Gainsborough Care Home Limited

Gainsborough Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 22 and 23 October 2018. The first day was unannounced.

Gainsborough Care Home 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.

Gainsborough Care Home accommodates up to 48 people on the ground and first floors of one building. Nursing care is not provided. There were 33 people living or staying there when we inspected, most of whom were living with dementia.

A new manager had started working at the service in July 2018. Their application to register as manager was being assessed by a Care Quality Commission registrations inspector. This was completed shortly after the inspection. 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.

There were usually enough staff on duty. There were checks before new staff started work so only staff who were suitable to work in care were recruited. We have made a recommendation about references from previous care employers. However, staff were not all skilled and competent to care for people safely. We observed a new member of staff assisting a person to eat in an unsafe and undignified manner, placing the person at risk of choking. They did not have a good understanding of fire safety. This was a breach of regulation. You can see what action we told the provider to take at the back of the full version of the report.

There were also shortfalls in the cleanliness of the service, which the manager was addressing. Staff did not always use disposable gloves properly, which increased the risk of spreading infection. This was a breach of regulation. You can see what action we told the provider to take at the back of the full version of the report.

The premises were accessible to people with restricted mobility. Much of the décor was tired and scuffed. There was limited signage suitable for people who were living with dementia and had lost the ability to read, to help them find their way around the building. A programme was in place for redecoration. We have made a recommendation about the redecoration considering good practice guidance about decoration that meets the needs of people who live with dementia.

The provider told us doors across the upstairs corridor were locked to prevent access to the stairs, as instructed by the local authority safeguarding and quality teams. The manager and provider had identified that this was potentially unduly restrictive for people. They were considering what action to take, in consultation with the local authority.

The manager had a good understanding of the Mental Capacity Act 2005 and the service worked within its principles. They understood when people should be viewed as deprived of their liberty and had ensured DoLS applications had been made to the appropriate local authority.

There were regular health and safety checks. The provider and manager were aware of repairs and redecoration that were needed, and a programme was under way to address this. Risks in relation to individual people were assessed and managed.

Staff followed safe procedures when administering medicines. Eye and ear drops, and medicines taken by mouth or injected by district nurses were stored securely. Quantities of medicines in stock were accounted for in people's medicines records and there were procedures to ensure there were always sufficient amounts on hand. However, prescribed creams and ointments were not stored safely, and some were overstocked. The manager had already identified this was an issue and was acting to address it.

People were protected from abuse. Staff understood their responsibilities to report safeguarding concerns within their organisation and knew how to blow the whistle about poor practice.

Staff reported accidents and incidents and the management team took appropriate action.

Food was not all appetising or presented in a way that would encourage people to eat. A member of staff usually employed in a different role was covering until the new chef started work. The dining environment was not always pleasant and conducive to people enjoying their meal. People mostly made meal choices in advance of the meal when staff asked them. This method of choosing a meal can be difficult for people who live with dementia, who may have difficulty remembering or understanding the alternatives. We have made a recommendation about reviewing dining environments, method of offering choices and food presentation to encourage people to eat.

Staff generally treated people kindly and with respect but were largely focused on tasks. When they spoke with people it was with warmth and kindness but mostly about whatever needed doing. People's dignity and privacy was not consistently promoted.

People were encouraged to make choices about their life at Gainsborough Care Home and these were respected, for example what time they got up or where they wanted to eat their meal. People were encouraged to personalise their rooms as they wished. Mostly, care staff explained to people what was going to happen and kept them informed of what they were doing.

Staff generally had a good understanding of the care people needed. Preadmission assessments had been undertaken before people moved into the service, so the service could be sure it would be able to provide the care and support they needed. Care records did not all contain detail about people's backgrounds and preferences to help staff view people for who they were. The manager had identified that care plans were not all up to date and person centred and was in the process of reviewing and rewriting them to make them more detailed and relevant to the person. People were supported to access healthcare as they needed. They were supported at the end of their life to have a dignified and comfortable death.

An activities coordinator had recently been appointed and there were visiting entertainers and trips out locally. However, people often sat withdrawn or asleep in the lounges with the television playing and little interaction from staff, who were busy with other things. Activities were not clearly publicised.

Information was displayed in the reception area about how to raise a concern or complaint. No formal

complaints had been received since the manager had been in post. However, people living at the service and relatives expressed ongoing frustrations about lost clothing. The manager was trying to address this.

The manager worked closely with staff and sought to cultivate a positive, open culture. They set out clear expectations regarding what staff were responsible for and how things should be done. Staff were supported through supervision meetings and received coaching where necessary to improve their performance.

Quality assurance systems were in place to monitor the quality of the service but had not identified all the issues found at inspection. The manager responded promptly and constructively to issues we raised. Not all concerns identified through audits were addressed with an action plan and audits were not all sufficiently comprehensive. There had been multiple demands on the manager's time since they started in post, which limited their time to oversee all aspects of the service. You can see what action we told the provider to take at the back of the full version of the report.

