Black Country Housing Group Limited

Gower Gardens

Inspection report

Kent Road
Halesowen
West Midlands
B62 8PQ

Tel: 01212893965
Website: www.bchg.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Gower Gardens is registered to provide accommodation and personal care for up to 66 people, who are mainly older people with dementia. At the time of our inspection 46 people were using the service. Our inspection was unannounced and took place on 21 and 22 June 2017. We received concerns that people were not being safely supported in relation to their risk of falls and equipment used for moving and handling people was being incorrectly used. This prompted us to undertake this inspection earlier than was planned and included an evening visit. This was the first inspection since the service was registered in October 2016.

The manager was acting in an interim role and was not registered with us as is required by law. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The acting manager told us they had been in place for two months and our records showed that the previous manager had cancelled their registration in November 2016.

The service was not always effective in how it minimised the impact on people from falling and risk assessments were not always updated as required. Administration and recording of medicines given was not always carried out safely. Staff understood the procedures they should follow if they witnessed or suspected that a person was being abused or harmed. Safe recruitment practices were in place and were followed.

There were concerns that night staff did not know how to support people effectively. Staff received an induction prior to them working for the service and they felt prepared to do their job. Staff could access on-going training to assist them in their role. Staff could access supervision and felt able to ask for assistance from the acting manager and senior staff, if they should need it. Staff knew how to support people in line with the Mental Capacity Act and gained their consent before assisting or supporting them. Staff assisted people to access food and drink and encouraged people to eat healthily. Staff supported people's healthcare needs.

There were differences between day and night staff as to the level of person centred care provided to people. People were involved in making their own decisions about their care and their own specific needs. People felt listened to, had the information they needed and were consulted about their care. Staff provided care with dignity and respect to people. People were encouraged to retain an appropriate level of independence with staff there ready to support them if they needed help.

People's preferences for how they wished to receive support were known and considered by the care staff. People were able to participate in activities should they wish to do so. People knew how to raise complaints or concerns and a procedure was in place for staff to follow.

We did not always receive notifications as required. Audits were carried out, but they did not always give

enough information to enable people to receive appropriate support. People felt that there was inconsistency in management within the home. People felt settled and liked the environment.

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 consistently safe.

Measures put in place by the provider to manage risks were not always effective.

Medicines were not always given, stored and recorded appropriately.

Staff recruitment was carried out safely.

Is the service effective?

Good

The service was effective.

Staff were provided with an induction before working for the service and received on-going supervision and support.

Staff knew how to support people in line with the Mental Capacity Act and gained their consent before assisting or supporting them.

Staff assisted people to access food and drink

Is the service caring?

Requires Improvement

The service was not always caring.

There was inconsistency in how caring staff were towards people.

People were involved in making decisions about their care and how it was to be delivered.

Staff maintained people's dignity and provided respectful care.

Is the service responsive?

Good

The service was responsive.

Staff understood people's needs.

Staff considered people's preferences.

People knew how to raise complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We were not always notified of accidents and incidents.

Some quality assurance audits were carried out, but they were limited in the information provided and their effectiveness in identifying trends?.

People liked living in the home.

Gower Gardens

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 checked 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.

Our inspection was unannounced and took place on 21 and 22 June 2017. The inspection was carried out by two inspectors, a pharmacy 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. We received concerns that people were not being safely supported in relation to their risk of falls and equipment used for moving and handling people was being incorrectly used. This prompted us to undertake this inspection earlier than was planned and included an evening visit.

The provider had completed a Provider Information Return (PIR) and returned this to us within the timescale requested. 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 asked the local authority their views on the service provided. We also reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We used this information to plan what areas we were going to focus on during our inspection.

We spoke with nine people, six relatives, seven members of staff, the deputy chef and the acting manager. We viewed care files for five people and the recruitment and training records for four members of staff. We looked at nine people's medicine records. We looked at complaints systems, completed provider feedback forms and the processes the provider had in place to monitor the quality of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We looked at nine medicines administration records (MARs) and observed staff administering medicines to five people. We found that the systems and process did not make sure that people's medicines were always managed safely. Staff checked the medication fridge temperatures daily. However, the maximum and minimum temperatures were not recorded and therefore it was not possible to say if medicines were stored at the correct temperature continuously. Staff were taking the temperatures in line with the providers policy but this was not fit for purpose. The medicine administration records (MARs) were completed accurately and demonstrated that people received their medicines as prescribed. However, staff told us they applied people's creams but did not always complete the administration records to evidence this and therefore it was not possible to say if these products were applied as prescribed.

