

Mr & Mrs J Boodia

Gables Care Home

Inspection report

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Gables Care Home is a care home which provides personal care and accommodation to people with a mental health diagnosis, people living with dementia or a learning disability. It can accommodate up to 16 people and has communal lounge and dining areas. At the time of our inspection the service provided personal care to eight people.

People's experience of using this service and what we found

The provider had not ensured there were sufficiently trained staff at the service who knew and understood people's needs. The management of medicines was not safe and there was a risk that people would not always receive their medicine. The management of risks associated with people's care was not robust which put people at risk.

There were parts of the service that were clean and well maintained, however the disposal of continence aids did not adhere to good infection prevention control. The provider was not undertaking appropriate recruitment processes to ensure that only suitable staff were working at the service. The oversight and management of the service was not robust and there was a lack of clear direction for staff.

People looked comfortable with staff and told us they felt safe. Staff understood what they needed to do if they suspected abuse. There was a system in place for staff to record and report accidents and incidents. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the Safe and Well Led key questions, the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture

Right support:

- Model of care and setting did not maximise people's choice, control and Independence

Right care:

- Care was not person-centred and did not always promotes people's dignity, privacy and human rights

Right culture:

- Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered live.

The last rating for this service was Inadequate (published 5 June 2021).

Why we inspected

We received concerns in relation to insufficient staff being on duty and the safe recruitment of staff. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gables Care Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risks related to the care being provided to people, the management of medicines, recruitment processes, staff levels, staff training and supervision, and the lack of robust provider and management quality assurance at this inspection.

For requirement actions of enforcement which we are able to publish at the time of the report being published. Please see the action we have told the provider to take at the end of this report.

Follow up

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate ●

The service was not well led.

Details are in our well-led findings below.

Gables Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

Our inspection was completed by two inspectors.

Service and service type

Gables is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission who was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-

We spoke with three people who used the service about their experience of the care provided. We spoke with four members of staff including the provider and care staff.

We reviewed a range of records. This included four people's care records and multiple medication records. We reviewed a variety of records relating to the management of the service including five staff recruitment files and audits of the service.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We also gained feedback from one health care professional.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection of the service, we found the provider had not managed the administration of medicines in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

Using medicines safely

- At the previous inspection there was no formal assessment of staff competency to administer medicine. We found that this was still the case. There were two members of staff who administered medicines which included the provider. The second member of staff had received training however they had not been assessed to ensure they were competent to administer medicines in a safe way. We continued to find shortfalls around the administration of medicines despite both the provider and the staff member having received updated medicines training since the last inspection.
- When the provider took charge of medicines administration, they continued to ask another member of staff to physically give people their medicines without verifying administration. This was identified on the previous inspection. They relied on the staff member to accurately report back to them that people had received their medicines, rather than witnessing it themselves. A member of staff told us about this, "(The provider) gives it to me and I take it to residents at breakfast, always in the dining room here."
- The recording on people's medicines administration record (MAR) was not accurate and there was a risk that people could have too much of a prescribed medicine. One person required their medicine to be given to them one day a week. We confirmed this was only given to them once a week. However, the provider was recording on the person's Medicine Administration Record (MAR) they had received this medicine every day. They acknowledged to us this was an error however other staff administering medicines may have mistakenly given the medicine every day based on the previous recordings on the MAR.
- One person's prescribed medicine had not been added to their MAR chart and no steps had been taken by the provider to address this. This meant there was a risk that the person would not receive their prescribed medicines.
- Another person was self-medicating with their asthma pump outside of the provider's observation. Although the person had the capacity to do this, the provider was recording on the MAR they had witnessed the person administer the medicine each day. The provider had not undertaken a risk assessment for people that self-medicated as advised by a visiting pharmacist on an audit they undertook at the service in June 2021.
- The 'as and when' medicine for people did not have always have the appropriate guidance in place for staff to know when it needed to be offered. For example, one person had been prescribed a medicine to help manage their pain. However, the provider's guidance stated that the purpose of the medicine was for

the 'management of anxiety disorder.' The person was being given this medicine three times every day. There was no evidence the provider had contacted the person's GP to determine whether this needed to be reviewed as it was only prescribed for occasional use.

- Whilst administering medicine the provider was at times leaving the medicine on the table for the person to pick up rather than offering it in a medicine pot to reduce the risk of contamination.
- Information on people's MAR did not always include allergies that people had. For example, according to a health professional record one person had previous adverse reactions to two medicines. This had not been recorded on their MAR despite it being identified as a concern by a visiting pharmacist in June 2021.