The service and provider sought to foster community links and work in partnership with other agencies.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe in all respects.

Staff were not all skilled and competent and up to date with safety-related training.

Medicines were not all stored safely, although the manager was addressing this.

There were lapses in cleaning and in good infection control and food hygiene practice.

Is the service effective?

Requires Improvement

The service was not wholly effective.

Signage around the building was not all suited to the needs of people who live with dementia.

The dining environment was not always pleasant, and food was not always well presented.

The manager had a good understanding of the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff mostly, but not always, treated people kindly and respectfully. On occasion some staff did not uphold people's privacy and dignity.

Staff were at times more focused on tasks than people and their wellbeing. Support was inconsistent and not always respectful.

People were encouraged to make choices, and these were respected.

Is the service responsive?

Requires Improvement

The service was not wholly responsive.

Care was often task-focused. Activities were provided but people often lacked enough stimulation.

People knew how to raise any concerns or issues.

The service worked with healthcare professionals when people were at the end of life to provide a dignified and pain-free death. Families felt involved and supported during the final days of a person's life.

Is the service well-led?

Requires Improvement

The service was not wholly well led.

There was a new manager in post.

Governance was not always reliable and effective, as the provider's quality assurance systems had not identified all the issues we found at inspection. The manager's time for oversight of the service was limited.

The manager fostered an open, positive culture.

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 was prompted by a series of safeguarding concerns relating to the standard of the care people received and the safety and cleanliness of the premises. This was a comprehensive inspection that considered all aspects of the service, including care, safety and cleanliness.

The inspection took place on 22 and 23 October 2018. The first day was unannounced.

The inspection team on the first day was composed of an inspector, an assistant inspector, an expert by experience and a specialist professional advisor. The specialist professional advisor was a registered nurse who looked particularly at infection control, nutrition and management of pressure ulcers. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector and assistant inspector returned on the second day.

Prior to the inspection we reviewed the information we held about the service. This included information from notifications about significant events such as deaths, and information from stakeholders such as the local authority quality and safeguarding teams. As the inspection was brought forward, we did not request a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 11 people and four visiting relatives. Because people were not all able to tell us about their experience of the service, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care in communal areas to help us understand the experience of people who cannot describe this to us. We also spoke with a visiting health professional, 11 staff, the manager, an operations manager, the quality manager and the operations director. We also made general observations around the service. We viewed four people's care records and parts of a further eight people's records, medicines records for both floors, four staff files and other records relating to the management of

the service, such as accident and incident records and audits. We obtained feedback from a further health and social care professional who regularly visits the service.

Requires Improvement

Is the service safe?

Our findings

Generally, people and visitors said that they felt they or their loved one were safe living there. People and relatives told us they thought there were usually enough staff on duty, although a relative said there did not seem to be sufficient staff on the floor, especially during the evening and at night. One person said staffing levels were not always good and that staff could take up to 10 or 15 minutes to answer call bells. Call bells were answered promptly during the inspection. Staffing levels were set at or above the provider's dependency calculation, with seven or eight care staff in the morning, and six or seven in the afternoon and evening. There were three or four staff at night, including, in emergency situations, the occasional sleep-in member of staff. Absence was covered through staff working extra hours or through agency staff.

There were checks before new staff started work to ensure only staff who were suitable to work in care were recruited. These included criminal records checks, getting a full employment history with reasons for leaving employment, and obtaining references. One staff file showed the worker had a six-year unexplained gap in employment; the reason for this had not been disclosed and the interview notes did not reflect that it was discussed at interview. The management team investigated the reason for this gap as soon as we drew it to their attention and acknowledged that this was a training issue for new interviewers. The provider's application form required references from the two most recent employers, so if a person was employed in care prior to this a reference was not necessarily obtained. This was the case for a member of staff who had been employed before the current manager started in post. The provider advised us they would seek an additional reference for this member of staff and would review their employment procedures, so they always sought a reference from previous employment in care.

We recommend the provider goes ahead with measures to ensure references are always sought from previous employment in care, and to ensure interviewers understand the information they need to obtain at interview.

However, staff did not all have the competence and skills to care for people safely. A member of staff who had worked at the service for a few weeks told inspectors they had not received induction training since starting at the home a few weeks before. Managers advised this was because they had completed their care certificate with the agency used to employ them, but there was no record of this on their staff file. The service's training matrix showed the worker had been issued with training materials in moving and handling, safeguarding, infection control and health and safety, but had not yet completed these. They had not yet completed fire awareness training and were not present at the previous week's fire training. The member of staff assisted a person who had swallowing difficulties with a meal when the person was not in a safe position to eat, as they lacked the understanding that this put the person at risk of choking. They attempted to get the person to eat faster by giving them spoonfuls of food in a hurried manner and telling them "come on"; this did not afford the person dignity or respect. The manager immediately addressed this when drawn to their attention. The member of staff was also blowing on the spoonfuls of food to cool them, indicating a lack of understanding of good infection control. They said that in event of fire they would, for a person cared for in bed upstairs, "cover the resident with a fire blanket" and leave them for the fire brigade. In fact, evacuation equipment was available for staff to use.

