Charis House Limited

Gardenia Court Nursing Home

Inspection report

21 Uphill Road North
Weston Super Mare
Somerset
BS23 4NG

Tel: 01934632552
Website: www.gardeniacourt.co.uk

Date of inspection visit:
17 February 2016

Date of publication:
12 May 2016

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

Gardenia Court Nursing Home is a care home providing accommodation for up to 29 people, some of whom are living with dementia. During our inspection there were 21 people living in the home. The home is situated close to the sea front in the town of Weston Super Mare.

We inspected Gardenia Court in February 2015. During that inspection we found the provider to be in breach of regulation 18 of the (Registration) Regulations 2009 because the provider had failed to notify us significant incidents. The provider sent us with an action plan of improvements that would be made. During this inspection we found improvements had been made, however we found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection took place on 17 February 2016 and was unannounced.

There was a registered manager in post. 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 2008 and associated Regulations about how the service is run.

Medicines were not always administered safely. People told us they were left to take their own medicines and there were no risk assessments for this in place. Medicines and creams were not always administered at the correct times. Nurses had not received medicines training to ensure they were competent at administering medicines.

There were enough staff to meet people's needs, but at times staffing levels had gone below minimum levels when staff were sick. Most of the people we spoke with thought there were enough staff available to meet people's needs. Relatives and staff thought there were enough staff to meet people's needs.

Staff were not always aware of risks relating to people and information about how to reduce risks were not always clearly recorded in people's care records. People did not always have call bells within reach so they could summon staff support.

A recruitment procedure was in place and staff received pre-employment checks before starting work with the service. One staff members personnel file did not contain evidence of a pre-employment check, the manager provided us with evidence confirming this was in place after the inspection. The provider did not have a system in place to monitor the nurses' registration.

The mealtime experience was not inclusive and where people were at risk of malnutrition and dehydration accurate records were not always kept. People in their rooms did not always have access to drinks. People were complimentary of the food provided. Where people required specialised diets these were prepared appropriately.

People and their relatives told us they or their relatives felt safe at Gardenia Court. There were systems in place to protect people from abuse and the staff we spoke with knew how to follow them.

Care staff received training to understand their role and they completed training to ensure the care and support provided to people was safe. New members of staff received an induction which included shadowing experienced staff before working independently. Staff received supervision and told us they felt supported.

People and their relatives told us they were happy with the care they or their relative received at Gardenia Court. Staff interactions with people were caring.

Relatives were confident they could raise concerns or complaints with the registered manager and they would be listened to. The provider had systems in place to collate and review feedback from people and their relatives to gauge their satisfaction and make improvements to the service.

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

Some aspects of the service were not safe.

People's medicines were not always administered safely or consistently. Nurses had not received recent medicines training.

At times staffing levels dropped below required levels which meant there would not be enough staff available to meet people's needs.

Staff were not always aware of risks relating to people, information about risks to people were not always clearly recorded.

Recruitment procedures were in place to ensure staff with suitable character and experience were employed.

Staff told us about the different forms of abuse, how to recognise them and said they felt confident to raise concerns with the manager.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Where people lacked capacity to make decisions the principles of the Mental Capacity Act 2005 were not always followed.

The mealtime experience did not consider the needs of people living with dementia. People who were at risk of malnutrition and dehydration did not have accurate records kept of their fluid and food intake. People and relatives were positive about the food provided.

People were supported to have regular access to health care services.

Staff received training to meet the needs of people. Staff received one to one supervision to discuss their concerns and development needs.

Is the service caring?

Good

The service was caring.

People were supported in a way that considered their dignity and respect.

People were supported by staff who knew them well and had developed relationships.

People and their relatives spoke positively about staff and the care they received.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Some of the care plans lacked information relating to how to support people.

People did not comment positively about the activities on offer. We observed some people enjoying and activity in the afternoon.

There were systems in place to collate and review feedback from people and relatives on the service received.

There was a system in place to manage complaints. People and relatives told us they knew how to raise any concerns or complaints and were confident that they would be taken seriously.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The quality of the service provided to people was monitored and where there were shortfalls these were not always identified.

