Gilead Care Services Ltd

Gilead House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Gilead House is a newly registered nursing home providing accommodation and personal care for up to 22 people older people who may have mental health conditions and physical or sensory impairment. The home was registered with CQC on 24 March 2017. There were nine people living at the service at the time of our inspection.

The home had a registered manager in place. 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.

We conducted this inspection because we had received concerns about the care and support provided at the home. The inspection took place on 12 May 2017 and was unannounced. This was the first inspection of the home since it was registered.

People were unsafe as identified risks to their safety and well-being were not always acted upon and addressed. People who were at risk of choking did not always receive food that was safe for them to eat. Accidents and incidents were not effectively monitored or recorded to reduce the risk of them reoccurring. Safeguarding Incidents had not been appropriately reported to the local authority for further investigation. This meant people were at risk of receiving unsafe support following an allegation or incident.

Medicines were administered safely however they were not stored appropriately. The temperature in the room used to keep medicines was too high and had not been monitored. This could reduce the effectiveness of people's medicines. There were times prior to our inspection that there was not a qualified member of nursing staff on duty but on the day of the inspection there were sufficient care staff available. Recruitment checks were not fully completed to ensure that staff employed were suitable to work in the home.

The provider had developed a contingency plan to ensure people's care would continue during an emergency. However people did not have individual evacuation plans completed to help ensure they would be kept safe in the event of an emergency.

Staff knowledge of people's support needs was limited which put people at risk of harm. Staff had not been given an appropriate induction when they started to work at the home and had not received training to help them support people living there. Both clinical and care staff had not received any supervision to ensure they were following best practice and this limited their opportunities to raise any concerns or training needs they may have had.

People's rights were not always protected as the Mental Capacity Act 2005 was not appropriately followed. Capacity assessments had not been completed for specific decisions such as an application under the

Deprivation of Liberty Safeguards.

People's healthcare needs were not always met because people were not registered with the local GP. This meant that referrals to specialist healthcare professionals could not be made. There was a lack of positive interaction from staff and people were not always treated with dignity. Staff did not always know people and were not clear about how to support people with specific health conditions. People and those close to them were not always involved in how they would like their care to be delivered. Visitors to the home told us they were made to feel welcome and staff were friendly and polite and treated people well.

People did not receive person centred support in line with their needs. Pre-admission assessments were not fully completed before people moved into the home so staff were unclear about whether they could meet their needs. Care plans were not fully completed and lacked detail and did not provide guidance to staff on how to support people. There was a lack of meaningful activities provided to people and staff did not support people to follow their interests. There was a complaints policy in place and people and relatives told us they would know how to raise concerns if they needed to. However one incident had been raised informally but had not been recorded by the registered manager as a complaint.

There was a lack of managerial oversight of the service with ineffective quality assurance processes. Records lacked the detail required to ensure people received consistent, safe care. The registered manager was providing care and support that was not in line with the provider's statement of purpose and had admitted one person whose needs could not be met. Significant incidents were not reported appropriately to the local authority or to CQC so effective monitoring of the home could not be completed. Feedback from people, relatives, staff and health professionals was not sought so areas for improvement were not identified or acted upon..

During the inspection we found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found one breach of the Care Quality Commission (Registration) Regulations 2009. We have made one recommendations.

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 time frame. 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

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.

Risks to people's safety were not being adequately identified and addressed. Accidents and incidents were not effectively recorded and monitored to minimise on-going risks.

Safeguarding incidents had not been reported appropriately and staff were unclear about what they should do if they had concerns.

People's medicines were not always safely stored. There was a lack of 'as required' medicines guidance. Medicines were administered appropriately.

Safe recruitment checks were not completed to ensure staff were suitable to work at the home. People were support by sufficient staff on the day of inspection.

Is the service effective?

Inadequate

The service was not effective.

People did not have access to health and social care professionals as people were not registered with a GP. As a result specialist health input could not be obtained.

Staff had not received an appropriate induction or training to meet the needs of the people. Staff did not know people or their specific needs well.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not followed which meant people's human rights were not protected.

People were able to make choices regarding their food and drinks but views on the quality of meals was mixed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect by staff and there was a lack of positive interaction from staff at times.

