Charis House Limited

Gardenia Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 February 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches relate to Regulation 12, safe care and treatment and Regulation 14, meeting nutritional and hydration needs.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to these issues. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gardenia Court Nursing Home on our website at www.cqc.org.uk

This inspection was unannounced and took place on 2 August 2016.

Gardenia Court Nursing Home is a care home providing accommodation for up to 29 people, some of whom are living with dementia. During this inspection there were 23 people living in the home. The home is situated close to the sea front in the town of Weston Super Mare.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was not present during this inspection. The deputy manager was covering in their absence.

At the last inspection we found people were at risk of unsafe care because medicines were not always administered safely. Staff were not always aware of risks relating to people and information about how to reduce risks were not always clearly recorded in people's care records. People did not always have call bells within reach so they could summon staff support. At this inspection we found improvements had been made to people's medicines management, people's medicines were administered safely and at the correct time. Staff were aware of risks relating to people and the measures in place to reduce risks. We observed people had call bells within their reach and they were able to summon staff support.

At the last inspection we found people were at risk of not receiving adequate nutrition and hydration because there were not effective systems in place to monitor this. We also found some people who were in their rooms did not have access to drinks. At this inspection we found people were receiving adequate hydration. People had access to drinks. Where people were at risk of dehydration or malnutrition this had been identified and systems were in place to manage this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found action had been taken to improve the safety of the service.

Staff were aware of risks relating to people and records included information on how to reduce the risk.

People's medicines were administered safely and at the correct time.

People had access to call bells and could summon staff support.

Is the service effective?

Requires Improvement

We found action had been taken to improve the service's effectiveness.

People had access to adequate nutrition and hydration; systems were in place to support this.

Gardenia Court Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Gardenia Court Nursing Home on 2 August 2016. This inspection was undertaken to check that improvements to meet legal requirements and improve the quality of the service planned by the provider after our 17 February 2016 inspection. We inspected the service against two of the five questions we ask about services: is the service safe and effective. This is because the service was not meeting some legal requirements.

The inspection team consisted of one adult social care inspector.

During the inspection we spoke with four people about their views on the quality of the care and support being provided. We also spoke with the deputy manager, the administrator and four members of staff. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for four people. Before our inspection we reviewed all of the information we held about the home, including the provider's action plan following the last inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 17 February 2016 we found people were not always safe because staff were not always aware of risks relating to people and information about how to reduce risks were not always clearly recorded in people's care records. People did not always have call bells within reach so they could summon staff support.
At this inspection we found improvements had been made. The deputy manager told us since our last inspection processes had been put in place to ensure staff were aware of risks relating to people. We saw minutes of a staff meeting that had been held following our inspection. This meeting was used to discuss the concerns we found and the action required to make improvements.

We saw each person had a folder in place that included a summary of their care. The folder also contained daily records that staff were required to complete once specific aspects of care had been delivered. These records included documentation of how often people should be repositioned where they were at high risk of pressure ulceration. Repositioning is important as it reduces the risk of pressure ulcers developing. The staff we spoke with were able to tell us how often people should be repositioned. Records confirmed people were being repositioned in line with their care plans. We saw the nurses checked the records on each shift to ensure they had been completed and signed the record to confirm this. One staff member told us, "[name of person] had a pressure sore, this has got much better now. We are regularly changing their position and recording this".

Staff told us since the new system had been implemented they thought things had improved. Comments included; "Things are getting better, there has been a big improvement we have regular handovers from the nurses with all the information we need to know" and "Things have improved, we get told about all changes to people's needs in handovers, care plans are updated and we read the care plans regularly".

The deputy manager told us important information relating to people and any identified risks were discussed in the handover. We looked at the handover record which confirmed this. Areas discussed included changes in people's health, where people had experienced falls and where a person had a pressure ulcer. The handover was used to inform staff of what action was needed in response to people's change in need. For example, one person was identified as loosing weight and the handover was used to inform staff of this and ensure they were aware of the need to encourage the person to eat and drink. This meant risks relating to people's needs and any action required was shared with the staff team.

