HC-One Oval Limited

# Gable Court Care Home

## Inspection report

111 Roxy Avenue
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Romford
Essex
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Tel: 02085976041

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10 September 2018
11 September 2018
13 September 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

Gable Court 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.

Gable Court can accommodate 50 older adults who may have dementia in a purpose built three storey building. At the time of this inspection, 50 people were using the service.

This inspection took place on 10, 11 and 13 September 2018. The inspection was unannounced. This was the first inspection since the service was registered under the provider HC-One Oval Limited in December 2017.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were knowledgeable about reporting safeguarding concerns and whistleblowing. People had risk assessments carried out to mitigate the risks of harm they may face. Building safety checks were carried out in line with building safety requirements. Recruitment checks were carried out before new staff began working at the service. There were enough staff on duty to meet people's needs. There were systems in place to manage medicines safely. People were protected from the risks associated with the spread of infection. The provider used accidents and incidents to make improvements to the service.

People's needs were assessed before they began to use the service to ensure the right care could be provided. Staff were supported with regular supervisions, annual appraisal and training opportunities to help them to carry out their role effectively. The provider had communication systems in place for staff to be updated on people's well-being and changes in care needs. People were supported to eat a nutritionally balanced diet and to maintain their health. Staff understood the requirements of the Mental Capacity Act (2005) and the need to obtain verbal consent before delivering care. However, the provider did not have a system to document people's consent to receiving care and treatment.

Staff described how they developed caring relationships with people. The provider had a system in place where each person had a named nurse and care worker who had overall responsibility for the person's care. People and their relatives were involved in decisions about the care. There was a 'resident of the day' system where each person had a day dedicated to them to make them feel special. Staff were knowledgeable about equality and diversity. People were supported to maintain their independence and their privacy and dignity was promoted.

Care plans were personalised, contained people's preferences and were reviewed monthly. Staff understood

how to deliver personalised care. People were offered a variety of activities and their communication needs were met. Complaints and compliments were recorded and used to improve the service. People's end of life care wishes were only recorded when they were nearing the end of their life and were not captured as part of future care planning.

People, relatives and staff gave positive feedback about the management of the service. The provider obtained feedback from people using the service and relatives through regular meetings. Meetings with people using the service and relatives were used to update people on service development and for improvement suggestions. The provider had various quality assurance systems in place to identify areas of improvement. The home worked in partnership with other agencies to improve the service provided.

We have made two recommendations about working within the requirements of the Mental Capacity Act (2005) and future care planning.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe. Staff were knowledgeable about safeguarding and whistleblowing procedures.

People had risk assessments in place to mitigate the risks of harm they may face. Building safety checks were carried out.

The provider had a safe recruitment process. There were enough staff on duty to meet people's needs.

Medicines were managed safely. People were protected from the risks associated with the spread of infection. The provider used accidents and incidents as a learning tool to make improvements.

### Is the service effective?

Good

The service was effective. People had their care needs assessed before they began to use the service. Staff were supported to carry out their role with supervisions, appraisals and training.

People had choices of a variety of nutritional food and drink and were assisted to maintain their health. There were systems in place for the staff team to share updates on the well-being of people using the service.

Staff demonstrated they were aware of the legal framework of decision-making and the need to obtain consent before delivering care. However, the provider did not have a system in place for documenting consent to receive care and treatment.

### Is the service caring?

Good

The service was caring. People and their relatives told us staff were caring.

Staff explained how they got to know people and their care needs. People and their relatives were involved in decisions about the care.

Each person had a named nurse and care worker who had overall responsibility for their care. The provider had a system in place where each person had a day when they were made to feel special.

Staff described how they treated people fairly and equally. People's privacy, dignity and independence was promoted.

## Is the service responsive?

Good

The service was responsive. Staff understood how to provide a personalised care service. Care plans were personalised, contained people's preferences and were reviewed monthly.

People were offered a variety of activities to meet their social needs. Care plans included people's communication needs.

The provider kept a record of compliments and complaints and used these to make improvements to the service.

Although people had their care wishes documented for end of life care when they were nearing the end of their life, the provider did not capture this information as standard practice as part of future care planning.

## Is the service well-led?

Good

People, relatives and staff gave positive feedback about leadership at the service.

People, relatives and staff had regular meetings to give feedback about the service and to be updated on service development.

The provider had various quality audit systems in place to identify areas for improvement.

The home liaised with other agencies to ensure people received good quality care.

