Mr & Mrs J Rzepa

The Gables Care Home

Inspection report

37 Manchester Road
Buxton
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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

An unannounced inspection took place on 9 January 2017; a further visit on 16 January was an announced visit. Our previous inspection on 9 June 2015 found the provider was not meeting two regulations at that time. These were in relation to inadequate practise related to infection control and care and support that was personal to people, that met their needs and reflected preferences. At our visits on 9 and 16 January 2017 we found that improvements had been made regarding infection control and standards were now met. However, we did not find any improvements in relation to care and support that was personal to individuals or reflected their preferences.

The Gables Care Home provides support for up to twenty three people, including those living with dementia. On the day we visited there were twenty people living there. The home is situated in Buxton and in large building with big rooms and high ceilings. There is a garden for people who live in the home to use.

There was a registered manager in post at the home, who is also the provider of 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.

Risks to individuals were not always assessed or acted upon. However, people were protected from bullying and harassment by a staff team who understood what to do if they had any concerns. People's medicines were managed in a way that kept them safe. There were sufficient staff to keep people safe and recruitment of staff was done in a safe way.

Staff had the knowledge and skills to undertake their caring responsibilities and people were supported to have sufficient to eat and drink. However, the storage of food did not always meet standards to ensure people were given food which was safe to eat and drink.

People were supported to maintain good health and appropriate health care referrals were made. Consent to care and treatment was undertaken in line with the Mental Capacity Act and Deprivation of Liberty Safeguards.

People did not receive care that was personal to them and people's preferences and wishes were not sought nor met. People knew how to make complaints.

There was not a person centred culture in the home which was open and empowering. Staff were supported by supervisions but did not feel supported by the registered manager. There were not sufficient systems and processes in place to ensure high quality care was delivered to people.

At this inspection we found two 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 safe.

There were insufficient staff to consistently respond to people's needs in a timely manner.

Risk assessments did not always identify ongoing risks for people's well being and referrals to appropriate agencies were not made.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not effective.

People received support that was delivered by staff who had the appropriate skills and training to undertake their responsibilities.

Consent to care and treatment was sought.

People were not protected from nutritional risks around the safe storage of foods.

People were supported to maintain good health care and treatment was sought when this was required.

Is the service caring?

Good

The service was caring.

People were supported by staff who had built up relationships with them and who understood their likes and dislikes.

People's privacy and dignity was protected and maintained.

People were not always asked their views about how they liked to receive their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not receive personalised care that was responsive to their needs.

People were able to approach the registered manager with any concerns or complaints they had.

Concerns and complaints were not used to improve the service that people received.

Is the service well-led?

Requires Improvement

The service was not well led.

There was not a person centred culture in the home and staff did not feel empowered to make suggestions for improvements in the care people received.

There was insufficient and spartan auditing of the records and a lack of identification of improvements required in the home.

Staff did not feel supported in their day to day responsibilities.

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 January 2017 and was unannounced. A further visit took place on 16 January and was an announced visit. The inspection team consisted of one 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.

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 six people who lived in the home and three family members. We also spoke with the registered manager (by telephone), deputy manager, assistant deputy Manager , senior care assistant, two care assistants and two of the cooks. We also spoke with two professionals involved with the service.

We carried out observations of care being provided including a short observational framework for inspection (SOFI). SOFI is a way of capturing people's experience about the support they receive when they are unable to communicate their views.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2015 we found the providers' arrangements for the control of infection did not fully protect people against the risks associated with cross infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that satisfactory improvements had been made and the home now met this requirement.

People told us staff were available to support them with their daily care needs when this was required. However they also told us staff were always busy and did not have time to stop and spend time with them. One relative said "Staffing mostly seems okay, they're all overstretched at times". When we talked with staff they told us there were insufficient staff to carry out their role in a safe manner at all times. For example, there had been one occasion when two people were requiring extra care and support as they were nearing their end of life. When they asked the provider if they could have extra staff to support them they were offered a small number of extra support hours by removing the cleaner from their duties to help with care and support. This would have meant the cleaning in the home was not undertaken and would have put people at risk from a lack of infection control.

