the sound of the trolley coming out of the lift. Often its 10–15 minutes before anything arrives for me."

A person's relative said, "we're really trying to keep [my relative] well-hydrated because we don't want them getting another urine infection. I brought in a large number of individual fruit drinks with straws, but whenever I come in (daily) I have to move them closer to them as they're never placed near enough for [my relative] to reach them." They also said, "No one has asked [my relative] about their life." Another person's relative told us, "I have observed that staff spend a lot of time taking people up and down to activities. I have noticed that this means people upstairs don't always get help quickly."

A person who needed to spend most of their time in bed due to a medical condition told us, "activities usually only happen in the downstairs lounge, which I can't get to." They also said, "I'd like to do gardening and we did have some school children come to do it with us once, but it's not on offer otherwise."

Another person told us, "there was a party in the lounge for my birthday - all my family came. It was lovely. But generally I have nothing to do, so things get on my nerves. The weekends are especially boring and lonely."

Gable Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection on 29 April 2014 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1. This was an announced inspection, which meant the provider was informed two working days beforehand to ensure that key members of the management team would be available in the office.

We reviewed the information the Care Quality Commission held about the home and used this to plan our visit. The previous inspection of the service took place 13 June 2013 when the service was found to meet the required standards. The provider was unable to complete a report about the service prior to this inspection due to recent management changes at the home. The inspection team comprised a lead inspector, a pharmacist inspector and an expert by experience with knowledge of care services for older people.

There were 38 people living in the home at the time of the inspection. We spoke with seven people who lived in the home and three of their relatives. We observed people having their lunch and evening meal. We looked at all areas of the home and we asked people for permission to see their rooms. We checked the arrangements for storing and administering people's medicines. We viewed four people's care records and looked at information on staff recruitment, supervision and training. We read incident reports and other documents relating to the management of the home. We spoke with the manager and two members of care staff.

After the inspection we spoke with a person's relative at their request and obtained feedback from representatives of two local authorities who commissioned care for people at the service.

Are services safe?

Our findings

Staff told us they did not have the time to communicate well with people who had complex needs. During the inspection we observed that a person was their room distressed and shouting out for several minutes for staff to help her get into bed. We spoke to the nurse in charge of the care team about this and they said that care staff could not come to her assistance until they had finished helping other people with their evening meal. The nurse said they had tried to explain this to the person but they were unable to retain the information due to their dementia. The manager told us she had already asked this person's local authority to consider assisting them to move care home because the home was unable to meet their needs. The person was at risk of falling and there were insufficient staff on duty to keep them safe. This was a breach of a health and social care regulation (Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). The action we have asked the provider to take can be found at the back of this report.

The manager told us that the provider's staffing plans for the home were based on the number and needs of the people using the home. Staff we spoke to said that they were very busy and "could always do with more staff." On the day of our visit (which was announced) the number and staff on duty and their qualifications was in line with the provider's staffing plan.

A person's relative said, "staff spend a lot of time taking people from the first and second floor up and down to the activities on the ground floor. On one occasion I asked the staff to assist a person who was in distress. They told me the person would have to wait for help until after they had finished taking people downstairs."

Medicines in the home were kept securely in locked cabinets and were only accessible to staff authorised by the provider to handle them. The room temperature of the clinical room and the refrigerator were monitored daily and both were being maintained within the required range which meant that medicines were stored correctly. Controlled drugs were kept securely and in accordance with required legal safeguards.

We checked 10 people's medicines administration record (MAR) charts covering the day of the inspection and the previous two weeks. We found that these records were not always accurate, therefore we could not be certain that people received their medicines as prescribed. Peoples' health may have been at risk due to this.

We could not accurately audit some people's medicines because there were omissions on their MAR charts in relation to the amount of medicine received into the home. We could not be certain that they had received their medicines by counting the balance of medicine remaining.

In three instances, peoples' MAR charts had staff signatures missing, so we could not be sure that they had received their medicines as prescribed. In another three cases, there were signatures on the MAR chart which indicated that a person had received their medicines but in fact they were still in the packet and they had not received them.

One person's MAR chart had a signature to show that they had received an incorrect dose of Warfarin on one occasion. Records indicated that they had received half the prescribed dose. This drug is prescribed in a variable quantity depending on a person's blood test results. If it is not administered at the correct dose there may be serious consequences for a person's health. Another person had not received pain relief as prescribed because their supply of analgesic medication had run out and had not been replaced.

