The Gables Care Home Ltd

The 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?	**Requires Improvement**
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
The Gables is a residential care home providing personal care and accommodation for up to 21 people. At the time of inspection there were 20 people living in the home. There are 15 single rooms and three shared rooms. There is one large communal area downstairs which serves as the lounge, dining area, office space and staff area. There are three floors in total with lift and stair access.

People's experience of using the service and what we found
People had not always been protected from the risk of avoidable harm. Risks in relation to access to and from the home, access to the kitchen and the use of the lift had not been assessed or mitigated. Not everyone's needs had been assessed properly before admission which meant the provider could not be assured, they were able to meet their needs. People's toenails had not been attended to regularly which meant they may have experienced discomfort and were at risk of potential harm from falls. Fire safety checks had not been completed with sufficient frequency to help ensure people would be protected in the event of a fire. Not all people had access to a call bell which meant they may have been unable to call for support, in a timely way, when in their bedrooms. Some staff had not received essential training in moving and handling to help ensure they could support people safely. Some staff were seen wearing personal protective equipment (PPE) incorrectly.

Not everyone had been involved in decisions about their care. Some people had moved into shared rooms without their agreement or consultation with their relatives. Two of the three shared rooms did not have any privacy screening to help protect people's dignity when receiving personal care. People's personal information was not always secured. There was a lack of oversight of the quality of care, records and the premises which meant the registered manager could not be confident people were receiving good quality safe care.

Rating at last inspection
The last rating for this service was good (published 25 October 2018.) At this inspection the rating has deteriorated to Inadequate.

Why we inspected
The inspection was prompted in part due to concerns we received about; safe care and treatment, medicines management, lack of access to call bells, moving and handling practice, dignity concerns in relation to shared bedrooms and lack of effective governance. 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.

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; safe care and treatment, safeguarding people, premises and equipment, fit and proper persons, dignity and respect, good governance and duty of candour. We have made recommendations in relation to; recording medicines, staff supervision, adaptations and design and meeting people's communication needs.

In response to serious concerns we identified during inspection, we took enforcement action to impose conditions on the registration of the provider using our urgent powers identified under s.31 of the Health and Social Care Act 2008.

● The provider must not admit new residents or readmit residents without written permission from CQC. The provider has agreed to comply with this condition.
● The provider must complete a risk assessment in relation to access to the lift for one person and consider all other people who may be at risk. The provider has met this condition.
● The provider must review the call bell system to ensure call bells are accessible to residents who can use them and where a person cannot use a call bell alternate arrangements are identified and provided. The provider has met this condition.
● The provider must ensure access and egress to the building is secure. The provider has partially met this condition.
● The provider must provide suitable moving and handling training to staff identified in the notice of decision. The provider has met this condition.
● The provider and registered manager must undertake training in relation to governance and auditing practices. The provider has not yet met this condition but is seeking appropriate training.

Full information about the Care Quality Commission's (CQC's) regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 act 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 of 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 always effective.

Details are in our effective findings below.

Requires Improvement

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

The 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 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.

The inspection team
The inspection was completed by two inspectors, a pharmacy inspector 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 care service.

Service and service type
The 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. This means that they and the provider 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the relatives of 12 people, the registered manager, ten staff including care staff, a senior carer, night staff, the maintenance person and the provider. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at the communication section of

everyone's care records. We looked at three staff files in relation to recruitment and staff supervision and the training matrix. We looked at a variety of records relating to the management of the service, including, audits and governance completed by the registered manager, staff meeting minutes, fire safety checks, maintenance records, rotas, menus, and some policies and procedures.

