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 effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
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 nine people.

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

There were not enough staff deployed at the service which left people at risk. Risks associated with people's care was not always being managed in a safe way including the management of medicines and safety in the event of a fire. Incidents and accidents were not always followed up on to avoid the risk of reoccurrence.

Staff had not received appropriate training and supervision that ensured good practice within the service. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The provider was not always working with health care professionals in ensuring people's health needs were being met.

People did not always have choices around their care delivery and at times were not treated with dignity and respect. There were not sufficient meaningful activities to keep people occupied and meet their need for mental stimulation and well-being.

We found complaints required further information on what actions had been taken to address the concerns. We have made a recommendation around this.

The provider was not effective in ensuring staff were delivering appropriate care and had failed to maintain robust oversight of the service. As a result, the level of care had deteriorated from the last inspection.

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People were not always supported with their independence. Staff did not always have an understanding of the support and care people needed to enable them to have a fulfilled life. The was a closed culture at the service where practices were at time institutionalised.

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 lives

People told us that staff were kind and we did see examples of this. Relatives and visitors were welcomed as often as they wanted.

Rating at last inspection (and update)
The last rating for this service was Good (published 25 May 2018).

Why we inspected
We received concerns in relation to the delivery of safe care to people. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led. However, whilst at the inspection we identified further concerns and as a result looked at key questions Effective, Caring and Responsive.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive, 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, incident and accident reporting, care planning, activities, the assessment of people's capacity, 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?

The service was not safe.

Details are in our safe findings below

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below

Inadequate

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 called and spoke with four people who used the service about their experience of the care provided. We spoke with three members of staff including the registered manager 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 three staff recruitment files and audits of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, a further two care plans, two DoLs applications and complaint records. We received feedback from one relative, two health care professionals and Surrey Fire and Rescue.

Inadequate

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 Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Risks associated with people's care was not managed in a safe way. One person, who had a history of pressure sores, had developed a pressure sore and was being supported by a district nurse. The person's care plan did not have sufficient detail on how they should be repositioned or what moving and handling equipment was required to support staff with this. The care plan stated the person needed to be supported by two staff, "At all times." However, a member of staff told us they repositioned the person on their own. The member of staff said, "I put something under (the person) and (the person) helps me all the time to move her. (Person) has a good sleep so only need to move her once." The guidance from the district nurse was that person required to be re-positioned every two hours to reduce the risk of the wound worsening. There was no evidence that the person was being repositioned at this frequency in order to reduce the risk of future pressure sores developing.
- The recording of the condition of the pressure sore was inconsistent. Although the provider told us it was healing, the last record on the body map in the person's care plan that referenced the wound was on the 13 March 2021. The provider also told us they had decided to stop repositioning the person at night despite them telling us they had not consulted with the district nurse in relation to this. This left the individual at risk of developing further pressure damage.
- Another person had seizures and in the letter to the GP in March 2021 the provider stated, "No one can predict when [person] will have a seizure." There was a lack of detailed risk management of the seizures in their care plan. There was no mention of what type of seizures the person may have and what they may look like so that staff could respond and monitor effectively. Although there was some guidance for staff if they observed a full seizure, this was generic and not specific to the needs of the person. According to the provider their seizures could be,'silent' however there was no guidance for staff on what they needed to do if this happened. We saw from incident reports the person had suffered a seizure on at least three occasions this year which had resulted in injury. It stated in the person's care plan that dehydration could cause a seizure however there was no formal monitoring of how much the person had drunk throughout the day in order to mitigate this risk.
- In the event of a fire, there were not appropriate measures in place to mitigate risk to people and staff. There were people who smoked who had smoking risk assessments in their care plans. However, there was no fire safety equipment in the garden where they smoked such as a fire extinguisher. Two of the bedroom doors (that people occupied) were not able to close fully. One person wedged their door open with a chair and the other person was only able to shut their door fully if they locked it. In the event of a fire, a closed door provides a level of protection for a fire spreading and/or reaching the individual behind the closed door. The provider told us after the inspection they had fixed the doors.
- There was one person who lived on the first floor but was unable to access the stairs independently. In event of a fire the registered manager told us the only evacuation chair was kept on the ground floor which

could delay evacuation if a fire prevented that part of the ground floor from being accessed. The fire service visited after the inspection and confirmed shortfalls around fire safety they identified in 2016 had still not been addressed by the provider. The fire service advised that that none of the fire doors were compliant with the fire safety regulations.

