Gedling Village Ltd

Gedling Village Care Home

Inspection report

73 Arnold Lane
Gedling
Nottingham
Nottinghamshire
NG4 4HA

Tel: 01159877330

Date of inspection visit:
19 January 2021
27 January 2021

Date of publication:
23 March 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Gedling Village Care Home is a care home providing personal care for 36 people aged 65 and over, some of whom were living with dementia. The service can support up to 60 people in one adapted building over three floors.

People's experience of using this service and what we found
People living at the service were not safe and were placed at risk of harm. Staffing levels, risk management and poor infection control practices at the service put people at risk. Medicines were not consistently managed safely, and action was not taken when issues were found. Records relating to people's care contained contradictory information; this did not enable staff to provide safe care.

We received mix feedback from people and their relatives regarding the quality of care and the support people received. People were left alone for long periods of time and when people called for help, they also waited for long periods; our observations supported this and indicated there were not enough staff to meet people's needs.

The leadership, management and governance measures did not provide assurances the service was well-led, and that people lived and were cared for in a safe environment. Lessons were not being learned, and this resulted in a pattern of incidents which placed people at risk of harm.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 10 July 2019) and there were multiple breaches in regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 27 February 2019. Breaches of legal requirements were found around regulation 12 (safe care and treatment), regulation 9 (person centred care), regulation 17 (good governance) and regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC issued requirement notices and a warning notice for these breaches of regulation. We did not follow up on the warning notice in a timely manner and due to the pandemic were unable to conduct a comprehensive inspection of the service. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions Safe, Responsive

and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to Inadequate. This is based on the findings at this inspection.

Following receipt of further information and ongoing concerns relating to people's care, we carried out an early morning second visit to the service on 27 January 2021.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gedling Village Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Following our second visit to the service we sent a letter to the provider outlining the concerns we found during the inspection, which they responded to with a detailed plan of what action they would take. The provider took immediate action to reduce risks and ensure the safety of people at the service.

We have identified breaches in relation to keeping people safe, risk, medicines, infection control, staffing, care planning and governance at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Gedling Village 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This Inspection was carried out by two inspectors

Service and service type
Gedling Village 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.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
On 19 January 2021 we spoke with seven staff members including the registered manager, deputy manager,

care workers, maintenance worker and kitchen staff. We observed interactions between staff and people. We reviewed a range of records. This included multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including concerns and complaints were reviewed.

We contacted seven relatives to ask about their experience of the service. We contacted twelve staff to ask them about how they cared for people and their experience of working at Gedling Village Care Home. We sought further information from the provider, that we were unable to review on site, to inform our inspection judgements. This included five peoples care records, staff training information, staff rotas and policies.

On 27 January 2021 we spoke with five members of staff including care workers, senior care workers, the deputy manager and registered manager. We spoke with three people who used the service. Some people were not able to fully share with us their experiences using the service. Therefore, we spent time observing interactions between people and the staff supporting them in communal areas.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the area manager who provided further information when requested.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were enough staff to meet people's needs and ensure their safety. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation.

- There continued to be not enough staff to meet the needs of people.
- During both days of our inspection we observed that there was insufficient staff. People were left alone for long periods and were made to wait for support. We observed people shouting for help and call bells ringing for an extensive period. We observed staff silencing call bells and leaving people without giving them the support they required.
- People told us 'I have to shout for help, but I have to wait, and I can't reach my buzzer sometimes'.
- Staff told us due to staffing they felt they could not give people the care they needed. Staff explained they felt at times they could not keep people safe due to low staffing numbers. On both days of our inspection we observed people were left alone for long periods.
- The registered manager had not taken enough action in ensuring there were always enough staff on duty, despite having risks highlighted to them during the first day of our inspection. Poor management of staff placed people at an increased risk of avoidable harm.

The provider failed to ensure there were enough staff on duty to safely meet people's needs. This is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were not protected from risks associated with their needs. People's needs were not being appropriately assessed and risk reduction measures were not in place.
- We found some radiators that were too hot to touch, this left people at heightened risk of burns and scalds.