# Gable Court Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 10, 11 and 13 September 2018 and was unannounced. The inspection team consisted of one inspector, a specialist nurse advisor and an expert-by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority with responsibility for commissioning care from the service to seek their view about the service.

During the inspection we spoke with nine staff which included the registered manager, the deputy manager, three care workers, two nurses, the activities co-ordinator, and the chef. We also spoke with six people who used the service and four relatives. We observed care and support provided in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed ten people's care records including risk assessments and care plans and reviewed six staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation.

Good

# Is the service safe?

## Our findings

People and their relatives told us they felt the service was safe. One person told us, "I feel very safe, of course." Another person said, "I feel very safe. I get what I need." One relative told us, "Staff are always popping in to see if [person] is okay." Another relative said, "It's normally safe enough. I don't press the bell, I fetch someone. [Person] is checked regularly as would be expected."

The provider had safeguarding and whistleblowing policies which gave staff clear guidance on the actions to take if a person using the service was being abused. Staff had received training in safeguarding adults. The management knew how to handle safeguarding concerns and had appropriately notified the local authority and CQC.

Staff explained to us the actions they would take if they suspected abuse. One staff member told us, "First of all, check with the [person] if it is okay to report it. Check with the nurse and the manager. Make a log of what is going on. If you are not happy about something, you speak up to the nurse, or the management or CQC." Another staff member said, "I would speak to the nurse then if they are not going to do anything I would take it to the manager. Whistleblowing is like 'speak up' where we can do it anonymously. It could be to our manager. There's a number we can call." A third staff member told us, "I would tell my line manager. If you wanted to say something you can anonymously. You can ring CQC directly." This meant the provider had systems in place to protect people from the risk of abuse.

People had risk assessments carried out to mitigate the risks of harm they may face. These included risk assessments for skin integrity, malnutrition, choking, bedrails and mobility. One person had a falls risk assessment which indicated they could not weight bear and wore slippers when out of bed sitting in a chair. The management plan stated, "[Person] is able to tell you if [they] want to get up or not. [They] can consent for staff to get [them] up safely with full body hoist. Needs two carers to assist with transfers. Explain to [person] prior to the task. Ensure the bedrail is in place when in bed for safety. Reassure [person] as we perform the task. [Person] likes to go out in the garden and meet other [people using the service]." This meant the provider took steps to mitigate the risks of harm to people.

Building safety checks had been carried out in accordance with building safety requirements and equipment was checked with no issues identified. For example, a gas safety check was carried out on 6 June 2018, electrical portable appliances were tested in 7 September 2018 and moving and handling equipment had the annual service on 4 October 2017. The service had regular fire drills and the last one was carried out on 25 July 2018 with no issues identified. The weekly checks of the fire alarm system was up to date and fire equipment was serviced on 31 August 2017.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. Staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had provided written references. New staff had undergone criminal record checks to confirm they were suitable to work with people and the provider had a system to obtain regular updates to check their continued suitability. This meant a safe recruitment procedure was in place.

The service had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK and ensures nurses and midwives keep their skills and knowledge up to date and they maintain professional standards.

People and relatives told us that on occasions there was not always enough staff to meet their needs. One person told us, "I want to go out sometimes, but no one is available." A relative told us, "Staff levels vary. They are adequate but the weekends can be hit or miss. [Person] is regularly checked when I am here."

Staff told us that generally there were enough staff except when somebody called in sick at short notice. The registered manager told us they currently had 120 nursing hours vacant which they were trying to recruit to. They told us they were currently using agency to cover the vacant nursing hours and staff absences if permanent staff did not take up the offer of overtime.

We reviewed the staff rotas from 17 August until the 30 September 2018 which showed there were enough staff on duty to meet people's needs. We saw there were two nurses, one senior carer, and nine carers on duty during the daytime and two nurses and four carers at night. Additionally, there was an activities co-ordinator and three volunteers who worked at the service during the day. We observed there were enough staff on duty to meet people's needs and people were responded to in a timely manner when they required assistance. This meant there enough staff on duty to meet people's needs.

The provider had a comprehensive medicines policy which included clear guidelines to staff about medicine administration, ordering and receiving stocks of medicines and record keeping. People's medicines were stored in locked cabinets or trolleys in a locked room on each floor. Staff checked the temperature of the room and the medicine fridge daily and these were within the correct range. Some prescription medicines are controlled under the Misuse of Drugs legislation to prevent them being misused, being obtained illegally or causing harm. The provider had effective systems in place to ensure controlled drugs were stored appropriately and correctly accounted for in line with current legislation.