The failure to always manage people's medicine in a safe way was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong

- Risks associated with people's care was not managed in a safe way. One person was at high risk of developing a pressure ulcer and was being supported on a pressure relieving mattress. The provider told us the person had not been weighed since August 2020 and that their last recorded weight was 67 kilograms. However, the mattress was set at 50 kilograms meaning the person may be getting the appropriate support needed to reduce the risk of pressure sores. The provider told us they did not check the pressure mattress settings.
- We noted that another person's legs and ankles were swollen. The person was aware of this and told us, "I don't bother putting my feet up." The person's care plan did not mention any risks associated with this or any actions staff could take to help reduce the swelling. The provider told us, "We do know her ankle is puffy, but it's always been that way since she has been with us. It could be poor circulation it could be anything like that." The provider had not taken any action to address this despite them being aware.
- One person had a prescription for a thickener for their drink to prevent the risk of choking. We saw from the person's care plan they had been assessed by the speech and language therapist (SLT) in November 2009. However, there was no available guidance to explain why the person required thickener or whether it was still required given the length of time that had passed since the last SLT assessment. The provider told us the person only required thickener when drinking orange juice as at times they would, "gurgle" when drinking it. The MAR stated two scoops were needed per 250ml however the provider told us they had put one scoop of thickener in the person's hot drink that morning but was not sure how much fluid was in the person's cup. They told us they had not taken steps to refer the person to the SLT to see whether the person still required thickener and what amount was recommended to manage the risk of aspiration (breathing in liquids).
- The risks around people's behaviour was not managed in a safe way which placed people at risk. According to one person's care plan, they had a history of suicidal thoughts and making specific allegations. There was no guidance for staff on what signs to look out for or steps to take should there be any deterioration in the person's mental health. Staff we spoke with were not aware of this risk and one member of staff told us they had not read people's care plans. There was a note from a health care professional the person which read, "Person should not be left alone with other residents in communal areas, only to work with female staff." However, we saw times during the day where the person was with other people at the service, without the presence of a member of staff. The staff member on duty the majority of time during the night was a male member of staff.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. People were at risk of getting an infection as infection control practices were not always robust. For example, we noted in one person's bathroom, there were used loose continence pads placed directly into their bin that had no bag. A member of staff told us it was likely the pads were from the previous

day as they had disposed of that day's continence pads as soon as they attended to the person on the morning of the inspection. We saw three general waste bins at the front of the service were overfilled with used continence pads that were not in bags. Two people's mattresses smelled of urine and we identified that both people's continence pads had not been changed through the night which may have been the cause of the odour.

- We were not assured that the provider was accessing testing for people using the service and staff. During the inspection the provider told us staff were testing using the PCR weekly. After the inspection the provider sent in confirmation of tests for staff however this showed staff were only being tested monthly.
- We were somewhat assured that the provider was using PPE effectively and safely. There were times when we observed that the provider and one staff member was not wearing a mask.

The failure to always manage risks associated with people's care in a safe way was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

At our last inspection of the service, we found the provider did not have sufficient staff to meet people's needs in a safe way. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 18.

Staffing and recruitment

- At the previous inspection we identified concerns relating to the staff levels during the day and at night which put people at risk. Prior to the latest inspection the Local Authority contacted us to raise concerns that there was not always an awake member of staff on duty at night as expected. They also raised concerns that during a visit to the service during the day there were not always sufficiently safe staff levels.
- We found at this inspection there were not enough staff deployed to safely meet people's needs. The provider told us they assessed that three staff should be on duty during the day (which included the provider) and one awake staff at night. On the day of the inspection, two carers had been scheduled to work, one of whom was the provider. The provider told us another member of staff was absent due to sickness, but they had made a decision not to bring in an agency care to cover the shift. They told us this was due to them not having confidence in agency staff working at the service.
- We observed a member of staff was providing support to people in their rooms for part of the morning and spent the rest of the morning cleaning parts of the service. This left people in communal areas who were at risk of falls and other behaviours associated with their mental health diagnosis often unsupported by a member of staff. At times the only member of staff present downstairs was a newly recruited member of staff who had come to the service to complete a shadow shift.
- The provider had failed to ensure staff had the necessary skills to carry out their duties. A member of staff had been scheduled to work night duties seven days a week. However, we found this member of staff had a lack of knowledge around the needs of people. We asked the member of staff whether they had read the care plans for people and they told us, "I have not read the care plans." They told us as they saw people every day, they felt they knew people well.
- The provider told us the role of the member of staff at night was solely to check that people were sleeping,

and not to provide any care for example checking people's continence aids or repositioning people in who were at risk of developing pressure sores. The provider said to us they had told the night staff member, "Anything you need you call for assistance, we [provider] are the ones, we would do it if the resident is not settled, (member of night staff) will call us and we will go there and check them." However, this meant that in an emergency people's care would be delayed whilst the night member of staff went to wake the provider and ask for their assistance.

- Staff lacked understanding of the needs of people at the service and had not had appropriate training around their specific needs. For example, the majority of people had a diagnosis of mental health, one person had diabetes and two people had asthma. One member of staff incorrectly told us that no one at the service had any of these health conditions.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of the service, we found the provider had failed to ensure that robust recruitment procedures were in place for staff. This was a breach of regulation 19 (Fit and Proper Persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 19.