There were shortfalls in the cleanliness of the service, which the manager had already recognised and was in the process of addressing. There were unpleasant smells in places around the building. Some carpet was smelly and stained. Replacement carpets and flooring were on order for areas where the smell was ingrained. One person's bedroom smelt strongly because a bin bag containing a used incontinence pad and a laundry bag containing soiled clothing had been left there. These were attended to when brought to the manager's attention. Housekeeping staff were unable to clean all areas daily, especially when only one was on duty. On these occasions people's rooms were prioritised over communal areas. Cleaning schedules were not signed consistently so it was not always clear which rooms had been cleaned and when. We observed a housekeeper using a dust pan and brush to clean a bedroom carpet. They said there was only one functioning vacuum cleaner, which was in use on the other floor. However, two brand new vacuum cleaners that had been delivered a day earlier were available to staff.

Disposable gloves and aprons were readily available for staff when needed during personal care, as they were kept in a secure drawer in each person's bedroom. However, these were not always used appropriately. On the first day of the inspection a member of staff wore disposable gloves as they walked through communal areas. This presented an infection control risk; either the gloves had already been used and not discarded or were about to be used for someone's care after being worn around the home touching items. We highlighted this to the manager who spoke with the member of staff. The next day the same member of staff again wore gloves as they walked through the hallway, into the office and back towards the bedrooms.

These shortfalls in relation to staff competence and skills, and cleanliness and infection control are a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The National Institute for Health and Care Excellence Helping to prevent infection (2017) guidelines were in place and staff had been given training packs. However, two staff told us they had not been able to complete this training as there was no protected training time. Following the inspection, the provider and manager confirmed that training time was indeed made available to staff who were required to complete workbooks.

The acting chef usually worked in another role at the service. They had been doing most of the cooking since the last chef left. They had previous experience in a food handling environment. They had undertaken the provider's three-day induction training when they started working for Agincare in 2017; this covered basic food hygiene and nutrition. The acting chef and other catering staff had recently been signed up to a level two course in food hygiene and safety. Following the inspection, the provider provided us with a copy of their certificate dated 29 October 2018.

The manager was acting to address cleanliness and infection control issues. The manager had identified that two bedrooms had been affected by bed bugs brought in to the home in a resident's furniture. They had identified an external company who had carried out treatment in the affected area. The kitchen had been deep cleaned in response in response to a recent environmental health inspection. Some cups and glasses looked smeared or had rims where they had previously held drinks. Two people told us mugs and cups were not always clean. Staff washed up by hand as there was an industrial glass washing machine but no dishwasher. A multi-purpose dishwasher was on order but had not yet been delivered.

Information about risks and safety was not always comprehensive or up to date. There were two staircases between the ground and first floor. Many people living or staying at the service could walk independently and could be at risk on the staircases. Prior to the inspection someone had fallen on the stairs, although they were not seriously injured. Since then, the doors along the upstairs corridor had been closed with

keypad locks to prevent access from the first floor. Both staircases remained open at the ground floor. The general risk assessment for the stairs predated the fall and did not reflect the locked doors upstairs. Individual risk assessments did not consider people's mobility in relation to the stairs and the measures needed to keep them safe. Shortly after the inspection, the manager showed us how they had revised the falls and moving and handling risk assessment templates to include this information. They later confirmed that all moving and handling assessments had been updated to take account of the stairs.

The provider told us the doors across the upstairs corridor were locked to prevent access to the stairs at the insistence of the local authority safeguarding and quality teams; the provider did not favour doing so. However, most people were unable to use the keypad locks and so could not all access communal areas from their bedrooms, or their bedrooms from communal areas, without intervention from staff. People who were in their rooms and unable to use call bells were reliant on staff checking them. A relative said they thought their family member would be far better with a room downstairs as they did not like the corridor doors locked. The manager and provider had identified that this was potentially unduly restrictive for people. They were considering, in consultation with the local authority, what the least restrictive practicable solution would be.

Other risks in relation to individual people were assessed and managed. These included risks relating to tissue viability, malnutrition and swallowing difficulties, and each person had a Personal Emergency Evacuation Plan that was also kept with the fire file for use in an emergency. Risk assessments were reviewed regularly and updated as necessary. One person had a history of becoming agitated and was prescribed a medicine to calm them if needed, although this had not been used in the past month. Their care records were yet to be updated by the manager and there was no care plan in relation to supporting the person in the least restrictive way possible when they became distressed. The manager wrote a suitable care plan when we drew this to their attention.