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 requires improvement. At this inspection this key question has now 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

- The provider had not assessed or mitigated risks in relation to access to the kitchen. The kitchen was not secured which meant people living in the home, who may not understand the risks, could have been exposed to serious harm from equipment including sharp knives and a boiling water geyser.
- Opportunities to learn lessons from incidents had been missed. After one person had fallen when they had got out of the lift on the wrong floor, the provider had not reassessed the support they needed to use the lift or considered adjusting the access to minimise the chance of it happening again. One person had accessed the kitchen, removed knives and threatened to harm staff. The provider had not reassessed access to the kitchen to minimise the risk of this happening again.
- Pre-admission assessments had not always been completed thoroughly, in part due to the impact of the pandemic. This meant the provider could not always be confident they were able to support people safely.
- One persons' care record did not contain enough detailed information about their complex needs. The records identified the person would need a full social care assessment prior to moving but this had not been completed. The care record also identified the person would need to be supported by staff with training in relation to mental health. No staff had received this training.

We found evidence that systems were not in place to assure us risks were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We identified further risks in relation to access to the lift, security of entry and exit to the home and access to call bells. We have addressed these concerns outside of the inspection using our urgent powers.

- The provider had not completed regular fire safety equipment checks. Tests of the emergency lighting system, fire bells and fire doors had not been carried out for several months. This meant there had been a risk the equipment may have failed in the event of a fire. This could have led to serious harm for people living in the home and staff. This has been addressed during the inspection. We have also made a referral to the fire service, who have visited the home and made some recommendations, we will seek assurances from the home about their response to these.
- Personal emergency evacuation plans, (PEEPS) which describe the support people need to get out of the home in the event of an emergency, such as a fire, had not been completed for everyone. We found some people who had moved into the home did not have a PEEP and some people who had moved bedrooms did not have an up to date PEEP. We discussed this with the registered manager who remedied this straight away.

We found evidence the provider had not ensured equipment had been properly maintained. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People had not always been protected from the risk of abuse. The provider had not sought podiatry services in a timely way. One persons' toenails we looked at had grown very long and were overlapping neighbouring toes. A review of all people's toenails by the provider, completed at the request of the inspector, found four people living in the home needed their toenails attending to. The registered manager arranged for a podiatrist to visit.

●Staff had received training about safeguarding, information about how to raise a referral was displayed.

We found evidence the provider had not ensured people were safeguarded from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider had a robust recruitment policy in place. Records we reviewed showed the provider had not always followed their procedures. One recruitment file we reviewed did not contain an application form, interview notes or references for the job the person was now doing.

We found evidence the provider had failed to ensure fit and proper persons had been employed. This was a breach of Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not ensured new staff had received training to help ensure they were competent to support people safely. Two staff had not received moving and handling training but had provided people with support to transfer, including the use of hoists. We reviewed the rotas and found occasions when the only staff on duty had not received training from the provider. This was addressed during the inspection by the registered manager. We have received feedback from the provider and accept one of the staff had previous experience in care and in moving and handling.

Using medicines safely

● The provider had medicines management policies and procedures in place which helped ensure people's medicines were managed safely. Staff responsible for administering medicines had received training. The provider had a system for checking staff competencies.

● Medicine administration records (MAR) we reviewed showed not all medicines had been signed for. The provider had used a highlighter pen on MAR charts to show staff where to sign. Where one line was missed for one person, no staff had signed the MAR for one month. We had no evidence the medicine had not been given. Some topical medicines which included creams had not always been signed for.

We recommend the provider considers current guidance on the recording of medicines.

Preventing and controlling infection

● The provider had policies and procedures in place to help minimise the risk of infection. This included additional procedures in response to the Covid-19 pandemic.

● Cleaning routines had been developed. Staff on duty were also cleaning the home. Staff we spoke with said they usually had enough time. Some staff had picked up additional cleaning duties until a domestic

could be appointed. The home appeared to be clean and tidy.

● Some staff, including the registered manager, did not wear face masks properly. We raised this with the registered manager who has addressed this.

Requires Improvement

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 requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law, Staff working with other agencies to provide consistent, effective, timely care

- Pre-admission assessments had not always been completed thoroughly, in part due to the impact of the pandemic. This meant the provider could not always be confident they were able to support people safely. We have addressed this in the safe domain of this report.
- Not all care records had been updated frequently. One record showed a person to be at very high risk of skin breakdown. This had not been reviewed for two months.
- Care records included contact information for other professionals involved in the care of people living in the home.