People were not involved in how their care was planned and delivered.

Relatives told us they were made to feel welcome when visiting the service.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed before they moved in and care planning was not detailed or person centred.

Activities were limited and people were not encouraged to develop interests.

There was a complaints policy in place and people and their relatives told us they knew how to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

Auditing systems were not in place to monitor and assess the quality of the service and shortfalls in people's care had not been identified or addressed.

Records did not always contain consistent information.

The registered manager was providing support to people that contradicted the services' statement of purpose.

The registered manager had not notified us of significant events at the home.

Staff told us they felt supported by the registered manager.

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 12 May 2017 and was unannounced. The inspection was carried out by two inspectors.

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 responsive inspection we had not requested 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 nine 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 five staff members, including a nurse, during the inspection. We spoke to two relatives of people living at the service.

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, complaints records, policies and procedures and staff records.

Inadequate

Is the service safe?

Our findings

Risks to people were not always acted upon in order to keep people safe. Two people were at risk of choking as they had swallowing difficulties. Both had been assessed as needing a 'soft' diet to minimise the risk of them choking. During the inspection both people were offered a fried breakfast in the morning and fish and chips at lunchtime. Staff were not aware of the risk this posed to people's health. We spoke to the registered manager immediately who said he would ensure that the people received food that met their particular needs.

People who were at risk of malnutrition and dehydration did not have their food and fluid intake regularly monitored. One person had refused their meals on the day of the inspection. Staff encouraged the person to eat their meals but no alternative was offered to them. This person also refused the offer of drinks throughout the day. Staff did not record this which put at the person at risk of not having their nutritional and hydration needs met.

People with nursing needs were not supported safely. People's health needs were not monitored which put people at risk of their health deteriorating. For example people who were at risk of developing pressure sores were not supported safely to reduce this risk. Risks were not highlighted in care plans and assessments and turning charts were not completed. This meant that staff did not know when they had last been moved or what position they should be moved to. People with poor skin integrity need to be repositioned regularly to stop the skin becoming damaged and to help prevent a pressure sore developing. Staff did not know when one person needed to be turned or the equipment they used to reduce this risk.

Nursing staff also did not know about risks to people. One member of staff told us "The registered manager said that there are some risk assessments for people, but I don't know who." Another person who was at risk of developing pressure sores was reported to have redness on their skin. They were sat in an armchair in the lounge without being encouraged to move by staff throughout the day of the inspection. They did not have any pressure relieving equipment in place to help reduce the likelihood of their skin deteriorating. Another person had been discharged from hospital and had skin that needed to be monitored by staff. The registered manager told us he was not aware of this.

Staff did not identify and minimise risks to people's health and safety. One person had a known history of falls. Despite this it was not until they were hospitalised as a result of a fall that an assessment and plan was put in place to reduce the risk. Another person became anxious, distressed and was at risk of becoming physically aggressive. There was no guidance in place for staff to support this person if they became agitated. This put the person and others at risk of harm.

Accidents, incidents and concerns were not always reported or acted upon. People's daily care notes highlighted times when incidents occurred and when they should have been recorded. For example when a person fell or when they became agitated. Two incidents had been reported by staff and had been analysed. One of these incidents involved a person who left the home without staff support. This had been highlighted before they moved in and the registered manager told us they needed one to one support most of the time.

Despite this staff were unaware they were missing for 30 minutes and the person had been found by the police who had taken them back to the home. A similar incident had occurred recently and staff were again unaware that this person had left the building.

Whilst staff were aware of the need for this person to be monitored we observed several times when this person was not in the presence of staff and they did not know where they were.

The environment was not always safe for people. One person was being nursed in bed and had to use a call bell to get help from staff. The call bell in their room was not working and a plug socket that was being used to power their profiling bed and mattress had come apart which exposed the wiring. We asked the registered manager to address this immediately.

Arrangements in place to manage the safety of people if a fire broke out at the home were inadequate. There was an evacuation plan and fire risk assessment however no fire drill had been conducted since people moved to the home. People's individual needs when it came to the safe evaluation of the home had not been considered. People did not have their own personal evacuation plan (PEEP) and staff lacked knowledge of the emergency evacuation procedures. This put people at risk in the event of having to evacuate the home quickly. As a result of these concerns we made a referral to Surrey Fire and Rescue Service. Since the inspection the registered manager has completed PEEPs for people living at the home.

