The Brandon Trust

Gilbert Scott Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Gilbert Scott Care Home provides accommodation and personal care for up to 5 people with learning disabilities. At the time of our inspection there were four people with diverse and complex support needs living in the home.

The service had a registered manager at the time of 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.

We inspected the home in July 2015 and identified concerns related to the implementation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), the environment people lived in, the governance of the service and how people were treated with respect. We took enforcement action and told the provider to make improvements in how people were treated with respect and the implementation of the MCA and DoLS and during an inspection on December 2015 we found these improvements had been made.

At this inspection we found that improvements had also been made regarding the environment and governance of the service.

People felt safe and well cared for, they were relaxed in staff company and sought out staff when they needed assistance. They were protected from harm because staff understood how to reduce the risks they faced. They also knew how to identify and respond to abuse and told us they would be confident to do so.

People had support and care when they needed it from staff who had been safely recruited and understood their needs. Staff were consistent in their knowledge of people's care needs and spoke confidently about the support people needed to meet these needs. They told us they felt supported in their roles and had taken training that provided them with the necessary knowledge and skills to support the individuals living in the home. Staff were cheerful and treated people and visitors with respect and kindness throughout our inspection.

People saw health care professionals when necessary. Records reflected that staff responded appropriately to emerging, ongoing and emergency healthcare needs. People received their medicines as they were prescribed.

Staff understood how people consented to the care they provided and encouraged people to make decisions about their lives. Care plans and practice reflected the framework of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards had been applied for when people needed to live in the home to be cared for safely but did not have the mental capacity to consent to this.

The home was clean throughout and how there was on going work related to how people could make the

most of the space available for leisure, relaxation and daily living.
People were engaged with individual activities that reflected their preferences both within their home and the local area.

People had food and drinks that reflected their preferences and there were systems in place to ensure people had enough to eat and drink. When people needed particular diets or support to eat and drink safely this was in place.

Quality assurance had led to improvements being made and staff were actively encouraged to contribute their views to this process. People could not contribute verbally to improvement plans but their wishes, needs and reactions to changes were reflected in all improvement planning and review undertaken. Staff and professionals spoke positively about the management and staff team as a whole.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were supported by staff who understood the risks they faced and provided consistent support in response to these risks.

There were sufficient staff to support people at the times when they needed and wanted support.

People received their medicines as prescribed.

People were protected by staff who understood their role in keeping them safe.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were: knowledgeable about their needs; felt supported and had received relevant training for their role.
People were supported by staff who worked within the framework of the Mental Capacity Act 2005 and where needed, decisions were made in people's best interests.

People were supported to access healthcare professionals appropriately for both ongoing and acute healthcare needs.

The environment was used in a way that considered people's needs.

Is the service caring?

Good

The service was caring.

People had a good rapport with staff and we observed that people were relaxed in the company of staff.

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

People had their privacy and dignity respected.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive. People's care reflected their changing needs and wishes.

People had person centred care plans and were involved appropriately in regular reviews about their support.

People were enabled to access the complaints process by staff who advocated on their behalf. Where concerns and complaints had been received, these had been responded to appropriately.

Is the service well-led?

Good

The service was well led.

Staff told us that the management team were all approachable and that they were encouraged to discuss any ideas, issues or concerns.

Staff and management communicated well and shared an ethos of care. This meant people's needs and wishes were responded to by the service.

Quality assurance measures were in place and used to identify trends and areas for development.

Professionals spoke highly of the management and staff team.

Gilbert Scott Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 January 2017 and was announced. We announced the inspection because we wanted to make sure there would be staff available at Gilbert Scott Care Home as we visited at the weekend and people may have been out. The inspection was carried out by one inspector.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding concerns. The provider had completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the provider does well and what improvements they plan to make. We also spoke with three social care professionals who had visited or worked in partnership with the people and staff in the home.

We spoke, and spent time with, the four people who lived in the home and observed the support they received from staff. The people living in the home did not always use words as their main communication method. They used signs, words and gestures throughout the day to indicate their needs and contentment with staff and the inspector. During the day we also spoke with six members of staff, the registered manager, a visiting relative and health care professional. We looked at a range of records during the inspection. These included records related to the four people's care and two staff files. We also looked at information relating to the management of the service including quality assurance audits, staff information, meeting minutes and staff training.

Good

Is the service safe?

Our findings

At our inspection in July 2015 people were not living in a clean environment. There was a breach of regulation. At this inspection we found improvements had been made. The environment was clean throughout. Where there were difficulties associated with the building and immediate environment these had been addressed and followed up with the housing association who owned the property.

