Mr & Mrs J Rzepa

# The Gables Care Home

**Inspection report**

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires improvement |
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

An unannounced inspection took place on 9 June 2015. Our previous inspection on 2 May 2014 found the provider was not meeting two regulations at that time. These were in relation to safety and suitability of premises and assessing and monitoring the quality of service provision. At our visit on 9 June 2015 we found that some improvements had been made to meet these requirements.

The Gables Care Home provides support for up to twenty three people, including those living with dementia. On the day we visited there were seventeen people living in the home. The service is situated in Buxton and was originally built as a family home for local merchants and has large rooms and high ceilings. There is a garden for the people who live in the home to use.

There was a registered manager in post at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

# Summary of findings

People were not protected from the risk of cross-infection and the provider's infection control policy was not always being followed.

Care plans were reviewed and updated. However, people did not always receive care that was appropriate to their needs and reflected their preferences. Staff did not always recognise people's needs and respond appropriately. Opportunities for people to pursue their hobbies and interests were limited.

There were sufficient numbers of staff employed to keep people safe on a day to day basis and there were effective recruitment processes in place. However, staff were not always responsive to people's needs and we saw that some people were ignored when they tried to attract the attention of staff. Some staff promoted people's dignity and protected their privacy, however we observed occasions when this did not happen.

Staff received training and support to help them meet the needs of people living at the home but this had not always been put into practice.

People's medicines were stored and administered safely but accurate medicines records had not always been maintained.

People were protected from avoidable harm and risks most of the time. Staff were trained to recognise and respond to signs of abuse and were confident in approaching the registered manager.

There was adequate food and drink and the chef cooked fresh food on a daily basis and made nutritious soups from fresh vegetables, which were always available. However, people were not always assisted to eat their meals in a timely manner.

The staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People had been involved in their care planning but their consent had not always been recorded.

The registered manager had a positive relationship with people who used the service and with staff; they were also well known to visitors to the home and had a good rapport with them. Improvements had been made to quality assurance systems within the home but these had not always identified issues in relation to care delivery. There was a clear vision for the home but this was not always evident in the staff practices we observed. Complaints were investigated and responded to appropriately.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we asked the provider to take 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.

**Is the service safe?**

**Requires improvement**

The service was not consistently safe.

People were not protected from the risk of cross-infection.

There were sufficient staff available to meet the needs of people living at the home but opportunities for support outside the home were limited. Robust recruitment practices were in place.

People were mostly protected from the risk of avoidable harm and abuse.

Medicines were safely stored and administered but accurate records had not always been maintained.

**Is the service effective?**

**Requires improvement**

The service was not consistently effective.

Staff did not always use appropriate knowledge and skills to care for people effectively.

The food was nutritious and people were supported to have sufficient to eat and drink. However people were not always supported with their meals in a timely manner.

Health care was sought actively for people when they needed it.

**Is the service caring?**

**Requires improvement**

The service was not consistently caring.

There were positive caring relationships between some of the staff and the people who used the service. However, this was not consistent and on some occasions people were ignored by staff.

Staff did not always take the time to talk to people as they walked around the home though there was some interaction between the staff and the people who used the service.

Staff did not always promote people's dignity.

**Is the service responsive?**

**Requires improvement**

The service was not consistently responsive.

People did not always receive care that met their needs and reflected their preferences. There were limited opportunities for people to engage in meaningful activities.

Care plans were up to date and complaints were investigated and responded to.

# Summary of findings

**Is the service well-led?**

The service was not consistently well led.

There was a positive culture between the registered manager and the staff team. However, staff had not always acted in accordance with the values of the provider when providing support for people.

Improvements had been made to quality assurance systems, but these had not identified shortfalls in some areas of service provision. The registered manager was aware of their responsibilities to ensure the quality of life of the people who lived in the home and what resources were required to do this.

**Requires improvement**

# The Gables 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 was 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.

The inspection took place on 9 June 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service along with any notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We also contacted the local authority and took the information they provided into account as part of our planning for the inspection.

We spoke with ten people who used the service, one relative and two friends of people who lived in the home, the registered manager and assistant deputy manager as well as four care workers. We carried out observations of care being provided. We also reviewed a range of records about people's care and how the home was managed. This included six care plans. We also looked at staff records, medication records and records in relation to the management of the service such as audits, checks, policies and procedures.