Medicine administration record (MAR) sheets had been completed and signed with no gaps to indicate people had received their medicines as prescribed. People who required 'pro re nata' (PRN) medicines had detailed guidelines in place. PRN medicines are those used as and when needed for specific situations. Reasons for giving PRN medicines were documented on the back of the MAR charts. The provider kept a record of medicines in stock. We checked the amount of medicines in stock against the records and found these were correct.

Covert medicines are those that need to be given in a disguised format because the person lacks the capacity to understand why the medicine is needed. People who required their medicines to be given covertly had guidelines on how to safely administer the medicine and signed agreement by the GP. However, the provider's medicine policy stated the guidelines should be drawn up by a nurse and we found one person's covert medicines guidelines had not been completed by a nurse. Although the guidelines were signed by the GP there was no evidence that pharmacy advice had been sought on the best method to disguise the medicines. We raised this with the registered manager on the first inspection day who took immediate action and this was rectified the next day.

The registered manager told us about one occasion a person was admitted with all their medicines in a different language. Staff liaised with the GP and the pharmacy to make sure the person received their medicines at the right time and dose and by the right route. This meant medicines were managed safely.

People were protected from the risks associated with the spread of infection. During the inspection we noted the premises were free from malodour. Comments from people and relatives included, "The premises are clean", "The place is clean and tidy", "It is nice and clean" and "Clean and tidy surroundings." Staff told us they were provided with sufficient amounts of personal protective equipment such as gloves and aprons. There were handwashing facilities available including in the medicine storage rooms with hand soap and paper towels. The provider employed domestic staff to keep the premises clean.

The provider kept a record of accidents and incidents. The registered manager gave us examples of where lessons had been learnt at the service as the result of incidents. One example was where the service had not been staffed on the ground floor at night. The service had been burgled where someone had broken in at the ground floor, so the registered manager insisted the staffing levels were increased so there would be one staff member on the ground floor at all times. This meant the provider used accidents and incidents to learn lessons and make improvements.

Good

# Is the service effective?

## Our findings

Relatives told us staff had the skills need to care for people. One relative told us, "Staff are good and competent in caring for my relative." Another relative said, "The staff have the skills to care for [person]." A third relative told us, "Staff care for [person] properly."

People had a pre-admission assessment before they began to use the service which gave the reason for admission to the service and information about medical needs, communication needs, personal care needs and equipment required. When a person first began to use the service a more comprehensive assessment was carried out and a detailed care plan put together. Assessments included people's preference of gender of care staff and cultural needs. One person's assessment included, "Normal diet. No problems with swallowing. No religious or cultural dietary needs. English speaking is limited however can be understood most of the time. Some carers and nurses can speak in [person's] language." This meant people's needs were assessed and important information about the person could be captured to ensure the service could meet their needs.

Staff told us they had regular opportunities for training. One staff member told us, "Yes. It's always good to refresh on everything." Another staff member said, "We have refresher training. Yes, it's useful." This staff member told us they had received training in oral health care the previous week.

Training records showed staff received regular training including safety related topics such as emergency procedures, food safety, health and safety, moving and handling and fire safety.

The registered manager told us, and records showed new staff received induction training. This consisted of three days face to face training in all mandatory subjects and shadowing for one week. Staff who were new to their role could have an extra week of shadowing. New staff had to complete a six-month probation period which included a review at six weeks and if needed a review at three months. This meant people were supported by suitably qualified staff.

Staff told us they were supported with supervisions to help them to carry out their role effectively and they found them useful. Responses included, "Yes, I do find it useful", "Yes, like the training very useful" and "Yes, they are actually [useful]". Records showed topics discussed in supervisions included supporting people who wear glasses, hearing aids or dentures, call bells, team work, training, communication, new documentation medicine competency and supplementary charts. We reviewed staff annual appraisals and saw these were up to date. Staff carried out a self-evaluation before meeting with their line manager to discuss their performance over the past year, areas for further development, training and goals for the next twelve months.

People told us they liked the food. The registered manager told us people had a choice of food and said, "It comes from the pre-assessment to find out their dietary needs. Some families will tell us where we can get the food from." People who enjoyed the social aspect of eating could choose to eat breakfast in the dining room where a 'breakfast club' was held each morning. There was a snack box in the day room with a variety

of sweet and savoury snacks on offer.

