Gainsborough Care Home Limited

Gainsborough Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

This inspection took place on 20, 24 and 31 July 2017. The first day was unannounced and the second two days were announced.

Gainsborough care home provides accommodation and personal care for up to 45 people. At the start of the inspection there were 33 people living in the home. The service is located in a residential area of Swanage and is a large detached building set over two floors. The home had two communal lounges and dining areas and an accessible garden. The majority of people living in the home had complex needs relating to the impact of their dementia.

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 2008 and associated Regulations about how the service is run.

When we last inspected the service on 27 April 2016 we had concerns about how people's risks were managed and people were not provided with the necessary support to eat or drink. The provider sent us an action plan which detailed how they would meet the regulations and be compliant by August 2016. At this inspection we found that improvements had been made.

Staff were aware of the risks people faced and their role in managing these. Care plans provided information about risk but were not individualised.

Audits were completed regularly and covered a range of topics. They were used to drive improvements but did not consistently identify gaps where improvements were needed.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of how to whistle blow if they needed to and reported that they would be confident to do so.

People had care plans which provided detail about how to support people but needed more information to be person centred and reflect the histories of people and what was important to them. Care plans were regularly reviewed with people and their loved ones where appropriate.

There were enough staff available and people did not have to wait for support. People had support and care from staff who were familiar to them and knew them well. Staff were consistent in their knowledge of people's care needs and spoke confidently about the support people needed to meet these needs.

The home had good links with health professionals and regular visits and discussions meant that people were able to access appropriate healthcare input promptly when required.

People were supported by staff who had the necessary training and skills to support them. Training was provided in a number of areas the service considered essential and other learning offered was relevant to the conditions that people faced.

Staff understood and supported people to make choices about their care. People's legal rights were protected because staff knew about and used appropriate legislation. Where people had decisions made in their best interests, these included the views of those important to the person and considered whether options were the least restrictive for the person.

People spoke positively about the food and had choices about what they ate and drank. The kitchen were aware of people's dietary needs and where people required a special diet or assistance to be able to eat and drink safely this was in place.

Staff knew people well and interactions were relaxed and caring. People were comfortable with staff and we observed people being supported in a respectful way. People were encouraged to make choices about their support and staff were able to communicate with people in ways which were meaningful to them.

People were supported by staff who respected their privacy and dignity and told us that they were encouraged to be independent.

People were supported by staff who knew their likes, dislikes and preferences. Staff told us that they communicated well and there were regular handovers. There were clear processes in place for each shift and staff knew their roles and responsibilities.

People were able to engage with a range of activities including one to one time with staff. People told us that they had enough to do at the home and enjoyed the activities on offer.

Relatives spoke positively about the staff and management of the home. They told us that they were always welcomed and visited when they wished. Both relatives and people told us that they would be confident to complain if they needed to.

Feedback was gathered both formally and informally and used to drive improvements at the home. Quality assurance measures were regular and also used to identify gaps and trends which were then used to plan actions to drive high quality care.

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 aware of how to manage the risks people faced but care plans needed to be more individual to reflect how these affected people.

People were protected from the risks of abuse because staff understood their role in reporting concerns and had confidence to do this.

People were supported by staff who had been recruited safely with appropriate pre-employment, reference and identity checks.

People received their medicines and creams as prescribed.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about the people they were supporting and received relevant training for their role.

People who were able to consent to their care had done so and staff provided care in people's best interests when they could not consent.

People enjoyed a choice of food and were supported to eat and drink safely.

People were supported to access healthcare professionals appropriately.

Is the service caring?

Good

The service was caring.

People had a good rapport with staff and we observed that

people were relaxed in the company of staff.

Staff knew how people liked to be supported and offered them appropriate choices.

People were supported to maintain their privacy and dignity.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was generally responsive.

People had care records which identified what support they required but needed to be more person centred to include information about people's history and what was important to them.

People enjoyed a range of activities and staff spent one to one time with people.

People and relatives knew how to raise any concerns and told us that they would feel confident to raise issues if they needed to.

Is the service well-led?

Good

The service was generally well led.

Quality assurance measures were in place and used to drive improvements but did not consistently identify gaps in recording.

People, relatives and staff felt that the registered manager was approachable and had confidence in the management of the service.

Staff felt supported and were confident and clear about their roles and responsibilities within the service.