Requires improvement

# Is the service safe?

## Our findings

At our last inspection in May 2014, we found that the provider's arrangements for the maintenance of the premises did not fully protect people against the risks associated with unsafe premises. This was a breach of Regulation 15 of the HSCA 2008 (Regulated Activities) Regulations 2010. Following our inspection the provider told us about the action they were taking to address this and at this inspection we found that sufficient improvements had been made.

However, at this inspection we found that people had not always been protected from the risk of cross-infection. There was a lack of gloves available for staff to wear when assisting with personal care as these were not always available on each floor of the home. However, we did not see any occasions where staff were not using gloves when providing care. We also found that heavily soiled clothes were not being separated to control the risk and spread of infections. Although separate yellow bags were available for this purpose, they were not always being used by staff. We saw that clothes ready for the laundry were all in black bags and had not been separated to ensure that heavily soiled clothes would be washed separately. We also saw that the sink where commodes were washed did not have a supply of plastic aprons for care workers to wear while washing the commodes to prevent the risk of cross contamination.

Some areas of the home were unclean, for example one toilet that was used by people was dirty with faeces. In toilet areas we saw that there were no handwashing facilities, soap dispensers were out of soap, paper hand towels were not replenished and there were no toilet rolls. This meant that people did not have access to appropriate facilities to ensure good hand hygiene and so there was an increased risk of cross-infection. There was a policy on infection control in place; however, this was not followed. The provider's arrangements for the prevention and control of infection did not fully protect people from the risk of infection.

**This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

When we spoke with people they told us that they felt safe. Staff were knowledgeable about how to protect people from the risk of abuse and what to do if they saw, or suspected, that any person was the subject of abuse. However, one member of staff that we spoke with was not aware of any 'Whistleblowing' policy. Whistleblowing is about supporting staff to raise concerns about poor or unsafe practice.

Local safeguarding procedures were available on how to protect people from the risk of abuse.

We saw that some risks in the home to people's physical well-being were identified and that plans were put in place to mitigate these risks. For example, we saw that one person who had a risk of falling had been supported to move to a bedroom which was in a more accessible place in the home. Staff were also aware of the risk of pressure sores and took action to mitigate those risks. A visiting health professional confirmed that the home managed pressure area care well.

Risk presented by the environment had been recognised and mitigated against. For example, a lock had been placed on a door that was at the top of the stairs.

People were encouraged to remain independent but risks associated with this had not always been recorded. For example, we saw one person climbing the stairs to the first floor who looked very unstable; when we spoke with them they assured us that they could go up and down the stairs unaided. We discussed this with the registered manager and they told us that they supported people to be as independent as possible. However, we could find no evidence of a risk assessment for this activity.

Accidents and incidents had been recorded. We saw that there was an accidents and incidents book which showed that over the last six months there had been thirty incidents. All of these had been followed up appropriately.

We looked at staffing levels within the home. A relative told us, "Yes, I think there are enough staff on duty". Our observations confirmed this as we saw there were enough staff on duty to meet the day to day needs of people, however, staff weren't always responding in a timely manner. The staff told us that there were insufficient staff available to take people on visits or walks outside the home. The registered manager told us that they spent some time with people taking them out for a drive when weather permitted.

Requires improvement

# Is the service safe?

We looked at staff recruitment files and these included the necessary checks and references.

People received their medicines as prescribed and when required. For example, when people were in pain, pain relief was given. Staff told us that each person was able to indicate if they were in pain either verbally, or they recognised it through body language. This ensured that appropriate pain medication was given when necessary.

However, we found that medicines were not always recorded properly in the Medication Administration Records (MAR). The MAR chart for one person showed that there was no reconciliation between the amount of tablets in stock and the amount that had been given. Staff told us that some had been "brought forward" from the previous cycle of medicine and staff had not recorded how many times the medicine had been given (this medicine was given only when the person became agitated). This meant the provider did not have an accurate record of how much medication was in stock for this person and when they had received it.

Medicines were stored appropriately and the medication trolley was securely fastened. There was a photograph for each person with the medicines record so that staff could identify that they were giving the correct medicine to the right person.