● There were people that independently left the service during the day. However, there was no formal recording of when people left the home or returned. This was a particular risk if there was a fire and staff were unable to confirm who was in the service. This was raised as a concern in January 2021 where the provider told us, "As discussed, service users always notify when they are going out and when they are likely to return. Going forward, we will record this in the visitors log as a complete record of who is on the premises." However, we found this was not in place. We have notified Surrey Fire Safety and Rescue of these concerns.

● The building and garden area was not always maintained to ensure people's safety. For example, on the first floor there were building items and furniture being stored in the corridor and in one of the bathrooms that people accessed. In the garden there was building work taking place. The site had not been properly secured and was easily accessible to people that lived there who frequently went in the garden to smoke.

● Accidents and incidents we reviewed had very little detail on what preventative measures had been taken to reduce further occurrence. For example, according to incident reports one person had sustained an injury as a result of their health condition on three separate occasions. However, their care plan had not been updated with details on any preventative measures.

● The lift at the service had not worked since at least December 2020. There was one person who lived on the first floor who was unable to use the stairs without staff support.

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

Using medicines safely

● Medicines were not managed safely. In the morning of the inspection we noted the provider was signing all people's medicine administration record's (MARs) in one go. Their medicine policy stated each medicine should be, "Signed for by the person responsible immediately following the administration and before moving onto the next service user" which is best practice for safe administration of medicines.

● In addition to signing all the MARs at the same time the provider also pre-recorded that two people had received their medicine for lunch and evening as well despite this having not been administered yet. The provider approached us about this when they realised their error, but they were unsure how this needed to be addressed. The provider said, "Now that it is signed, I would do nothing, when I come tonight, I would not sign it again." They had not considered that if they were not the person to administer the medicines at lunch and evening that staff may not know the person had not had their medicines already.

● The provider administering people's medicine at times asked other staff to give medicine to people. This meant they were relying on the staff member to say the person had swallowed their medicine. A member of staff told us, "The manager does not like me to sign; I tell her when I have done it and she signs it." This is not in line with best practice nor the provider's own policy that the responsible staff member administering medicines should record that administration immediately after medicines were given.

● We found on one person's medicine that a tablet was not in foil and had become loose in the packaging. We asked the provider what they would do in this instance. They told us, "I don't know what I am meant to do with it. I believe I can use it." The provider had not considered the infection control risk and they could not be certain the tablet had come from the foil packet. The service policy stated to, "Transfer the medication from the bottle or pack into a medication pot and give directly to the service user" and that, "Medication must not be handled." After the inspection the provider confirmed they had consulted with the pharmacist. The provider told us, "For hygiene purposes, the single tablet found within the box should be

returned. The GP will be contacted to provide a replacement tablet."
● There was medicine that had not been dated on opening that had a limited 'shelf life'. There was a risk people would receive medicine that was out of date and therefore impact upon its efficacy and safety. The provider had also taken the medicine out of labelled box so there was no identifiable information on the tube to indicate who the medicine was intended for and prescribing instructions.
● There was no formal assessment of staff competency to administer medicine to ensure this was being done safely and in line with the provider's policies. The provider told us about one member of staff that did on occasion give medicines, "I have watched her (member of staff) do this and I believe she is competent."

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

Staffing and recruitment
● People were at risk as sufficient staff were not deployed at the service. The provider told us at night there was one waking member of staff and one sleeping. However, people confirmed to us that the waking member of staff, who lived on site, would go to sleep around 22.30 when they went to bed. We asked a member of staff who was scheduled to work in the evening if they stayed awake through the night. They told us, "There is no need. I am here all the time, so I am the sleep-in. If I hear something I will check. If something is wrong, (person) will let me know if something is not right – she will knock on my door."
● There were people that required to be checked through the night however this was not taking place. For example, one person required to re-positioned during the night however, this was not taking place. Another person had seizures, yet the provider had not ensured there was a waking member of staff to monitor them through the night. The person was also doubly incontinent, and their continence aids needed to be checked through the night. We found from their daily care notes most mornings they were found to have been incontinent. We noted in another person's care plan who was also incontinent, "Sometimes I wake at night and have the urge to go and I like staff to support me on demand to go to the toilet." The provider confirmed to us later in the inspection that staff were not awake the whole night.
● The provider told us they did not assess the staffing levels based on the needs of people. They said, "I live and work here every day and I know that we are managing it and it is comfortable." However, they also said, "Did usually have four people on shift but are recruiting now." They said, "That will give me a bit more time to do things." Assessing people's needs is intended to help the provider and staff to deliver good quality care for individual people and to support decisions on the overall staffing of the home.

