Gilead Care Services Ltd

Gilead House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

Gilead House is a newly registered nursing home providing accommodation, nursing and personal care for up to 22 people. There were five people living at the service at the time of our inspection.

We conducted this inspection because we had received significant concerns about the administration of medicines at the service. The inspection took place on 19 July 2017 and was unannounced. This inspection was a focused inspection to see if people were safe at the service. At the last inspection on 12 May 2017 we rated the service as inadequate.

Although some improvements had been made by the registered manager since the last inspection there were still more improvements needed to ensure people were receiving safe care.

People were unsafe as they did not always receive their medicines as prescribed. This put people at significant risk of their health deteriorating. Concerns relating to medicines we picked up during the last inspection had been addressed.

People would be at risk if a fire broke out at Gilead House as plans implemented were not specific to people's needs.

People were unsafe because their nursing needs were not being safely monitored. This put people at risk of their health deteriorating.

Risks to people's health and wellbeing had been highlighted and some of them were being managed. People were unsafe because accidents and incidents were not effectively monitored to mitigate the risk of them reoccurring.

People had been referred to their local GP and could receive support from them when required.

People were protected by safe recruitment practices and they were supported by sufficient number of staff to meet their needs.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This

will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection we found one continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive their medicines as prescribed.

People's nursing needs were not safety monitored.

Risks to people's safety were identified however accidents and incidents were not monitored to minimise on-going risks.

Staff had knowledge of how to report suspected abuse.

There were sufficient recruitment checks to ensure staff employed were suitable to work at the service. People were support by sufficient staff on the day of inspection.

Gilead House

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 inspection took place on 19 July 2017 and was unannounced. The inspection was carried out by two inspectors, one of whom was a pharmacy inspector.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection we were in contact with the local authority, safeguarding team and the clinical commissioning group (CCG) regarding feedback on the service. This enabled us to ensure we were addressing potential areas of concern at the inspection. As this was a focused inspection we had not requested a Provider Information Return (PIR) from the provider. The PIR 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 spoke to three people living at Gilead House about their experience and observed the care and support provided to them. There were some areas that people did not have the capacity to answer questions on. We spoke to the registered manager and three staff members, including a nurse, during the inspection.

We reviewed a range of documents about people's care and how the home was managed. We looked at three care plans, medication administration records, risk assessments, accident and incident records, policies and procedures and staff records.

Inadequate

Is the service safe?

Our findings

When we last inspected Gilead House on 12 May 2017 we found a number of risks to people's safety which resulted in a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we saw that some improvements had been made but there was still more to do to ensure people received safe care. The registered manager told us, "We still need to improve in areas."

Since the last inspection on 12 May 2017 the local authority had moved four people out of Gilead House. The people who moved from Gilead House were people with higher support needs and who were at greater risk. This had given the registered manager an opportunity to start managing the risks associated with the people who remained at the service.

During the last inspection on 12 May 2017 medicines were stored unsafely and medicine stock checks were not completely safely. There was also inadequate guidance for staff to follow when administering people's 'when required' medicines. During this inspection we found staff had taken action to address these issues. Staff monitored the temperature of the room used to store medicines, to make sure they were stored safely. Additional information was in place for staff to make sure medicines prescribed 'when required' were given safely and appropriately. Staff also made records of the running totals of people's medicines.

Despite improvements made with the storage and guidance of people's medicines we found that people did not always receive prescribed medicines. We found four examples of inaccuracies of the recording of medicines, which indicated a person may not have received their medicines. Medicine records also showed one person had been given the wrong dose of medicine on two occasions. Only one of these medicine errors had been picked up and reported by the registered manager. Not receiving prescribed medicines puts people at risk of significant harm.

The registered manager had implemented a medicines policy. However, the staff were unaware of this policy and what it said. This meant staff were unaware about the correct and safe procedures they should follow with regards to people's medicines.