When we asked one member of staff if there were sufficient staff on duty they said "Sometimes yes and sometimes no". They went on to tell us when they were busy the laundry frequently did not get done. This put people at risk from not always having clean clothes available to wear. Another member of staff said "No, not enough staff" and said they were concerned they might miss something, for example if a person was unwell they would not notice as they were "Flying past". This meant people could be feeling unwell and the staff did not notice and arrange appropriate care.

During the inspection visit we observed there were insufficient staff to respond to people in a timely manner. For example at one time during the day there was one member of staff to support seven people. This meant if someone had required assistance of two members of staff with personal care the member of staff would have had to summon someone from another activity they were undertaking, or the person would have had to wait.

We saw that risks for individuals had been identified but there were not always appropriate follow up action taken to try to ensure the continued safety of people. For example, a risk of falls had been identified for one person with the risk assessment saying "[person] to be observed closely" but no other action identified. This action does not mitigate any risk of falls. There was a further risk of falls recorded for another person in their care plan on admission to the home with no actions to mitigate the risk. This person went on to have seven falls in one month. We saw risk assessments for nutritional well-being were not always completed in full. This meant people were not being protected from the risk of falls in the home or inadequate nutrition. Also, there were no personal evacuation plans (PEEPs) available to guide staff on how to support people if an emergency evacuation of the home was required. This put people at increased risk if an emergency evacuation of the building was required, for example, fire.

People told us they felt safe living at The Gables Care Home. They told us they believed the staff looked after

them and would help them when they needed support. One person said "They're really very good", another person said "Staff come pretty immediately". One relative said "[family member] is safe here". Another relative said "My [family member] and I both feel [family member] is safe here".

Staff we spoke with had a good understanding of different types of abuse. Staff understood their roles and responsibilities in recognising and reporting any potential abuse to keep people safe. Staff told us if they had any concerns at all that someone might be at risk of abuse they would report this to their line manager. Records showed staff attended training in safeguarding people. We saw the safeguarding policy was available to staff in the office. The provider had a whistleblowing policy in place which supported staff if they felt it necessary to report a concern. However, when we spoke to some staff they were unaware of how this policy protected people.

We reviewed staff employment records and found checks had been undertaken before prospective staff worked at the service. These included obtaining references, proof of identity and undertaking criminal record checks with the Disclosure and Barring Service (DBS). DBS is a way of helping to ensure that staff employed by the service are suitable to work in a supporting environment. This meant people and their relatives could be confident staff had been screened as to their suitability to care for people who received care and support in the home. This helped to keep them safe.

None of the people we spoke with expressed concern about their medicines and said they received these regularly. One person said "I get my pills every day". Medicines were safely stored and records showed staff followed current legislation and guidance. We reviewed medicines administration records (MAR) and observed staff during a medicines round. We saw the staff member ensured people received the correct medicines at the correct time and completed the MAR chart afterwards. Staff who were responsible for the administration of medicines had taken part in training in the safe handling and administration of medicines. We saw that medicines were managed safely and safe policies and procedures for giving medicines were followed.

Requires Improvement

Is the service effective?

Our findings

People told us they considered staff knew what they were doing and they believed they were well trained. One person said "I'm sure they are [well trained], I'm looked after alright". Another person said "Most of the time [staff] seem to know what they're doing". One relative said "They seem well trained, they're friendly and helpful".

Staff told us they had received training and one member of staff said it was of "Good quality", another member of staff said "It [training] is adequate and sufficient". Records were available which demonstrated training had been undertaken in a wide range of subjects, including safeguarding, moving and handling and first aid. The deputy manager was being supported to achieve qualifications to enable them to apply to be the registered manager with CQC.

Staff told us they had been supported with their induction when they first began working at The Gables Care Home and they were well supported with frequent supervision from their line managers. Supervision is a way of providing an opportunity for staff to talk about their concerns and learn from their line manager about best practice.

The registered manager understood their responsibilities under the Mental Capacity Act 2005 (MCA). The 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 so that they can 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and it was. When required, the registered manager had made applications for people to be assessed under DoLS and policies and procedures were in place for staff to follow in relation to the MCA. One member of staff explained how important it was to understand that people can "Have capacity in so many things and then don't have capacity in so many others". They went on to explain how capacity for people can change from day to day. One member of staff explained how they gave people choices where this was possible, for example what to wear in the morning. They said "They've still got their personality". We saw that consent to assist people with personal care was sought before they were supported.