The manager promoted an open culture and was visible and accessible to people living in the home, their relatives and the staff.

People were supported and cared for by staff who felt supported by an approachable manager.

Gardenia Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 February 2016 and was unannounced.

The inspection was completed by two adult social care inspectors and a specialist advisor who was a nurse. Before the inspection we reviewed previous inspection reports. We also viewed other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We requested this information during our inspection. We also obtained the views of service commissioners from the local council who also monitored the service provided by the home.

During the inspection we spoke with people and two relatives about their views on the quality of the care and support being provided. Some people were unable to tell us their experiences of living at the home because they were living with dementia and were unable to communicate their thoughts. We therefore 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. We also spoke with the registered manager who was the nurse on duty and eight staff members including domestic staff and chef. We looked at documentation relating to five people who used the service, three staff recruitment and training records and records relating to the management of the service. After the inspection we spoke with two relatives and requested feedback from two health professionals.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe.
There were systems in place to manage people's medicines. We found the systems did not always ensure medicines were safe for people receiving them. For example, medicines were not always administered in line with prescription guidelines. One person had a prescription that stated the medicine should be administered before breakfast; we observed the person was supported to take their medicines two hours after they had eaten their breakfast. We discussed this with the registered manager who told us they would ensure the medicines were given at the right time and that all of the nurses would be made aware of this. During the inspection two people told us they were left to take their own medicines after the nurse had given them to them. One person commented, "Normally staff leave the tablets on a table and disappear". This meant people were at risk because staff were not monitoring they had taken their medicines. We discussed this with the registered manager who told us people should not be left alone to take their medicines and clarified the nurses should observe them being taken. They assured us they would raise this issue with all of the nursing staff.

Some people were prescribed creams and ointments which were kept in their rooms and applied by care staff. There were folders in people's bedrooms which contained a medicines administration record for the creams and ointments. We found these records were inconsistently completed by staff. For example, one person was prescribed a medication which was to be applied to affected area five to six times a day, the record indicated this medication had been applied seven times in 54 days. Another person was prescribed medication which was to be applied twice a day, the record indicated this had not been applied for four days. One staff member told us, "Staff sometimes forget to complete the records". The registered manager confirmed that staff should complete these records each time a medication is administered. This meant people were at risk of not receiving their prescribed medicines or possibly having them applied too often.

The registered manager told us the nurses had not received recent medicines training. They said three of the nurses had not received any medicines training since 2013. They told us they had access to online training and this would be completed by the nurses as a priority. The nurses had also not received competency assessments whilst administering medicines. Competency assessments are observations of staff giving out medicines to make sure they are safe. This meant people were at risk of not receiving their medicines as prescribed because staff had not received up to date training. Following our inspection the registered manager told us they had a plan in place for all nurses to complete medicines training and have a competency assessment by April 2016.

Two people told us they were happy with how their medicines were administered, commenting staff were, "Helpful". The medicine administration records (MARs) we looked at had all been signed and there were no gaps which indicated that people had received all of their medicines as prescribed. Medicines were stored safely and in line with relevant regulations and guidance.

People had risk assessments in place and they covered areas where people could be at risk, such as moving and handling, falls and where bedrails were required on beds to prevent people from falling. Most of the risk

assessments included details of how to reduce the risks and were regularly updated. However we found staff were not always aware of all of the risks to people and guidance wasn't always available. For example, two people's records identified they were at high risk of developing pressure ulcers. Two of the staff we spoke with were unable to tell us about the risks to the people relating to them developing pressure ulcers. The care plans did not include any guidance for staff to inform them how often the people should be repositioned. Staff told us they, "Just know when to turn people". Records demonstrated inconsistent recording of when people were repositioned. For example, in one person's records they went without repositioning for five hours, at other times they were repositioned every two hours. Repositioning people is important to reduce the risk of them developing pressure ulcers. This meant people were at increased risk of developing pressure ulcers because there was no guidance to reduce the risk in place for staff to follow and staff were unaware of the risks to some people.