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

● After the inspection we spoke with the funding authority about the unsafe staffing levels at night. They took steps to work with the provider to ensure people's safety.

● The provider did not operate safe recruitment practices when employing new staff. Although appropriate checks were undertaken with some permanent staff, there were three members of the provider's family that provided care to people at the service. There had been no recruitment checks including DBS, full employment history or references undertaken for them. The provider told us, "I didn't think they needed to because they are family." After the inspection the provider had not taken action to address this and continued to rota a family member on shift to support people without sufficient recruitment checks.

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

Systems and processes to safeguard people from the risk of abuse

● People fed back they felt safe with staff with one person telling us, "I feel safe, I like the staff." However, the provider failed to have appropriate systems in place to identify and investigate alleged safeguarding concerns. For example, we noted from an incident report in January 2020 one person was found with a cut mark to the left side of their face that was not witnessed. The cause of the incident was recorded as, "Unknown." The provider had also not investigated the possible cause of the injury to a person's face.

● The provider failed to understand their responsibility to report safeguarding concerns to the local authority. The local authority is the lead agency for adult safeguarding and should be notified whenever abuse or neglect is suspected or reported.

● We noted from incident reports that one person had suffered three seizures on separate occasions and had sustained injuries. On another occasion the person was found to have an injury to their face. We had already made the local authority aware of one of these incidents however none of them had been reported to them by the provider. On another occasion a person had sustained an injury whilst on an outing from the service. Again, this had not been reported to the local authority. We spoke with the local authority after the inspection who confirmed all these incidents should have been reported to them.

● One member of staff told us they knew what to do if they suspected abuse. They told us, "We need to protect them all the time. I am all the time near them to help. I have never had to report (abuse). If I need to report something, I can send an email to CQC and to Social Services." Despite this, concerns were not being investigated or reported to the local authority where necessary.

Failure to investigate and report instances of alleged abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Whilst on the inspection a visitor had been invited into the service before staff had checked their COVID-19 status. We raised this with the provider at the time who then asked the visitor to return to their car to undertake the test.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely. There were times when it was confirmed by people that the registered manager did not always wear a mask.

● We were not assured that the provider was accessing testing for people using the service and staff. During the inspection the registered manager told us staff were testing using the polymerase chain reaction (PCR) once a month. However, requirements are that staff have a polymerase chain reaction test once a week in addition to lateral flow tests. We asked the provider to send us evidence of what PCR tests people and staff had taken, and we have not received this.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There had been no reported cases of Covid-19 for people using the service.

● 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.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- There was an inconsistent approach by the provider to ensure that people had the involvement of health care professionals in relation to their care. According to their notes the provider identified a pressure sore on a person on the 4 March 2021. Although the person's daily records stated the GP needed to be contacted on that day, it was a further six days before any further record was made of the pressure sore. It was only on the 11 March 2021 according to the records that the provider contacted the GP to report the concern by which point the wound had deteriorated.
- Although the person was now being visited by a district nurse the provider had not consulted with the professional before deciding to stop the recommended of re-positioning the person. The provider told us, "I decided that was the best."
- An occupational therapist visited the service on the 29 March 2021 and recommended that staff undertook moving and handling training as they had observed poor practices at the service. When we inspected the provider had still not arranged any moving and handling training for them either online or face to face. This was despite people at the service that required support with their mobility.
- The provider was not using any recognised good practice and national-recognised assessment tools to ensure that people's care was provided appropriately. For example, when people moved into the service there was no formal assessment of their skin integrity by using a 'Waterlow pressure ulcer risk-assessment tool' to review the risk of developing pressure ulcers.

As care and treatment was not always delivered in line with current legislation, standards this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We did see examples where the provider had consulted the GP in relation to people's care. The provider had also supported some people with hospital appointments around their medical conditions.

Staff support: induction, training, skills and experience

- People were not always supported by staff that had undergone training to give them the skills to care for people effectively. There were people at the service with diagnosis of dementia, epilepsy and mental health. Of the six staff regularly working at the service none had received training around these areas of health and care needs. The provider had not received any training themselves other than moving and handling in 2014. This was despite the service's dementia policy stating, "Care delivery will be by staff who have had specialist

training in dementia care." One member of staff had not received any training in any areas and they had been providing care to people at the service since May 2020. The provider told us of this member of staff, "No training because of COVID." The provider had not explored alternative options for training in the interim.