Generally people were positive about the food they ate. They thought it was good and most people said there was enough food. One person told us they would like larger helpings of food at meal times, but also said if they asked they could have second helpings. One person said "Food's good", another person said "A relative said "[family member] enjoys the food".

Staff told us people were not involved in the choice of food on offer. They could not recall any time when people had been asked what they enjoyed the most and what they would like to see on the menu. On the

first day of the inspection people were offered a choice of main meal at lunch time but there was only one choice available on the second day of our visit. Also, on the second day of our visit, there were eleven chicken pieces available to provide a main meal for eighteen people which meant there were no second portions available for people if they wanted them.

Risks around nutritional needs were not adhered to. For example, when we looked in the fridge we could see some of the food was out of date. Eggs were five days past their best before date and milk was eight days past the best before date. When we discussed this with the provider they explained the supermarket had made a mistake on their delivery and they would rectify the situation and ensure all food was within best before dates. When we visited again several days later we could see eggs and milk in the fridge were within best before dates.

However, there were also items of open food in the fridge which did not contain any date of opening. This put people at risk from eating food which was unsafe to eat. When we visited on our second visit we saw the food in the fridge was stored correctly.

People and their relatives told us they were able to access health and social care support when this was required. We could see from care records that referrals had been made to appropriate agencies and a visiting health professional confirmed they were called to the home when someone required their support.

Good

Is the service caring?

Our findings

People told us staff were kind and caring and they felt content in the care home. One person told us they were pleased as "Most staff have got a sense of humour which helps. They seem to be kind". Another person said "They're good at caring". A relative told us they supported their family member with their personal requests and said "On the whole it's a decent place; they look after [relative] well".

One staff member told us caring was "All in the approach" and that smiling and giving eye contact was very important. We saw staff interact with people in a cheerful way, chatting with them in a friendly and familiar manner which showed they knew the people well. One member of staff said "It's their home, they need to be happy". Another member of staff said "It's about being there for them". This helped to show the staff had a caring approach to their role. We spoke with a professional involved with the home who said "My experience of the Gables, including [registered manager] is that they are always approachable". We spoke with another professional who said "The staff seem really caring".

Relatives told us staff cared for their family member with kindness and compassion. One relative told us their family member was treated with dignity and respect. They said they had never heard a raised voice in the home. We saw people were cared for by staff who showed them kindness and consideration. Staff had developed good and empathic relationships with people. Throughout our inspection we heard staff speak with, and respond to, people in a calm, considerate and respectful manner. We saw and heard staff responded to people's requests for assistance in a sensitive and discreet way which helped to maintain their dignity. One person said "They're good at caring, there's no embarrassment". A relative said "They do treat [relative] with dignity". One professional told us their service user had chosen The Gables as "[Service user] felt he was treated with dignity and respect". Staff told us they helped to maintain people's dignity by ensuring doors and curtains were closed while they were providing personal care and also felt it was important to explain why they were doing this.

Staff reassured people who showed any signs of anxiety or distress and responded quickly and calmly when people required assistance. One member of staff explained how they sang to one person while they were assisting them with personal care as they liked it; they said "I think that's important isn't it?"

When we talked to people and relatives about care plans most people told us they could not recall being invited to be involved in informing care plans. Only one person told us they had been involved in discussions regarding their care and support. Most people were not aware of care plans; one person said "No-one's mentioned a care plan". This meant people's views and wishes were not fully respected or acted upon for some people.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June 2016 we found the providers arrangements people to receive care and support which met their needs and preferences was not in place. This meant people were not receiving care that was personalised to them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there were no improvements and people were still not in receipt of receiving care that was personalised to them.

Some people told us they were bored and had nothing to do. One person told us they did not have any hobbies now as there were no activities suitable for them. They said "Most people don't know what they're doing, there's no activities for me, some for the older ones, they do colouring". Another person said "I can be very bored". A third person said "They're [people] all asleep, not much stimulation". A fourth person said "There was a singer and father Christmas at Christmas time, not much else". A relative told us "[person] is looked after well, but there's no stimulation". However, we did see one person enjoyed helping with drying the pots following the tea round and this was supported. One member of staff undertook this task with them and chatted throughout.

