HC-One Oval Limited

Old Gates Care Home

Inspection report

Livesey Branch Road
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Old Gates Care Home provides accommodation in three units, for up to 90 people who need either nursing or personal care and support. These units are Cherry, Holly and Rowan. Care and support for people living with a dementia is provided in Rowan. There were a total of 75 people using the service on the days of our inspection.

People's experience of using this service: People's experience of Old Gates varied depending on the unit on which they lived.

We were unable to visit Rowan unit due to an outbreak of diarrhoea and vomiting. However, staff who had recently worked on this unit told us improvements had been made since the last inspection and the quality of care people received was good. One staff member commented, "It's fun on Rowan. You go home smiling."

People on Cherry unit, which provided care for people who did not require nursing care, was generally good. However, people on this unit told us there were not always enough staff to respond to their needs in a timely manner. During the inspection, we observed a lively atmosphere on Cherry unit with people engaged in conversation and activities.

Our observations, discussions with staff and review of records on Holly unit showed people's quality of life was adversely affected by staffing levels. People on this unit had complex nursing needs and required two staff to meet their needs. Many people who lived in this unit remained in bed during both days of the inspection and we saw limited positive interactions between staff and people they were caring for. Staff told us they did not have the time to provide people with the care they needed. People's medicines on this unit were not always safely managed.

Rating at last inspection: This was the first inspection since a new provider had taken over the running of the service on 15 December 2017.

Why we inspected: This comprehensive inspection was prompted by information of concern we had received from the local authority quality team and local clinical commission group following their visits to the service in January 2019.

Enforcement: We identified three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014; these related to staffing levels and the support and training staff received, the unsafe handling of medicines and the lack of robust systems to monitor the quality and safety of the service. Information relating to the action the provider needs to take can be found at the end of this report. Full information about the Care Quality Commission's regulatory response to the more serious concerns found at inspections and appeals is added to reports after any representations or appeals have been concluded.

Follow up: We will continue to monitor the service to ensure that people receive safe, compassionate, high

quality care. Further inspections will be planned for future dates. We will follow up on the breach of regulations at our next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-Led findings below.	**Requires Improvement**

Old Gates Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by concerns raised by the local authority and clinical commissioning group regarding the environment, care record documentation and the lack of supervision for staff.

Inspection team: Both days of the inspection were carried out by an adult social care inspector, an assistant inspector and an Expert by Experience; the expert had experience of residential care services for older people. On the first day of the inspection, the team was joined by a specialist advisor in nursing care. On the second day of the inspection, the team was joined by a medicines inspector and regional manager from the medicines team.

Service and service type: The service was a care home which provided nursing care.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The first day of the inspection was unannounced. The provider was aware that we would be returning on the second day.

What we did:

Before the inspection: Our inspection plan took into account information the provider sent us since they took over the running of the service in December 2017. We also considered information about incidents the provider must notify us about, such as abuse or serious injuries. We requested information from the local authority quality and safeguarding teams, the local clinical commissioning group and Healthwatch. Healthwatch is an independent organisation which ensures that people's views and experiences are heard by those who run, plan and regulate health and social care services in Blackburn with Darwen.

As the inspection was brought forward, the provider had not been asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all the information gathered to plan our inspection.

During the inspection: We spoke with 12 people who lived in both Holly and Cherry units and seven visiting relatives. Due to an outbreak of diarrhoea and vomiting, we were unable to speak with people who lived on Rowan unit. We also spoke with the registered manager, the deputy manager, a unit manager, two registered nurses, three members of care staff, a hostess, a member of the kitchen staff and two well-being staff who were part of the team organising activities for people who lived in Old Gates. In addition, we spoke to two visiting health professionals, the area director and the area quality director.

We looked at 13 people's care records and a selection of medicines and medicines administration records (MARs). We looked at other records including quality monitoring records, staff recruitment and training records and records of checks carried out on the premises and equipment.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Details are in the key questions below.

The report includes evidence and information gathered by all members of the inspection team.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Staffing and recruitment

•Staffing levels meant that some people's needs were not always met and their quality of life was affected. As a result of the concerns, we raised an organisational safeguarding alert with the local authority in relation to the home.