Medicine lists were not updated when people's medicines changed. We saw discrepancies between the MARs and the list of medicines, which could cause errors if a person was transferred elsewhere, for example to hospital. However, staff told us that they would send the person with the MAR to ensure accuracy. Protocols for medicines given, 'as and when' were not always fully completed, or signed and dated by the GP which was against the provider's policy. We saw three people prescribed anti-psychotic medicines that did not have regular reviews recorded. Staff administering medicines did not know why people were taking certain medicines and could not give details what side effects to be aware of for the high risk medicines, which meant that staff may not have the knowledge to request appropriate medical support for someone experiencing adverse effects to their medicines. People were encouraged to maintain independence by self-administering their own medicines. However, the process for people self-administering medicines was not managed safely. We looked at the care plans for two people who self-administered all their medicines. There was no recorded risk assessment, no regular reviews, and no spot checks that the people were managing their medicines safely and their medicines were not stored securely. We saw a strong painkiller stored on a window sill in an unlocked bedroom and prescription medicines in an unlocked drawer in another bedroom. This meant that people may be able to easily access medicines not meant for them.

Senior care staff administered medicines safely with patience and care. Staff involved with the administration of medicines received annual training and a thorough competency assessment. Staff carried out regular medicine audits and identified areas for improvement. However these failed to identify the issues we had noted during our inspection. Staff recorded when medicines were disposed of and returned to the pharmacy.

We had received information prior to our inspection about people experiencing numerous falls and on our visit to the home we saw records that confirmed this. We saw that risk assessments considered falls and offered information on how people should be supported, such as having equipment close to hand, but these were sometimes not updated until after the person had fallen more than once. An example of this was a person falling from bed and hitting their head on bedroom furniture, only to do it again a short time after the first incident. Relatives told us that preventative measures would often not be put in place until people had fallen a number of times. This meant that several people had fallen repeatedly and been hurt as a consequence. However, we saw that where multiple falls had occurred professionals had been contacted

and equipment such as alarm sensor mats or walking frames had been introduced or the person was waiting to be assessed. Patterns and trends around falls were noted by the acting manager, however people were still falling at a high rate, often having numerous falls in quick succession, which showed that action taken was not always having the effect that was required.

Records showed that the majority of falls occurred during night time hours and people we spoke with shared with us their concerns about staffing levels during the night. People told us that they did not think there were enough staff available at night. One person told us how they had called for staff when a person in a neighbouring room had fallen, but nobody came and they had to go and find a staff member. The acting manager told us that this would be investigated. Relatives told us, "The attitude of the night staff isn't great" and, "The continuity of staff on the top floor is variable. Weekends and nights seem to be a particular issue [person's name] has fallen several times and has needed a hospital visit". The acting manager talked us through the staffing tool used to calculate the amount of staff needed and said that they were running above care hours required during the night. We were told that calculations were made on people's level of independence and contact hours required. However the link between falls at night and evidence from people telling us staff did not always respond in a timely manner to their needs means that the tool may not always be effective.

People and relatives told us that they felt that numbers of staff available during the day time was good. One person said, "There are enough staff [during the day] they would come running if I shouted". A relative told us, "When I have been here there has always been enough staff". Some staff members we spoke with told us that they felt that at times they were too busy to offer a quality service to people, but they were aware that recruitment was in progress. People shared some concerns about the number of agency staff working in the home and told us that these staff members didn't know people well enough to give person centred care. The acting manager told us that they were hopeful that successful recruitment of permanent day and night staff would mitigate the use of agency employees.

We found that effective recruitment systems were in place. Staff confirmed that checks had been completed before they started work. We looked at four staff recruitment records and saw that pre-employment checks had been carried out. This included the obtaining of references and checks with the Disclosure and Barring Service (DBS). The DBS check would show if a prospective staff member had a criminal record or had been barred from working with people due to abuse or other concerns. Where disciplinary measures had been taken these had been carried out appropriately.