There was no orientation for people about the day of the week or the month of the year on display. This meant people were not supported to orientate themselves to time. The Christmas tree was still up in the dining room which would have been very confusing for people with dementia. We saw very little in the way of activities for people during our inspection and there was no up to date programme of activities on display. This meant support was not designed to meet people's preferences. Nor did it provide opportunities for people to participate in decisions about how they spent their time. People were dozing in chairs or walking around communal areas and we saw very little interaction between people and staff other than when they were meeting their personal care needs.

When we spoke with staff they told us there was little time to spend with people and one member of staff said there should be "More activities going off". They went on to tell us there was currently colouring, dominoes or snakes and ladders available to people when there was time but there were insufficient staff time to spend with people following their interests.

Staff were able to describe to us what the various likes and preferences were of people living in the home. However, they told us they had little opportunity to support people to follow their interests. During our inspection we saw people were walking around the home with little intervention from staff with regard to being supported to follow interests. People were sitting in chairs, often falling asleep, due to a lack of stimulation. Staff gave us two examples of people being assisted to go on visits outside of the home, but said this was infrequent. We looked at the activities diary and could see there were a few examples of people being engaged in activities but these were infrequent and sporadic.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) person centred care 2014

When we talked to people and their relatives about making complaints they said they were aware of who to complain to if they had any problems. One person said "I know how to complain". We looked at the complaints folder and could see the registered manager had responded to some complaints in writing. However, there was no consistent analysis of complaints which would have allowed the registered manager to look at any themes emerging and to take appropriate action.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they could talk to the registered manager about any concerns they had. They told us [registered manager] was approachable and one person said "I do know who the manager is". However, staff told us they did not feel comfortable approaching the registered manager with concerns and were inclined to talk to their direct line managers. Staff also told us they did not feel comfortable making any suggestions towards any potential improvements within the service. One member of staff said the registered manager "Does not involve staff or [member of staff] in what is happening".

Accident and incident forms had been completed and were available for us to look at as part of our inspection. However, there were no consistent systems in place to mitigate risks in relation to the health, safety and welfare of people. Nor was there an analysis of the incidents which might have identified patterns which could have then been mitigated against. This meant there was a potential increased risk of accidental injury due to lack of a thorough evaluation and proportionate action. For example, one person had been found on their bedroom floor on seven times in the month of October 2016. However, there was no pressure mat in the bedroom to inform staff when they got out of bed, nor did we see any record in their care plan they had been referred to community professionals for an assessment to help prevent falls. Similarly, another person had been found on the floor on twice in November 2016, four times in December 2016 and twice in January 2017. Again we could not see what action had been taken to assess and help prevent this person from falling. When we spoke with staff they told us there were no falls mats in people's bedrooms to alert staff when someone was getting out of bed and was at risk of falling.

There were no consistent audits of the service or how they identified where, or if, any improvements were needed. This included audits to help ensure there were sufficient staff on duty to support people in a safe way. The scarcity and inconsistency of quality auditing and monitoring meant there was no way of the provider ensuring the service was fit for purpose.

We did not see any evidence that regular meetings with the staff team were held to update them on what was happening in the home or seek to involve them with what was happening. Staff told us staff meetings were not held consistently and they did not feel informed about the future plans for improvements in the home or how to better support people. This meant the views and recommendations of staff, who worked closely with people, were not taken into account when any changes were planned in the home.

People and their relatives were not aware of any regular or systematic sampling of their opinions or the care provided. One person said "There's no residents' meetings I know of". When we looked at records we could not see where the views and opinions of people who lived in the home, or their relatives, had been sought. This meant people were not actively invited to participate in improvements to the care they received in the home.

We saw policies and procedures for managing falls in care homes, prevention and control of infections in care homes and information on diabetes. There was also information and guidance available on flu pandemics in care homes. Not all of the policies and procedures were available in the procedures file, for

example, activities procedure complaints procedure and emergency crisis procedure.

This was a breach of Regulation 17 if the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

There was a registered manager in post who was familiar with the processes required in relation to notifications. They knew written notifications, which they are required by law to tell us about, needed to be submitted at the earlier opportunity. For example, notifications of a person's death or an event which may affect the effective running of the service.

We saw arrangements were in place for the day to day management and running of the service when the registered manager was not there. The registered manager was supported by a deputy manager.