New Servol

Gillott Respite Services

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

About the service: Gillott Respite Service is a care home that provides accommodation for up to six people for people who need crisis support with their mental health. At the time of the inspection two people lived at the home.

People's experience of using this service:
Medication management was unsafe and placed people at risk of harm. People's medicines were not received into the home in a safe way and the records relating to people's medicines were poor.

The systems and processes in place at the home to monitor the quality and safety of the service were not always effective in identifying and driving up improvements in the service.

Referral information in respect of people's needs and risks was received by the service prior to their admission. On admission to the service people's needs and risks were not always assessed by the provider to ensure that staff had clear guidance on how to provide people with safe and appropriate, person centred care.

Some of the language used to refer to people in records relating to their support was inappropriate as it referred to a person by a 'number' as opposed to a name. This depersonalised people and was disrespectful.

Records showed that people did not always engage with staff or that staff ensured that people received the support they needed. Some people had a meeting with their keyworker whereas others had not.

The provider's complaints policy and procedure needed greater detail of who to report concerns to, if people were unhappy with the support provided.

People were supported to be independent by shopping for and cooking their own meals, doing their own laundry and other domestic duties.

Regular meetings took place with people who lived at the home to involve them in the running of the service and seek their feedback. A survey of people's views of the service had also been undertaken.

During our visit we saw that staff members treated people kindly and with respect.

People's needs were met by a range of health and social care professionals involved in supporting the person's mental health. The provider also ensured the person was supported to access local services such as housing, benefits agency and local GP and dentists.

The premises were clean and well maintained.

Staff told us they felt supported by the manager. Staff training was sufficient and the majority was up to date.

The atmosphere at the home was warm and inviting. The culture of the staff team was open and transparent. The manager and staff were responsive to our feedback and committed to improving the service.

Rating at last inspection and why we inspected: This was the first inspection of the service since it registered as a regulated provider with CQC.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led

Details are in our Well Led findings below.

Gillott Respite Services

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.

Inspection team: This inspection was undertaken by one adult social care inspector.

Service and service type: Gillott Respite Services is a care home. People in care homes receive accommodation and personal care. 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 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: We reviewed information we had received about the service since the service was registered. We assessed the 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 also contacted the local authority to gain their feedback on the service. We used all this information to plan our inspection.

We talked with one person who lived at the home at the time of our inspection. We spoke with the manager and member of support staff. The day after the inspection we also spoke by telephone with the Chief Executive Officer.

We reviewed a range of records. This included two people's care records and a sample of medication records. We viewed two staff recruitment files and other records relating to staff training and support of staff and the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Medication management was unsafe and did not adhere to best practice guidelines specified by NICE (The National Institute for Health and Social Care Excellence).
- People's medicines were removed from their original packets and put into a weekly pill box in advance of their administration. This is called secondary dispensing. Secondary dispensing is not good practice as it increases the risk of an error being made when medication is administered.
- Medicines booked into the home were not properly accounted for. People's medication records were handwritten by a member of staff on duty without a second member of staff or healthcare professional checking it was correct.
- Medication administration records did not include sufficient information about people to enable staff to ensure they were administering the right medication to the right person.
- There was also no information on people's medication allergies in order to prevent a medication being prescribed for the person that was unsuitable for them to take.
- There were no suitable 'as and when medication plans in place to advise staff on the circumstances in which such medicines should be given. This meant there was a risk that these medicines would not be given to the person when they needed them.
- Shortly after our inspection, the manager contacted us and told us that they had ceased the secondary dispensing of medication. They said that medication was now only administered from its original packaging in line with best practice guidance. They also provided details of other improvements they intended to make with regards to medication management.
- Referral information about people's needs and risks was provided by other health care professionals prior to admission. This information enabled the provider to make a decision as to whether the service was able to meet their needs. A basic risk management plan was then developed.
- We looked at the care files belonging to two people. We found that neither person had an assessment of their needs on admission to the service. People's support plans had also not been completed at the time of our visit.
- We recognised that people living in the home came into the service quickly due to requiring crisis support and only stayed in the home for a maximum of 21 days. Nevertheless support planning and risk management required improvement to ensure people received safe and appropriate care.
- A handover meeting was planned to take place when there was a changeover of staff from one shift to the next. Records showed that these handover meetings were not consistently undertaken. This meant there was a risk that important information on people's well-being was not communicated to other staff members when they came on duty.