Staff support: induction, training, skills and experience
- Not all staff had received essential training. We have addressed this in the safe domain of this report. Some staff we spoke with said they had not received any training at all. We reviewed the training matrix and found two staff were not on it. No staff had received training in mental health though the home had recently admitted a person with mental health needs who had been identified as needing trained staff. We have addressed this in the safe domain of this report.
- The provider did have an induction programme in place which some staff had completed. Staff were able to keep up to date with some training online.
- The provider had a supervision policy. Supervision is a one to one meeting for staff with a senior or manager to consider their training and development needs and to address any concerns. We reviewed the supervision matrix and saw not all staff were on this. We looked at the recruitment files for two staff not on the matrix, we found they had not received individual supervision.

We recommend the provider considers current guidance on staff supervision.

Adapting service, design, decoration to meet people's needs
- People's bedrooms had their photographs on the door which helped people identify their rooms.
- There were a variety of adapted bathrooms in the home to support people to bathe or shower according to their preferences.
- We did not see any additional environmental adaptations which may help people living with dementia, to find their way around and orientate themselves.

We recommend the provider considers current guidance on dementia friendly environments.

Supporting people to live healthier lives, access healthcare services and support
● People had not always been referred to health professionals in a timely way. 18 of the 20 people living in the home were found to need podiatry services. We have addressed this in the safe domain of this report. A visit from a podiatrist had been arranged during the inspection.
● People had been supported by staff to access some health services, including; their doctors, district nurses, dieticians and speech and language therapists. We saw advice from other professionals in people's care records and this had been included on the handover records. This helped ensure staff supported people in line with best practice guidance.

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.
● The provider was following the principles of the MCA and had applied to the local authority for DoLS when required.
● People's ability to make decisions and the support they needed, had been assessed. Not everyone who needed support from relatives had been supported by them. Two relatives we spoke with had been unaware their relative had been moved into a shared room and felt they should have been consulted about this. We have addressed this in the caring domain of this report.
● Records showed some people had been supported by relatives to make some decisions in relation to their care.

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.

Respecting and promoting people's privacy, dignity and independence

- Some people had been transferred from single into shared bedrooms. Not everyone had consented to this. Not everyone's relatives had been consulted about this. Two of the three shared bedrooms did not have any privacy screening. This meant peoples' dignity needs had not been considered or respected. People were exposed to the risk of degrading treatment.
- Personal information was not always kept private. The communal lounge and dining area also served as an office space. We saw personal care records and handover documents were frequently left unattended on the dining tables. Care records displayed on the computer screen were visible to people walking by. On occasions the screen was left open on a persons' care record when the desk was unattended.

We found evidence the provider had not ensured people were supported in ways which respected their privacy and dignity. This was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Relatives we spoke with said they found staff to be caring and kind. Comments included, "The staff are kind and [name] knows them well", "There is always staff there and they are absolutely caring." and "The staff seem helpful and caring." One relative we spoke with said they felt there had been a change and some staff had left.
- Care records we reviewed included important information for people, about their preferences in relation to culture, religion and identity. Care records had been written in respectful language.

Supporting people to express their views and be involved in making decisions about their care

- We looked at the communication section of everybody's care records. We found their communication needs and preferences had been recorded.
- We observed staff interactions over the four days of the inspection. We found people's experiences differed. Some staff were kind and attentive and chatted with people. We found on occasions staff did not interact or chat with people. On one occasion staff did not listen to a person when expressing their choice of food and gave them something different. We raised this with the registered manager who agreed this needed to be addressed.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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

- Care records included person-centred assessments which reflected people's individual needs and preferences for care.
- Not everyone had been supported to have choice and control in relation to shared bedrooms. We have addressed this in the caring domain of this report.

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.

- We reviewed the communication section of everybody's care records. We found how people communicated and the support they needed to be involved in decisions had been considered. Information to support staff to support people to communicate was included. We observed some staff interactions, not all staff interacted directly with people for example at mealtimes or when offering support. We have addressed this in the caring domain of this report.
- The majority of signage around the home we saw was instructional information for staff.