- The provider did not operate safe recruitment practices when employing new staff. At the previous inspection we found that there had been insufficient checks including Disclosure and Barring Service (DBS) checks, full employment history or references undertaken for the provider's family members who worked at the service. Although DBS checks had now been undertaken there remained no employment history or appropriate references for family members.
- The provider requested DBS checks for three new members of staff, only one of which had been returned. Despite this lack of assurance, two of these staff had already worked at least one day at the service. In addition, two had recently been living abroad. The provider had not requested police checks from these countries to satisfy themselves of any previous convictions that may not be identified by DBS checks.
- Appropriate references had also not been sought for staff; for example one member of staff had handed the provider a reference. However, the provider had not proactively sought any other references for this member of staff and could not tell us who this reference was from. Two of the new staff members also did not have a full employment history.

Failure to undertake robust recruitment of staff was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of the service, we found the provider had failed to ensure that incidents of safeguarding were investigated and reported to the local authority when required. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse

- One person we spoke with said they felt safe and told us, "Nobody upsets me, there are staff around." We observed that people were relaxed in the presence of staff.
- We reviewed the incident reports and safeguarding folder at the service. There had been no incidents raised since the last inspection. The provider told us that there had been no safeguarding concerns raised

that required to be reported.

- One member of staff told us they knew what to do if they suspected abuse. They told us, "I would talk to the manager, social service, if abuse from manager talk with police, social services, there is poster on the board with contacts."

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection of the service, we found the provider had failed to have robust systems in place to monitor the quality of care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care;

- There remained ineffective systems in place to quality assure the care being provided. Since the last inspection in April 2021 no audits had been undertaken by the provider. There had been no audits of care plans or health and safety of the environment (including infection control) since March 2021. We found areas for improvement in both of these areas that could have been identified through audits.
- A pharmacist visited the service in June 2021 and had identified areas where some improvements were needed, including the recording of people's allergies and updating the medicine policy to include what actions to take if the room temperature where medicines were kept exceeded 25 degrees Celsius. This had not been addressed at this inspection. The provider had also not undertaken any audits of medicine since the last inspection.
- A fire safety inspection had been undertaken at the service in June 2021 which identified 15 areas of action for the provider to address. Whilst the majority of these had been addressed, there were still outstanding fire safety measures that had not been undertaken. For example, the report stated that, "Clear instructions need to be provided to all visitors on how to override the security system on the main door by the office." This had not been actioned at the time of our inspection. It also stated that, "The doors to the linen cupboards and store cupboards should be kept locked shut when not in use." We found both doors were left unlocked throughout the inspection.
- There was no effective system in place to ensure staff were aware of their duties and allocated jobs for their shift. The provider told us that since the last inspection a member of staff had been recruited to clean the service. However, we saw from the rotas the member of staff was also scheduled to work as a carer. The night staff were not allocated duties to ensure they provided safe care. The provider told us the night staff member was not to provide any care and that if any care was to be provided the member of staff needed to wake the provider.

- Where the provider identified shortfalls with staff practice this was not always followed up. For example, we identified that two people were having more than one continence aid placed on them at night to avoid having to change their pads more frequently. There was nothing in the people's care plans to suggest they required to have multiple pads placed on them. Wearing continence aids for too long can lead to poor skin hygiene and cause bad odours. The provider told us they were aware staff were doing this and this should not be happening. However, the staff we spoke with told us this was common practice and was not aware this should not be done.
- Although health care professionals had been contacted by the provider in relation to people's care, the advice provided was not always incorporated into people's care. One person had been seen by a continence nurse in 2019 and was assessed as fully continent. However, the provider told us the person was incontinent, yet they had not been re-referred to the nurse for an assessment.
- Another person was diabetic and we found a letter dated May 2021 from a health care professional stating the person required a further blood test reading as this previous one was, "Unclear." There was no evidence this had been followed up and there was no care plan in place in relation to their diabetes.
- At the last inspection we identified practices at the service that were institutionalised. We found these practices were still in place and people's individualised needs and preferences were not always being considered. For example, people were all required to have their meals at the same time and go to bed when they were asked to by the provider. The provider told us that structure was needed with people however they acknowledged this 'one-size-fits-all' approach was for the benefit of staff rather than for people living there.
- Since the last inspection the provider had met with people in June 2021 to talk through menu choices and activities, they might like to take part in. The provider told us they had created a new menu, however on the day of the inspection the menu on display remained the same as when we inspected previously. The provider told us they had not yet introduced the new menu and therefore food being served did not reflect the choices made by people.
- The provider told us, 'We should work honest and open....a lot of things are happening, we do have mistakes, we correct them.' However, this was not reflective of our findings. There were shortfalls around staffing, recruitment, the management of medicines, care planning and the management of risks we identified at the inspection in April 2021. We found the same concerns during this inspection .

As systems or processes were not established and operated effectively to ensure compliance with the requirements this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We asked the provider for evidence that staff meetings had taken place. They told us they met with staff regularly but had not made a record of these conversations. This was also raised with the provider at the previous inspection. However, one member of staff told us they felt supported by the provider and the provider would update them on any changes around people's needs.
- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Although there had been no incidents that would require a notification to the CQC since the last inspection the provider told us they understood their responsibility to do so.