● The Care Certificate (The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors) was introduced in April 2015. We found that only one of the care staff was undertaking National Vocational Qualification to the equivalent standards to the Care Certificate.
● During our inspection we found shortfalls in the practices of staff and the provider including assessing people's capacity and the management of medicine. In each person's care plan, it stated if a person should choke, they would need to render, 'first aid' however not all staff had received first aid training. Therefore, the provider could not be assured that staff were sufficiently trained to carry out that instruction safely.
● Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. Although the provider had undergone observations of care in 2019 for two members of staff these were general and focused on the tasks staff undertook with no direct interaction with them. There was a limited structure to how staff were supervised and what criteria of competency they were assessed against in supporting them to undertake their duties. The provider told us, "I'm in the home; I just look and supervise."

As there is lack of staff training, knowledge and competency this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet;
● People were at risk of not receiving adequate nutrition and hydration. One person had a lost a significant amount of weight prior to moving into the service in 2018. Despite this no formal assessment of their nutrition had taken place to determine if they were at high risk of malnutrition. The service nutrition policy stated, "Service users will be assessed for nutritional status using a validated screening tool. Service users will be weighed on admission and monthly." Although the person was weighed monthly, we noted they had lost a kilogram in April 2021 yet there was no information on their care plan to determine why this might be.
● Another person had been admitted to the service in 2008 and their pre-admission assessment by the provider stated they were, 'obese.' However no nutritional assessment had taken place to determine this or care plan in place to support them. We saw from their weight charts they had not been weighed since August 2020. The provider told us this was because the person was unable to weight bear. They said they, "Only have a standing up scales; not a sitting down one." Yet no steps had been taken to address this. This meant their weight loss or gain was not being monitored appropriately which could have impacted on their health.
● One person frequently had loose bowels and was a risk of dehydration. It stated in their care plan the person needed to have lots of fluids however there was no record of how often drinks were being provided or how much. This was despite dehydration to be a known trigger for their seizures.
● Another person had a history of self-neglect including not eating prior to moving into the service in 2020. However there had been no nutritional assessment undertaken at the service or any evidence they had been weighed since moving in. Staff were also not recording what the person had eaten or drunk to assess if they are eating and drinking sufficiently to meet their needs.
● People fed back they liked the food at the service however we noted they were not always provided with choices of hot meals. Most days the option would be one hot meal or a salad. We noted that some fresh food in the fridge was out of date including vegetables, yoghurts, eggs and fruit.

As there was a risk that people were not supported to eat and drink enough to maintain a balanced diet this

is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Where decisions were being made for people there was no evidence that their capacity had been assessed. For one person their care plan had conflicting information about whether they lacked capacity to give consent or whether they could be supported to make some decisions. We saw the person had received a flu vaccination in 2021 and a health care appointment had been cancelled for the person in relation exploring a health concern. There had been no capacity assessment or any evidence of the discussion to determine this was in the person's best interest to have the flu jab or for their appointment to be cancelled.
● Although the person's family were involved in their care there was no evidence, they had Lasting Power of Attorney for their health and as such able to make decisions around their care. However, we found a number of consent documents signed by a family member on behalf of the person including consent to a flu vaccination
● The provider advised us there were three people who lacked capacity to make certain decisions. All people had received their COVID-19 vaccinations however there was no evidence their capacity had been assessed in relation to this or evidence of any best interest discussion before the vaccine was administered.
● There were five people being restricted from leaving the service on their own due to their frailty and health care conditions. The provider had not undertaken capacity assessments in relation to this. Neither had they submitted a DoLS application to the Local Authority in relation to this restriction.
● Three staff members had received training in the past around MCA and DoLS. However, there was a lack of understanding of the principles of MCA and DoLS by staff and the provider. One member of staff told us, "I think it is about being able to do something to see if they can eat or drink."
● The provider confirmed with us they had never undertaken any mental capacity assessments for people. They said, "I don't do mental capacity assessments. Surrey County Council do that. Do you want us to do MCA then? How do we do that?" The provider's MCA policy was clear on when capacity assessments needed to be completed and there were records within the policy to assist with the assessment. The provider was not working to their own policy in relation to this.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs
● The corridors and rooms were spacious to allow people to move freely. The lounge and communal areas

were tastefully decorated with modern fixtures and fittings.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● Care plans contained some information on the likes and interests that people had but this was not detailed. There was information missing on people's preferred routines and their life histories.

● People were not always supported to make decisions around their care. For example, in relation to going to bed. One person told us, "We are always told to go to bed about 22.30. (The provider) says 'bedtime, time to go to bed' I'm ok with that as I watch TV."