Staff told us their shift times had changed following our last inspection and how they felt this had led to improvements in care because they felt they had time to complete tasks and records without rushing. This involved the morning staff working an hour later which meant there were four staff on shift for an hour during this handover time. Comments included; "Having the hour definitely helps, it's much better we can keep on top of records and ensure people are receiving the care they need" and "Things have got better, having the 2pm-3pm with more staff has helped. Communication has improved and we know what we need to do".
During our last inspection we found some people were at risk because they had call bells out of reach and

they would be unable to summon staff support. During this inspection we completed observations throughout the day and saw that people had call bells in reach. The deputy manager told us daily checks were completed by themselves, the registered manager, the administrator and the provider when they were in the home. We saw records of these checks. The deputy manager told us this had improved because staff had got into a routine of ensuring people had call bells in reach and it had become part of their daily practice. Staff confirmed this. The provider was also completing daily call bell audits to identify any concerns in call bell responses.

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

During this inspection we found improvements had been made. We observed the medicines round which was completed by the deputy manager who was also the nurse on duty. The deputy manager told us no one was left with their medicines. We observed the deputy manager ensuring each person had swallowed their medicines before leaving them. We looked at the medicines administration records (MARs). Each person's medicines on the MARs were colour coded to demonstrate what time they should be taken. Where people were required to take medicines before food this was recorded in a specific colour to inform the nurses. We saw medicines that were required to be taken before food were given at the appropriate time.

Some people were prescribed creams and ointments which were kept in their rooms and applied by care staff. There were records in the person's care folder which contained an administration record for the creams and ointments. There were also instructions of what the creams and ointments were for, where they should be applied and a body map that confirmed this. The staff we spoke with were aware of when creams and ointments should be applied and what they were for. We found the records of the administration were consistently completed by staff and checked by the nurses.

The deputy manager showed us staff files which contained certificates confirming the nurses had received training in medicines. They also showed us records of observation competency checks that had been completed for medicines administration. This meant people were receiving medicines from staff who had received the appropriate training and assessments.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 17 February 2016 we found people were at risk of not receiving adequate nutrition and hydration because there were not effective systems in place to monitor this. We also found some people who were in their rooms did not have access to drinks.

At this inspection we found improvements had been made. We saw in records that one person had been identified as losing weight. The person had been placed on a food and fluid record for one week and staff had been monitoring and recording their intake. They were also being weighed weekly. The result of the monitoring was that the persons appetite had improved. However, the weight monitoring identified they had experienced some weight loss. The deputy manager had arranged for the person's GP to visit them and as a result of this the person had been prescribed fortified drinks to increase their weight. This meant the person was receiving adequate nutrition because staff were responding to their changing needs.

Staff told us if people were refusing food and drinks this would be reported straight away to the nurse in charge for them to take action. No one was on a food and fluid monitoring chart at the time of our inspection. The deputy manager confirmed everyone living at the home was currently eating and drinking well and not at risk of malnutrition or dehydration.

People told us they had access to drinks. One person told us, "I always have enough to drink". Another commented, "Yes I have enough to drink and the staff check I'm ok". We completed observations of people's room and found they had access to drinks. We observed two people who were unable to independently support themselves with drinks and saw adequate hydration had been received throughout the day. Staff told us how they regularly checked people in their room to encourage them to drink and they recognised the importance of this. During our inspection we observed staff regularly encouraging people to drink and ensuring people's jugs and glasses were full. One staff member said, "Anyone that can't physically pick up a drink we keep a close eye on their fluids". Another commented, "We make sure everyone has their bell and drinks, we walk around and check and if people's glasses are empty we fill them up". This meant people were receiving adequate nutrition and hydration to meet their needs.