Gainsborough 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 20, 24 and 31 July 2017. The first day was unannounced and the second two days were announced. The inspection was carried out by a single inspector.

The provider had completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does and improvements they plan to make. We used this information during the inspection. In addition we reviewed notifications which the service had sent us. A notification is the form providers use to tell us about important events that affect the care of people using the service. We also contacted the local authority quality improvement team to obtain their views about the service.

During the inspection we spoke with seven people and seven relatives. We also spoke with two healthcare professionals who had knowledge about the service. We spoke with seven members of staff, two of the operational managers, the registered manager and deputy manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked around the service and observed care practices. We looked at the care files of six people and reviewed records relating to how the service was run. We also looked at three staff files including recruitment and supervision records. Other records we looked at included Medicine Administration Records (MAR), emergency evacuation plans and quality assurance audits.

Good

Is the service safe?

Our findings

When we last inspected the service in March 2016, we found a breach in regulation around management of risks. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches and told us that they would be compliant with the regulations by August 2016. At this inspection we found that they were no longer in breach and improvements had been made.

People generally received their medicines as prescribed. We looked at the medicine administration records (MAR) for seven people and saw that these had been recorded accurately. Some people had medicines prescribed 'as required'. We observed that staff asked people whether they wanted these before administering and recorded their decision. People had 'as required' medicines forms which indicated why the medicine was prescribed and guidance for staff about how the person would indicate that they needed this if they were unable to communicate their decision. Some of these forms were not in place for people but their MAR showed that they had been receiving their medicine. Staff were able to explain how they used observations of people's expressions and body language to inform whether their 'as required' medicines were needed. Some people had prescribed creams which staff supported them to apply. Staff were able to explain what creams people needed and how they were to be administered. Again there were body maps in place indicating where creams needed to be applied and the frequency, but some of these were missing. The registered manager immediately addressed these recording gaps and we observed that the missing documentation was in place by the end of our inspection.

Care plans included the conditions and risks that people faced but did not always provide individual detail of how these affected people. For example, one person had diabetes. Their care plan included details about possible signs of their blood sugars becoming high or low but this was a generic form. Staff knew people well and understood how their conditions affected them. When the person had presented as upset, staff noted this and tested their blood sugars. However their care plan did not give guidance to staff about signs and symptoms the individual might have if there was an issue with their blood sugars. The registered manager told us that they would ensure that people's care plans reflected this individual detail.

Staff were aware of the risks that people faced and their role in managing these. One staff member told us about a person who was losing weight. They explained that they were monitoring this weekly and encouraging the person to eat what they could. The chef explained how they were fortifying the persons foods and they had the up to date malnutrition score from the persons care plan which indicated that they were at increased risk. Another person was at risk of developing sore skin. They had equipment in place to support them which was regularly checked to ensure it was set correctly. The person's skin was more vulnerable on one side and they required assistance to turn regularly. Staff were consistently able to explain the support and frequency of turning the person needed, and charts showed that the person had been supported to move line with this. Another person had been identified as at risk of falls. They had a falls risk assessment in place which identified that they were at high risk and indicated that a falls diary and referral to the falls team was required. We saw that the person's care plan had been updated to identify the increased risk and that a referral had been made to the falls team. There was a falls diary in place and in

addition, a piece of equipment had been put into place to reduce the risk of injury for the person if they fell out of bed. This demonstrated that the service had taken appropriate steps to manage the risk the person faced.

People and relatives told us that the service was safe. One relative explained "I'm happy to leave (name) here, I know(name) is in the best of hands". A person told us that staff "support me on to the commode, they know how to do that safely". We observed a staff member supporting a person to walk with some equipment. They offered reassurance and a steadying hand on the person's back and offered guidance to ensure that they were able to move to sit in a lounge chair.

Staff were aware of the possible types of abuse and how to report. One staff member told us that they would look for signs of "unusual marks or bruises, people being withdrawn or fearful…changes in behaviour". Another explained that because they knew people well, they would look for "changes in facial expression….grimacing or aggression….I'd be confident to report". Staff also understood when they may need to whistle blow and told us that they would be confident to do so. The service had policies on protecting people from abuse and whistleblowing in place and accessible for staff.

Recruitment at the service was safe. Staff files included references from previous employers, application forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role to identify whether staff had any criminal records which might pose a threat to people. The registered manager told us that recruitment was one of the biggest challenges for the service and at the time of inspection, some staff had been moved from another Agincare service to provide support.