● We found temperatures within the care home to have a detrimental effect on the well-being of people. We observed one-person shouting 'Please someone help me, I am just so dry, I need some water'. We raised the concern regarding both these issues with the management and action was taken.
● People had experienced multiple falls and adequate action had not be taken to reduce further risk. For example, we found people who were at risk of falls left alone for long periods without appropriate care and support, this led to a high number of repeated unwitnessed falls.
● Information surrounding people's needs were not always available. For example, we found information relating to people's dietary needs had not always been passed to kitchen staff.
● The provider kept a log of incidents and recorded what actions had been taken, however we found the actions documented had not always been taken and incidents were repeated.

Using Medicines safely.

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not managed safely.
● Medicines were not always stored in a safe way. We found medicines which should have been locked away on the floor, staff did not know who they belonged to and action had not been taken to rectify this.
● Medicine trolleys were left unattended in areas where people were left alone.
● We found staff training in regard to knowledge surrounding medicines were not assessed effectively. This placed people at risk of harm.

The provider failed to ensure that people received care and treatment in a safe way and protect them from risk of harm, this is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were at risk of infection due to poor infection prevention and control practices.
● Best practice guidance was not consistently followed to help reduced the risk of COVID-19. For example, people were not cared for in-line with current guidance following a hospital stay. We also observed staff supporting
people without appropriate personal protective equipment [PPE].
● Social distancing guidelines were not followed; people were sat in very close proximity to each other and we observed staff embracing one another. This practice increases the risk of possible transmission of COVID-19.
● The home appeared clean, however staff did not dispose of PPE appropriately. During the second day of our inspection we observed used PPE on the floor throughout the home.

The provider failed to ensure that infection prevention control measures were in place to ensure people received care and treatment in a safe way, This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and process to safeguard people from the risk of abuse
● People were not always safeguarded from risk of abuse.
● We received mixed feedback from staff in the confidence they had in the management team in regard to

reporting safeguarding incidents. Whilst some staff told us they felt concerns were acted upon other staff told us they could not approach management and when they did their concerns were not acted upon.

● People told us they felt management listened to some concerns but had to make repeated requests for others, 'I have to tell them constantly about what they may think as of minor things but I know they would bother my [relative], it can be quiet upsetting'.

● Safeguarding concerns were reported however action was not always consistently taken.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure people's needs were met through a personalised service and this left people at risk of inconsistent support. This resulted in a breach of regulation 9 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- Care and support was not always delivered in a person-centred way.
- During our second day we visited the service at 5am, where we observed people being woken very early in the morning for personal care, we then observed the same people asleep in chairs and at dining tables shortly after. Staff told us people were woken to make things easier for the next shift rather than it being a person's choice.
- Care was task orientated and was not person centred, we found staff had a list of tasks to complete for each person and these tasks were the same for each person.
- Care plans did not always reflect people's current needs. For example, one person was receiving a liquid diet, care plans did not reflect why this was the case or who had made this decision.
- People's representatives told us they had not always been involved in planning care for their loved ones. One person told us they had to make several requests to be involved in care planning meetings.
- Care records detailed people's religious beliefs, however these had not been updated to reflect how peoples religious needs had been supported through the current COVID-19 pandemic.

The provider had failed to ensure that people received person centred care. This is a continued breach of Regulation 9 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Peoples communication needs were not always met.
- Information on the menu board located in the dining room was not clearly written and no other menus were observed to be available.

● People who were hard of hearing were shouted at to gain an understanding of what they required. We observed one member of staff walk away from a person stating, 'oh I don't what [they] were saying'.
● Information such as complaints and guidance surrounding COVID-19 were displayed in written format only. Although this format did not meet the communication needs of everyone living at the service, evidence was provided to show that staff had spoken to people about COVID-19.