We observed lunch and saw people had napkins and there were boxes of tissues and condiments on the tables. People were offered bread rolls and were asked if they would like gravy with their meal. Soft music played in the background as people ate their meal. A choice of drinks were offered and people could choose to have a glass of wine.

Kitchen staff were knowledgeable about people's dietary requirements. Records showed that people chose their meal the day before. The chef told us that people could change their mind on the day and alternative meals were available. Menus were varied and offered choices for all meals including mid-afternoon snacks of fruit and smoothies. We observed kitchen staff making cakes for the teatime meal. The kitchen was well stocked with a variety of nutritious foods. Fridge and freezer temperatures were checked daily and were within the correct range. This meant people's nutritional needs were met.

The provider had a system in place for staff finishing their shift to handover to staff taking over. Staff told us communication within the staff team was effective. One staff member told us, "It's done fairly well. We do get told. I ask all the questions anyway." Another staff member said, "The nurse always informs us. We have our handover when we come in the morning." This meant staff received updates on people's well-being and changes in need.

People were assisted to maintain their health. One staff explained that escorting people to healthcare appointments was part of the job and said, "Basically make sure they have a good balanced diet. We offer fruit. We have a chiropodist come in who comes in to do gentle exercise." Another staff member said, "We do escort them to appointments and what we are told we come back and report to our nurses." A third staff member told us, "You can sit them up, put them in the chair. Making sure they have enough to eat and enough to drink. There is exercise in the activities."

Care records showed that people had access to healthcare professionals as required including the GP, diabetic nurse, tissue viability nurse, chiropodist, optician, speech and language therapist and dietician. We noted that people did not always have health specific care plans in place. For example, one person with a stoma bag did not have guidance regarding this in their care record. We raised this with management, immediate action was taken and guidance on stoma bags was added to their care plan. Another example was the care plans for people with diabetes did not always contain clear guidance about the symptoms of low or high blood sugar which staff should be aware of. Immediate action was taken, and suitable diabetes guidelines were sourced to be added to people's care records.

People's bedrooms were spread out across three floors which were accessible by lift. A few rooms could be difficult for wheelchair users to access due to the design of the building so these rooms were currently allocated to people with more mobility. The provider had listened to the requests of people using the service and were planning to install a water feature in the garden area at the side of the building.

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. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of this inspection there were nine people with legally authorised DoLS and five people awaiting a decision because they required a level of supervision that may amount to their liberty being deprived. Records showed assessments and decision-making processes had been followed correctly.

Staff demonstrated they were aware of MCA and DoLS. One staff member told us, "DoLS is where you can't take something away from people because that is deprivation of liberty. The Mental Capacity is don't assume that a person has not got capacity. It's all about giving them choice." Another staff member said, "DoLS is about restricting [liberty] in the best interests. MCA is whether they have got the capacity to make the choice." A third staff member told us, "Mental capacity is that someone's deemed to have capacity until I am informed differently. If they can't relate we have to take the best interests [decisions] for them."

Staff were knowledgeable about the need to obtain verbal consent before delivering care. One staff member who was male gave an example of checking with family and female people using the service if they are okay with him helping with personal care and told us, "I've always been told to always check with them. You get consent if you are washing and dressing [a person], if you are feeding them and if you are toileting them." Another staff member said, "We get consent for everything we do. It's not our choice to make. You can tell by facial expression."

However, we noted the provider did not have a system in place for documenting consent to receiving care and treatment. We recommend the provider seek advice and guidance from a reputable source about working within the requirements of the MCA.

Good

# Is the service caring?

## Our findings

People and their relatives told us staff were caring. One person told us, "Definitely kind and caring. I am glad that I am here." Another person said, "Staff are kind and caring. They listen to me." A third person told us, "Staff are very caring and friendly. I don't allow anyone to talk over me. I think politeness is very important." A relative told us staff were, "Generally good but some staff are better than others." A second relative said, "As caring as you would expect. Staff do listen to me about the care." A third relative told us, "Staff are very patient with [person]." There was a calm, relaxed and happy atmosphere throughout the home.