People were relaxed around each other and the staff. People smiled with staff and initiated interaction throughout our inspection. A relative told us they felt their relative was safe and amongst people who were "caring and well-meaning". They were confident they were kept informed and this reassured them. Staff who had worked in the home for a long period of time were able to describe behavioural changes that indicated that people were experiencing less anxiety as restrictions on their choices were lifted.

People were at a reduced risk of harm because staff were able to describe consistently the measures they took to keep people safe and this understanding reflected care plans that were written to mitigate assessed risks. For example staff described how they: helped people manage anxiety that could lead to harm; protected people's skin from developing sores and reduced the risks associated with eating and drinking safely. During the inspection we observed care being delivered in ways that were described in people's care plans to reduce risk. For example, one person used equipment to assist their mobility and staff understood how to support them to use this safely in ways that protected their skin integrity. Another person was supported to reduce risks associated with their lifestyle choices in a respectful manner that promoted their dignity by giving them control.

Staff were confident they would notice indications of abuse and knew how they should report any concerns they had. One member of staff described how they had been involved in the processes of a safeguarding concern and had been able to follow the correct processes because of their training and support. Staff told us they had received information about how to whistle blow and were committed to doing so if it was ever necessary.

Accidents and incidents were reviewed and actions taken to reduce the risks to people's safety. For example where people had fallen there was a system in place to ensure appropriate referrals were made. Incidents were also considered within the framework of a learning log. This meant that there were opportunities to understand the causes of incidents and to reflect and learn from them. This meant that people were at a reduced risk of reoccurring incidents and accidents, and they received support guided by the expertise of appropriate professionals.

There were enough staff to meet people's needs safely. We saw that people received one to one support whenever they initiated it. Staff told us there were enough staff to meet people's needs. One member of staff said: "There are almost always four staff. It is rare that we go down to three. We are safe then but we would only do it because of something last minute like sickness." This was reinforced within care delivery records that reflected agreed care plans.

There were organisational policies and procedures governing safe recruitment. The registered manager described how they assured themselves of the appropriateness of newly recruited staff through the implementation of robust checks. We were not able to see documentary evidence of this process as these records were held at a local office which was not accessible on the day of inspection.

Good

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People received care that was designed to meet their needs and staff supported people's ability to make choices about their day to day care. People living in the home were able to make some decisions about their day to day lives and the support they needed and did so throughout our inspection. They were able to make these decisions because the staff paid careful attention to their non-verbal communication. Where people were not able to make decisions this had been clearly assessed and decisions made on their behalf reflected the principles of the MCA. Staff understood how this legislation provided a framework to their work and talked about the importance of encouraging choice and seeking the least restrictive option wherever possible. This included access to rooms in their home that had previously been locked. Staff were seeking ways to support people with this access safely and in ways that met each person's needs.

The home had applied for Deprivation of Liberty Safeguards (DoLS) where necessary. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made that there are no other ways of supporting the person safely. We spoke with an advocate who had been employed as the relevant person's representative for a person living in the home. This is a role defined by the MCA to act on the person's behalf in respect of their DoLS. The advocate told us that the staff had understood their role and liaised appropriately. They also told us they had a "real interest in the person as an individual".

Professionals told us the staff had the skills they needed to do their jobs. One professional observed that the staff had developed the skills necessary to care for a person when their needs changed. Staff told us they felt supported to do their jobs. They spoke competently about the needs of people living in the home and told us that their training was appropriate for their role. Essential training included training related to protecting people from abuse, the law around decision making, communication and the safe administration of medicines. They talked about having the competencies to carry out tasks and also how they were trained to support people as individuals. One staff member of staff described their induction saying: "It was a great time for me I was able to learn what made them smile." Another member of staff told us the "I feel very supported." Staff described how guidance from the whole management team and their colleagues ensured

they were kept up to date with people's needs. Training reflected national changes such as the introduction of the Care Certificate which ensures that staff who are new to care receive a comprehensive induction to care work. There was a system in place for ensuring that staff training was kept up to date and training was reviewed in respect of the changing needs of the people living in the home. For example a training course had been arranged to ensure staff understood how to use new mobility equipment safely, staff also had information available so that they could learn individuals communication methods and this added to their basic communication training. We saw staff using these communication methods with people.

Staff told us that they received supervision from the management team and that these covered both practice and development issues.

People had food and drink that reflected their preferences and they were encouraged to make personal choices when the meal available was not to their preference on the day. This meant that choice was supported in ways that was meaningful to the individual people living in the home. People went into the kitchen and made choices about what they wanted to eat and drink frequently, this meant staff built up a better understanding of both their skills and preferences. One person told us they liked to cook. We saw another person making a smoothie with support. People who needed support to eat and drink received this and where people had guidance in place about safe eating and drinking this was followed.