There were regular health and safety checks to help ensure the environment was kept safe. The provider and manager were aware of repairs and redecoration that were needed. Parts of the carpet were worn, which could present a trip hazard. Specialist contractors carried out periodic fire, gas, water and electrical safety checks. Equipment such as fire alarms, extinguishers and emergency lighting were checked and serviced in accordance with the manufacturer's guidelines. The provider checked water temperatures, flushed infrequently used taps and descaled showerheads to reduce the risk of legionella. Legionella are water-borne bacteria that can cause serious illness. An empty bedroom was unlocked with haphazardly stored items on shelves and on the floor, presenting a trip hazard. The manager told us empty rooms should be locked and door was locked by the end of the first day.

The manager and provider were acting on a plan to address maintenance issues. There had been a vacancy for a maintenance person since the manager started in post in July 2018; a new maintenance person had recently started work, although they were on leave during the inspection. The maintenance person had identified tasks that were required, such as redecoration and reinstating architraves that had been removed when new door closers were fitted. Wardrobes and other furniture also needed securing to the wall to reduce the risk of it falling on people. Following the inspection, the manager confirmed that the maintenance person had addressed this on return from leave.

Medicines were not all stored safely and securely. Eye and ear drops, and medicines taken by mouth or injected by district nurses were stored in locked, secured cabinets. Medicines that required refrigeration were stored in a dedicated medicines refrigerator. Temperatures of the refrigerator and drugs storage areas were monitored to ensure they stayed within correct ranges. Quantities of medicines in stock were accounted for in people's medicines records and the manager had introduced procedures to ensure there

were always sufficient quantities of medicines in stock. However, prescribed creams and ointments were stored in people's rooms; some of these were overstocked, which had led to them being stored inappropriately as there was limited space available. In one person's room there were four containers of cream on top of a radiator cover and seven containers in direct sunlight on a window sill. This could reduce the effectiveness of the cream. We found four containers of cream opened without a date recorded on the label, which increased the risk these would be used past their expiry date. In one person's room there were four opened tubs of the same prescribed cream. This indicated a lack of monitoring of topical (skin) medicines. The manager had already identified the need for creams and ointments to be stored safely and so had ordered additional shelving for the medicines room. When we informed them of our findings they immediately introduced a more rigorous system for monitoring medicines, with closer involvement from themselves.

Staff followed safe procedures when administering medicines. Staff who administered people's medicines were trained to do so. Their competence in handling medicines safely was checked at least annually. They explained to people what their medicines were for and did not rush them. One person who refused their medicines but lacked the mental capacity to understand the consequences of this, had their medicines concealed in food and drink. This was on the GP's instructions, but the service had no record of consultation with a pharmacist and no record of a best interests decision recording each of the person's medicines. The manager immediately addressed this when we raised it, obtaining advice from the pharmacist about what it was safe to mix the medicines with and completing a best interests decision in partnership with the GP.

People were protected from abuse. Staff we spoke with knew about different sorts of abuse, how to report safeguarding concerns and how to blow the whistle about poor practice. Information about safeguarding adults, such as contact details for raising concerns with the local authority, were displayed in the reception area. The manager worked openly with the local authority safeguarding team to report concerns and to act on concerns raised.

Staff reported accidents and incidents and the management team took appropriate action. The manager had attended the provider's training in reviewing accidents and the standard of follow up and monitoring had improved following this. Accidents and incidents were analysed at provider level to identify trends that might indicate changes in practice and procedures were necessary. The manager was working openly with the provider and local authority to help ensure people's safety and wellbeing in the future. They had produced an action plan prior to the inspection of issues that needed to be addressed and were making progress towards this.

Requires Improvement

Is the service effective?

Our findings

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.

The manager had a good understanding of the MCA and the service worked within its principles. Where people were able to consent to their care, this was obtained. Where there were doubts about their capacity to give this consent, their mental capacity had been assessed. If the person was found to lack capacity, a best interests decision was recorded regarding the least restrictive option for providing the care the person needed. The manager had identified shortcomings in the way mental capacity assessments and best interests decisions had been recorded previously and was in the process of reviewing these as people's care plans were updated. Relatives were involved in this process. They covered decisions about matters such as living at Gainsborough Care Home and receiving personal care, medication, and having photographs taken for identification and to monitor wounds. Where people had delegated lasting power of attorney for health and welfare decisions, the service had recorded proof that this had been registered with the Office of the Public Guardian.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

The manager understood when people should be viewed as deprived of their liberty and had ensured DoLS applications had been made to the appropriate local authority. They recognised that some people's DoLS authorisations had expired before they started in post and that fresh applications had not been made. They had therefore ensured these applications were made as soon as possible. There was a system for tracking when authorisations expired and that any conditions were met. At the time of the inspection, there were no conditions on authorisations to deprive people of their liberty.