Staff explained how they developed positive relationships with people from when they first began to use the service. One staff member told us, "First of all, you would introduce yourself. Give them a tour and show them around the place and introduce them to the other [people] in the day room. For me, I ask the nurse what the person's needs are. Reading their care plan gives you an insight. Build up the relationship." Another staff member said, "First thing I always go to their care plan and I go and introduce myself." A third staff member told us, "You are only going to get to know them by speaking to them. Just listening to them apart from what you have been informed by the nurse. The ones that can't speak sometimes you can tell by body movement and sometimes their eyes. You get to know their likes and dislikes. I always read their care plan." This meant care was provided to people by staff who knew what assistance they required.

Each person using the service had a named nurse who reviewed the care plan with the person and their relative and was responsible where appropriate for making referrals to other agencies. People had a keyworker who was responsible for ensuring their wardrobe was tidy and ensured their clothing and toiletry needs were met. Keyworkers were named care workers who were also responsible for finding out if the person would like to go out on a day trip.

The provider had a 'resident of the day' system in place where two people using the service each day were made to feel special. On this day, the person could choose to have a special meal made for them, to have an activity of their choice and their relatives were invited.

People and their relatives were involved in decisions about the care provided. The registered manager told us, "We have open door policy, relatives' meetings, open door surgery which is a set time for relatives to pop in, coffee morning every Thursday and we are open to the public the last Thursday of the month, resident committee meetings once a month." Staff confirmed how people and relatives were involved in decisions about the care. One staff member told us, "We have a relatives and residents meeting. We have 'resident of the day'. We have a residents' meeting just for the [people using the service]." Another staff member said, "I know they have meetings with residents and their relatives to update them on the information." A third staff member told us, "We ask [people]. You go in and ask them. We have to go by the [person] not by the family."

The provider had an equality and diversity policy which gave guidance to staff about providing an equitable service. Records showed staff received equality and diversity training. The registered manager told us "[Staff] have equality and diversity on the induction training and they do a refresher a year later." We asked the registered manager how they ensured staff treated people fairly and equally. The registered manager said,

"An example is none of the care staff know who is privately funded and who is social services or health funded. All [people using the service] have a voice and are able to express their wishes."

Staff knew how to treat people equally. One staff member told us, "Make sure you don't favour anyone. Don't give to one person and not another." Another staff member said, "We give them choices. Everybody's different." A third staff member told us, "You aren't really going to treat anybody differently. You treat them the same. I can't see any reason for me to discriminate against anyone."

The registered manager and staff explained how they would support people who identified as being lesbian, gay, bisexual or transgender (LGBT). One staff member told us, "Treat them fairly. Treat them as an equal." Another staff member said, "Everybody's supposed to be treated with dignity and respect. If that's what you are then that's what you are." A third staff member told us there were people using the service who did identify as being LGBT. This staff member explained, "To be honest, I treat [LGBT people] just the same as everybody else. I don't know if [they] know that I know. I was informed. It's not for us to judge." The registered manager told us, "[We would] find support groups and get different staff members to go with the person so they can find out information and bring it back to share with the staff team. We can draw information from people [LGBT staff] who are already working here. Questions are asked about sexuality at pre-assessment." This meant staff were aware of equality and diversity.

People's privacy and dignity was promoted. The provider had a policy which gave guidance to staff about promoting people's privacy and dignity. We observed staff knocked on doors before entering people's bedrooms. One staff member told us, "I would ask them they mind if I give them a shower. We close the door and put up the 'Bath in Progress' sign. Cover their bottom half." Another staff member said, "We make sure they are covered. And the door's shut and they know exactly what I'm going to be doing." A third staff member told us, "Obviously when you are doing personal care the door is shut. I always cover the bottom part when I am washing the top. Knock on the door."

Staff described how they promoted people's independence. One staff member told us, "If they can do things for themselves we allow them to do as much as they can. I do try to promote that as much as possible. I always let them do what they can do for themselves." Another staff member told us, "If there are things they can do for themselves, you let them do it. Sometimes you have to do it again, but you let them have a go. As long as they are able then all you do is assist." Staff knew what people were able to do themselves and what tasks they needed support with. For example, one staff member explained that one person was able to clean their own teeth independently but needed assistance from staff to eat their meals. This meant people were assisted to maintain their independence.

Good

# Is the service responsive?

## Our findings

Staff understood how to deliver personalised care. One staff member told us, "It's when the care is centred around the person." Another staff member said, "Everybody is different, so the care is different." A third staff member told us, "It's taking their needs and interests into consideration."

