Giltbrook Carehomes Ltd

Giltbrook Care Home

Inspection report

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Date of inspection visit:
17 August 2017

Date of publication:
27 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 4 and 5 April 2017. A breach of Regulation 17 for Good governance was found under the Health and Social Care Act 2008 (HSCA) Regulated Activities, Regulations 2014. This was because the provider did not have an effective system to regularly assess and monitor the quality of service that people received.

After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this unannounced focused inspection on 17 August 2017 to check that the provider had followed their plan and to confirm that they now met legal requirements. We found they had not and the provider was still in breach of Regulation 17. We also found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. This was because the registered persons did not ensure that medicines were safely managed at the service.

This report only covers our findings in relation to 'Safe' and 'Well-Led'. You can read the report of our last comprehensive inspection by selecting the 'all reports' link for Giltbrook Care House on our website at www.cqc.org.uk

Giltbrook Care Home provides accommodation and personal and nursing care for up to 40 older people, some of whom are living with dementia. The premises are on two floors with a passenger lift for access. The service has a range of communal areas and a secluded garden. There were 24 people using the service at the time of our inspection.

A registered manager was in post. This 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.

During this inspection we found significant shortfalls in the quality of the care being provided.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received. This had also been an issue at previous inspections in May 2015 and April 2016. At this inspection we found the provider had failed to identify that medicines management at the service was unsafe, care plans and risk assessments not always fit for purpose, and safe staff recruitment procedure had not always being followed.

Medicines management was unsafe in some areas due to medicines being stored at the wrong temperature, poor stock recording, missing medicines, liquid medicines and topical creams not labelled with the date of opening, gaps in MARs (medicines administration records), and medicines not given in line with the

prescriber's instructions.

Although some risk assessments were fit for purpose others were in need of improvement. For example, one person had lost a significant amount of weight and another person had had a series of falls. However inaccurate and incomplete records meant we could not be sure that risks to these people were being safely managed and addressed.

There were enough staff on duty on the day of our inspection visit to ensure people's needs were met. Relatives said there had been a high turnover of staff which had 'unsettled' family members. The provider and registered manager acknowledged this and said they had had difficulty recruiting new staff including nurses but the situation was being resolved with new permanent staff starting work at the service.

Improvements were needed to the provider's recruitment procedure to ensure the correct background checks were done before new staff started work at the service.

Staff were trained in 'safeguarding' (protecting people wo use care services from abuse). There had been a relatively high number of safeguarding issues at the service. The provider and registered manager were working with the local authority to address all the issues raised with a view to improving people's safety at the service.

Following our inspection visit we attended a relatives meeting at the service called by the local authority. Some relatives said their family members were happy at the service, the care was 'good', and the staff 'fantastic'. Others raised concerns about poor communication, a missed healthcare appointment, staffing issues, the laundry, and the quality of the personal care staff provided. The provider and registered manager said they were taking action to address these issues and had already made some improvements.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Medicines had not always been safely stored, managed and administered.

Not all staff had been safely recruited. There were enough staff on duty meet people's needs.

There had been a relatively high number of safeguarding issues at the service. The registered manager and provider were addressing these in conjunction with the local authority.

Improvements were needed to people's risk assessments.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The provider's governance system remained ineffective as audits to check on the quality of the service had failed to identify a number of shortfalls.

The provider and registered manager had listened to relatives' concerns about the service and were taking action to bring about improvements.

Giltbrook Care Home

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 focused inspection took place on 17 August 2017 and was unannounced and looked at 'Safe' and 'Well-Led'.

The inspection team consisted of an inspection manager, two inspectors, and a specialist advisor. A specialist adviser is a person with professional expertise in care and nursing. Our specialist advisor had nursing expertise.

This inspection was prompted in part because we received concerns about the quality and safety of people's care at the service from local authority and health authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. The commissioners told us they had ongoing concerns about this service and were working with the provider and registered manager to bring about improvements.

As this was a focused inspection we did not ask the provider to send us 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 reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We spoke with five people using the service and four relatives. We also spoke with the provider's representative, the registered manager, a nurse, a staff member employed to review care plans, two care workers, the maintenance person and the cook. We also observed care practice throughout the service, including people being supported in the main lounge, the dining room during lunchtime, and on the first

floor.

We looked at records relating to the safety and governance of the service including care and nursing, staffing, and quality assurance. We also looked at six people's care records.