People's weights and other indicators of adequate nutrition and hydration were measured regularly and there were systems in place to make sure that action would be taken if anyone became at risk of malnutrition or choking.

People were supported to maintain their health and records indicated they saw medical professionals whenever this was appropriate. We saw that guidance was in place for people following referral and input from a range of health professionals including Speech and Language Therapy, Physiotherapy and a District Nursing. Staff understood the guidance and recorded that they were following it. Staff were able to describe how people communicated if they were feeling unwell including facial expressions and bodily gestures. One person had needed to access a range of medical interventions in a limited time period. Staff anticipated the difficulties this may cause the person and worked with health professionals to reduce their anxiety and prepare for these individual events. A health professional had sent an email complementing the staff on their work supporting the person. They identified that the staff support had been a determining factor in the success of the health interventions for the person.

The environment was being considered to ensure it met people's needs. People's responses to changes were respected as part of this process. For example a room had been designated as a sensory room but the people living in the home had not engaged with the space. As a result the use of the room had been changed and people were being encouraged to use it as a place to carry out their hobbies and relax with or without staff input. Another room had been made into an activities room but people were choosing to take the activities to other parts of the home. As a result the room was being considered as a space that might improve the quality of life of one person who could no longer use their room in the way they had done previously.

Good

Is the service caring?

Our findings

People were relaxed in the company of staff and were confident seeking out staff throughout our inspection. A visiting health professional commented that staff were always "courteous and friendly" adding: "They are always very caring and supportive." Staff were kind and respectful with everyone using communication methods that worked for each person. Where people had developed their own communication methods such as individual signs, staff had learned and used these. Staff were also working to support people with new systems that could enable them to take more control of their lives. For example one person used objects to communicate and would get the car keys when they wanted to go out. Staff were trying to develop on this person's skills by taking some cutlery with them when they went out to eat to reinforce that the cutlery meant a meal out. They were working towards the person being able to communicate when they wanted to go for a meal out. We heard laughter, from some people and staff, during our inspection, and staff were quiet and used gentle touch with another person. The different approaches were reflected in care plans describing communication needs.

People were supported and enabled to make choices and the care provided reflected this. People were encouraged to choose their food and drinks, what activities they joined and day to day decisions such as when they got up and when they went out. We saw people initiating trips out, bathing, having snacks and time spent in meaningful activity. People's independence was promoted and staff described how they only helped when needed and encouraged people to take on responsibilities such as doing their own laundry.

Staff took time to build relationships with people in an individual way and spoke of, and with, people with affection. They described people using language that valued their abilities and attributes rather than focussing on possible problems. For example one member of staff described a person as being "very enthusiastic" about their use of the laundry. This language was important as it underpinned a supportive and empowering attitude amongst the staff.

Staff spoke confidently about people's likes and dislikes and were aware of people's social histories and relationships where this information was available to them. During our inspection they were able to talk with a relative and were keen to understand more about the person. They told us this information helped them understand people better. At Christmas time everyone had received a present that staff had considered carefully. For example, one person liked to use the swing during warm weather and staff had reflected on this and purchased a rocking chair that they could use indoors all year round.

Staff described the importance of respect for individuals when providing care. For example, they described small details that people appreciated when they were supported with personal care and spoke with appreciation about the skills people were developing. Privacy was respected by staff who did not share personal details that would not ordinarily be shared amongst people in communal living in front of people. For example where someone's needs had changed following ill health this was referenced but the precise details of their illness were not. This ensured that relevant information was shared whilst protecting privacy. People had their private space respected and were confident in this. People were able to lock their rooms and they determined access to these spaces.

There was a communal atmosphere promoted by staff when people were together in groups. Staff acknowledged and respected the relationships people had forged with each other and supported communication between people.

Good

Is the service responsive?

Our findings

People received the care they needed in ways that suited them. Staff reviewed and discussed people's current care needs and this ensured that people experienced continuity of care. Systems in place supported staff to achieve this. For example updated plans were kept in an updates file until staff had read them. Staff knew people well and were able to describe recent changes in their support needs with confidence.

People, professionals and people's relatives when appropriate, were involved in developing the care and support they received. People's views were gathered using tools that identified the outcomes that were most important to them and the skills and attributes they had that would help them achieve these. Where professionals had provided guidance about people's needs, staff followed this and were able to share appropriate information with professionals so that they could review the care provided. One professional highlighted how responsive the staff in the home had been in making the changes necessary for a person to continue to live there after a substantial change in their health. They told us this reflected the approach of the staff team to meeting people's individual needs. The outcomes that had been identified as important to people were often associated with meaningful engagement and emotional well-being. Staff spoke about examples of people's achievements and experiences with enthusiasm and pride. One member of staff said: "I could talk about this for hours." The achievements they described included: people being able to relax and enjoy daily activities; initiating activities independently; managing their expectations around drinks with lessened anxiety by using a visual cue; keeping possessions in their rooms, and enjoying trips away.