The building was not decorated or adapted in a dementia-friendly way, despite many people at the service living with dementia and being able to move around independently. The provider wanted people to feel like they were at home and was concerned that dementia-friendly decoration might seem clinical. However, premises can be both dementia-friendly and homely. There was limited signage suitable for people who were living with dementia and had lost the ability to read, to help them find their way around the building. Toilets and bathrooms mostly had written signs on the doors, some with pictures, but were not identified through distinctive features such as different coloured doors. However, doors were kept open when the rooms were not in use, so people could clearly see into the room to identify its purpose. Bedroom name labels were very small and hard to read, for people who were able to read. For people who had lost the ability to read, there were no personal items to help people identify their room. However, bedroom doors had been painted in different colours and decorated to look like a front door, to help people identify their

room through the colour of the door and its design.

We recommend the ongoing redecoration project takes account of good practice guidance in relation to decorating premises to meet the needs of people who live with dementia.

The building was accessible to people with restricted mobility. There were adapted baths and wet rooms on both floors. Bedrooms and lounges were situated on the ground and first floors, which were connected by a passenger lift as well as two staircases. There were a couple of steps along the upstairs corridor, although the lift was on the same level as the upstairs lounge and some of the bedrooms. Downstairs, there was a large lounge-dining room as well as a quieter lounge, and a facility for staff and visitors to prepare drinks and snacks. Upstairs, there was a smaller lounge-dining room. There was a garden to the rear of the property, and several on-site parking spaces.

People and relatives expressed mixed views about the food. A person living at the service said Sunday dinners were nice at times, but that otherwise food was not tasty. They said chicken and sausages featured heavily on the menu. A relative said food was good and that their family member's special dietary needs were met. Two people and a relative talked about meals not being hot when served; one said, "I have had cooked eggs on toast, but by the time they have arrived it's cold and hard. Even the porridge can be cold and like concrete."

Food was not all presented in an appetising way. There was no chef or cook in post during the inspection, although one was due to start soon. A member of staff usually employed in a different role was covering in the interim. Bowls of unappealing brown pureed food looked as if the meal had all been pureed together rather than in its separate components. However, the management team stated that pureed meals would always have each component pureed separately. Portion sizes were hearty, which could be daunting for those with a poor appetite. One person eating lunch in their room told inspectors, "It's too big. This is a man's size." A person in the dining room also complained their meal was too big. A person slowly ate their initially warm main course for half an hour, by which time it had cooled. Staff placed desserts in front of people before they had finished their main course, which had the potential to distract and confuse people. Meals were served on white plates in spite of research evidence that supports people who live with dementia being served food on coloured crockery as this helps them to see it more easily. The manager informed us the service had crockery with coloured rims available; they did not know why this had not been used.

People had a choice of meal. However, people mostly made their meal choices in advance of the meal when staff asked them. This method of choosing a meal can be difficult for people who live with dementia, who may have difficulty remembering or understanding the alternatives. Apart from a person choosing from two plated meals as they were sat at the dining table on the second day, there were no visual cues for people who might have difficulty understanding or remembering a list of alternatives. People had drinks in front of them, although we did not hear a choice of drink being offered.

The dining environment was not always pleasant and conducive to people enjoying their meal. Downstairs on the first day of the inspection, the sound of music competed with a loud television as lunch was about to be served. Upstairs, the television was off but there was no background music at all during the meal and little conversation. There were table cloths on the tables, but some of these looked grubby. On the second day tables were laid with salt and pepper.

We recommend the service reviews how its dining environments, method of offering choices and food presentation afford a good mealtime experience and encourage people to eat. This should take into

consideration good practice for people who live with dementia.

People's care plans contained details of their dietary requirements, and information about these was held in the kitchen. This included details of texture modifications such as mashing or pureeing food to reduce the risk of choking, as instructed by speech and language therapists who had assessed people's swallowing. Staff were aware of who had a safe swallow plan and knew where they could find the details of this. The manager advised us that the acting chef had undertaken awareness training in relation to dietary needs, although their staff file did not contain records of this.

Staff encouraged people to eat and drink, and people had drinks to hand for much of the day. There were places in the lounges for people to help themselves to cold drinks and people used these if they were able to. However, a member of staff gave a very frail person a large mug of hot tea filled to the brim, which they could not pick up from the table. People's weights were monitored regularly, and unplanned weight loss followed up appropriately. People's risk of malnutrition was reviewed at least monthly, more often if people were at a heightened risk. Where necessary, staff requested people's GPs to refer them to a dietitian. The service had recently acquired some hoist weighing scales so people who could not use the sit-on scales could be weighed rather than estimating their weight from the circumference of their upper arm. Three out of six people's food and fluid charts had gaps where the total fluids taken should have been recorded, even though these should have been reviewed at the end of each day. The management team were about to introduce an electronic record system to improve the monitoring and recording of food and fluid intake.