In one case, where a person had been prescribed a course of antibiotics, it was not evident from their MAR chart that the person had received these antibiotics on the correct dates. The dates recorded on the MAR chart for administration were for the previous week.

The administration of topical medicines, such as creams and ointments prescribed to treat skin conditions, was not being recorded appropriately. For example, one person was prescribed a barrier cream to be used daily, but there was no evidence that that had received it since 22 February 2014. Another person was prescribed a topical analgesic to be applied three or four times a day, but there were no records about whether they had received it. A third person was prescribed a medicine that is delivered via a patch and needs to be applied to a different area of the body each day. Their MAR did not include information about where it had been applied. Record charts for the administration of topical medicines for one person was found in another person's folder and could have been mistakenly used to record administration to the wrong person.

Are services safe?

Staff were not using people's MAR charts to accurately record whether people had received their medicines as prescribed which may put the health and welfare of people at risk. Systems to manage people's medicines were not safe and this was a breach of the relevant legal regulation of(Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 The action we have asked the provider to take can be found at the back of this report.

People were protected from harm because the provider had ensured most staff knew how to recognise and report abuse. We spoke to two members of staff about arrangements for safeguarding training. A qualified nurse who had worked in the home for some time said they had received training in this area but was able to explain to us how they would recognise abuse or neglect. They were aware of how to report concerns and of the protection offered by the provider's whistleblowing policy if they needed to report a concern outside the organisation.

We also spoke with a new member of staff who had started work at the home in March 2014. They told us they had received some training on this subject when they first started to work in the home as part of their induction. They said they had not received any further support or supervision from the provider on this topic. They were unclear about the organisation's safeguarding procedures but said they would ask a manager for advice.

We checked the recruitment files for two staff. The provider had undertaken checks on job applicants' suitability in relation to working with vulnerable people before they started work. For example, references had been obtained from the applicant's previous employer and the appropriate checks had been undertaken to ensure they did not have a criminal record.

People's care records included assessments of risk in relation to issues such as their skin care and nutrition. They were up to date and explained the actions staff should take to ensure people were kept safe. For example, there were detailed guidelines in relation to how a person should be supported by staff when they were assisted to move around the home.

Staff were able to explain to us how they worked in line with the requirements of the Mental Capacity Act 2005. For example, when a person lacked the mental capacity to make a decision, staff involved their relatives in making a decision that was in their best interests. We spoke with staff and the manager and confirmed they understood the Deprivation of Liberty Safeguards (DoLs) and knew how to make a DoLs application to the local authority if a person's circumstances warranted it. There were no DoLs currently in place, however, the manager knew the correct procedures to follow to ensure people's rights were protected. We did not observe any potential restrictions or deprivations of liberty during our visit. During our inspection we spoke to staff about DoLs. They said they understand the importance of DoLs and had received appropriate training.

Are services effective?

(for example, treatment is effective)

Our findings

Some new staff had not had key elements of their training in areas such as safeguarding reinforced in supervision and at team meetings. This meant they had not developed their skills and knowledge to a sufficient standard to ensure that people received a quality service. Staff told us that due to management changes at the home they had not received an annual appraisal in accordance with the provider's standards. People were at risk of receiving care and support from staff who did not have the necessary skills and experience to meet their needs. This was a breach of a health and social care regulation (Regulation 23 (1)(a)) of the Health and Social Care Act Regulations 2010). The action we have asked the provider to take is at the back of this report.

A person's relative told us, "I cannot fault the nursing care [my relative] has had. The nurse in charge of [my relative's] care has been really on the ball and noticed when their health was going down and taken action." The same person said, "on the other hand staff are very busy and don't seem to have the time to talk to people. [My relative] stays in their room all the time and doesn't get to see staff much for a chat or join in activities."

We checked four people's care records. We found that people's needs had been assessed prior to them moving to the home. People and their relatives told us they had been involved in this process. Assessment reports included full details of the person's health and mental state, their communication needs and their background and preferences. Using this information, care plans had been developed which set out how peoples' needs were met by the service. For example, in the case of a person who had swallowing difficulties, their care plan explained how they received their meals safely and there were risk assessments in place about this. Staff had completed a daily record which showed that the person's care had been delivered as specified in their care plan.