During the last inspection arrangements in place to manage the safety of people if a fire broke out at the home were inadequate. During this inspection we found that people would still be at risk if a fire broke out at Gilead House. Since the last inspection the registered manager had put evacuation plans in place and had made improvements around the service, including installing fire resistant doors. Despite this the contingency plan and people's personal evacuation plans were not specific to their needs. There was no clear guidance on how to evacuate people safely. The registered manager had to be told by the local authority that having a muster point inside the building was unsafe. This puts people at continued risk. Since the inspection the registered manager has had a visit for the fire safety department and has made changes to the evacuation procedures for people.

During the last inspection we found that people were not being supported safely with their nursing needs. We also found that people's nursing needs were inadequately monitored. This put people at risk of their

health deteriorating. At this inspection we saw that people with specific nursing needs had a care plan for staff to follow. For example people who had a risk of developing pressure sores now had an associated care plan to inform staff how to reduce the risk of these developing. Staff were aware of these plans and the actions they needed to take to reduce this risk. Despite this people's health needs were still inadequately monitored. For example, when people needed to be regularly turned this was not being safely monitored as turning charts had not been started. This put people at risk of developing pressure sores as staff were not aware when the person was last turned.

During the last inspection we found when risks had been highlighted people were not being supported to reduce them in line with best practice guidance. We also found people were unsafe because accidents, incidents and concerns were not always reported. At this inspection people had assessments completed, which highlighted risks involved in their support. A variety of risks had been identified that included skin integrity, swallowing food, malnutrition and dehydration and behaviours that may challenge. When risks were highlighted around a person's ability to swallow food they were referred to the speech and language team (SALT). SALT had given staff guidance to keep this person safe while eating, which staff understood and followed.

People were unsafe as not all risks were being reduced. Since the last inspection on 12 May 2017 two incidents had been recorded and there had been one recorded medicine error. These had been investigated and action was taken to ensure people were safe following incidents. It was however unclear what action had been taken to reduce the risk of similar incidents occurring in the future. For example, one incident involved two people becoming distressed and anxious. Although the aftermath of this incident was managed appropriately there were no measures put in place to reduce the risk of this type of incident reoccurring. The behaviour the people displayed during this incident was also not risk assessed.

During the last inspection on 12 May 2017 staff did not highlight health and safety concerns so they could be addressed. During this inspection we had no further concerns regarding the maintenance of the property or the equipment people were using. However following the inspection we received concerns about an air mattress being used unsafely and staff having limited knowledge on how to use it. This put people at risk of receiving unsafe support. This could also increase the likelihood of people developing pressure sores.

People were still unsafe at Gilead House. This is a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the last inspection on 12 May 2017 people were not safe as the registered manager had failed to raise safeguarding alerts with the local authority. Since the last inspection the registered manager had reported a safeguarding incident. Staff had received training on safeguarding and had a better understanding of how to notice and report suspected abuse. One member of staff said that they would whistleblow if they were concerned about someone. They said, "You inform the manager and if you are concerned about the manager we would report to safeguarding (local authority). We have the numbers on the board."

During the inspection on 12 May 2017 we found people were not safe as they did not have access to health and social care professionals. Since the last inspection people had been registered with a local GP surgery. This meant that people could now receive medical support to keep them safe when it was needed. Since the inspection on 12 May 2017 people had seen the GP when unwell. This reduced risks for people as staff could now respond safely to health and nursing needs.

During the last inspection on 12 May 2017 people were not protected by safe recruitment practices. During this inspection we saw that improvements had been made in this area and this breach of regulation was

now being met. The registered manager had information on staff recruitment. Staff files now contained employment history, references and application forms. Staff checks had been made with the Disclosure and Barring Service (DBS). These checks are in place to make sure people are suitable to work with people who use care and support services.

During the last inspection on 12 May 2017 we asked the registered manager to give us assurances that they would continue to employ sufficient numbers of staff so people's needs could be met. We were reassured that during this inspection people were supported by sufficient numbers of staff. When people were in the lounge we observed staff responding to people's needs when required throughout the day. The registered manager informed us that the staffing levels were calculated on the dependency of people. The registered manager said this would be reviewed when people's support needs changed.