•People on both Holly and Cherry units told us there were often not enough staff available to meet their needs in a timely manner. Comments people made to us included, "There are only two people on duty at night and I feel it's unsafe", "The trouble is, there are not enough staff. They say 'sorry, I'm busy. I'll be back in a minute'; they're run off their feet. You're having to wait for help and there's a bit of a bottleneck in the mornings. You can ring, but they're busy", "There are not enough staff; absolutely not. They're running around like blue-tailed flies. They're under a great deal of pressure." Visitors also commented, "I don't think there are enough staff because I was once sitting with [name of relative] in their room for a couple of hours and it took them 15 to 20 minutes to come when I pressed the buzzer" and "Three quarters of an hour ago, we buzzed [for care]. The carer said [name of relative] is not allowed to do it on her own, so it hasn't happened yet."

•The view from other people we spoke with was that, although there were not always enough staff on duty, this did not impact directly on the care they received.

•Staff on Holly unit told us due to the complexity of people's needs and the time it took for staff to meet them, they did not have enough time to complete important paperwork such as developing or updating care plans. Our review of records showed one person did not have any up to date care plans in place, other than a seven day care plan which was completed on their admission three weeks before our inspection.

•Staff on Holly unit told us they did not have time to deliver personal care to people and that, although people always received a bed bath, they were not regularly being given a bath or shower. One person who lived on this unit told us they were expecting to have their first shower the day after the inspection; they had been admitted to the home before Christmas 2018.

•Staff told us there had been three occasions when staff had been asked by managers to work a night shift when they had already completed a 12 hour day shift. They told us they had been advised by managers they could use a spare bedroom on the unit to 'sleep-in' during these night shifts. When we discussed this with the registered manager they confirmed there had been two occasions when staff had been asked to work an additional shift but denied staff had been told they could 'sleep-in'.

•Following the inspection, we were contacted by a member of staff who worked nights at the home. They told us due to the complexity of people's needs, the lack of staff at night had a direct impact on their ability to provide people with safe care and treatment.

•Our observations on Holly unit showed that many people remained in bed throughout both days of the inspection. One person told us they had asked staff to get them out of bed to eat their lunch but had been told staff were unavailable to do so at the time of their request. We later saw them eating their lunch in bed. Another person told us they had spent the previous day in bed as staff had not asked them if they wanted to

get up. They told us staff would generally get them out of bed if they requested to do so. However, our observations showed most people on Holly unit would be unable to make this request of staff.
•□Records we reviewed showed there had been numerous occasions in the two weeks prior to our inspection when staff on Holly unit had not provided a person with the pressure relief they required. This meant there was a risk the person's skin integrity would be affected.
•□Recruitment checks were not always fully completed; staff had not been asked to explain any gaps in their employment history.

This demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
•□Medicines were not managed safely in the home.
•□Records for adding thickening powder to drinks, for people who have difficulty swallowing, were insufficient to keep people safe
•□Records to show topical preparations such as creams were being applied were not always completed regularly; therefore, we were not assured people's skin was cared for properly
•□Records to demonstrate the times medicines were administered were not always completed; the four-hour time interval required between doses of paracetamol was not always observed.
•□Records of the application of patches was not always completed; information regarding application of the patch was not always followed.
•□Additional records to document the administration of 'when required' medicines were not always completed to inform staff when medicines were needed.
•□The documented evidence of authorisation to administer medicines covertly, hidden in food or drink, was not always in place

This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
•□Staff had a good understanding of how to keep people safe and three quarters of the staff team had received recent training in safeguarding adults.
•□People who lived in the home and their visitors had no concerns about safety, bullying or harassment. Comments people made to us included, "I definitely feel safe here but I'd speak to one of the carers if I didn't, and they'd go to the unit manager. My rights are respected" and "I feel safe, no problems at all."

Assessing risk, safety monitoring and management
•□Records showed one person who should have been identified as at risk of choking due to their medical history, did not have a relevant risk assessment in place. This meant staff might not have the information necessary to provide the person with safe care.
•□Systems were in place to record and review any accidents or incidents which had occurred.
We found a number of people did not have Personal Emergency Evacuation Plans (PEEPs) in place; this meant staff might not be aware of the support people required in the event of an emergency at the home.

Preventing and controlling infection
•□The home was found to be clean. Appropriate action had been taken in relation to an outbreak of diarrhoea and vomiting which had occurred on Rowan unit.