Another person was identified as being at high risk of falls and they had experienced six falls in 2016. One of the staff members we spoke with was unable to tell us about this risk, they said they had, "A couple of falls a year". This meant people were at increased risk of harm because staff were unaware of the risks relating to their care and support. We looked at the persons care plan and there was a falls risk assessment in place that identified the person was at high risk of falls and measures were in place to reduce the risk. The registered manager told us risks to people were discussed during the handover. They also said they were in the process of getting all staff to read all care plans and sign a document to state they understood them.

People had call bells in their bedrooms to enable them to call staff for assistance. During our inspection we observed eight people who were in their bedrooms and unable to support themselves had their call bell out of reach. We observed one person in their bedroom banging their cup on a table in their bedroom to summon staff support as their call bell was out of reach. The person told us, "I need my painkillers". This meant people were at risk of not receiving support because they were unable to summon staff. Following our inspection the registered manager told us the call bells would be checked each shift to ensure they were in reach for people and this check would be recorded on the handover record.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).
Most of the people we spoke with thought there were enough staff available to meet their needs. One person told us, "I think there are enough staff, they are jolly good workers". Another commented, "I call them a lot and when you call they come quickly, they are never far away". However one person said, "There are not enough staff, if I ring the bell they take their time". Relatives had mixed views about staffing, one relative said they were not sure if there were always enough staff on duty, they said that sometimes staff were not visible in the lounge area.
Staff told us they thought there were enough staff available to meet people's needs and keep people safe. The registered manager told us they had a tool in place whichwas used to determine the staffing levels within the home and they confirmed the minimum staff levels with us. At times there were enough staff to meet people's needs but the staffing rota showed that staffing levels had fallen below the minimum staffing level set by the provider to meet people's needs.The registered manager told us they had tried to request agency staff at these times but were unable to get cover. They also told us at times when the home was short staffed non-care staff would help out in tasks such as making drinks and serving meals. The registered manager told us they were in the process of recruiting more staff.
A recruitment procedure was in place to ensure people were supported by staff with the experience and character required to meet the needs of people. We looked at three staff files to ensure checks had been carried out before staff worked with people. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant had any convictions that may prevent them working with vulnerable people. Staff told us these checks were completed prior to them starting work. We found

one of the staff files did not include a DBS certificate number. We discussed this with the registered manager who told us the certificate was with the staff member and we saw the DBS had been applied for. The registered manager told us they would obtain the certificate number and ensure it was recorded in the file.
People and their relatives said they or their family member felt safe at Gardenia Court. One person told us, "I feel safe here". A relative said, "Yes my family member is safe".
Staff told us they had received safeguarding training and we confirmed this from training records. Staff told us they were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. Staff described how they would recognise potential signs of abuse through people's body language, their mood and physical signs such as bruises. They told us this would be reported to one of the nurses or registered manager and they were confident it would be dealt with appropriately. One staff member said, "I am always looking out for how people appear, I would report any concerns to the manager they are always available and I am confident they would manage it". Another staff member said, "I know the residents and I would recognise if things weren't right and I would go to the manager straight away". Staff were also aware of the whistle blowing policy and the option to take concerns to agencies outside of Gardenia Court such as CQC and the local authority.

Requires Improvement

Is the service effective?

Our findings

Some aspects of the service were not effective.
People's rights were not fully protected because the correct procedures were not being followed where people lacked capacity to make decisions for themselves. The Mental Capacity Act 2005 (MCA) provides the legal framework for making particular decisions on behalf of people who may lack the 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found where people lacked capacity to make decisions for themselves the principles of the MCA were not always being followed. For example, where people had bed rails in place and lacked capacity to agree to their use, we found capacity assessments and best interest decisions had not been completed. One person had a sensor mat in place to detect their movement whilst they were in their bedroom, the person did not have capacity to understand the sensor mat was in place or agree to its use and there was no best interest decision for this. This meant people were at risk of receiving care and treatment which was not in their best interests and breached their rights.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We spoke with the registered manager who told us they would review their processes for assessing people's capacity in line with the MCA. At the time of the inspection there were no authorisations to restrict a person's liberty under DoLS. The manager had made four applications to the local authority and was waiting for the outcome of these. They were in the process of completing applications for other people and they told us they would liaise with the local authority regarding this.