Following our inspection visit we attended a relatives meeting at the service called by the local authority to enable relatives to raise any concerns they might have about the care and support their family member were receiving.

After the relatives meeting we spoke with the registered manager by phone to find out what she and the provider were doing to address the concerns raised.

Requires Improvement

Is the service safe?

Our findings

We looked at how people's medicines were managed and found this was not being done safely.

Medicines were stored in a designated room. One the day of our inspection visit the temperature of the room was within safe limits (15C to 25C). However the temperature was recorded as being between 26C and 30C consistently in the week prior to our inspection visit, and had been above 25C on several days during the week of our inspection visit. These issues identified meant that medicines had not been stored at a safe temperature and their effectiveness could have been compromised as a result. When we discussed this with the registered manager we were told the air conditioning unit had not been working properly but was now functioning so the situation had been resolved.

The temperature of the refrigerator, recorded daily, was within safe limits. However, the maximum/minimum temperature had not been reset for some time and staff were unable to reset it during the inspection. This function was in need of attention to help ensure the temperature of the refrigerator remained consistent.

A system was in place for the regular ordering and supply of medicines. We saw the medicines for the start of the next cycle, at the beginning of the following week, had been delivered. This meant there was time to rectify any discrepancies prior to the medicines being needed. However, medicines administration records (MARs) did not provide a prompt for recording the receipt and quantity of medicines received each month and whether any medicines were carried over from the previous month. We asked a nurse how they recorded their checks and receipts. They showed us a separate blank form, but were unable to locate any completed forms for previous deliveries. As a result, it was not possible for staff to track and monitor the usage of medicines and whether any medicines were missing. That meant there was a risk of people not having an adequate supply of their prescribed medicines in stock.

We saw one MAR recorded that 112 tablets of an analgesic medicine was supplied at the beginning of the current medicines cycle and none were recorded as being administered for the person during the cycle. So if an assumption was made that no medicines were carried over from the previous month, there should have been 112 tablets remaining when in fact we only found 91. The medicine was supplied in foil blisters and some of the tablets were missing from each of the sets. Staff could not account for the loss of this medicine. This was a further example that showed the medicines management system was not safe.

We found four gaps in the administration record of one medicine (used for prostatic hyperplasia and urinary retention) for a person indicating the medicine either had not been given, or the person giving the medicine had not signed the MAR. This increases the risk of the person receiving their medicine twice. The MAR for the same person indicated that a medicine which is given once a week was not given on the correct days. The signature record on the MAR was not clear and it appeared the person had received one dose of their medicine one or two days late and another dose two and three days later. This meant this medicine had not been given as prescribed which might potentially put the person's health at risk.

We reviewed the MARs and associated documentation for two people with diabetes. We saw there was a record of monitoring of their blood sugar levels although some of these recordings were poorly completed and illegible in places. We asked staff about these people and how frequently their blood sugar needed to be monitored. We were told they both required daily monitoring. However there was no record of a reading for three days during the current month for one person and no record for the other person between 19 July 2017 and 13 August 2017. One person's care plan stated they were given their insulin by the community nurse who also monitored their blood sugar levels, where in fact the blood sugar levels were completed by staff and the person administered their own insulin which the staff provided for them. The inaccuracy of the care plan could have led to the person not receiving their insulin if the staff were not familiar with their needs.

We found other issues that showed that medicines were not being managed safely at the service. When medicines were prescribed to be given only when required (knows as PRN medicines) protocols were not always in place to instruct staff when to administer these. Approximately half of the liquid medicines and topical creams were not labelled with the date of opening. Records of the application of prescribed creams were not completed consistently. When medicines were handwritten on the MAR they were not always checked by a second person to ensure accuracy of transcription.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The provider did not ensure that medicines were safely managed at the service.

We discussed this with the registered manager and provider's representative. They immediately arranged for their contract pharmacist to visit the service and carry out an audit of their medicines stocks and systems. Following our inspection visit the provider notified us that the pharmacist had come to the service on 19 August 2017 and as a result of their visit the provider said as a result they had introduced a new management of medicines system. The provider said this new system, which included the use of a medicines scanning device, should help staff to avoid medicines errors in future.

During our inspection visit we also asked the registered manager and provider's representative to review their induction and medicines training for staff, including agency staff, to ensure their safe management of medicines policies and procedures were being followed. Following our inspection visit the provider contacted us to say that since our inspection visit all the nurses had completed medication management competency training and care staff had completed topical cream/ointment competency training.