Learning lessons when things go wrong

• The registered manager had daily meetings with senior staff and regular meetings with unit managers. These were used to share lessons learned as a result of complaints received or incidents which had occurred.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience
•□Staff had not always received the training and supervision to help ensure they were able to provide people with effective care.
•□Although records we reviewed showed all staff had completed an induction, only 76% of staff had completed the provider's mandatory training. Staff told us they were too busy to complete required training.
•□Records showed staff were not receiving regular supervision. Supervision is an opportunity for staff to discuss their role, concerns they might have and any training and development needs. Senior staff responsible for providing supervision, told us they did not have time to carry out this duty.

This demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•□People's needs were assessed before their admission to the home; this was intended to ensure staff were able to meet their needs. However, staff on Holly unit told us they were concerned that one person had been admitted to the unit in spite of two preadmission assessments which had concluded that their needs were too complex for the unit. The registered manager told us they had arranged the person's admission as they did not agree with the outcome of these assessments; we saw evidence of their rationale for this decision.
•□We saw that the preadmission assessment was used to develop care plans and risk assessments relevant to people's needs.
•□People told us their choices were generally respected. However, as reported under the Safe section of this report, some people's preferences regarding personal care were not always met.

Supporting people to eat and drink enough to maintain a balanced diet
•□People provided mixed feedback about the food provided in the home. During the inspection we observed people were not always given the support or equipment they needed to eat their meals in a dignified way.
•□People's food and fluid intake was not always recorded when they were identified as at risk in this area. Staff spoken with on Holly unit were not following the advice provided for one person by a Speech and Language Therapist (SALT). They told us this was because the information had not been communicated to them. Handover records for the day the SALT team visited were missing so we could not check what information had been given to staff at the end of the relevant shift.

Staff working with other agencies to provide consistent, effective, timely care

•□The home was part of the 'red bag' scheme; this is intended to improve communication between care homes and hospitals. When a person was admitted to hospital, care staff packed a red bag which included paperwork documenting the person's needs, the person's medicines, clothes and personal items. The registered manager told us this system was working well in the home.

Adapting service, design, decoration to meet people's needs
•□Improvements had been made to some areas of the home since the last inspection, including the unit for people living with dementia. An on-going plan of refurbishment was in place.
•□People spoken with told us they were happy with the environment.

Supporting people to live healthier lives, access healthcare services and support
•□People told us staff were good at contacting health professionals if they were unwell.
•□A visiting health professional told us the service was good at acting on advice given to improve people's health outcomes. They also told us that staff were always able to give them detailed information about people's needs.

Ensuring consent to care and treatment in line with law and guidance
•□The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•□People told us staff always asked for their consent before they provided any care.
•□We saw evidence that mental capacity assessments had been completed. However, it was not always obvious to which specific decisions these referred.
•□The registered manager had ensured necessary DoLS applications had been submitted to the local authority when people were unable to consent to their care arrangements in the home. They held a central record to show when any applications had been authorised and any conditions included in each authorisation; this helped to ensure people's rights were protected.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

- Staff were provided with training on equality and diversity. Policies advised staff of the importance of ensuring people were treated equally and their rights respected.
- People's cultural and religious needs were considered as part of the assessment and care planning process. Arrangements were in place for religious ministers to visit the home. Some staff were able to communicate with people in their preferred language.
- Although we saw limited positive interactions between staff and people living on Holly unit, particularly on the first day of the inspection, people told us staff were generally kind and caring although they did not have time to spend with them. Comments people made included, "Most of the carers are very, very kind. We've had a lot of kindness shown. There's one or two who are very hasty. I feel I've got to try and keep up with them rather than the other way round" and "The staff are quite nice but I see sometimes they don't attend to [name of relative] when they need it; they take a long time to come."
- We observed that, although staff on Cherry unit were busy, they took the time to have friendly exchanges with people living on the unit while completing tasks. Comments made by people on this unit included, "The two carers this morning were fantastic, some of the most caring people I know" and "Everybody's kind; you can't fault them for that."

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

- We saw some evidence that staff asked people about their choices regarding their day to day care. However, as reported under the Safe section of this report, due to staffing levels, some people on Holly unit did not feel staff always asked about the care they wanted or acted in accordance with their expressed wishes.