Where people were identified as being at high risk of malnutrition and dehydration we found there were no effective systems in place to support them. For example, during our inspection we observed the registered manager discussing with three people they were concerned the people were not drinking enough fluids. We asked the registered manager if these people had fluid charts in place and were told that no one living at the home currently had a fluid chart to monitor their fluid intake . The registered manager told us they determined who needed a fluid chart by staff monitoring the colour of a person's urine. They said when this became darker in colour they would implement a fluid chart. This meant people were at risk of developing urine infections because the provider was being reactive to concerns rather than preventing them.

A member of staff told us one person living at the home had a fluid chart in place because they were at risk of dehydration. We looked at the persons fluid chart record and noted over a four day period the person had recorded 200ml fluid intake. The person's records stated they were high risk of dehydration and malnutrition and poor fluid and food intake should be reported to the nurse in charge daily. During these four days it was recorded the person refused food and had a poor fluid intake. Records did not demonstrate the poor fluid and food intake was reported to the nurse in charge. The nursing records for this person contradicted the fluid chart record and they stated the person had drunk large amounts of fluid. People had jugs of fluid available in their rooms. We observed two people did not have the jugs of juice within their reach. One person told us, "I definitely don't get enough to drink, they put the jug out of reach". This meant people were at risk of not receiving adequate nutrition and hydration and concerns were not reported to the nurse in charge.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We discussed this with the registered manager who told us they would ensure all staff would be made aware of the importance of people having jugs of fluid within their reach. They said they would also ensure staff would keep accurate records of fluid and food intake and this would be fedback to the nurse for action where required. We observed people in communal areas of the home were supported to have regular fluids and snacks. Following our inspection the registered manager confirmed they had raised these concerns with staff and would monitor the situation closely.

People were not supported to have an inclusive lunchtime experience. We observed lunchtime in the dining room and one person being supported to eat their meal in their bedroom. Five people living at the home required support with their meals. The mealtime experience for people was not calm and organised. For example, we observed one staff member supporting three people at the same time who were unable to verbally communicate and needed support to eat their meals. The staff member left the room on at least three occasions without telling the people where they were going. People were not supported by the same staff member throughout their meal. One staff member did not tell a person what they were eating until half way through the meal. We also observed a staff member supporting people with their meals whilst standing up which meant they were not at the same level as the people they were supporting. When helping people to eat their food it is important to see they are able to chew and swallow properly, to avoid choking. It is also undignified for people to have someone standing over them while they are eating. We observed two staff members discussing what was going on in the news between themselves whilst supporting people with their meals. They did not involve the people they were supporting in the conversation. This meant people were not prompted or encouraged to eat and may not enjoy their meal.

People had mixed views on the food provided. Comments included; "The food's not too bad", "The food's fine", "I don't like the food, I can't stand it", "The food's pretty good" and "The food's fantastic, I have had my favourite every day". Relatives told us, "The food is fantastic" and "The food is lovely, the lunchtime meal looked delicious". Another relative told us how their family member likes specific food and said they always try to accommodate their wishes.

There were two meal options on offer each day and the cook showed a list of alternative options they could offer if people did not like what was on the menu. The cook demonstrated knowledge of people's likes and dislikes, allergies and dietary needs and they had a list of these available in the kitchen. We also saw a record of this in people's rooms. They told us they spent time with people asking them for feedback on the meals and updating their records in response to this. Guidelines were in place to ensure people received a diet in line with their needs and staff were following these.