People told us that they felt safe with one person saying, "I feel completely safe here. The staff are so good. We are all cared for and I don't have to worry about anything". A second person shared, "I feel safe, everything is locked up. I have settled down quite well". A relative told us, "I would say [person's name] is safe because she can't get very far. The staff are brilliant. They take care of her when I am not here. I think it is an excellent service from that point of view".

Staff told us that they understood how to safeguard people with one staff member telling us, "I feel that my training and experience helps me to safeguard people. I know what to look for and I would recognise any signs of abuse and report them". A second staff member shared, "If there was any evidence of physical abuse I would body map the person. If they have a bruise I want to know how they got that bruise. I don't care if it wasn't my shift I want to know how it happened". We saw that where safeguarding concerns were raised the providers policy was adhered to and the appropriate external agency were notified.

We saw that risk assessments were in place and these covered medical needs and taking medicines, risk of dehydration and not drinking enough, communication difficulties and mobility concerns amongst other

issues. We found that risk assessments were rated by their impact of the risk to the person and the current controls in place to mitigate any risks. We saw that people had personal evacuation plans in place in the event of an emergency and staff were able to discuss what action they would take in the event of such a situation.

Good

Is the service effective?

Our findings

People told us that they felt that staff were effective in their roles. One person told us, "I know the staff and they are getting to know me. It is working well". A relative told us, "I would say that they [staff] are well trained. They know what they are doing. I have the confidence in the staff to leave [person's name] quite safely in their care. I do think the agency staff need extra training to care for people with more complex needs". We spoke with an agency staff member who told us that they were given enough information on people's needs to do their job effectively and that they were appropriately trained.

Staff members told us that they had received an effective induction. One staff member said, "We were in training for five weeks before we were even allowed to come into the home. We had weekly meetings with the deputies during the induction period. The new staff shadow me now, I think it is essential that they spend time with the residents". We found that new starters who did not have an NVQ qualification were enrolled on the Care Certificate. The Care Certificate is a set of standards, which care staff are expected to adhere to. We found that staff participated in on-going training and saw the training matrix which noted who had completed which courses and when they were due to be updated. One staff member told us, "I have had recent training in mental capacity, dementia, challenging behaviour and skin issues". Another staff member said, "I have been fully trained on giving medicines by an outside agency who are very knowledgeable".

Staff members told us that they received regular supervision and we saw that this had been documented. Staff told us that they felt able to speak with senior members of staff at any time and that there was an 'open door' culture. Annual appraisals were being planned as the service had been running under a year.

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. 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). We found that where it was thought that people may lack mental capacity appropriate assessments were in place. DoLs applications had been submitted appropriately to the supervisory body. Staff told us that people were cared for in the least restrictive way, wherever possible. Where a relative had Power of Attorney in order to make decisions on the person's behalf we saw that they had been involved in any decisions, with best interest meetings minutes recorded. Staff we spoke with had an understanding of MCA and DoLS and were able to talk to us about why people may have their liberty restricted. We saw that staff asked people's consent before carrying out any task or assisting them. A staff member told us, "I respect their [person's] choice. I cannot make the decision to do something if they refuse".

People told us that they enjoyed the food and we saw that a healthy, nutritious menu of fresh meat, fish and vegetables was provided. One person told us, "The dinner is nice, lots of choice and fruit and veg". A relative

shared, "I am pleased with the food. It is generally quite good. I often have Sunday lunch here". A staff member told us, "The meals are fabulous and people have afternoon snacks such as fruit and chocolate. We also do a cheese and wine board twice a month. We do the best we can to give them [people] plenty of choice". We saw that dietary requirements were recorded within care plans and observed people being given specific meals to suit their needs. At mealtimes people were assisted as required and we saw that one staff member noticed a person struggling to eat following a recent dental procedure tooth extraction and so they ensured that a lighter meal was brought to them. People told us that they received regular drinks and we saw this occurring. We found that daily recordings and charts for weight, food intake and output were up to date for the people we reviewed.