Respecting and promoting people's privacy, dignity and independence

- Most people told us staff helped them to be as independent as possible. Comments made to us included, "The staff try to push me forward in my independence" and "I've been walking from my room into the dining room, with my frame. Staff walk behind me with the wheelchair ready, in case I start to 'go'. They're only just starting to do that though; it's more intense at the moment, to get me home."
- People told us staff always respected their dignity and privacy. However, our observations showed some people were left in their bedrooms with the door open and their catheter bag visible to visitors on the unit. There was no evidence in the records we reviewed to show that people had agreed to their door being open during the day. Records showed only 40% of staff had completed training in providing dignity informed care.

Requires Improvement

Is the service responsive?

Our findings

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

RI: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Our observations and conversations during the inspection showed that people did not always have choice and control over the care they received.
- The provider had a 'resident of the day' system in place but we did not see evidence that this was being used effectively to ensure people were receiving the care they wanted and needed.
- Some of the care plans we reviewed showed evidence that the person, or where appropriate their relative, had been involved in the review of care plans. However, comments some people made to us showed they were unaware of the care planning review process and had not been offered the opportunity to contribute to it.
- We saw evidence that a range of activities was provided to help improve the well-being of people who lived in the home; this included both group activities and 1-1 time with individuals who chose not to participate in groups. During the inspection, we observed well-being staff encouraging people to join in with activities.
- The provider used technology to help meet people's needs; this included the use of sensor equipment to help keep people safe when they were at risk of falls.
- People's communication needs were identified, recorded and highlighted in care plans.

Improving care quality in response to complaints or concerns

- The provider had systems in place to ensure all complaints were documented, investigated and responded to. The registered manager told us the outcome of any complaint was always discussed with the relevant unit manager; this was to help avoid similar events happening in the future.
- People told us they knew how to make a complaint and that appropriate action had been taken if they had raised any concerns. Comments people made included, "I made a complaint about a staff member; I spoke to [registered manager] and it was sorted out" and "[My relative] did complain about the food and spoke directly to the chef. They came up to the unit and [my relative] says it has improved a bit since."

End of life care and support

- People's end of life wishes were documented. Some staff told us they would like additional training on how to provide sensitive and compassionate end of life care.

Requires Improvement

Is the service well-led?

Our findings

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

RI: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Staff had job descriptions which set out the key requirements of their role. Policies and procedures were in place to guide staff in their practice.
- Staff told us they were concerned that there was a lack of clinical leadership in the home and that this had been impacted upon by the provider's decision to appoint a deputy manager who did not have a clinical background.
- Staff were generally positive about the registered manager. However, they felt the registered manager did not get enough support from the provider and that staff morale had deteriorated since the new provider had taken over the running of the service.
- Although the registered manager and provider were carrying out regular checks and audits regarding the quality and safety of the service, we found these had been ineffective; this had resulted in us identifying shortfalls during our inspection. We noted actions had not been taken in response to care plan audits as staff told us they did not have the time to complete required actions. The handover process on Holly unit had not always been effective enough to ensure staff were updated about changes in people's needs.

This demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The provider had a policy in place which outlined how they would fulfil their duty of candour when things went wrong with the care and treatment a person received in the home.
- Although staff demonstrated a commitment to the wish to provide high quality care, they told us their ability to do so was compromised by staffing levels in the home. Staff did not feel their concerns were always listened to or addressed; this had had a negative impact on staff morale.

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

- People who lived in the home and their relative had opportunities to provide feedback on the service provided in the home. We saw the results from the last survey distributed by the provider in June 2018 were largely positive.
- Staff told us regular staff meetings took place. Most staff told us they were confident to express their views

in these meetings.

Continuous learning and improving care

• The provider had systems in place to share learning across services. The registered manager had daily meetings with senior staff from the three units. We observed these meetings were used to hold staff to account and help ensure action was taken to improve the care people received.

Working in partnership with others

• Evidence we looked at demonstrated the service worked in partnership with the wider professional team. Records noted the involvement of GP, mental health teams, social workers and commissioners of people's care.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always safely managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to ensure the quality and safety of the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs.

The enforcement action we took:

We issued a warning notice