Fire evacuation procedures were in place and each person had a personal emergency evacuation plan (PEEP) which included details of what support they would need to evacuate the premises safely. There were regular checks of the fire alarms, fire doors and fire safety equipment and any maintenance issues were raised and dealt with by the maintenance staff at the service.

Good

Is the service effective?

Our findings

When we last inspected the service in March 2016, we found a breach in regulation around people receiving the necessary support they required to eat and drink. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches and told us that they would be compliant with the regulations by May 2016. At this inspection we found that they were no longer in breach and improvements had been made.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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."

We saw that people had MCA assessments in place and that these were decision specific and provided evidence about how the decision had been made. For example, one person had a capacity assessment around the possible need for their medicines to be given covertly. There was a decision made in the person's best interest which had included their GP and family when considering whether this was the least restrictive option for the person. The home had made applications for DoLS for several people and had clear records about when applications had been made and whether these had been authorised. Some people had DoLS which had been authorised but expired and the registered manager confirmed that further applications had been made in these cases.

Staff had the correct knowledge and skills to support people. One person explained how staff understood how to use a piece of equipment they needed to assist them to move safely. A relative explained that staff understood that their loved one had dementia and knew how to interact with them in a way which was meaningful to them. Staff were confidently able to explain about the condition people faced and their role in supporting them. For example, staff reported that they had observed that one person appeared to be in discomfort. The service had promptly contacted the GP who sent a district nurse out to see the person.

Staff understood how to communicate effectively with people. Some people living at the home required staff to communicate in different ways to enable them to be involved in decisions about their support. For example, a staff member explained how they used picture cards with two people to help them to communicate their needs and wishes. Where people had sight or hearing loss, these were known by staff and we observed staff speaking with people in a way which assisted their communication.

Staff received training in topics which were relevant to the people they supported. Training was completed in a number of topics which the service considered essential, these included infection control, moving and assisting and how to protect people from abuse. Other training was available and staff were encouraged to undertake training in diabetes, dementia and other areas including end of life care and record keeping. One staff member explained that they had completed diabetes training which had been helpful in assisting them to understand how this condition affected the people they supported. The registered manager explained that staff had received training in nutrition and hydration and behaviours that challenge from an external resource which had been beneficial.

New staff received an induction into their role which incorporated the standards set out in the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. We saw certificates for those who had successfully completed this. A staff member explained that they had shadowed more experienced staff as part of their induction and had been offered and completed various training since starting in post.

Staff received regular supervision and were encouraged to consider their own learning and development needs. One member of staff said that they were able to reflect in supervision on "what I feel I'm good at and improvements I can make". They felt supported by this. We saw supervision records which indicated that development needs were discussed. For example, one staff member had expressed an interest in completing their medicines training and this had been identified as a goal for them to work towards.

People spoke positively about the meals at the service and had choices about what they ate and drank. The chef was able to confidently explain about peoples dietary needs and had clear systems in place to identify where people required a soft diet to eat safely. Meals and drinks were fortified where there were concerns about weight loss and the chef explained that they made fresh milkshakes daily with milk and cream which people enjoyed. They also knew what foods people liked and provided finger foods where this meant that a person was able to eat independently. They provided a smaller plate of food for some people who found larger portions difficult and we saw on several occasions, staff requesting a particular food for a person who had a poor appetite. This responsive approach meant that the person had several small meals of their chosen food when they wished and the chef fortified these to increase the person's nutritional intake. The menu was available with pictures for people to see what the options were and the chef made both options so that people were able to decide at the time of their meal, which one they wished to have.

Where people required support to eat, this was provided. Meals were started slightly earlier for people who required assistance and senior staff completed a plan which was displayed in the kitchen to ensure that there were sufficient staff to provide people with the support they needed. We observed this chart being completed and saw that staff communicated well together to ensure that people received the necessary assistance they required. People had access to a choice of drinks throughout the day and they were dated to ensure that drinks were fresh for people.

People had access to healthcare promptly when required. We spoke with two health professionals who had knowledge of the service and both felt that referrals were made promptly and appropriately for people. One explained that staff had been "quick to identify changes in pressure areas" for a person and said that staff knew a lot about the people they supported. We saw that people had involvement and referrals to a number of health professionals including podiatry, physiotherapy and GP's.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring and we saw that there was good rapport and that people were relaxed in the company of staff. One person told us "the staff here are excellent, they really are good and do what they can to help you". One relative explained "staff interaction with (name) is very good, they are very kind to (name)". A health professional told us "staff are caring they clearly feel for the residents". Another relative said "carers are all terrific, (name) seems content with the staff". We observed staff chatting with people and using tactile contact appropriately.