Medicines were not stored safely. The temperature of the room they were stored in was higher than the recommended temperature for their safe storage. The temperature of the room had not been monitored and no action had been taken to reduce the temperature. This meant that the effectiveness of people's medicines could be affected. The registered manager said this would be addressed immediately.

Medicine stock checks were not completed. We found a discrepancy with the auditing of one medicine. Inadequate auditing of medicines indicates a risk that people may not be receiving their medicines as prescribed. There was also a risk to people that there may be unaccounted medicines in the home. People did not have written protocols in respect for receiving medicines on an 'as needed' (PRN) basis. PRN protocols were needed to explain to staff when and how 'as needed' medicines are given to people.

Failure to safely manage risks to people and poor storage of medicines is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had medicines administration records (MAR). Staff checked that people had taken medicines before signing the MAR to ensure that records accurately reflected the medicines people were prescribed. There were no gaps on the MAR charts that would indicate people had not received their medicines.

Recruitment practices were not robust. There was limited information in staff recruitment files. The files lacked employment history, references and application forms. Without this information the registered manager could not make an informed decision whether staff were suitable to work with vulnerable people. Staff files did not have documentation confirming that 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 vulnerable adults. One member of staff had a DBS which highlighted they had a criminal conviction. There had been no risk assessment completed in respect of this. For qualified nursing staff there was no evidence that checks had been made with the Nursing and Midwifery Council (NMC) to ensure they were safe to practice. The registered manager said they would address this.

The recruitment procedures to ensure staff employed were fit and proper were not followed. This is a breach

of regulation 19 Health and Social Act 2008 (Regulated Activities) 2014.

Safeguarding concerns were not made appropriately to the local authority. One relative informed the local authority of an incident that occurred when staff should have known to refer this themselves. The lack of incident reporting put people at risk as this should have led to an investigation by the local authority. There was a safeguarding policy in place but staff did not have a clear understanding of how to raise concerns or who to. Staff told us they would inform the registered manager of any concerns but were not able to explain the role of other agencies such as the local authority, CQC or Police. Since the inspection another safeguarding incident had not been appropriately reported. The registered manager told us staff would have safeguarding training to ensure they knew the safeguarding procedures.

Failure to have an established system in place to refer safeguarding concerns is a breach of regulation 13 Health and Social Act 2008 (Regulated Activities) 2014.

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Before the inspection we received concerns that there was not always a qualified nurse on duty at the home. We found that this was not the case on the day and there were sufficient numbers of nursing and care staff on duty. The registered manager told us that there had been instances when a qualified member of nursing staff had not been present at the home but this had been addressed.

We saw staff responding to people's needs in a timely way 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 and when more people moved into the home.

Inadequate

Is the service effective?

Our findings

People did not have access to health and social care professionals to ensure their health needs were met. On the day of inspection seven out of the nine people were not registered with a local GP. This meant that staff could not respond to changes in people's health needs or seek appropriate support and guidance. As a result people had not been referred for specialist health input when needed. For example, there had been no input from the Speech and Language Therapy Team (SALT) when choking risks had been identified for two people. Following the inspection we received confirmation that all people were now registered with a GP and people with specialised health needs have now been referred to the appropriate health professionals.

Staff lacked the knowledge of peoples diagnoses and were unaware of people's health and care needs. One person was diabetic however the nursing staff were unaware of this. When we asked a member of care staff about another person they said, "I don't know why X is here I think X has dementia." The providers Statement of Purpose (SOP) sets out the purpose, aims and objectives of the home. The SOP details the aims of the home which included being able to, 'Offer skilled care to enable people who live there to achieve their optimum state of health and well-being.' The registered manager told us they would update care plans and provide training so staff had a better understanding of people's needs.

Staff had not received an adequate induction when they started work at the home. Staff told us when they started work that "They showed me around the home." There was no formal induction to enable staff to get to know the home or the people living in it. A new member of staff explained that they had to ask about people's support needs as they did not know them and had not been told, for example, "Who needs a hoist or a wheelchair." Staff explained that they had not been given any training to carry out their roles and responsibilities. One member of staff said, "I have had no training here, I had training in my previous home." Another member of staff also said, "I haven't had any training here." Training in manual handling, safeguarding and mental capacity had not been provided although we did not see unsafe manual handling practice on the day.