We looked at how risks to people at the service were managed so that people were protected from harm. When people first came to the service staff completed a range of risk assessments for them. These risk assessment covered areas such mobility, the use of bed rails, tissue viability, and nutrition and hydration. This meant staff had clear guidance on how to maintain people's safety. The records we saw showed that risk assessments were reviewed following any accidents or incidents.

For example, when we looked at the service's accidents and incidents book we saw that one person had had seven falls in the last two months. To address this staff had put a care plan and risk assessment in place dated 10 August 2017 stating, '[Person] is to be assisted at all times by one or two carers when he is mobilising to limit his risk of falling to help steady him and to stop him from further injuring himself.' All the staff we spoke with were aware of this instruction and told us that the person only mobilised when they had staff support them and at night they had a sensor mat in place to alert staff if they got up. We observed this person mobilising and saw that the care plans and risk assessment were being followed. We also saw the sensor mat in their room.

Although there was some evidence of actions taken to reduce the risk of a person falling, documented in their care plan, which had recently been reviewed, it was not entirely accurate. It stated the person was to be reviewed regularly by a dementia outreach team. However, a letter from the dementia outreach team sent in January 2017 stated this person had been discharged and did not require regular reviews. Although the member of staff we spoke with told us the person had been seen by the dementia outreach records did not support this but rather showed the dementia outreach team were not involved in the person's care and support. This meant that it was unclear how the risk of this person falling was being managed and by who.

In addition, people's weights had not always been safely managed. Records showed that although people were weighed monthly their weights were not always transferred to the care record. We noted the most recent weight recorded in one person's nutritional assessment was four months previous. Another person had lost 15kg in weight between January 2017 and July 2017. The only action recorded was for the person to be provided with supplements. Their nutrition care plan stated they required a pureed diet and normal fluids and needed assistance to eat and drink. The care plan was reviewed monthly between March 2017 and July 2016 but did not contain any information about action taken or the use of supplements. There was a comment in April 2017 that the person's appetite was decreasing and the reviews in May and June 2017 stated there were no changes to the care plan and no record of any input from the person's GP or a dietician. We therefore could not be assured that appropriate action had been taken in response to the person's weight loss.

We discussed these issues with the provider's representative and the registered manager. We pointed out that risk management had also been an issue at our last inspection on 4 and 5 April 2017 when we found that risks to people's safety were not always effectively assessed and managed. They said care plans and risk assessments were in the process of being reviewed and improved. They said they would oversee this review to ensure that in future care plans and risk assessments were accurate and fit for purpose.

We looked at how the provider ensured there were sufficient numbers of suitable staff employed to keep people safe and meet their needs. One person said, "They [the staff] get to you up as soon as they can but sometimes you just have to wait." At the relatives meeting following our inspection visit some relatives expressed concerns about staffing levels, particularly at weekends, as they said it took a long time for call bells to be answered. On the day of our inspection staffing levels were satisfactory but past rotas showed this had not always been the case and there had been a shortage of permanent nursing staff at the service.

We looked at nurse duty rotas from 14 to the 24 August 2017. These showed that during that period cover was needed for both early and late shifts for nine of the 12 days. The registered manager told us this situation had come about due to a number of nurses leaving the service. She said the gaps had been covered by bank nurses or agency nurses and on one occasion, when cover couldn't be arranged, she had provided this herself meaning she wasn't able to carry out all her management responsibilities at this time.

A relative said the turnover of staff had been unsettling for their family member. They told us, "There are constantly new faces. It's unsettling and very disconcerting to see so many changes. It's important to build a relationship with the staff, so you can trust them, and I do. It's been very confusing and upsetting for my [family member] who just gets used to someone and them they go." One person said, "There's lots of comings and goings with the staff, more than I like, but they look after me very well."

We discussed this issue with the provider's representative and registered manager who were aware of it and had been actively trying to recruit new nurses. They told us two new permanent part-time nurses would be starting work at the service the week following our inspection visit. A further nurse was being interviewed on

the day we inspected. The provider's representative and registered manager told us recruiting nurses had been a challenge but they hoped they would soon have a full complement of nursing staff. They said that until then agency nursing staff would be used to fill any gaps in the rota.

They also told us they had recently recruited new ancillary staff. One, known as a hostess, was employed to serve meals and assist in the dining room. Another was employed to make the beds, refresh the jugs of water and juice in people's bedrooms, and assist with the laundry. The appointment of these two staff members meant that care staff had more time to support people, including those who needed assistance with their meals. An administrator had also been employed to do all the in-house administration meaning the registered manager had more time to focus on the care and nursing side of the service.