When we checked the records we saw that medication training had been carried out for staff responsible for their administration. The pharmacist came on a regular basis and carried out an audit on the medicines which meant there was an audit of medicines undertaken periodically. This helped to promote the safer handling of people's medicines.

Requires improvement

# Is the service effective?

## Our findings

One person told us that the staff cared for them in a very skilled way. One member of staff told us that they had an induction period when they started working at the home and also a three month trial. This was to ensure that they had the appropriate skills to meet the needs of people. Another member of staff told us that the job had been explained to them by the registered manager. Also, that they had worked alongside a more experienced member of staff when they first started the job. This helped to give care staff the skills required.

When we looked at staff supervision records we saw that they were detailed and up to date. We looked at the training that staff had received and records showed that staff had received training in areas related to the needs of people living at the home. For example, using appropriate restraint for people living with dementia.

All staff we spoke with told us that they felt very supported and could go to the registered manager and discuss anything even outside of formal supervisions. However, our observations found that staff were not always putting their training into practice. For example, we found that staff had not always recongised and responsed to people's needs in relation to their dementia.

One person told us that the staff in the home had discussions with them about how they wanted to receive their care. We also spoke with a relative of a person who used the service who told us that they were also included in discussions about the care plans for caring for their relative. However, when we looked at care records we saw that not all of them showed that consent to care and treatment had been discussed with people. We spoke to one relative who told us they were involved in writing a care plan and who said they felt involved in the care their relative received.

The provider had followed the principles of the Mental Capacity Act (MCA) and the registered manager had a good understanding of the requirements of the Act. The MCA is a law providing a system of assessment and decision making to protect people who do not have the capacity to give consent themselves. Assessments of people's capacity had been carried out when required and ensured that if people did not have capacity to make decisions they were made in their best interests.

Requirements of the Deprivation of Liberty Safeguards (DoLS) were known and understood. The DoLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. We found the provider had followed the correct process. This meant that legal authorisation had been sought when they believed they may be caring for someone in a way that deprived them of their liberty.

We saw that three people's records showed that advanced decisions had been made, in their best interests, for them not to be resuscitated in the event of their sudden collapse. However, the records did not show the rationale for not consulting with them, or a valid reason for this decision. Although an external health professional was responsible for the decisions and completion of appropriate records, the provider had not recognised their responsibilities to ensure that MCA processes were followed and referred these issues back to the appropriate professional.

One person told us, "It's very good here; decent food and anything you want you can ask for, more than you can eat sometimes". However, they told us that they never saw a menu and just ate what they are given. They said, "If it's supposed to be hot it's hot". We observed the meal times and though there were no menus displayed we saw that people were offered a choice of food at lunch time.

We spoke with the cook who showed us pictures of cakes they had made for people's birthdays and we saw that there was plenty of food available in the fridge and the freezer. Menu plans we saw on the day showed that there was a good variety of meals which included fresh fruit and vegetables.

People were not always assisted to eat when required and this left some people with cold food or food that was out of their reach. We saw one person who was propped up in bed in their room with a plate of food by their side on a tray on wheels, but this was angled so that they were unable to reach it. The registered manager said this person was assisted to eat by the care staff and we remained in the room until the care staff appeared to assist the person. When we remarked that the food must be cold by now as it had been standing for more than ten minutes, the care worker took the food away to put it in the microwave to reheat. However, this was prompted by the inspector and although the person was then served a hot meal it was one which was not served freshly prepared.

Requires improvement

# Is the service effective?

We saw in another room that one person was just about managing to eat using their fingers and clearly required assistance. When we asked the care worker how many people needed assistance with their meals in their rooms they were unclear of the number of people.

When we looked at care records we saw that each person was weighed monthly and the records showed that people's weight had been maintained.

Staff understood what people's health care needs were and what support was required. For example, they understood what to do when someone had chest pains and sought the appropriate medical help. We saw that care records contained detailed information about people's health care needs and that referrals had been made to health professionals when this was required.

Requires improvement

# Is the service caring?

## Our findings

One person we spoke with said that life in the home was, "Very nice, you feel comfortable", another described the staff as "willing" and another described the atmosphere as "relaxed". A relative told us that when their family member came to live at the home they were very pleased with the way they had been received and were being cared for. The relative spoke highly of staff saying they were "friendly" and that they were made welcome at any time.