During the inspection we asked the registered manager how they monitored the registration of the registered nurses. Nurses are required to register with the nursing and midwifery council and are issued with a number called a Pin. The Pin is proof of their registration and entitlement to practice as a nurse. Employers are responsible for checking their employees are registered to work as a nurse and must regularly check their registration status throughout the time they are employed. At the time of the inspection the registered manager was not undertaking checks of the nurses Pin numbers to ensure they were registered. This meant people were at risk of receiving support from nurses that may not be entitled to practice. Following our inspection the registered manager confirmed they had checked the registration Pin number of all of the nurses and they were entitled to practice.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staff told us they had enough training to keep people safe and meet their needs. We looked at the training matrix and saw training included core skills training such as moving and handling, safeguarding adults from abuse and fire safety. Staff also received training in caring for people living with dementia. One staff member described the training as "Good", they went on to say there were plenty of training opportunities. They told us there was a list of additional training available if staff felt they wanted to complete it. We saw training included training on people with learning disabilities, people with autism and people who have epilepsy.

Staff received an induction when they joined the service and records we saw confirmed this. We saw the induction linked to the Care Certificate Standards. The Care Certificate Standards are standards set by Skills for Care to ensure staff have the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. They said the induction included a period of shadowing experienced staff and looking through records, they said this could be extended if they needed more time to feel confident. Staff received one to one supervision to provide support and guidance about their work. Staff told us during supervision they received constructive feedback and were able to raise any concerns. One staff member told us supervisions were, "Really supportive". We saw in supervion records training needs were discussed and the registered manager responded to staffs requests for further training. Comments we observed on the supervision records indicated that staff were happy working at Gardenia Court and able to discuss any issues with the managers.

People saw a GP when required. A local GP visited the home routinely every two weeks or sooner if required and relatives told us they were kept up to date with any changes to their family member's health. One relative told us, "They always phone and keep me up to date" another said, "They respond to my family member's health needs and keep us up to date when the GP has visited". Records confirmed people were supported to see health professionals such as their GP, district nurses, occupational therapists and chiropodist. We saw where one person had experienced several falls the registered manager had made a referral into the falls team and requested the persons medicines were reviewed by a GP. The registered manager told us they had developed links with the local hospice for support.

We recommend the provider seek guidance on how to support people living with dementia and provide them with opportunities to enjoy a sociable meal time experience.

Good

Is the service caring?

Our findings

The service was caring.
People and relatives told us they were happy with the care they or their relative received and the way staff treated them. One person told us, "Well, I can honestly say the staff here are fantastic, so friendly, they come in and tell you their name". A relative told us, "It's very good here, the carers really care. They always smile at them and are incredibly patient". Other comments included, "The staff are amazing, absolutely fantastic". We observed staff interacting with people in a friendly and relaxed way and engaged people in positive conversations.

People were supported by staff who knew them. One person told us, "Staff are like family". One relative said, "The staff have asked us for information to find out more about their life". Another relative told us how staff had requested they complete a life history document so they had information available to discuss the persons past interests and history. Staff told us they spent time with people chatting with them and their families so that they could find out what was important to people. Staff talked positively about people and were able to explain what was important to them such as family relationships, favourite food and their personal items. One staff member told us, "The people living here feel like part of my family" and another said, "We are like their family".

People and their relatives told us they and their family members were treated with dignity and respect. One person told us, "Things are really good. I'm treated with respect and dignity". A relative told us, "They treat my family member with a lot of dignity, they have so much empathy".
We observed a file containing a number of thank you cards and letters from relatives. The words 'caring', 'compassionate', 'kindness' and 'treated with dignity' featured repeatedly in these cards. We saw positive comments from relatives giving feedback on the service. These included, 'We have no concerns, we are offered refreshments and meals every time we call, regardless of the time. I always feel welcome and staff always seem happy and welcoming'. Another comment stated, 'There is always lovely atmosphere with staff interacting with residents'.

Relatives told us they were involved in the assessment and planning of their care. One relative commented, "I am involved in the care plan and aware of what's going on". Another relative commented, "I am involved in decisions, they call me and ask for my opinions". Staff told us how they involved people in making decisions about their day to day life such as meal choices, where to spend their time and what to wear.

Staff described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains, covering people's body parts whilst supporting them with personal care and knocking on people's bedroom doors. One staff member said, "We think about people as individuals and we respect their wishes, I always talk through what I am doing and make sure they are happy and comfortable". Staff also told us how they ensured they did not discuss people in front of others. During our inspection we observed staff knocking on people's doors before entering.