Improvements were needed to the provider's recruitment procedure. Records showed that one nurse had been employed via an agency. We looked at their references and found that one was from the agency itself and appeared to be based on what the nurse had told staff at the agency. The other was from a person who the staff member has worked for six years ago. This meant there was no reference from a recent employer even though the nurse had consistently worked in health and social care for the last six years. The provider told us they had sent a reference request to the nurse's most recent employer, and there was a record of them doing this, but had not received a reply. This would have made it more difficult for the provider to determine the suitability of the staff member.

We also found that the service's handyman had left and their work was being covered by the person usually employed to maintain the gardens on a temporary basis. Although this person was not employed for the purposes of a regulated activity (for example assisting with personal care) they had unsupervised access to some of the people using the service. However there was no risk assessment in place for this so we could not be sure this person was suitable for their role.

We discussed these issues with the provider. They agreed to review their recruitment procedure to ensure it was fit for purpose and carry out a risk assessment for the person working at the service as temporary handyman. This will help to ensure that only suitable staff work at the service.

We looked at how staff protected people using the service from abuse. One person told us they felt safe because 'they've got some lovely carers here – they're nice and kind'. A care worker told us they'd been trained in safeguarding at their induction and knew to report any concerns they might have about a person's well-being to the person in charge and outside the service if they didn't get an appropriate response. Throughout the day we saw that people were comfortable and relaxed with the staff and asked them for assistance when they needed it.

Safeguarding had been an issue at our last inspection on 4 and 5 April 2017 when we found that a safeguarding incident had not been reported the local authority or CQC in line with the provider's safeguarding policy. We checked the policy was in place and available to staff and found that it was. In addition safeguarding was displayed at the service to give guidance to people and their relatives and staff if they had concerns about anyone's safety or well-being. Records showed staff had been trained in safeguarding.

Record showed there had been a relatively high number of safeguarding issues at the service and the local authority had been involved in investigating these. Some of these investigations were ongoing at the time of our inspection visit. The provider and registered manager said they had been working with the local authority to address all the issues raised with a view to improving people's safety at the service. They also said they had clarified with the local authority the type of incidents that needed to be reported as

safeguarding concerns.

Inadequate

Is the service well-led?

Our findings

We found that Giltbrook Care Home was not well-led and did not demonstrate good governance.

At our last comprehensive inspection on 4 April 2017 we found the provider did not have an effective system to regularly assess and monitor the quality of service that people received. This had also been an issue at previous inspections on 20 April 2016 and 18 and 19 May 2015 and resulted in us making a requirement action on each occasion.

The provider had failed to competently assess and monitor the quality of medicines management at the service and identify that it was unsafe in some areas. The provider's action plan stated that the 'clinical room thermometer is reset daily and the room temperature is monitored should not be over 25'. On the day of our inspection visit the temperature of the room was within safe limits (15C to 25C). However the temperature was recorded as being between 26C and 30C consistently in the week prior to our inspection visit, and had been above 25C on several days during the week of our inspection visit. These issues identified meant that medicines had not been stored at a safe temperature and their effectiveness could have been compromised as a result. This was contrary to the provider's action plan.

The provider's action plan stated that protocols must be in place for all PRN (as required) medicines and confirmed that this action had already been completed. However at this inspection visit we found that this was not the case and there were no protocols in place for some people's PRN medicines. This meant staff did not always have the information they needed to administer PRN medicines when they were needed. This was contrary to the provider's action plan.

The action plan stated that handwritten MARs (medicine administration records) must be double signed by staff. The action plan confirmed this action had been completed by the end of July 2017. However at this inspection we found handwritten MARs that had not been double signed. This was evidence that the provider's action plan was in parts ineffective meaning we could not be sure medicines were being safely managed at the service. This was contrary to the provider's action plan.

The monitoring of people's care and support was not always effective and these shortfalls had not been identified by the provider. One person had lost 15kg in weight between January 2017 and July 2017. The only action recorded was for the person to be provided with supplements. Their nutrition care plan stated they required a pureed diet and normal fluids and needed assistance to eat and drink. The care plan was reviewed monthly between January 2017 and July 2017 but did not contain any information about action taken or the use of supplements. There was a comment in April 2017 that the person's appetite was decreasing but the reviews in May and June 2017 stated there were no changes to the care plan and no record of any input from the person's GP or a dietician. This meant that despite the person's care plan being reviewed six times during this period their significant weight loss was not effectively addressed or actioned. This showed that the provider's care plan review system was not fit for purpose.