Care plans were personalised and contained people's preferences. One person's sleeping care plan stated, "[Person] likes the light off and the door open at night." Another person's care plan stated, "[Person] likes to go to the hair dresser once every three weeks. [Person] likes [their] nails to be trimmed and painted weekly different colours. When [person] is up [they] likes a little bit of make-up especially eye shadow." Each person had a one page profile at the front of their file which gave a summary of the person including the way they preferred to be addressed and important things in their life. Records showed care plans were reviewed once a month or sooner if there was a change in need.

We asked the registered manager what they had done to implement the Accessible Information Standard (AIS). The AIS requires providers to evidence that they record, flag and meet the accessible communication needs of people using the service. The registered manager said for people with a sight or hearing impairment they would take the following action, "We offer pictures, we have the local mobile library that offer [talking] cassettes. We offer person centred care, so we find out the best way to communicate with somebody. We explain verbally in depth and use open questions. For written communication, use pictures if needed. We have a few [people] with hearing aids who come under audiology."

People had a communication care plan which gave information to staff on their chosen method of communication. One person's care record stated, "[Person] is able to verbalise but words come out slowly. Staff need to be patient and acknowledge [their] wishes. Person] is able to express [their] view and needs. Able to see clearly and hear with no problem. [Person] is able to choose."

People had the opportunity to participate in a variety of activities. Care plans included information about the activities people had participated in. One person's care plan noted, "[Person] likes to go in the big lounge for home activities but in the evening likes to lie on [their] bed, listening to music."

The registered manager told us staff and people using the service had a weekly interaction session which included competitive games such as play your cards right, indoor bowls, and skittles. They also explained day trips out including a recent trip to Greenwich were arranged and relatives were invited to meet at the destination. The registered manager told us themed meals at home were arranged, such as fish and chips in cones to create a seaside theme. We saw that recently a 'wish list' was introduced, for example, one person had indicated they would like to play bingo away from the home, so this was arranged.

The activities offered to people were displayed as a timetable in the home. There was a picture board and folders of photos of people enjoying the variety of activities on offer.
These included bingo, arts and crafts, quizzes, exercise to music, sing-along, cinema afternoon and coffee morning. We saw there was a monthly trip out in the summer to a seaside place or place of interest, themed

days such as 'mad hatters tea party' and ladies Ascot day and garden parties. Entertainers were booked to visit the home twice a month and a musician visited once a month. Photos showed banners were put up, and a cake and card were given to people when it was their birthday.

During the inspection we observed a visiting singer. A staff member went to each person attending the entertainment with a microphone and many people joined in a line or two of the song. Staff were dancing and interacting and encouraged people to wave their arms along with the music. People were seen to enjoy this session by their facial expressions and willingness to join in.

The activities co-ordinator said people could receive daily newspapers of their choice and they offered one to one activities each day for people who chose to remain in their rooms. Records showed there was a monthly church service at the home. The activities co-ordinator told us previously they used to take one person fortnightly to their chosen place of worship but now a representative from that faith came to the home to pray with them.

People and staff told us they knew how to make a complaint if there was any aspect of care they were not happy with. One person told us, "I have no complaints about the staff."

Staff were knowledgeable about how to deal with complaints. One staff member told us, "You would talk to them and if they are able to express, you would give them the complaint form and refer them to the nurse or the manager." Another staff member said, "I would ask them what the problem is. If they don't want to speak to me, I would refer them to the nurse or they might want to speak to the manager." A third staff member told us, "First I would ask if they want to talk to me then maybe I would call the nurse."

The provider recorded complaints and actions taken in order to make improvements in the service provided. There was a complaints policy which gave clear guidance to staff about the actions to take if they received a complaint. We reviewed the record of complaints and saw five complaints were recorded since the new provider had taken over and saw these were dealt with appropriately. For example, a family had complained about the meal experience. The registered manager met with the family to discuss this and to agree a resolution.

The provider kept a record of compliments. One recent written compliment stated, "Found the staff friendly and welcoming. Friend was well looked after. Home was nice and clean. Residents seemed happy." Another recent written compliment stated, "My [relative] has been a resident at Gable Court Care Home for two years. The care [they] receive from everybody here has been marvellous. The staff are caring, compassionate and patient. We are also made very welcome and nothing is too much trouble. I would have no hesitation in recommending Gable Court Care Home to anyone who needs care."