People who needed support to eat mostly received this, although a relative told us staff sometimes did not place meals directly in front of their vision-impaired family member, which made it difficult for the person to eat. Additional assistance was on hand over lunch during the first day, as the provider had sent a team of managers and an activities coordinator to Gainsborough Care Home to support the manager and staff with the inspection. Even so, there were periods of several minutes at a time where staff left the room to carry out other duties. When a person started to cough, a care worker came and prompted them to drink. One person who needed assistance with meals was sleepy during lunch. A member of staff left a full bowl of soup in front of them. The person tried to feed themselves, but the spoon handle got covered in soup. We asked staff if this person was independent with eating and staff attempted to assist them. The person declined, and the soup was taken away.

Preadmission assessments had been undertaken before people moved into the service, so the service could be sure it would be able to provide the care and support they needed. There were more detailed assessments once people arrived at the service and these were kept under review, along with people's care plans. The manager had recognised that assessments and care plans were not sufficiently detailed and person-centred and was working to review and revise them. Assessments and care plans updated and rewritten by the manager were more comprehensive. They covered areas such as nutrition and hydration, skin integrity and the risk of developing pressure sores, continence, communication, mobility and dexterity, moving and handling, night time and sleep, and mental health and wellbeing.

People were supported to access healthcare as they needed. There were prompt referrals to health professionals if there were concerns about people's health. People had contact with GPs, district nurses, community mental health nurses, physiotherapists and other specialist staff as necessary. The manager sought to establish relationships with visiting professionals. One of the provider's senior managers held a role as an Admiral nurse; the role of an Admiral nurse is to provide information, advice, guidance and support to families of people who live with dementia. Their role was also to develop practice in relation to dementia.

Most staff we spoke with said they felt supported in their roles. Staff had supervision meetings with a more senior colleague to discuss their work, the impact it was having on them and any support they needed to perform their role. Some staff who needed to improve their performance had informal coaching from the manager, and this took place during the inspection. The manager was keen to develop staff in a constructive way, teaching them how tasks should be carried out rather than telling them off. Staff had training in key topics such as moving and handling, infection control and safeguarding every year, with health and safety training every two years. Other training, including dementia awareness, diabetes awareness, the Mental Capacity Act and equality and inclusion, was provided on an ad hoc basis. The provider had an in-house training department that enabled them to organise training in response to people's particular needs, such as specific conditions, and staff to access timely training towards diploma qualifications.

Requires Improvement

Is the service caring?

Our findings

Staff generally treated people kindly and with respect but were largely focused on tasks. When they spoke with people it was with warmth and kindness but mostly about whatever needed doing, such as getting ready for a meal or encouraging people to eat and drink. People's faces lit up when staff spoke with them, if just in connection with such tasks. People and relatives told us staff were kind; for example, a person talked about "the friendliness of the staff" and said, "Staff are very kind. They put themselves out to do anything." Someone else told us the staff were "lovely, absolutely lovely".

People's dignity and privacy was not consistently promoted. Personal care was offered discreetly, and most people received this behind closed doors. However, a care worker started delivering personal care to someone with a door open and had to be prompted to close the door. A relative told us staff frequently left their family member's door open, even though this person valued their privacy and preferred the door closed. Some care staff knocked on people's doors and waited for a response, others just walked into people's rooms. A person who would have difficulty making an informed decision not to wear clean clothes was wearing a jumper with a large stain on the front. Staff spoke with the person to offer menu choices, to ask where they would like to eat their lunch and to offer a clothes protector, but at no point offered help to change. The manager was dismayed to hear our feedback about this, in view of their values about treating people with dignity and respect. Shortly after the inspection they introduced a dignity audit to evaluate how staff were upholding people's dignity. In addition, senior care workers were tasked to check during each shift that people had received the care and support they needed to maintain their dignity.

People and relatives told us people were encouraged to make choices about their life at Gainsborough Care Home and these were respected. For example, a relative said their family member could get up when they wanted to, and had that day got up just before they visited. People and relatives told us there were no restrictions on visiting times. People's choice to spend time in their rooms or in communal areas was respected, as was their decision about where they wanted to sit to eat their meals. People were encouraged to personalise their rooms as they wished. For example, people who enjoyed reading had shelves of their books, and people had their own pictures and photographs in their rooms.

Care staff explained to people what was going to happen and kept them informed of what they were doing. For example, a relative stated that when the care staff hoisted their family member, they communicated each stage they would be performing. A member of staff assisted a person to eat. They spoke with the person first and told them what they were planning to do. They offered the person a clothes protector, helped them put it on and discussed what meal the person was having. The member of staff assisted the person to eat in a dignified and respectful way, encouraging independence where possible. The person responded well.

Requires Improvement

Is the service responsive?

Our findings

People and relatives said they were happy with their care and that staff knew what care was needed. For example, a person told us, "I've been well looked after." Most people did not remember being involved in their care plan and reviews; this may have been due to their memory impairment. A relative told us how they had been involved in a review recently to have their family member moved downstairs, as the person was not happy upstairs.