Staff lacked knowledge of best practice, including safeguarding, gaining consent and how to keep people safe. They also lacked information about people's individual needs. There was no record of training each member of staff had already completed before working at the home and no system in place to ensure staff had the right skills, knowledge and competencies to support people effectively. The providers SOP states, 'We manage and train our employees with the aim that all our carers achieve NVQ level 2. All employees receive the training appropriate to their work.' This had not been happening. Following the inspection the registered manager had informed us that a programme of training had begun.

Although staff said they knew who to talk to if they had any questions or needed support, no formal systems to supervise them had been introduced. Supervisions are an opportunity for staff to speak about concerns, how to support people effectively and their own personal training needs. If staff were regularly supervised the registered manager would have had a greater understanding of staff training and development needs. There had been no clinical supervision of qualified nursing staff completed to ensure that best practice was

followed.

The lack of staff knowledge, support and training is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) 2014.

People were not always able to make their own choices and decisions about their care. We looked to see if the service was working within the principles of The Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

The requirements of the MCA were not fully met. Mental capacity assessments had not been completed when people had been identified people to lack capacity to make certain decisions. For example, one person was unaware of how to keep themselves safe in the community but had not had a mental capacity assessment in respect of this. The registered manager told us "We have not completed paperwork for capacity. It is obvious speaking to X they do not have capacity. I think that going through the motions of capacity is not worthwhile. The presumption of capacity does not count in this case." We gave feedback to the registered manager that this is unlawful and had to remind him of the key principles of the MCA.

Staff had limited knowledge of MCA and consent. One member of staff described people lacking capacity as having a, "Brain disease". This lack of staff knowledge and understanding put people at risk of being unlawfully treated and restricted as consent was not being sought in line with best practice. It also put people at risk of having decisions made for them by people who did not have legal authority to do so.

When decisions had been made for people, meetings or discussions were not arranged to ensure that these decisions were in their best interest. Two people had their dietary requirements changed by the registered manager. In both cases these decision went against guidance that had previously been put in place by the SALT team .These did not follow the best interests principles.

Despite not completing mental capacity assessments some people's freedom had been restricted to keep them safe. People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in nursing homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made DoLS applications to the relevant authorities. These applications reflected the specific restrictions in place but before any application can be made a mental capacity assessment must be completed. One application was for the constant supervision of a person.

The requirements of the MCA and consent for care and treatment was not followed. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager told us they had completed mental capacity assessments for people that needed them.

There was mixed views about the quality of food from people. One person said, "Food could be better. I have Weetabix or porridge. Supper is a sandwich, soup, ice cream or a banana." Another person said, "I get given what I am asked for. I'm sure there is a menu but I haven't seen one". A recently appointed chef was working to develop a menu with more involvement from people to try to understand their likes and dislikes and any

specific nutritional needs. The chef explained that they currently completed the menu on the day and then shopped for the food. We observed a mealtime and heard staff asking people what they wanted to have for lunch and these requests were followed.

The design of the home did not always meet people's needs certain needs were not considered before they moved into the home.. The corridors and doorways were narrow and we observed it was hard for some people to move around the home. One person said, "It's not wheelchair friendly. The corridors are narrow. I have difficulty getting into the toilet. I just about squeeze in".

Requires Improvement

Is the service caring?

Our findings

People had mixed feelings about the caring approach of staff at Gilead House. One person said, "Staff offer all the time for help. I can't criticise them". Another person said that staff are, "Polite," and, "Kind." A relative described the care as, "Great," and the home as, "So peaceful, restful and attentive."

Despite these positive comments people were not always treated in a caring way. One person said, "I am fed up. I don't see people, yesterday someone only came in once or twice (to see me). I want to be treated like a human being. Staff don't really talk with me." We spoke to the registered manager about this and asked what staff did to engage with this person. At first the registered manager replied, "Not much." He then explained that staff, "Engage," with the person but could not give any specific examples of how this was done.