● There was a small typed menu on display in the dining room that stated fish and chips was the lunch on the day of the inspection. However, the meal people were given was heated pies with potatoes and green beans. The provider told us they had changed the menu but had not consulted with the people that lived there to determine whether this was what they wanted. People told us they were not involved in the menu planning.

● People were not always encouraged or supported to be involved in their activities of daily living. For instance, we asked the provider why people were not encouraged to participate in cooking meals, and they told us this was not a consideration. One person told us, "We are not allowed in the kitchen." There was nothing in the care plans to suggest that people were not safe preparing food or participating in cooking. This was despite the providers service user handbook stating under, "Supporting Independence" that access to the kitchen would be considered for each person.

● There was a note in a person's care plan that was not respectful or dignified for the person. In one person's care note the provider had written, "(Person) was difficult and outspoken to everyone the whole day, not pleasant, never seen such behaviour display." On another date the provider had written, "(Person) was very uncooperative." The provider had also written in another person's care notes references to a disagreement they had with a visiting health care professional rather than recording this on a separate incident form.

As people were not always treated with dignity and respect this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were people who chose to stay in their rooms and staff respected this decision.

● People were able to personalise their room with their own furniture and personal items and each room was individual to the people who lived there.

Ensuring people are well treated and supported; respecting equality and diversity

● We saw that when staff interacted with people this was done a kind and caring way. However, staff were

very busy at the service which left little time for them to have a lot of meaningful interactions with people.

● There were two care staff on duty on the day of the inspection. However, when we spoke to one of them, they told us they could not speak English very well and struggled to answer our questions. This meant the member of staff would struggle to interact and communicate with people in any meaningful way.

● Relatives and friends were encouraged to visit and maintain relationships with people. One relative told us, "Each time I have visited the Gables it is calm and the residents happy."

● There were religious services at the local church for people which they told us they enjoyed.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
http://crmlive/epublicsector_oui_enu/images/oui_icons/cqc-expand-icon.png

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support; Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● There was not always sufficient and up to date guidance in the care plans around the specific needs of people. The plans did not provide staff with sufficient information so they could respond positively and provide the person with the support they needed in the way they preferred. For example, there were people with a mental health diagnosis and there was limited information in care plans around how they needed to be supported with this. Staff also showed a lack of understanding what this meant for people. One staff member told us, "(Person) has mental health all his life. He never asks for anything. His mental health problems are that (person) cannot remember anything; for him I think he is between normal and mental health. sometimes he remembers things."
● Another person had a diagnosis of Alzheimer's however there was a lack of guidance around what this meant and how it affected the person. Staff showed a lack of understanding of this condition. One member of staff said, "(Person) brain is very damaged; we need to feed (person) when their brain is not working normally." They were also unable to tell us about another significant health condition the person had and how this affected them.
● There was a lack of assessments around the needs associated with people's mental health diagnosis. According to their care plan, one person had a history of 'paranoid thoughts' however, there was no care plan in place in relation to this or what staff needed to do to support them with this. As care plans notes were not detailed, we were unable to determine how the person was managing with this.
● There was a 'Maslow's hierarchy' tool in each person's care plan. This is used to assess people's physiological needs, safety needs, love and belonging needs, esteem needs, and self-actualization needs. However, this was not used appropriately for people. The records were sparsely completed and did not reflect how people could be supported in these areas to have fulfilled lives and have good mental health.
● Daily records were all completed by the provider at the end of each day rather than contemporaneously by staff who delivered the care and support. They lacked detail around the support people received throughout the day. We asked the provider how they would be able to retain everything throughout the day. They told us, "I know everything that goes on here, it is not difficult to remember." Notes were often limited to whether the person was, 'comfortable' in the night, that they had eaten, what personal care they had

received and occasional activities. A lot of the entries were identical to what had been typed from the previous days. Having more detailed information can help provide responsive and personalised care to a person.

● End of life care was not being planned around people's wishes. There was insufficient evidence that discussions took place with people including people's spirituality, religion, what family they wanted around them and where they wanted to be at the end of their life.

● The majority of people living at the service were able to communicate without difficulty. However, for those who were unable there was no information in their care on how best to communicate with them. Care plans were also not written in an accessible way for people including for the person with a learning disability. The lunch menu was typed up in small print and left on the mantlepiece. However, for those unable to read this there was no alternative format offered such as pictures or larger print. There were no 'easy read' documents for people related to the provider's complaints procedure or safeguarding policies in order for people to be informed about their rights to raise a complaint or the provider's systems for safeguarding people from the risk of abuse and neglect.