Some people had complex medical needs. Their records showed that their health conditions were regularly assessed and monitored and the home had followed the advice of specialists in relation to their support. For example, a tissue viability nurse had given advice to the staff on a person's pressure area care. Their records showed how staff were implementing the care as advised, for example by helping the person turn in bed.

At the time of the inspection, no one at the home had end of life needs. From one person's file we saw that staff had made timely referrals to specialist health services and their GP in order to plan their end of life care. The manager told us that advice and support were readily available from these professionals which enabled them to support people with pain relief when they came to the end of their life.

People's records included regular checks on their weight and any special requirements in terms of their diet. When appropriate, referrals had been made to the GP and the dietician for advice. Some people were prescribed supplements or were on special diets. Records confirmed that they received these. We saw that staff gave people individual assistance to people to eat their lunch time and evening meals.

Some staff at the home were experienced and well qualified. A person said of a staff member, "they are very good at their job and I trust them totally." There had been a system for staff supervision in the home, which had been set up by the previous manager. This had lapsed in January 2014 when he had left. The current manger told us she was due to reinstate supervision systems in the home. Records of meetings that had taken place in 2013 showed that staff were given the opportunity to raise issues of concern and there were discussions of the quality of care and support. For example, notes of one meeting including a discussion on how to ensure people's nutritional needs were met.

Are services caring?

Our findings

People told us that staff were polite and kind and we saw some examples of staff supporting people in a way that promoted people's dignity and independence. People and their relatives said that staff were very busy and did not have the time to get to know them well. A person's relative said, "the staff who care for [r my relative] really don't know anything about their background." People said that some of the staff were long-standing and knew people well but other staff were new and they had not had much time to get to know them. A person told us, "I have been here for a good few years there is only one member of staff I am really friendly with but they have gone to work on a different floor now and I don't really see them." People did not receive support from staff who had time to communicate well with them and listen to their views about how they were supported.

People and their relatives said it took a long time for staff to give them their meals when they were sent up from the kitchen on the ground floor and consequently food was not very hot or appetising. One person told us, "there aren't enough staff to help. I've timed the delay based on the sound of the trolley coming out of the lift. Often its 10–15 minutes before anything arrives for me."

We observed some people having their lunch in the dining room. Some people received support that met their individual needs. For example, a staff member supported a person with needs related to moderate dementia appropriately, they used their name and said quietly, "hold your glass when you drink it" and positioned their hand around the glass and then said "cheers!" and drank from their own glass. This encouraged the person to drink and promoted their independence.

Staff did not always communicate well with people to ask them how they felt about the service. During lunch some people ate their meal independently. One of these people was observed to leave the dining room without eating much of the meal. A staff member asked them where they were going, but did not intervene to ask them why they did not want their lunch.

During the inspection we noticed most people stayed in bed in their rooms on their own. There were lounge areas on the second and third floor but these were not much used during our visit. Staff told us they respected each person's choice about whether they stayed in bed or not. People's care plans indicated that people were offered a choice about whether to stay in their room. We asked a person why they chose to stay in bed in their room. They said, "two staff need to use a hoist to help to move me so I would rather stay in here watching TV." Another person's relative said, "[my relative] used to be helped to get up and sit in their chair in their room, but one day they slipped down in the chair and could not call for help from staff. Since then they have said they prefer to stay in bed."

People's records showed that staff had communicated with them and their relatives about changes in their health and their end of life plans when it was appropriate to do so. People had given information about what they wanted to happen in terms of their treatment and who they wanted to be involved when they reached the end of their life. Staff had contacted specialist health professionals when they knew people were becoming seriously unwell. This ensured staff received good support and advice from these professionals to promote people's dignity and comfort at the end of their life.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People told us they were involved in making decisions about their care and treatment. Their care plans were regularly reviewed to ensure all their needs were met. A person said, "the staff do ask me if I want to go downstairs to activities, but I've said I would rather stay up here in bed."

The service complied with the requirements of the Mental Capacity Act 2005. For example, when a person had been assessed as lacking the capacity to make decisions, the service had involved their relatives in planning their care. A "best interests decision" had then been made by the people who knew them best about how they should be cared for. For example, they said they presumed that people had the capacity to make a decision them self unless an assessment of their mental capacity had determined that they were unable to do so. People told us they decided what to do themselves. For example, a person told us, "I know I could go downstairs, but I am staying in my room today and watching snooker on the TV."