The manager had identified prior to the inspection that care plans were not all up to date and person centred. They were in the process of reviewing and rewriting them to make them more detailed and relevant to the person. People and their families had written life history profiles describing past life events and their likes and dislikes, although these were not incorporated into the old-style care plans; one person's life history detailed their career in fashion. Although well written, the new care plans did not include much information about the person that would help staff to know and understand them better. The manager recognised more detail about life history would be beneficial but was unable to include this as they were still getting to know people, having only been in post since July 2018. As manager, their available time to work on care plans was limited and they were recruiting for a senior member of care staff to take responsibility for writing and reviewing care plans.

Staff generally had a good understanding of people's care plans. Accordingly, people mostly received the support they needed. For example, a person cared for in bed had a life history document that stated they enjoyed listening to music. On the second day of the inspection their radio was playing classical music. On the first day of the inspection some people appeared unkempt, but on the second day people had received their assistance they needed and wanted with their self-presentation, for example, styling their hair or having a shave. However, a relative commented that staff did not always accommodate their loved one's visual impairment when providing care. They said the person was not able to see their meal when staff did not ensure their tray was directly in front of them.

There was a call bell system. People who were able to use them had access to call bells that were within their reach. However, not everyone was able to use a call bell and relied on staff to check their wellbeing. Staff responded promptly to call bells when they rang.

Activities were provided. The service had a minibus that the provider told us was regularly used to take people out on trips to local facilities and events. An activities coordinator had recently been appointed. They spoke with people and encouraged them to take part in quizzes. They told us, "When I first started I went round to all the residents and asked what they liked. Now I ensure at least once a month people have something that they want to do." They had not yet had any training specific to their role. Activities were not clearly publicised. A list of activities was displayed at reception; it was printed in a small font that was difficult to read. Activities were shown as happening every other day, but the actual activity was not listed, just the word "activity". A relative told us their family member was not aware of any activities or when they are planned for; the person needed someone to tell them what was on offer and bring him into the lounge for the activity. Another relative said their loved one was not made aware of the activities or was not

interested in them. During the inspection there were visits from a singing duo and from someone who played the piano. However, at other times people often sat withdrawn or asleep in the lounges with the television playing and little interaction from staff, who were busy with other things. For the duration of the inspection a second activities co-ordinator from a sister home was present; the manager explained this was not a normal occurrence. The provider informed us this was to aid and support the home during the inspection as staff and resources might be additionally stretched.

Two people upstairs chose not to see the visiting pianist on the second day. They sat with an experienced care worker and enjoyed looking through magazines. One of these people was someone who lived with dementia and spent much time walking around upstairs. They sat for at least 20 minutes with the member of staff, looking at the magazines, smiling and engaging in simple conversation.

Wireless broadband was installed around the home shortly after the inspection. This would enable people to use the internet, for example for video calls. The service was planning to start using an electronic record system in November 2018.

The service met the Accessible Information Standard. This requires that health and social care providers ensure people with an impairment or sensory loss can easily understand information provided and get the right support to communicate effectively. Assessments and care plans flagged up sensory loss or communication difficulties and the support the person needed from staff. Impairments and communication difficulties were considered in pre-admission assessments, although one person's assessment that had been completed at the end of 2017 incorrectly stated a person wore two hearing aids. Their care plan noted they could hear very well, although it did flag up the person's communication difficulties. Another person's care plan highlighted that they wore glasses and needed their denture fixed in place to aid communication; they were wearing their glasses and securely fitting teeth during the inspection.

People were supported at the end of their life to have a dignified and comfortable death. A relative stated that the care staff could not do enough for their family member at this difficult stage in their life. Staff liaised with GPs and district nurses to manage any pain and distress. District nurses visited during the inspection to support a person with pain relief through a syringe driver as they were approaching death. Staff spoke sensitively with the person's visiting relative.

Information was displayed in the reception area about how to raise a concern or complaint. People and relatives stated that if they had any concerns or complaints they would speak to the manager. No formal complaints had been received since the manager had been in post. Inspectors were shown a file that held several thank you notes. One stated, "Like to express our heartfelt thanks for the wonderful care and kindness shown to mum over the past year. She came to regard Gainsborough as her home and was happy and content right up to the end. Thank you for your dedication and compassion."

People living at the service and relatives expressed ongoing frustrations about the loss of clothing when it went to the service's laundry, which was a problem that started before the current manager arrived. For example, a person who lived at the service told us, "I get other people's clothing most days. I have had sewn-in labels in my clothes, but it still goes missing. I have lost all my socks and have seen other people wearing my clothes. I have to keep my eye on what clothes come back from the laundry." A relative stated, "The only problem I have really is that my [relative's] clothes go missing in the laundry and we constantly get the wrong clothes back." They questioned whether anyone was listening as the problem continued. The manager was aware of the ongoing concerns, which had been discussed at residents' and relatives' meetings, and was still trying to find a way to resolve these. During the inspection, the laundry room was tidy and clean. People's belongings were in individual baskets.