We also saw that the registered manager was involved with the people who lived in the home and interacted with them positively and with visitors. We saw that visitors to the home were made welcome and they were offered to a cup of tea with their relative. This meant that people who lived in the home were supported to continue having relationships with people who were important to them.

However, not all of the relationships we saw between staff and people who used the service were caring. We saw little interaction between the care workers and people and few spontaneous conversations were started by the staff with people who used the service. We saw several instances where people were ignored by care workers when they were spoken to. For example staff not always acknowledging greetings from people. Positive interactions between staff and people were limited and there were several instances where people were left isolated and staff did not recognise this and take the time to interact with them. For example, we saw two people sitting in the dining room all morning and they were only once approached by staff over this period of time.

We saw that privacy and dignity was respected when people were receiving care and support during our visit for most of the time. For example, bedroom doors were closed when staff provided care for people. We saw an example of a person being treated with privacy when a visiting professional arrived to renew dressing on this person's legs. Staff immediately brought a portable hospital screen that was nearby to provide privacy. However, we also saw occasions where people's privacy and dignity was not always respected by the staff team. For example, we saw one person in the dining room who remained in their night wear throughout the morning. They were wearing only thin nightwear and it was inappropriate to cover them sufficiently to keep them warm.

We asked one care worker if personal care was provided by male carers for females and whether their consent had been sought, they were unable to tell us whether this was always the case. We discussed this with the registered manager and asked the same question and they told us that people were asked about gender care and they were all happy with the arrangements in place.

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# Is the service caring?

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Requires improvement

# Is the service responsive?

## Our findings

We observed that one person was left in a wheelchair in the dining room for most of the morning. When we spoke with them they told us they were cold. The person's legs were very cold and they were wearing nothing under their dressing gown. The person was living with dementia and was unable to communicate their needs effectively. We saw that the staff sometimes responded to them when they were attempting to communicate their needs but did nothing to ensure their comfort. When we pointed out that they were distressed and very cold and that they had been sitting at an empty dining table since we had arrived two hours before, staff took them to their room to make them more comfortable. However, staff had not been proactive in ensuring they were recognising and responding to people's needs.

Despite there being numerous people at the home living with dementia there were no activities which were tailored to meet people's individual preferences. Nor did we see that staff were aware of their needs and how to support them in an appropriate way. Staff were not proactive in spending time with people or recognising their need for stimulation and communication. When we talked to staff they told us they interpreted what people wanted and liked by watching body language. However, on the day we visited we did not see that this was consistent. We were informed by the registered manager that people were involved and connected with various faith groups in the community, of their choosing.

One person told us, "It is very good here….anything you want you can ask for". We saw that the registered manager was responsive to people's needs and engaged with them frequently by talking to people and responding to what they were asking. However, the staff team did not follow this approach and staff did not always have clear knowledge about people's individual needs and choices. For example, staff were not clear about which people required support with their meals and did not always recognise when people were uncomfortable or were asking for help. There was a radio on the window ledge in the lobby but it wasn't switched on. A person tapped it occasionally and said, "It does work normally" but no member of staff came to see if they wanted the radio on, despite staff hearing the comments this person was making.

One person told us that when the weather was nice that, sometimes, they could sit in the garden. The day we visited, which was sunny, we did not see any evidence of people being offered to go outside. Staff told us that there had been some activities inside the home but these had happened in the past and were not now a regular occurrence. One person told us that they liked the home but didn't go out much and we did not see that there were opportunities for people to go into the community or out on trips. When we discussed this with the registered manager they told us that in the summer they took people out for short journeys in the car to enjoy the countryside. However on the day that we visited there were no attempts to engage people in activities that were meaningful to them. Although, in the afternoon people were supported to engage in a 'singalong'.

People who were able were supported to be independent within the home. However, those who required assistance did not always receive the support they required to ensure their care and treatment met their needs and reflected their preferences. Staff had not always recognised what people's individual needs were or taken any action to identify people's wishes. This meant there were limited opportunities for staff to provide care that reflected these preferences, unless people were able to clearly vocalise their needs. Staff did not always have a good understanding of how they should respond to changes in people's needs. For example, one staff member told us they would tell a senior member of staff but could not expand on what would be required to happen.