People were actively supported to make decisions about their care and staff understood their role in supporting people to make choices. A staff member told us about one person who was able to make choices if these were presented visually and there were not too many options. They knew that if the person made a particular noise, this would indicate that they did not like the option presented to them. We observed a staff member offering a person a choice of drink. The person was not sure what to choose and the staff member went and brought the three options over for the person to see. They were then able to make their choice.

Staff knew people well and were aware of their preferences and how they wished to be supported. One staff member explained that a person loved magazines and anything related to the royal family. Another staff member told us about how they explained what they were doing as they supported a person who was suffering with increased confusion. They explained that the person was more confused at certain times and how they supported with this. Another staff member told us about how a person liked to spend their time and how they knew whether the person was in a happy mood.

People were supported to maintain their privacy and dignity. A relative explained that staff always asked them to leave the room if they needed to support their loved one with any intimate care. A person said "they are respectful, they knock before they come in and cover me when they are helping me to wash". The registered manager explained that they observed staff to ensure that they respected the dignity of people. For example, they had overheard an agency member of staff use the term 'feeding' when speaking about assisting people to eat. They immediately spoke with the staff member about this. A health professional said staff "have a good rapport, they are respectful and don't talk down to people".

People were supported to be as independent as possible. One person explained that staff encouraged them to do what they could for themselves. We observed staff encouraging and providing reassurance and verbal guidance for people to assist them to manage tasks independently.

People's information was stored confidentially. Records containing information about people were kept in a locked cabinet and we saw that staff updated records without removing them from the room. Staff details were also stored securely. Where people had daily notes which contained personal information, these were kept in their own rooms and only brought out to be completed and then returned.

Good

Is the service responsive?

Our findings

People had care plans which provided detail about what support people required but did not consistently provide information about what was important to or for people. The registered manager explained that where people were unable to provide details about their life histories and interests, they had written to peoples families asking for this information and some care plans included this detail. For example, one person's record included memories from their childhood, their occupation and family. These details meant that staff would be able to communicate with the person about areas and topics which were meaningful to them. Staff we spoke with knew people well and were able to communicate about areas which were of interest, however without this information in people's care plans, new staff would not be able to communicate in this way. The registered manager told us that they planned for keyworkers to take a lead role in working with people and their families to gather this information for the other people living at the service. This would ensure that communication was person centred.

We saw that care plans were reviewed monthly or more frequently where needed and changes were evidenced and cascaded to staff. For example, a person had been unwell and their care plan had been reviewed to include guidance for staff about what to do if the person was unwell again. This detail had been cascaded to staff through their communication book and added to their care plan. The registered manager explained that entries in the communication book were read to staff at handovers to ensure that staff were aware of any changes to people's support.

Relatives told us that they were updated about their loved one on a regular basis. One explained that when their loved one had been unwell "they were on it straightaway. They called the paramedics and let me know". Another relative explained that they had told the staff that their loved one preferred a particular breakfast which they had then been providing. Another explained that staff had discovered that their loved one really enjoyed a particular food and had been providing this regularly for them.

Visitors and relatives all told us that they felt welcomed at the service and visited whenever they chose. One relative explained staff were "always welcoming and offer drinks…they are always friendly, even new staff". Another said "Staff are always friendly and welcoming when we come in". A health professional described staff as "accommodating and friendly" when they visited. Visitors and relatives all explained that staff provided updates about people when they came into the home and this was consistent across all staff. We observed that relatives were greeted warmly and there was relaxed chatting and banter which demonstrated that there were positive relationships with people who visited the service.

The service held residents and relatives meetings regularly which were used to discuss the home and any feedback. We saw minutes from meetings which showed that staffing had been discussed and changes to the call bell system so that people and families were made aware of the planned work which would be undertaken in the home.