People told us that staff supported them with their on-going health needs. One person told us, "They [staff] would get the doctor if I was poorly". A second person said, "I regularly see people [professionals] the optician was here the other day". A staff member told us, "I have recently contacted the dietician as I have concerns over someone and I have phoned the doctor and hospital when I have been concerned over people's health". Records of health appointments and medical information were kept as required.

Requires Improvement

Is the service caring?

Our findings

People told us that they thought that day time staff members were kind and caring. One person said, "I like the staff they look after me". A relative told us, "I think the staff are friendly enough, they are always pleasant and speak to [person's name] by name. However lots of people we spoke to felt that care given during the night was not as good as they expected. One person said, "They [night staff] aren't as friendly [as the day staff]". A relative said, "The night staff let them [the organisation] down. It's the lack of continuity between the night staff and the day staff that worries me. The day staff will do things for people that the night staff won't. It needs to be nipped in the bud". A second relative told us, "I have to say it's the night staff, who are mostly agency staff, let them [service] down. They will forget to brush [person's names] teeth or they will give him the toothbrush and expect him to know what to do". A member of staff told us, "They [agency] just send anybody and people don't know them, I don't think it is good for people". This told us that night staff did not always respond to people's needs using a caring approach.

We saw that wherever possible people were encouraged to make their own decisions. People told us that they chose what time they got up and went to bed and that they chose what meal they wanted and what to wear. We saw people getting up and retiring at a time to suit them. A staff member told us, "I give people choices, for example I will show them a selection of clothes in the morning and I only assist them to wear what they have chosen".

We saw people being encouraged to maintain their independence with a number of people helping out around the home, undertaking such tasks as washing up and clearing tables, which they appeared to enjoy greatly. One person told us, "Your independence fades away and you can't do what you did at home, but I am quite happy to rely on the staff and I do as much or as little as I want". A staff member told us, "We encourage people to be independent and to do things for themselves, tidying around makes them feel useful and more at home, so we help to arrange it".

People felt that their dignity and privacy was promoted with one person telling us, "I am always kept covered up when they [staff] care for me". A second person told us, "All of the staff treat us with dignity, they treat me very nicely". A staff member told us, "People have privacy at all times. We don't give out confidential information and we always knock doors before being asked to enter". We saw that staff spoke to people in a respectful manner.

We were told that staff had good professional relationships with people and their relatives. One person shared, "I feel that we try to work well together". Relatives told us, "I like the set up a lot. All the staff are approachable. I come in every day and the staff make me very welcome. The cooperation I get here is good; we are a team in that sense" and, "Generally I am pleased. I have a good rapport with the day staff. It's the night staff who let them [service] down". Relatives shared examples of where staff had been responsive to their needs and this included, allowing them to hold a key to a relative's door so it could be locked in the daytime and arranging meetings when requested.

The acting manager told us that most people using the service used family members as advocates for them,

but if a person was in need of an advocate this would be arranged through the service using a local external provider. An advocate assists people to understand their rights and to express their views regarding decisions made about them.

Good

Is the service responsive?

Our findings

People told us that they had been involved in developing their care plan, with one person saying, "They [staff] asked me what I needed and they wrote it down". A relative told us, "They [staff] got us involved in taking the information and asked us about [person's name] and where he had worked; they wanted to learn everything about him". We saw that care plans were in place and that they covered cultural and religious needs, sexual orientation, communication needs and discussed how issues such as dementia would impact a person over time. Routines people were used to previously were still followed, such as preferred time to retire to bed and general likes and dislikes. We found that pre-admission information including medical history, cognitive ability, mobility, social wellbeing was provided and a history of the person had been taken. Staff told us that the care plans were updated regularly and one staff member said, "The care plans are updated if the person's needs change" [they gave an example of changes in equipment used to assist people]. We saw that although some care plans had been updated monthly as records suggested, this had not been the case for all care plans, with some not being updated for a number of months. The acting manager told us that lack of management staff had impacted upon this and it was something that she was seeking to address immediately.