The provider's action plan stated that care plans for people living with dementia were in need of

improvement to make them more personalised and this action would be completed by the end of August 2017. During our inspection visit a member of staff was in the process of doing this and we looked at some of the care plans they had re-written. We found there were some improvements to these care plans and they provided information about people's care and support needs and some information about their personal preferences. However, with regard to dementia care, some of the updated care plans contained a large amount of generic information about dementia but did not show how it affected the person in question. For example one care plan stated staff should look for generic triggers that might cause distress to the person, rather than identifying the specific triggers for that person as an individual. While it is understood that the registered manager had not yet reviewed the new care plans, the person had lived at the service for a considerable period of time and this information should have been available to enable staff to meet their needs. This was a further example of the provider's care plan review system not being fit for purpose.

Systems and processes to ensure safe staff recruitment had not always been followed. One person had been employed as a nurse without suitable references being obtained for them. Another person was working at the service on a temporary basis to provide cover for the handyman who had left. This meant they had unsupervised access to some of the people using the service. However in both cases there were no risk assessments in place to demonstrate the provider considered them suitable to work in a care environment.

This is the fourth consecutive occasion the provider has failed to comply with this regulation. This demonstrates that systems and processes to assess, monitor and improve the quality and safety of the service are not sufficient.

This is a continued breach of Regulation 17 HSCA RA Regulations 2014 Good governance. The registered persons still did not have an effective system to regularly assess and monitor the quality of service that people received.

Following our inspection visit a CQC inspection manager and inspector attended a relatives meeting at the service on the 22 August 2017 called by the local authority. The purpose of this meeting was to give relatives the opportunity to raise any concerns they had about the service with the provider, CQC, and the local authority. Twelves relatives attended this meeting.

During the meeting some relatives gave positive feedback about the service. One relative said some of the care staff were 'fantastic' and their relative was happy at the service and could have a cup of tea when they wanted one. Another relative said the registered manager had gone out to buy shopping for some people using the service which they thought was positive. And a further relative said they thought that overall the quality of care was 'good'.

However some relatives expressed a number of concerns about the service. They said communication was at times poor and they were not always informed if their family member was hospitalised or had a fall. One relative said they'd been told their family member had fallen and had stitches but when they got to the service none of the staff knew anything about this and their family member had no injuries. Another relative said their family member had missed a healthcare appointment due to staff not being aware of it.

Following this meeting the registered manager told us she had already put a communication book in place to keep staff informed about people using the service. This was being used to record hospital appointments, falls, and any other incidents that staff needed to be aware of so they could take appropriate action including letting relatives know where necessary.

Some relatives expressed concern about staffing arrangements at the service and queried whether the provider and registered manager employed enough staff. Following this meeting the registered manager told us she had recruited a number of new nurses and care workers and the service was no longer understaffed. She said these were permanent staff so staff turnover should reduce.

Some relatives said the laundry hadn't been working effectively and their family members' clothes frequently went missing. They also said clothes were put in wardrobes without being ironed and folded first and had sometimes been damaged in the wash. The registered manager said she had written to all relatives to explain about the laundry problems and say what was being done to address it but some relatives said they had not received the letter.

Following this meeting the registered manager told us she acknowledged there had been a problem with the laundry but since then she had recruited a new laundry assistant who was starting work at the service in September 2017. She said she hoped this would result in a better laundry service for people.

Some relatives said they had concerns about the quality of the personal care staff provided. They reported difficulties with continence management and confusion about whether or not their family members were being supported to have regular baths or showers.

Following this meeting the registered manager said care plans were being updated to ensure people needs with regard to continence and baths or showers were clearly set out and staff knew how to support them appropriately. She also said staff had been told to record it if someone had had a bath or shower or had been offered one and had refused. This meant she would have an overview of people's personal care which she could share with relatives where appropriate.

Both the registered manager and the provider said they had listened to relative's concerns. They said they had already made a number of improvements to address these. They said that as a result they hoped relatives would now have more confidence in the quality of the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not ensure that medicines were safely managed at the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not have an effective system to regularly assess and monitor the quality of service that people received.

The enforcement action we took:

We issued a Warning Notice to the provider due to their failure to comply with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.