**People did not always receive care that met their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

When we looked at records we saw that each person had a document called, "This is about me", this was a short social history about them and their families. This gave useful information and prompts about people's background. It included their likes and dislikes and the things they had enjoyed in life. It gave good information and talking points for staff to engage with people who used the service. However, this information had not always been used by the staff team in supporting them to engage with people.

We did see that there had been some learning from what the people in the home enjoyed. This was provided by a musical stimulation session which was provided weekly for

Requires improvement

# Is the service responsive?

the people by someone from outside the home. A visitor told us that their relative really "enjoys music and particularly this session" where they became involved in the "action". The registered manager told us about the music session and was keen for us to witness it. We could see the people were taking part and enjoying the music session, they were smiling and mouthing some of the words. However, this was the only example of activities taking place in the home that we were told about and not everyone was involved in this.

There were limited opportunities for people to express their views about the service although we did see evidence of family meeting minutes. The registered manager told us that a service user consultation was undertaken annually and this would have given people an opportunity to express their views

When we looked at records we saw that there was a complaints folder and complaints had been followed up appropriately.

Requires improvement

# Is the service well-led?

## Our findings

At our previous inspection we found that the provider was in breach of assessing and monitoring the quality of service provision. This was a breach of Regulation 10 of the the HSCA 2008 (Regulated Activities) Regulations 2010. On this inspection we saw that the registered manager had put in place some systems and processes to monitor the quality of the care that was received by people who lived in the home. We saw that the registered manager of the home had an open and positive relationship with the staff and the people who used the service. We saw that they dealt with matters in an open and transparent way. We also saw that that the registered manager was aware of people's needs and they spoke to staff in a way that demonstrated they had regular conversations with them. The registered manager was respectful when speaking both to staff and the people who used the service.

Although there was a clear vision for the home this did not appear to be efficiently put into practise. The registered manager promoted an open, inclusive and empowering culture but our observations showed that the staff did not always carry this through. Nor did they put into practise what they had learned from training. For example, staff did not appear to be aware of people's needs, were not proactive in meeting them and on occasion had not taken action to ensure people's comfort and well-being. These shortfalls in the way that the service was being delivered impacted on the people who lived in the home. However, the office door was mostly kept open and we saw that people were comfortable in coming into the office to talk with the registered manager.

We saw that the registered manager understood their responsibilities and we also saw examples of where they had made improvements in the home. However, this was inconsistent and there was a lack of direction which meant staff were not always aware of their responsibilities and acting accordingly. For example, we found that many staff were not actively engaging with people in a positive manner. The registered manager had not recognised this and so had not taken action to communicate to staff what was expected of them. Staff told us they got on well with the registered manager and one member of staff told us that the registered manager was "nice".

We spoke with the registered manager about some of the shortfalls we had identified with regard to meeting people's dementia care needs. The registered manager told us that the home had developed links with the local Alzheimer's society which was proving to be a positive link for staff and the people who lived in the home.

When we looked at the records we saw that staff meetings were held but these were held three or four times a year and there was limited evidence of how they were used to help drive improvements in the service or support staff in their duties.

When we looked at the records we saw that care plans were up to date and that policies and procedures were in place for whistleblowing, safeguarding, equality and diversity and restraint. Appropriate training had taken place in these areas. The recruitment process was robust and annual appraisals were undertaken. Staff files included the necessary checks. This demonstrated that there were some parts of the organisation and running of the home that were well organised.

There was an accidents and incidents book which showed that over the last six months there had been thirty incidents and all of these had been followed up appropriately. Comments and complaints were recorded with the action taken and agreed by the people who complained. The information contained in these showed that the provider was learning from this feedback.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**Regulation 12 of the H&SC Act 2008 (Regulated Activities) Regulations 2014**<br><br>**People were not protected from inadequate practises related to infection control.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>**Regulation 9 of the H&SC Act 2008 (Regulated Activities) Regulations 2014**<br><br>**People did not receive care and support that was personal to them, that met their needs and reflected preferences.** |