People's records showed that their care plans had been reviewed each month to ensure that they reflected people's current needs. Staff had clearly documented the actions required such as involving health professionals when people's needs changed. Records showed that people were involved at an early stage in making some decisions about who they wanted to be involved when planning their end of life care.

Activities took place in the home from Monday to Friday in the ground floor lounge. On the day we visited we saw six people were doing jigsaw puzzles and playing board games. The majority of people stayed in their own rooms. Some people told us they preferred to do this. One person said, "I am happy up here watching the snooker." Another person said, "I am in my room all day and it's really getting on my nerves." People and their relatives said the atmosphere on the first and second floor of the home was very quiet with people either in their own rooms or downstairs. The manager told us she was aware from feedback from people and their relatives that some people would like more activities available to them in their rooms and at the weekends.

Are services well-led?

Our findings

The errors identified during the inspection in relation to the management of peoples' medicines had not been identified by staff and internally reported. The manager told us that staff would be reminded to report medication errors in line with the provider's procedures.

The regional manager had made visits to the home to monitor the quality of the service. The report of her visit on 19 February 2014 included a number of actions to be taken to improve care planning arrangements in the home. For example, she had stated, "named nurses and key workers are to be displayed on peoples' bedroom doors." This had not been put into place by the time of the inspection and the manager told us there was as no planned implementation date. This showed that the provider did not have a robust system to ensure that the findings and recommendation from audits of the service were followed up effectively when there were management changes. This was a breach of the relevant health and social care regulation (Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).

At the time of the inspection the manager, who had taken up her post in March 2014, had not yet applied to the CQC for registration. We will keep this under review to ensure that an application is submitted and the home has a registered manager.

The manager told us she had started to make some improvements in response to feedback from people and their relatives. For example, people's relatives had complained that people were not receiving supplies of their prescribed medicines in a timely way. In response, the manager had changed the home's pharmacy supplier to a local company so that people's medicines could be obtained more quickly.

People and their relatives told us the manager was approachable and friendly and we saw that she responded appropriately to a complaint that a relative raised during the inspection. Staff we spoke with understood how to treat people with dignity and respect and people confirmed that their privacy and confidentiality were respected by staff.

Records of a staff meetings showed that staff had been told how the manager aimed to improve standards at the home in terms of record keeping and improving people's experience of the service. For example, guidance had been given on how people should be supported with their meals. The manager had also reminded staff of the provider's standards in terms of their behaviour and ensuring confidential information was kept securely.

The manager had recently completed an audit of people's dependency levels and was in discussion with the provider about the financial resources available to her in relation to staffing levels in the home. She explained that the provider calculated the available resources for staffing from the number and needs of people in the home.

The manager told us she had set up monthly meetings with people who used the service. She was aware from feedback from staff and relatives that some people felt isolated and bored in their rooms and were unhappy about the quality of the food and drinks. She said she was looking at how meals were brought upstairs from the kitchen and how activities were provided in order to address these concerns. In addition, people had asked about the possibility of having some pets in the home and the manager said she was looking into arranging this.

The provider had processes in place to ensure that incidents, complaints and safeguarding issues were dealt with and any lessons learnt. The manager showed us information relating to a current complaint, which confirmed that it was being thoroughly investigated. The local authority said that the provider had effectively worked with them in relation to the investigation of safeguarding incidents and had taken appropriate action to ensure people were safe.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Medicines. People who use services and others were not protected against the risks associated with unsafe use and management of medicines by means of the safe handling, using, recording and administration of medicines.

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. People's health, safety and welfare of people had not been safeguarded by ensuring there are sufficient numbers of suitably qualified skilled and experienced persons available at all times.

Regulated activity	Regulation
	Regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Supporting Workers There were not suitable arrangements in place to ensure workers were enabled to deliver care to people safely and to an appropriate standard by ensuring they receive appropriate training, professional development and appraisal.

Regulated activity	Regulation
	Regulation 10 (1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

This section is primarily information for the provider

Compliance actions

There were not suitable arrangements in place to assess the quality of the service provided and identify, assess and mange risks to people.