Staff told us how one person could become anxious whilst they were supporting them with personal care. They told us how they responded to the person by reassuring them and letting them know what they were doing. They said if the person continued to be anxious they would leave the person for a short period of time and go back and try again. A staff member said, "We talk them through every step of the way, the more you talk to [name of person] the easier going they are".

Each person who lived at the home had a single occupancy room where they were able to see personal or professional visitors in private. We observed people made choices about where they wished to spend their time during the day. Relatives told us visitors could visit at any time, there were no restrictions and they were made to feel welcome. One relative told us, "I can absolutely visit when I like, there are no issues". Another commented, "I go in anytime, day or evening". During our inspection we observed visitors coming to the home throughout the day, there was a visitors signing in book in the reception so the staff knew who was present in the building.

Requires Improvement

Is the service responsive?

Our findings

Some aspects of the service were not responsive.
Each person had a care plan that was personal to them. Some of the care plans lacked information for staff about how to support people. For example, they lacked information on how often people should be repositioned where people were identified as being at high risk of developing pressure ulcers. Some people required support to be repositioned using moving and handling equipment and a sling. Two of the care plans we looked at did not include information relating to the size of the sling staff should use. Staff told us they knew which sling to use depending on the size of the person. This meant the information would not be available for new members of staff or agency staff working at the home.

The registered manager showed us a new care plan format that they were introducing, they told us the new care planning system requested the information that was missing from the old care plans to be included. They said they were in the process of updating all the care plans and had completed seven so far. They told us all new people moving into the home would have a new format care plan completed and they had plans to have all of them in the new format by April 2016.

Relatives told us they were involved in developing care plans and happy they reflected their family member's needs. Comments included, "I am happy with the care plan and aware of what's going on". Care plans included information on how people wanted to be supported, what they were able to do for themselves and where they required staff support. People had personal profiles in place that included important information about them. This included their likes, dislikes, past histories, how they liked to spend their time, preferred routines and important relationships. We noted two people did not have these documents in place. The registered manager told us some of the documents were still with family members to be completed and they would ask for these to be returned.

The people we spoke with did not comment positively about the activities on offer. One person told us, "There's not enough to do" and another said, "It's very boring, there's nothing to do all day, just watch telly". One person commented, "I play cards with someone once a week". One relative said they thought their family member enjoyed the activities on offer. They told us, "They do karaoke and [name of relative] loves singing, they sing old songs, it's stimulating. They get involved in the quizzes too". Staff told us "We have a karaoke person every Monday afternoon, they are given instruments to play and families bring children in to help residents paint and draw. The activities person has individual sing songs with people in their rooms".

We saw there was a timetable of activities on offer that included; karaoke, aromatherapy, arts and crafts, games, movement therapy and reminiscence. The registered manager told us the activities coordinator was on holiday at the time of our visit. In the afternoon we observed staff encouraging residents to sing along to old time songs and play percussion instruments. People appeared to enjoy this activity. The registered manager told us they had developed links with the local church and the vicar visited Gardenia Court.

People and their relatives said they would feel comfortable about making a complaint if they needed to. People were aware of the complaints policy and were confident if they did raise any concerns they would be

dealt with by the registered manager. One person said, "If I wanted to make a complaint I would talk to the manager". One relative told us, "If I had any concerns I would speak with the registered manager, they are very approachable and you can talk to them about any issues". Another commented, "If I was concerned I absolutely feel they would take it on board, they really care". There had been six complaints received by the service and these were responded to in line with the provider's complaints policy.

People and their relatives told us they were asked for feedback on the service provided. One person told us, "I get a chance to say what I want to". A relative said, "I have an official form to fill in that asks for my views and comments". Resident's and relatives meetings were held to discuss topics relating to the home and for people to give their feedback. We saw records of these meetings and they covered people giving positive feedback about the staff and the cleanliness of the home.