People enjoyed a range of activities at Gainsborough Care home, some of which were in groups and others provided one to one time with people. There was an activities plan which was displayed for people and

included musical and craft based activities, exercise options and reminiscence opportunities. There were several external resources which included local singers and musical entertainers and also Thai Chi. One person preferred not to engage in group activities but told us staff "come in and sit and have a chat with me". During our second day of inspection we observed a staff member painting a person's nails and another engaged in a jigsaw with a person. On our first day of inspection, this was not evident because there had been less staff working. We discussed staff capacity to assist with activities with the registered manager who explained that staff had some time during morning and afternoon shifts to assist with one to one activities with people. Staff also told us that they had enough time to spend with people when they were fully staffed.

People and relatives were confident about how to raise concerns if they had any and the service had a complaints policy in place. One relative explained that they would "definitely be able to raise with management" if they had any concerns and were confident that this would be listened too. Where complaints had been received, these were recorded and investigated and actions taken where appropriate. For example, one complaint had been actioned by introducing a change in process to ensure that recording demonstrated the times that medicines had been administered where in line with prescribing instructions.

Good

Is the service well-led?

Our findings

We saw that although audits identified areas for improvement, these were not always consistent.
There were regular quality assurance checks which covered various areas of the service including medicines, infection control, staff files and care plans. Some audits were completed by the management team at the service and others were completed by operational directors from Agincare who visited the service regularly. An audit of medicines had been completed in May and June 2017 and identified that some records had not included directions for medicines which were 'as required'. We found that these had not all been actioned and some directions for as required medicines were still missing. Some charts advising staff how to administer prescribed creams were also missing. This meant that quality assurance checks did not always highlight gaps in recording. The registered manager advised that these would be put into place and we observed that this was actioned immediately.

Immediately prior to our inspection, the registered and deputy managers had both been absent from work at the same time. One of the operational directors explained that the registered manager from another Agincare service had been providing cover during this time. The registered manager had returned to work on the morning of our first day of inspection. They noted prior to our arrival that the staffing rota had gaps and had raised this with the operational director. Additional staff were then asked to work to cover this and were present during the inspection. The registered manager told us that they required six staff for the morning and five for the afternoons with three staff overnight. We saw that on two previous days in the same week, there had only been five staff working during the morning shift. The operational director acknowledged that this was the case. This demonstrated that the management cover which had been put into place had not ensured that there were sufficient numbers of staff to support people. Staff working on these days had been able to support people safely but had been under increased pressure because of the staffing numbers. The registered manager had picked this up immediately upon their return to work and the operations manager told us that they would consider how to ensure that this situation did not reoccur if management cover arrangements were used in future.

People, relatives and staff spoke positively about the registered and deputy managers. They felt that they were approachable and available. One relative told us One staff member said "registered manager is very helpful and is very active and helps in a variety of things". Staff described the registered manager as supportive and we observed that they assisted with mealtimes and worked on shifts with staff at busy times.

Staff were clear about their roles and responsibilities and communicated well. One staff member told us "staff team get on well and communicate well….the staffing structure works well when people are in post". Another explained "staff are very good, the atmosphere is very nice….staff are very helpful…very supportive". The service had handovers twice daily which provided updates about people. A staff member explained "handovers are useful to pass information over….we are given a handover sheet which includes basic information and space to make notes about people". Staff were able to confidently explain their responsibilities and those of their colleagues. Staff were also assigned as key workers with people and had responsibilities for these individuals including linking with families and assisting people with looking after

their rooms and belongings.

The home held regular staff meetings which were used to drive best practice and to discuss any changes or issues. We looked at minutes from a meeting in March 2017 and saw that staff had discussed fluid charts for people and concerns if people were not drinking the target amounts which had been set. The registered manager had explained what actions they took if this was the case. We saw that they had emailed the GP and sought advice when this had been reported to them. Capacity had also been discussed and a completed example of a capacity assessment had been shared with staff as an example to prompt discussion about best practice.

The registered manager was supported through regular supervision and told us that they had regular phone contact with their line manager which they found helpful. They had regular contact with the various operations managers at Agincare and attended quarterly meetings with other registered managers which provided an opportunity to discuss proactive ideas and share learning.

Feedback was sought from people through the use of surveys which were sent out annually. A relative told us that they had recently completed this and returned it to the service. Information from surveys was used by Agincare to populate an action plan and drive improvements. The registered manager explained that they observed staff on a regular basis, recorded how they carried out their role and any learning from this to improve practice. For example, they had observed one agency staff member using a description of a person which was not respectful. They explained that they had immediately explained to the staff member what they had observed and the learning from this for the member of staff to ensure that they used language which promoted the dignity of people.