Where changes were necessary in the home as a whole, staff considered each person and the best way to implement the change. A combination of planning and a willingness to be guided by people had meant environmental changes had been achieved successfully. These included the introduction of curtains and new furniture in communal areas.

The staff kept records which provided information about the care people received and this meant the care could be reviewed effectively and changes made when they became necessary. Records showed that relatives were involved and their knowledge about their relative was valued and sought out regularly. Relatives also told us that this was the case, explaining that they always felt they were informed and consulted appropriately. They told us that this made them confident in the care their loved one received.

Activities were planned individually and were based on what mattered to people. Staff understood the role of activities for people, both as a tool for developing relationships and as independent leisure opportunities. They shared people's experiences of activities when people indicated this was ok with them and gave people space when they indicated solitary activity was their preference. A wide range of activities were available to people both within the house and in the local community. These included spending time with animals, gardening, meals out, sailing and holidays. Their reaction to these activities was 'listened' to by staff and determined whether the activities were made regular options. During our visit people went out throughout the day on their own initiation. Consideration had been given to how people used their home for leisure and meaningful activities. An activity board was being developed to promote people's ability to plan

activities.

People were not able to raise complaints verbally due to their communication difficulties. Staff were encouraged to advocate on behalf of people and to consider how people acted as indication of their satisfaction with the service. Where they felt people were not happy staff were encouraged to make complaints on their behalf. We saw that this had happened and the concern raised was being addressed. Families were able to raise concerns and these were recorded and addressed in order to find outcomes that improved the service people received.

Good

Is the service well-led?

Our findings

At our inspection in July 2015 we found that there were not effective systems and processes in place to assess, monitor and improve the quality of experience of the people living in the home. There was a breach of regulation. At this inspection we found that improvements had been made.

There were systems and structures in place to ensure that the quality of service people received was monitored and improved. These included checks on medicines, health and safety and care plans. These audits had been effective in ensuring quality and identifying areas for improvement. Information gathered fed into an action plan that also included areas for improvement identified by other agencies and an internal review carried out by people who used Brandon Trust services. We reviewed the action plan and saw that it was a working document that reflected the ongoing improvements being made by the management and staff at Gilbert Scott Care Home. For example we saw there were plans around improving communication support and that actions had been taken such as the development of personalised communication passports, the implementation of the activities board.

There had been substantial change in the home following the July 2015 inspection. There was a new registered manager and senior staff had been identified from within the organisation to support the changes the provider was committed to achieving for the people living in the home.

The registered manager described their commitment to achieving a unified and valued staff team in order to achieve the best care for people. Comments from staff indicated that this commitment was reflected in their experience. Staff had a shared understanding of the ethos of the home and understood their responsibilities. They described both individual and a team commitment to ensuring the best for people living in Gilbert Scott Care Home. The staff shared an ethos of quality, person centred care that was reflected in both the way they described their work to us and how they interacted with people. Staff told us they felt a part of the changes and that their contributions were valued by their colleagues and management. One member of the staff team told us: "I am proud of this team, they are not afraid of change." We heard examples from all staff about suggestions they had made that had been acted on and could now see had improved people's lives. One staff member described changes to how the laundry was laid out, another staff described using a timer to help a person manage their anxiety, another staff member described creating an outdoor space that a person could use independently. They spoke highly of each other's ideas and said that management were supportive in making ideas happen. One member of staff reflected on this respect for each other saying: "There is an open culture here. Everyone is equally valued."

Staff meeting minutes reflected discussion and challenge regarding practice and a staff team who sought to improve the experience of people living in the home through team work. Staff opinion was also gathered as part of the quality assurance process and we saw that the findings of the staff survey had been incorporated into the action plan. Staff and professionals told us that the management team were accessible and that they felt heard. One member of staff told us: "They are all approachable. They always make time." This commitment to staff voices being heard was also reinforced as they had been afforded the opportunity to comment on and add to information submitted to CQC in the form of the PIR. Professionals told us they

were confident in the management of the home and told us that they experienced a team that were receptive and responsive.

The registered manger discussed how the provider organisation ensured the voices of people who used the service were reflected in organisational decisions and policy development through a group that met regularly. There was a new piece of work being started to consider how best to listen to people with complex needs at this strategic level. The registered manager was excited by this work and hopeful that it would find real ways for people living in Gilbert Scott to be heard. This showed a personal and professional commitment to the values of inclusion.