People who were at the end of their life had an end of life care booklet completed as part of their care plan. Information gathered in this booklet included what was most important to the person at that time, how they wanted further deterioration in their health to be managed and whether they wished to be resuscitated. However, the provider only gathered this information when a person was at the end of their life and not as a standard practice of future planning. We recommend the provider seek advice and guidance from a reputable source on best practice around planning future care.

Good

# Is the service well-led?

## Our findings

There was a registered manager at the service. People and relatives spoke positively about the management of the service. One person told us, "Very nice, [registered manager] is always happy." Another person said, "I know the manager. She gives eye to eye contact." One relative said, "I have been kept fully involved. The management is superb, and I have not needed to express concerns." Another relative told us, "[Registered manager] is well liked. Very good. The staff are well liked and dedicated. I think this is down to [registered manager's] management skills."

Staff gave positive feedback about the registered manager and the support they received. One staff member told us, "I can honestly say 100% supported. She is not just your manager she is also your confidante. [Management] are supportive." Another staff member said, "I do [feel supported]. Yeah I think [registered manager] is a very good one." A third staff member told us, "Yes definitely supported. [Registered manager] is firm but she is a good leader." Staff told us they felt the provider treated them fairly and equally.

The registered manager explained how they encouraged staff to improve their performance and said, "I have an open-door policy. Carers who have 100% accuracy on [completing] supplementary charts get given £25 on a monthly basis. We started this in August as an incentive."

The provider had an ongoing system of obtaining feedback through regular meetings with people and their relatives and once a year though a feedback survey. As it was less than a year since the provider took over the service, a feedback survey had not yet taken place but was being planned.

People and relatives had regular meetings to be updated on the development of the service and to make suggestions for improvements. We reviewed the minutes of the meetings held in April, May, June, July, August and September. Topics discussed included news related to the home, recognition of staff who performed well, update on regulatory issues, the meal service, activities, housekeeping and laundry.

The service had a 'resident committee' which met once a month. We saw these meetings were up to date and topics discussed included the kitchen, laundry, housekeeping, maintenance, activities and care staff.

The provider had a system of holding monthly staff meetings. Staff told us they found these meetings useful. One staff member told us, "Yes, very useful because it's a good way to express our opinions and to air any problems we have." We reviewed the minutes of the staff meetings held in June, July and August. Topics discussed included update on the home, completion of supplementary charts, promoting independence, maintaining dignity, call bell answering, staffing, completion of documentation and supervisions.

The registered manager held daily flash meetings with representatives from all the departments, to be updated about significant issues, people's well-being and any staffing issues. There were meetings for the unit leaders held every three months and we reviewed the minutes of the most recent meeting held on 9 August 2018. Topics discussed included Staff allocation, lounge person, on-call system, supervisions and ground floor staffing.

The provider held regular meetings for the managers of its homes. We reviewed the minutes of the most recent meeting held on 31 July 2018. Topics discussed included a human resources workshop, learning and development, clinical quality and area quality group governance. This meant the provider had a system of keeping staff updated on service development and sharing examples of good practise. This meant staff could receive regular updates on service developments and make suggestions for improvement.

The provider had a quality audit system in order to identify areas for improvement. The registered manager carried out a monthly home summary which captured how many people had pressure sores, weight loss, infections, bed rails, falls, were admitted to hospital or had died. This audit was up to date and we reviewed the one carried out in August 2018. We noted from this summary that people recorded as losing weight were weighed weekly and given a fortified diet.

The registered manager held a monthly clinical review meeting to discuss pressure sores, weights, hospital admissions and infections. Records showed information gathered at this meeting fed into the quality audit system. There were various audit systems in place which the registered manager used to identify issues and implement improvements. For example, the catering safety audit carried out on 2 August 2018 noted there was opened food in the fridge which was covered but not dated. We observed during the inspection appropriate action had been taken and all opened food was labelled with the date.

The provider carried out regular audits of the home. We reviewed the provider audit carried out on 25 April 2018 and saw it looked at the home's compliance with CQC's key lines of enquiry. The audit noted an area of strength identified under 'caring' was, "Colleagues were kind, respectful and attentive." An identified area for improvement was, "Continue to embed 'resident of the day' to ensure all departments consistently participate and ensure [people's] views are captured." Records showed this was being done and work continued to further improve this.

The service worked in partnership with other agencies in order to improve the service. The registered manager told us they liaised closely with the palliative care service, the tissue viability nurse and the hospitals to ensure people were provided with appropriate and good quality care. The registered manger said, "I have attended the provider's forum for networking and learning."