People told us that they participated in activities. One person said, "We do some activities, I like to draw. I go in the garden if the weather is nice". A second person shared, "There is a handicraft lady who comes in who teaches us to make things, she is brilliant. A man also comes in and we pass the ball with him". A relative told us, "People with dementia are limited in the activities they can do, [person's name] doesn't like to do much. They [staff] are trying, but the lack of organisation has a negative impact". A staff member shared with us, "Some days the activities are stimulating and some days not, however the activities have gotten better upstairs on the dementia unit. The computer lady and the craft lady are good. The people here like doing crafts, quizzes, bingo and talking about the past". We observed activities taking place and saw that people enjoyed what was on offer, such as a lesson on computers and people playing cards together. One person was carrying around a tin with a small aeroplane making kit in it that they appeared to enjoy.

We saw that surveys had been carried out into the care provided with questions posed to people and relatives. We saw that there were mainly positive responses returned. Feedback was provided to people in the form of a pictorial booklet. Comments include 'They are not like staff they are human with us' and 'I have never felt like I would want to live anywhere else'.

People told us that they were aware of the complaints policy. One person told us, "If I raise any issue they [senior managers] will deal with it. I go to the two 'under managers' and have a word with them". A relative told us, "There have been some minor issues that I think should have been dealt with before it reached a complaint, but they were dealt with once I spoke with staff". A second relative told us, "They [senior managers] will listen if you complain, but don't always do as you ask. I have complained about night staff not following the care plan and nothing has changed". We saw that complaints recorded had followed the procedure in place and that the complainants had been notified of the outcome of any investigations. The acting manager told us that all complaints had been followed up, but not every complainant was happy with the responses but that the policy had always been followed. The Provider Information Return (PIR) told

us, 'We will be introducing learning from complaints as an agenda item in staff meeting so that learning can be share consistently'.

Requires Improvement

Is the service well-led?

Our findings

We saw that accidents and incidents were recorded, but that we were not always notified of some significant incidents as required by law. This included head injuries where people had been taken to hospital with open wounds. This meant that we were not aware of how such incidents had been dealt with by staff, any outcomes for the people involved and what action the provider had taken to minimise re-occurences.

This is a breach of Care Quality Commission (Registration) Regulations 2009 Regulation 18: Notification of other incidents.

There was a system in place to monitor the quality of the service. We saw that a number of audits were completed each month by the acting manager and these covered areas such as safeguarding concerns, falls, incidents and accidents, recording of medicines administered and staffing to name a few. However falls monitoring was not effective as on-going actions had not been recorded, therefore it was not clear if such actions had been effective or if people required a different approach to minimise their falls. This additional analysis within the audit may assist staff to better understand people's needs. We also found that the medicines issues we identified had not been dealt with as part of the audit.

People told us that they didn't yet know the acting manager well, with one person saying, "I don't know who the managers are. I speak to the girls [staff members] if I need anything". A second person said, "There are quite a few managers here. It's getting to know what is coming or who is coming next. It constantly changes". A relative told us, "I don't know who the manager is. I don't have anything to do with them". A staff member told us, "I think the management team including the acting manager are supportive and I can speak to them. Sometimes you need that reassurance that you are doing the right thing". The acting manager told us that she understood that there were many changes that the service needed to go through in order to improve in some areas and said that she would be, "Working hard to improve things".

People told us that they enjoyed living at Gower Gardens and one person told us, "I like it here. I have no problems. I have a good life here. I do what I want. I have friends here". A second person shared, "I have been here seven or eight months. It is my home now. You get to know people". A relative told us, "Overall I am happy [with person's name care] but the home needs continuity, it doesn't have that at the moment". We saw that the atmosphere within the home was happy and buoyant and there was a lot of conversations between people and staff. We visited on very hot days and found that the temperature within the lounge areas were lowered by the use of fans and that the rooms felt comfortable.

We saw that meetings for people and relatives took place regularly. One person told us, "We have resident's meetings every six weeks". We saw minutes from meetings to reinforce what we had been told. Staff members told us that they attended meetings where they were given information on the service and had the opportunity to ask questions or share opinions.

Staff members told us that if they had any concerns with regards to how people were cared for by fellow staff members they would contact the appropriate external agency. One staff member told us,

"Whistleblowing applies if a member of staff feels that the issue is not being dealt with by managers. I would go to the director and go via the local authority safeguarding department".