Failure to plan care and treatment around people's needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People told us they liked going to mass each day and we observed a visit from a person from the local church on the day of the inspection. Visitors were also welcomed from family members and friends. However, people fed back that they would like to do more. One told us, "Sometimes I get bored." Another told us, "You have to entertain yourself. I do sometimes get bored; I like to keep myself busy." A third told us, I get a bit bored, but I try and find things to keep busy."

● People were sat in the living room for long periods of time without any meaningful interactions or activities with staff. The provider told us about activities, "It is general and also the residents do what they want to do; can watch their favourite programmes." They told us they did not have a dedicated member of staff to support people with activities. There was no evidence that people were encouraged to pursue any interests they may have other than watching television, board games and colouring which was frequently recorded in people's care notes. Despite one person's care plan stating, "I dislike doing drawings or colouring or craft activities as it does not interest me at all."

● People on the whole were accepting of the way they lived there lives at the service. However there was a lack of engagement in activities meaningful to them to support the process of recovery with their mental illness.

Failure to ensure people are people supported to follow their interests and take part in activities that are socially and culturally relevant and appropriate to them was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

● The provider sent us a copy of their complaints folder and we noted there had been no recorded complaints since March 2018. Although there was a record of who made the complaint it was not always clear what the concern was or how it was responded to in order to address the concerns raised.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, 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 Good. At this inspection this key question has deteriorated to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- People fed back they liked the provider with comments including, "(Provider) is nice", "(Provider) is alright" and "She is pretty good."
- However, there was no effective systems in place to quality assure the care being provided. Although audits were being undertaken by the provider, they were not identifying the shortfalls that we identified. For example, in a fire safety audit in March 2021 it stated there was, "Appropriate firefighting equipment" provided and that there were sufficient staff. However, we identified there was no evacuation chair accessible on the first floor for the individual who would require it and there was no fire extinguisher in the smoking area. We also identified there was insufficient staff to safely support people, particularly at night.
- In addition, the audit concluded there were effective systems in place to address maintenance concerns. We identified two people's bedrooms doors that were broken, a sink in one person's room had no hot water and the lift had been out of action for several months. The provider was aware yet had not taken action to address this.
- Throughout the inspection there were instances where the provider gave us incorrect information relating to questions we posed to them. For example, in the morning the provider advised us they had a 'waking' member of staff all night every night to support people. However, people and a member of staff confirmed with us this was not the case. On another occasion when we questioned the lack of training and recruitment undertaken for a member of staff, the provider told us they had, "Only just started." However, we established from old staffing rotas the member of staff had been working there for 10 months.
- There was no effective system in place to ensure staff were aware of their duties and their allocated jobs for the day. The provider told us they did not assign roles to staff through the day. They told us they themselves were allocated to work as a carer each day; however, we found this impacted on their duties around the management and leadership of the service. The provider has also failed to identify and act on known risks within the service, demonstrating a lack of oversight and leadership.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; 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

- People did not have the opportunity to be involved in the running of the service. There were no residents' meetings taking place to give people the opportunity to feedback things they would like to improve upon.

One person told us, "We haven't had one since being here. I think it's a good idea to have one." Another told us, "I would like to have a meeting. It would be nice to talk through anything you're not happy with." The provider told us they asked people about food preferences in their one to one however these were last recorded in June 2020 and there was no reference to menu suggestions.

● Staff fed back positively about the provider with one telling us, "Owner is a good manager, she works very hard." However, there was no meetings for staff to feedback any suggested improvements or to be involved in the running of the service.

● The provider's quality assurance policy stated that, "All residents of this home should be given a say in the running of the home through regular monthly meetings and through surveys carried out on an annual basis." It stated that comments and feedback will be encouraged not only from people but from staff as well. In addition to meetings not taking place there had been no surveys undertaken with people or staff per their policy.

● The provider's 'Service User Handbook' included the 'Principles and Values Underpinning our services'. This related to people receiving a 'high standard of individualised care' however we found this was not taking place and instead people were at risk of unsafe care and people were found lacking personalised care specific to their needs and aspirations.

● The provider had not always been open and transparent with CQC and external stakeholders and agencies. We found instances of safeguarding that had not been reported to the local authority per local safeguarding procedures.

● 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. The provider had failed to inform the CQC of significant events including incidents and safeguarding concerns. For example, were identified that one person had sustained a fracture to their elbow however the provider did not notify the CQC of this.

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.