Improving care quality in response to complaints or concerns
● Concerns were not always acted upon.
● People told us they knew how to complain but felt sometimes that concerns were not always acted upon. For example, one person told us they have to select which issues are the most important because things often go unresolved.
● The registered manager kept a record of formal complaints and had responded in a timely manner. However, there was no record of any informal comments or concerns raised by people or how it was addressed.

End of life care and support
● Care plans included information relating to end of life care.
● Some contradictory information was held in care plans. For example, we reviewed one care plan which held confusing information regarding whether a person should be resuscitated or not.
● People had been given the opportunity to discuss their end of life wishes.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Peoples interests were mostly recorded in care plans.
● We observed activities taking place during our first day of inspection. People appeared engaged and were seen laughing together. We observed the activities co-ordinator spending time with individuals who did not want to engage in group activities.
● Records evaluating people's involvement were in place.
● The provider had built a structure away from the home to allow for people to safely see their loved ones whilst COVID-19 was still a risk.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure consistent management and leadership to enable a culture that improved care. This was a breach of regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice detailing our concerns and telling the provider to become compliant with this regulation.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The registered manager had not had effective managerial oversight of risk. The internal quality assurance processes had not been used to monitor the service effectively and had failed to identify and improve shortfalls in relation to falls management and staffing at the service.
- The registered manager had failed to take action to reduce risks posed to people's health and safety. For example, we found where people displayed behaviours that may challenge, not enough action had been taken to reduce the risk these behaviours posed to people.
- Quality audits were not effective in improving outcomes. For example, audits relating to the safe management of medicines were inconsistent. The registered manager was aware of these shortfalls, but no action had been taken.
- Care records were not consistent and did not provide staff with accurate information for staff to support people safely. For example, we were informed that one person was no longer able to mobilise independently, but care records did not reflect this.
- We found that outcomes from incidents were not always accurate. Actions had not always been taken as assured by the registered manager to improve the safety and quality of care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- There was not always an open and inclusive culture within the home.
- Not all staff felt comfortable raising concerns and when they did, they did not feel listened too. Staff told us 'You can't really express your concerns much without either you being in the wrong or getting your head bitten off', and 'I raise concerns and I just get told do my job properly'.

● We received mixed feedback regarding the morale and support offered. Most staff we spoke to said morale was low in the home and this often dependent on the mood of the management team. One member of staff said, 'I honestly feel as though I cannot approach management for any sort of support, as I feel I am being belittled by what I say or judged because I am just a 'carer'.
● Professional advice and instructions from healthcare professionals such as community nurses, were not always followed. For example, one person who lived with pressure damage had instructions in place to prevent further damage however staff were not supplied with the correct equipment to follow these instructions.
● The registered manager had worked with the GP's surgery to safely deliver the COVID-19 vaccination programme within the home.

The provider failed to ensure that systems and processes were in place to promote a transparent culture to improve the quality of care in the home. This was a continued breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Following our second day of inspection we issued a letter of intent to the provider and received assurances and a comprehensive action plan which detailed how the immediate risks would be rectified.
● The provider took immediate action to reduce risks and protect people from harm.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager had submitted statutory notifications to CQC which is a legal requirement to inform the commission of events and incidents which impact people, however we found that action had not always been taken to reduce further events.
● Relatives told us that management informed them when things went wrong. For example, when a person fell relatives were contacted.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care leaving them at risk of inconsistent support. Reg 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to ensure people were safe, staff were not always deployed effectively to ensure people's needs were met. Reg 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at significant risk of harm from falls and their environment. Medicines were not always stored or managed safely. Infection control practices were not in line with current guidance leaving people at heightened risk during the COVID-19 pandemic. Reg 12 (a) (b) (g) (h)

The enforcement action we took:

We served a warning notice detailing our concerns and telling the provider to become compliant with this regulation within one month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety of the service were not effective. This had a negative impact on the quality and safety of the service. Reg 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

We served a warning notice detailing our concerns and telling the provider to become compliant with this regulation within six weeks.