People were supported by staff who did not know them well. Staff could not explain about people's needs or personal history and some staff did not know why some people were living in the home. For example staff did not know people's preferences. Staff therefore could not show their appreciation of people's individuality and character. Staff did not always give people time to listen and interact with them. Due to this positive relationships between people and staff had not always been developed which put people at risk of feeling isolated and lonely.

Although we did observe some caring interactions there were times when staff missed opportunities to engage meaningfully with people. For an hour in the morning one member of staff sat in the lounge with people but did not engage with anyone. We also observed occasions when staff did not listen to people. One person had been served breakfast and said to the member of staff "No you have it." The member of staff ignored this and walked away without responding. There was no attempt to engage with this person, listen to them and encourage them. As a result of the lack of engagement we observed people having to seek out staff to request support. For example one person had to go to the office to ask for a cup of tea. Throughout the day there were missed opportunities to engage with people. One member of staff was going to take a person out for a walk but decided against it because it was raining. This person kept saying they wanted to go out on several occasions during the afternoon when the weather had improved.

People were not involved in making decisions about their care and support. People were not involved in their care planning or reviewing their care needs. Care plans were written by the registered manager and nurses without any input from people.

People were not always given information about their care and support. One person who was receiving respite care asked staff how long they were due to stay for. The person did not get a response to their question and staff did not ask the registered manager about this. The person told us that they were frustrated that they could not get an answer. We informed the registered manager who told us he would talk to the person.

People's confidentiality and privacy was not always respected. We heard staff talk openly about people's

support needs in front of other people. This was not in line with the providers own confidentiality policy.

The registered manager had not ensured that people were being treated with dignity and respect and supported with their autonomy, independence and involvement. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that, at times, people's privacy and dignity was respected. A relative said that their loved one is, "Washed, shaved and dressed." A member of staff said they always close people's doors and curtains to respect their dignity. We also observed staff knocking on people's doors before entering their rooms.

Inadequate

Is the service responsive?

Our findings

People's needs were not adequately assessed. This meant that the provider could not be sure that they could meet people's needs. Assessments were incomplete. Some people had hospital discharge summaries that stated some of their care needs but these were not detailed. The registered manager had accepted a referral of one person living with dementia when the home was not able to provide care to people living with dementia. The providers SOP states, 'A pre-admission assessment will be carried out to assess the suitability of the match between needs and the services and facilities of the home.' However this was not being followed.

Following admission care plans were either not completed or did not have enough information in them. This meant that staff had limited information on how to support people and care for them appropriately. One member of staff said, "They are at the beginning, we started the care plans and risk assessments yesterday." Another member of staff said, "Now we are starting the care plans. We need the care plans." One relative was unsure of whether there family member had a care plan and told us, "We don't know if there are any care plans."

The care plans were generic and lacked any personal information about people regarding their basic support needs or their likes and dislikes. Information was contradictory one person used a wheelchair but their care plan stated they like to 'wander around'. Care plans did not reflect all the support needs and risks that had been highlighted through pre-assessments and hospital discharge summaries. This meant staff did not have information to support people in a personal centred way. This had a significant impact on the support provided to people as staff did not know them as individuals.

There was a lack of engagement and activities for people. One person said, "I just watch TV, there is nothing else on". Another person said, "We don't go out." Whilst another said, "It's not pleasant. I lie here all day". The registered manager showed us a list of potential activities staff could offer to people however there were no organised activities happening. Staff told us they would play cards and complete jigsaws with people. No activities were offered to people in the morning however in the afternoon jigsaws and puzzles were provided. People listened to classical music in the lounge and a member of staff played the piano for half an hour.
People were not supported to follow their interests.

People's individual preferences were not considered because there was a lack of staff knowledge about what people enjoyed doing. When activities were offered people they either did not want to do them or had no interest in them. One person said, "Someone came to do a jigsaw. I don't want to do them." We observed another person was asked to play dominos. This person told us they had never played dominos before and they did not want to. The provider's SOP states they 'Recognise the individual need for personal fulfilment and offer individualised programmes of meaningful activities to satisfy that need of service user and staff.' This was not happening on the day of the inspection.

Care planning had not been completed and the needs of people were not being met in a person centred

way. This is a breach of Regulation 9 Health and Social Care Act (Regulated Activities) Regulations 2014.