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

Regulations 2014.

Learning lessons when things go wrong
● Accident and incidents were clearly documented with the action taken by staff to support the person's wellbeing and safety at the time the accident or incident occurred.
● There was little evidence that accident and incident information was used in any meaningful way to learn from how accident and incidents occurred so that preventative action could be taken.
● The manager told us this information was analysed but that the staff member responsible for undertaking these analyses was currently off work. No evidence of these analyses was provided during the inspection.

Staffing and recruitment
● We looked at the recruitment records for two staff. Pre-employment checks were carried out prior to employment to ensure staff members were safe and suitable to work with vulnerable people.
● The previous employer references looked at during the inspection did not match the referees noted on the staff members' job application forms. The provider had not verified these references as being from an authorised and reliable source. This aspect of staff recruitment required improvement.
● On the day of our inspection the staff rotas indicated that staffing levels were sufficient to meet people's needs.

Systems and processes to safeguard people from the risk of abuse
● Staff received safeguarding training. The staff member we spoke with knew what action to take to protect people from the risk of abuse or improper treatment.
● Safeguarding records showed that appropriate action was taken to identify and investigate incidents of a safeguarding nature.
● There were a number of safeguarding incidents that had not been reported to CQC in accordance with the provider's regulatory responsibilities.

Preventing and controlling infection
● We looked around the home and saw that it was clean and tidy. The home was well maintained and standards of infection control were good.
● There were arrangements in place to monitor the risk of Legionella bacteria developing in the home's water system.

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.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had not been properly assessed on admission to the home.
- From people's care records, it was difficult to know if people received effective support in line with best practice as people living in the home did not have an adequate support plan in place. We spoke with the manager about this. They acknowledged that record keeping required improvement.

Adapting service, design, decoration to meet people's needs

- . The home was purpose built. The home's interior design and decoration met the needs of the people living there. There was also a well maintained back garden with small patio area for people to use.
- The manager told us that a significant number of people who came to live in the home smoked. The home had a no smoking policy inside in the home so people smoked outside. There was no adequate smoking shelter in the back garden to protect people from the elements should they wish to do this. This was because there was simply a table, chair and sun umbrella to protect people from the elements. In bad weather this would be unsuitable and would not protect people from getting wet and was unlikely to be able to withstand strong winds. This required review.

Staff support: induction, training, skills and experience

- The majority of staff training was up to date and sufficient to meet people's needs. For example staff received training in safeguarding; medication administration, mental health act, food safety, drug and alcohol awareness and positive behaviour support.
- Staff had access to regular supervision with their line manager and a yearly appraisal of their skills and abilities in respect of their job role.

Supporting people to eat and drink enough to maintain a balanced diet

- We saw that people purchased some of their own food independently. The home had ensured that each person had a designated space for their own food.
- People prepared their own meals and staff helped people shop or got the local food bank for supplies as and when required.
- One person told us "Staff bought some food for me when I first came here and helped me to settle in".
- We saw that people had free access to the kitchen during the day and cooked their own meals and made their own drinks as and when required.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live

healthier lives, access healthcare services and support

● People's mental health was supported by a range of health and social care professionals such as home treatment teams, community psychiatric services and GP's.

● The service worked with the benefits agency, local health care services and housing to help people's transition from the service when they left to go back home.

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.

●At the time of our inspection, there was no-one living in the home subject to DoLs.

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.