Surveys were undertaken to receive feedback on the service twice yearly. The survey forms were also on display at the entrance of the home for people and relatives to complete at any time. The survey included people's and relatives views on the quality of care, response to call bells, activities, how concerns were dealt with, laundry and the décor of the home. Feedback from the survey in 2015 identified there was an odour in one of the corridors. We noted the flooring in this area had been replaced.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well led.

At our last inspection in February 2015 we found the provider was not always notifying us of significant events in line with their legal responsibility. During this inspection we found improvements had been made and we were notified of events where required.

There were a range of audit systems in place that were completed by the registered manager monthly. We found the audit systems were not always effective in identifying shortfalls. For example, the medicines audit carried out in January 2016 did not identify the shortfalls in medicines that we found. The care plan audit did not identify where records were incomplete and
they had not identified the service had not followed the principles of the Mental Capacity Act 2005. The audits had not identified where we found breaches in the regulations.

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

There was a registered manager in post at Gardenia Court Nursing Home. The registered manager was a registered nurse. They told us they were a member of the Royal College of Nursing (RCN) and kept their skills and knowledge up to date by updates that were sent through the RCN updates. They also told us they attended local provider forums and found these meeting useful to talk to managers from other organisations and share concerns and ideas. The registered manager also worked as a nurse in the home and we saw they were regularly working shifts as a nurse. The registered manager was also responsible for the clinical supervision of the nursing staff.

The registered manager was also responsible for overseeing the management at another home owned by the provider. They told us this was a temporary measure in place whilst the other home was recruiting a manager. We asked the registered manager if covering the two homes and working as a nurse impacted on their ability to complete the management role. They told us they had recently employed a new administration staff member who would complete the admin work and relieve them from some of their workload. Following our inspection the registered manager told us they had stop working nursing shifts and was focusing on managing the service. We also spoke with the provider following our inspection and they told us they had recruited a manager to the other home the registered manager was overseeing.

Staff told us the registered manager was approachable and accessible and they felt confident in raising concerns with them. The registered manager told us they spent time with staff observing them informally and giving them feedback to support their development and promote best practice. The registered manager showed us an observation supervision form that they planned on introducing to give staff formal feedback on their performance. One staff member told us, "[name of manager] is approachable, they are one of the best and cares, they go the extra mile I have the upmost respect for them, they are a role model". Another staff member said, "[name of manager] is always available and very focused on resident and staff

happiness".

Staff spoke positively about working at Gardenia Court; two staff members told us they "Loved their job". One staff member told us how the staff team were a "Close team" that were "Comfortable working with each other".

The registered manager told us they felt supported by the organisation, they said they received supervision and the provider visited weekly and was available on the phone for support.
We looked at staff meeting records which showed meetings were held to address any issues and communicate messages to staff. Items discussed included training, concerns over care delivered, care plans and staff break times. The registered manager told us and we saw evidence that staff meetings were held six monthly or more regularly if required. Staff told us they felt able to voice their opinions during staff meetings. Comments included; "We get the opportunity to say what we feel, we are able to speak up and voice our concerns" and "Everyone is free to give their opinions and raise concerns and we are listened to".

We asked the registered manager what the challenges to the service were. They told us one of their key challenges was retaining staff, they said they had recently employed new staff and were working on ensuring they were trained and aware of their role. They showed us the systems in place to support the new staff with this.

We spoke with the registered manager about their vision for the service and they told us this was, "To deliver a high standard of personalised care". They told us they shared their vision through staff meetings. Staff told us the vision for the service was, "To give effective care and make sure the residents are happy and comfortable" and to "Make sure people are happy and to do our best for them".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Effective processes were not in place to support people to make best interest decisions in accordance with the Mental Capacity Act 2005. Regulation 11 3

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not always effective in identifying where there shortfalls in the service. Regulation 17 2 a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were no systems in place to check that staff met professional standards that are a condition of their ability to practice. Regulation 18 2 c

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not always administered safely. Regulation 12 2 g

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People did not always have access to suitable hydration. Regulation 14 4 a

The enforcement action we took:

Warning notice