We recommend the provider considers current guidance on meeting people's communication needs.

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

- The provider had developed a visiting pod to enable people to have visits safely during the pandemic. The provider had also used a social media platform to post pictures of activities and important events including birthdays and anniversaries.
- The visiting policy had been adjusted due to the pandemic and followed government guidance.
- Relatives we spoke with said they believed there were a variety of activities which their relations enjoyed. We did not see any activities taking place on any of the four days we visited.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and procedure in place. We asked to look at the complaints log, the registered manager advised there had not been any complaints.
- Relatives we spoke with raised a few issues which we have discussed with the registered manager.

End of life care and support

- People had been supported to consider their preferences in relation to end of life care. Where a person did not wish to consider their wishes at this time, this had been recorded.
- People had been supported by community-based health professionals and staff at the end of their lives.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager and provider had not been clear about staff roles and the duties expected of them. This meant one staff had not understood or completed essential equipment safety checks. This was addressed by the registered manager during the inspection.
- The provider had governance policies and procedures in place to ensure people received safe quality care which achieved good outcomes. However, the registered manager and provider had not followed these. This meant they could not be confident they had effective oversight of the service. We looked at a variety of records which included, fire safety checks, daily cleaning audits for bedrooms, cleaning checklists for night staff and bathroom cleaning checklists kept in bathrooms. We found there were significant gaps or irregular use of the records. This meant the registered manager and provider could not be assured of quality performance and had not identified the issues we had found during the inspection.
- We found the information in some electronic audit tools used conflicted with the paper records. One example we saw related to medicine management. The electronic system showed the home had achieved 100% in medicines but when we checked the audit records there had not been a medicine audit completed for that month. This meant the registered manager and provider could not be assured of quality performance and had not identified the issues we had found during the inspection.

We found evidence the registered manager and provider had failed to have effective oversight of the, quality of care, risk and governance. There was also the potential for people to experience harm. This was a breach of regulation 17 (good governance) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager and provider had not always consulted with people or their relatives in relation to incidents and decisions about their care. Two relatives we spoke with had been unaware people had been moved from single to shared bedrooms.
- One relative felt they had not been informed of an incident involving their relation needing urgent hospital treatment until too late after the incident. They also felt information provided about the incident had not been consistent.

We found evidence the registered manager and provider had not understood or exercised their duty of candour. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Not all incidents which the registered manager or provider should report to CQC had been reported. This included; safeguarding, a person who experienced a grade four pressure injury and a police incident. We are addressing this with the provider outside of this inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Care records we looked at, included important information about people's equality needs and preferences. Most staff had received training in equality and diversity.

● The provider had systems in place to consult with people living in the home and their relatives about their experiences of care. Due to the pandemic there had not been a consultation survey completed in the last 12 months. Relatives we spoke with said they had not received any newsletters recently. The home did use a social media platform to provide updates on activities in the home.

● Staff meetings were held on a regular basis. We looked at staff meeting minutes for the previous four months and saw there were opportunities for staff to discuss concerns.

Continuous learning and improving care, Working in partnership with others

● Some staff were working toward achieving higher levels of National Vocational Qualifications in care. Some opportunities to learn had been affected by the pandemic.

● Care records showed the registered manager and provider were working with other organisations and professionals. Entries in care records included input and advice from different agencies.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to arrange podiatry services resulting in harm for one person and 18/20 people being assessed as needing podiatry services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to complete regular fire safety equipment checks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to follow robust recruitment procedures in relation to the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to be open and honest with relatives about incidents and events

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people's dignity was upheld and their wishes respected. Shared rooms without consultation or appropriate screening.

The enforcement action we took:

Warning notice action plan

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and mitigate risks in relation to access to the kitchen. The provider failed to assess the needs of one person prior to admission resulting in risk of harm due to lack of understanding of their complex needs. No trained staff to support the persons complex needs. The provider failed to learn from incidents and reassess known risks.

The enforcement action we took:

Warning notice
Action plan requested

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective oversight of the quality of care, records and governance

The enforcement action we took:

Warning notice
Action plan