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

- Some of the language used to refer to people in records relating to their support was inappropriate as it referred to a person by a 'number' as opposed to a name. This depersonalised people and was disrespectful.
- Some aspects of the service did not demonstrate that the service cared about people's welfare at all times. For example, there was a lack of adequate assessment and planning of people's care which meant there was a risk that the person would not receive sufficient support.
- We observed that staff were kind, caring and respectful in all of their interactions with people.
- We heard staff giving people positive feedback on their appearance. In care files we saw that this was an area some people struggled with. People's daily records indicated that since coming to the home and with staff support people's physical appearance and personal hygiene improved.
- One person told us "The staff are nice. I've had a lot of help. I am much better than I was after being here".

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

- Monthly resident meetings took place to enable people to express their views on the service and any improvements required.
- A survey of people's opinion on the support provided had been completed in 2017. The majority of the feedback was good.

Respecting and promoting people's privacy, dignity and independence

- People independence was promoted. They were able to do their own laundry and cooking and were encouraged to clean their own bedrooms during their stay.
- People were able to come and go from the home as and when they pleased. We saw that staff supported people to maintain the relationships that were important to them.

Requires Improvement

Is the service responsive?

Our findings

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

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.

- One person's records showed that they had a meeting with their keyworker to talk about their well-being and progress within the first few days of admission to the service. Another person's records did not. It was difficult to tell what personalised support the person was in receipt of. We spoke with the manager about this and they told us they would review this with the staff team without delay.
- There was however some person centred information in people's files. This included information about their mental health needs, life history and the ongoing involvement of other professionals in the person's care.
- Daily records relating to each person's well-being were maintained and showed that people's well-being was monitored each day.

Improving care quality in response to complaints or concerns

- The home had a policy and procedure in place for receiving and responding to complaints about the service. The procedure was displayed on the noticeboard in the entrance area of the home,
- The procedure displayed required review. It did not provide the names and address for the service manager, team leader and provider to whom complaints should be addressed. The timescales for responding to the complaint were also unclear.
- People we spoke with told us they knew how to make a complaint but said they had no concerns.
- At the time of our visit no formal complaints about the service had been received.

End of life care and support

- The service did not support people who required end of life care. The majority of people who came to live at the home were younger adults in need of short term crisis support.

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

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; Continuous learning and improving care

- Systems and arrangements were not always used to monitor and improve the quality and safety of the service. For example, the management of medication was unsafe. The provider's medication audits and minutes from staff meetings showed that concerns about the way people's medicines were managed had been on-going for some time. Despite this no effective action had been taken.
- Other concerns we identified during our visit had also not been effectively addressed. The lack of timely assessment and support planning, inconsistent handover meetings and keyworker involvement in people's care were all identified via the provider's governance systems. Yet no robust action had been taken to address these issues.
- This meant that the provider's governance arrangements were ineffective in mitigating risks to people's health, safety and welfare. It also raised concerns about the provider's ability to recognise and respond to risk and their regulatory requirements.

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 not always ensured that notifiable incidents were reported to CQC. The number of incidents not notified appropriately was minimal. Registered providers however must notify CQC of certain changes, events or incidents that affect their service and the people who use it.
- The planning of person centred care required improvement. People's support plans had not always been discussed and agreed with the person in a timely manner.
- Policies and procedures had not always been followed to ensure people were protected from harm. For example, the provider's medication policy and admission procedure had not been followed.

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider worked closely with a range of health and social care agencies to ensure people's equality

needs were met. People's support was co-ordinated with home treatment teams, community psychiatric services and social services.

● The service had good links with the local community. People were supported to register with a local GP and obtain or resolve issues with their housing and other benefits. People were also signposted to other local services such as the local food bank.

● Weekly resident meetings took place to engage with people using the service and to ensure that they were happy with the service provided.

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 Medication management was not safe. People's needs were not properly assessed on admission to the home. Risk management required improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were governance systems in place were ineffective in identifying and mitigating risks to people's health, safety and welfare. Management systems in place had not ensured people's needs were properly assessed and planned for in the delivery of care.