We recommend a review of the laundry system to help stop lost clothing.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since July 2018. She worked closely with staff and sought to cultivate a positive, open culture. This all prioritised the needs of people who used the service; a health professional commented, "The manager is always welcoming, professional and responsive to my requests... [Manager] is willing to do whatever is needed for the residents and it is a pleasure to visit Gainsborough." Staff described "a very positive change" in the atmosphere of the service over this time. Comments included: "I do think she has done everything she can to change [things at the service]", "One hundred percent improved since [manager] has been here… People [staff] are more willing to do things, they're involved", "It's improving. Was tricky at one point but it's now starting to improve. I feel people [staff] are supportive to [manager] and feel they can raise concerns if they need to", "When [manager] started it was all change but things have started to improve", "She has been supportive right the way through… She listens to what you have to say", and "It's actually nice coming to work". Staff described the manager as "really hands on" and said they found the procedures she had introduced easier to work with.

Quality assurance systems were in place to monitor the quality of the service but had not identified all the issues found at inspection. The manager responded promptly and constructively to issues we raised. The provider monitored the service through regular reporting by the manager, visits by the operations manager and periodic reviews by its quality team. Audits overseen by the manager included monthly audits of hospital admissions, medication, health and safety, nutrition and hydration, tissue viability and infection control. Many concerns identified were addressed with an action plan. However, there was no documented action plan for a hospital admissions audit that identified a potentially avoidable hospital admission for a urinary tract infection. The most recent infection control audit identified issues that needed attention but there was no action recorded to address these, for example cleaning dirty hoists and wheelchairs. The audit did not address shortcomings in the general cleanliness of the home, nor people diagnosed with MRSA and barrier care protocols. The provider had surveyed people and their relatives in July 2018; the only negatives from the three residents' and 13 relatives' responses related to the standard of meals and satisfaction with activities. The responses had been collated but we saw no action plan for the service. The inspection identified that these areas were still problematic.

These shortfalls in the oversight of the service are a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

There had been multiple demands on the manager's time since they started in post, which limited their time to oversee all aspects of the service. Several staff had left with or shortly after the previous manager; this included the member of staff responsible for overseeing care plans. Recruitment conditions locally were challenging, although new care staff had recently started at the service. The service was without a permanent chef and until recently had had no regular maintenance person. As well as getting to know people, relatives and staff, the manager was busy addressing issues in connection with safeguarding enquiries. In addition, this was the manager's first post as a home manager; they were supported through the provider's quarterly management meetings, which included elements of training and development.

The manager had set out clear expectations regarding what staff were responsible for and how things should be done, acknowledging that some staff might find it challenging to have this structure. This was reflected in minutes of staff meetings that had taken place in July and September 2018. Expectations of staff were also discussed in supervision. All but one of the staff we spoke with was positive about the approach of the manager. A member of staff told us how previously they had not had supervision, "but when [manager] came she was straight on it". Other staff commented on how they had confidence in the way the manager was encouraging them to work: "We've got an input. She doesn't put things in willy-nilly, she discusses it with you", "[Manager] is supportive. We got off on the wrong foot, but now I feel appreciated and supported", and, "[Manager] is supportive. If I had any concerns or points to improve I'd speak to [manager]".

People and relatives were more sceptical as to whether the service was well managed. They described ongoing issues with laundry and perceived a "lack of response to resolve these issues". The last residents' and relatives' meeting had been held in June 2018. The new manager was introduced, and issues discussed included the laundry.

The manager had applied to register with CQC and their application was being assessed. Their registration was completed shortly after the inspection. The manager had notified CQC of significant events. CQC uses this information to monitor the service and ensure they respond appropriately to keep people safe. The service's previous inspection rating was clearly displayed in reception and on the provider's website.

The service sought to foster community links and, together with the provider, work in partnership with other agencies. It regularly had news published in the local paper, such as coverage of special events. It was in talks with a local school regarding have the school choir come to visit. The provider had a partnership with a further education college in the county, supporting students to find placements and boosting its in-house training. The provider was represented on the board of a national care trade organisation, which enabled it to share best practice across its services.

The provider had recognised challenges with recruitment. It had established a 'Believe in Good Care' campaign to remind everyone what good social care provision means for people, contrasting with negative media coverage of social care. It was hoped that this would help boost staff morale and raise the profile of care work.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not consistently provided safely for service users because care staff did not all have the necessary competence and skills, and because of shortcomings in cleanliness and infection control measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not operate effectively to enable the provider to monitor and improve the quality of the service provided. The systems and processes in place had not identified some of the issues the inspectors found. The manager's time for oversight of the service was limited.