People and relatives knew how to raise complaints and concerns. One relative had recently made a complaint to the local authority about the standard of care at the home. There had been no reported complaints that had been made directly to the registered manager. The registered manager told us that when complaints are received these would be taken seriously and used as an opportunity to improve the home. Despite this a complaint had been made by a neighbour regarding a clinical waste bin. This had not been responded to in line with the homes complaints procedure as the registered manager told us he did not see it as a complaint..

We recommend that the registered manager review the complaints procedure in line with current guidance.

Inadequate

Is the service well-led?

Our findings

Relatives described the care given at the home as "Nice". One relative said, "We are so pleased with this place. It's the ethos and the feeling, so different. It has a family run feeling, they have empathy. They are genuinely nice".

Despite this there were concerns with the management and leadership of Gilead House which led to a significant impact on people. These concerns have also been forwarded to us by the local authority. Following our inspection the registered manager provided an action plan that detailed how they would address the concerns raised, which he said he was working through

People's care and support were not monitored and areas needing improvement found at this inspection had not been identified. The registered manager had not started any quality assurance systems since the home had started to admit people. This lack of quality assurance led to the registered manager and staff being unaware of issues and concerns that significantly impacted on people's lives. For example inadequate personalised information in care plans, lack of mental capacity assessments, lack of staff training, concerns with dignity and respect, lack of safe recruitment processes and poor risk management. The registered manager did not have an adequate knowledge of people's needs and was not aware of people at risk of developing pressure sores. One person was administered medicines covertly (without their knowledge) . This lack of information and oversight put people at risk of not receiving safe care and treatment that met their needs.

Relatives and staff told us they could approach the registered manager with any problems they had. A member of staff said, "You can co-operate with him." Despite being described as "Transparent" by a relative we experienced a number of occasions when the registered manager had provided contradictory information. The lack of qualified nursing staff was raised during the inspection and we were given assurances that this would be addressed however the day after the inspection we were not told there was not a qualified nurse working in the home.

Following the inspection we were told by the local authority that one person had fallen and injured themselves. The registered manager was unaware of this incident. This demonstrates a lack of oversight and raised concerns about the communication within the home. The lack adequate training of staff, particularly in terms of first aid, safeguarding and the reporting of incidents should have been addressed sooner.

The home did not have robust quality assurances systems in place. During the registration of the home the registered manager said told us that there would be effective systems in place to ensure that safe care would be delivered. When discussed with the registered manager he understood there was a gap in the quality monitoring of the home and said he would implement a robust auditing system.

People, relatives and staff were not involved in the running of the home. There were no systems in place to address this or the care delivered to them. For example people did not have keyworker meetings or resident and relative meetings. There were no reviews of care plans completed. Team meetings had not occurred

where staff could be given the opportunity to discuss how to support people effectively and to raise any areas that required improvement. Despite this staff were positive about the management of the home. One member of staff said that the registered manager "Would listen to me." Another member of staff said, "I think he would listen and take things on board."

Although staff felt they could approach the registered manager ideas to improve people's support were not asked for. One member of staff told us that improvements were needed and said, "Need to talk to people, give them a choice. There should be regular activities. The sign in book should be by the door. Plus there should be care plans and paper work in place."

The registered manager told us that the home's missions and values were detailed in the homes SOP. We highlighted several areas during our inspection where the registered manager and staff were not working in line with the aims of the organisation stated in their SOP. These areas also contradicted what the registered manager had said he had in place during the registration process of the home. These areas include, staffing training, assessments of people's needs, individualised care and the monitoring of care. The registered manager had also accepted a referral of a person with support needs when they knew they could not meet their particular needs.
There were no systems or processes in place to monitor, review and improve the quality of care. People's assessments before they moved in had not been completed robustly and care plans had not been fully completed so staff did not have enough information to support people and to meet their needs and keep them safe.

A lack of robust quality assurance systems is a breach Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager was not aware of his responsibilities to report significant events in a timely way. We were told of two incidents where police had attended the home. These were incidents that should have been reported to CQC but had not been. Without these notifications we could not monitor that all appropriate action had been taken to safeguard people from harm. The registered manager had not informed us of significant incidents without delay.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.