

The Brandon Trust Gilbert Scott Care Home

Inspection report

Old Weston Road
Flax Burton
Somerset
BS48 1UL

Tel: 01275 646875

Website: www.brandontrust.org

Date of inspection visit: 27 and 28 July 2015

Date of publication: 12/10/2015

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Inadequate



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

The inspection took place on 27 and 28 July 2015 and was unannounced.

Gilbert Scott is a care home which provides accommodation and personal care for up to five people with a learning disability who may also have additional complex needs. During our inspection there were four people living at the home. The people living at Gilbert Scott were unable to verbally communicate their needs and relied on staff to support them with all aspects of their care and support.

There was a registered manager in post at the service. 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 and associated Regulations about how the service is run.

The registered manager did not have effective systems in place to monitor the quality of the service. The Department of Health's Code of Practice on the prevention and control of infections and related guidance

Summary of findings

was not being followed at the time of our inspection. There were areas of the home requiring maintenance and repair. The registered manager told us there were plans to improve the environment, however these were on hold due to the home potentially closing.

We found people's rights were not fully protected as the registered manager had not followed correct procedures where people lacked capacity to make decisions for themselves. We observed where decisions were made for people the principles of the Mental Capacity Act 2005 were not always followed.

Staff understood the importance of recording incidents, however the records did not always include enough details of the incident.

Our observations of staff interactions was mixed, staff did not always demonstrate a good knowledge of the people they were supporting or respond appropriately to their needs. Staff were supporting people to raise complaints as they were unable to verbally communicate these. The complaints were recorded however recent complaints had not been reviewed by the registered manager and there were no recorded outcomes.

People did not have an inclusive mealtime experience, staff served meals through a hatch and people were locked out of the kitchen unless staff were present.

People's relatives told us they thought their family members were safe living at Gilbert Scott. Staff knew how to recognise potential signs of abuse and were aware of their responsibility to report this. There were enough staff available to meet people's needs.

There were recruitment procedures in place to ensure only staff with suitable character were employed by the

organisation. Staff received appropriate training to understand their role and to ensure the care and support provided to people was safe. New members of staff received an induction which included shadowing experienced staff before working independently.

People's medicines were administered safely. The service had appropriate systems in place to ensure medicines were stored correctly and securely. People received their medicines when they needed them.

Plans were in place to manage risk relating to people's care. Relatives told us they were aware of and involved in reviewing the risk assessments.

People's needs were set out in individual care plans. The plans set out what people could do for themselves and the support they required from staff. The care plans were regularly reviewed and updated by staff. Relatives told us they were involved in planning and reviewing their family members care.

People had access to a house vehicle and were able to access the community.

Relatives told us they felt confident about raising concerns with the team leaders or registered manager. The service collated feedback from people's relatives in order to obtain their views on the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We have made recommendations to the provider, you can see what the recommendations were in the full version of the report.

Summary of findings

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.

Effective systems were not in place to monitor and reduce the risk of infection control. The environment was not clean and suitably maintained.

Recruitment procedures were in place to ensure people with the right experience and character were employed by the service.

The provider had systems in place to ensure that medicines were administered and disposed of safely. Medicines were stored securely and accurate records were kept.

Staff told us about the different forms of abuse, how to recognise them and said they felt confident to raise concerns with the team leader and registered manager.

Risks to people's safety had been appropriately identified. Assessments included relevant information for staff to support people safely.

There were enough staff available to meet people's needs.

Requires improvement



Is the service effective?

The service was not effective

Restrictions were placed on people without considering the principles of the Mental Capacity Act 2005. There was no clear evidence the restrictions were in the person's best interest.

Mealtimes were not a relaxed and inclusive experience.

Staff received training to meet the needs of people. Staff received one to one supervision to discuss their concerns and development needs.

People were supported to have regular access to health care services.

Requires improvement



Is the service caring?

The service was not caring.

Observations of staff interactions with people were mixed. Some interactions did not demonstrate respect and dignity.

Relatives spoke positively about staff and they told us staff recognised important family events.

Staff told us they had time to spend with people to get to know them and relatives told us staff knew their family member well.

Inadequate



Is the service responsive?

The service was not responsive.

Requires improvement



Summary of findings

Staff were encouraged to support people to raise complaints, the complaints were recorded however the registered manager had not recently reviewed or responded to them.

People had a care plan that described their needs; people's relatives were involved in reviewing their care plans.

There were systems in place to collate and review feedback from people's relatives on the service received.

Is the service well-led?

The service was not well led.

The registered manager did not have effective systems in place to audit the quality of the service and identify where there were shortfalls.

The registered manager was not aware of the negative culture within the service.

The registered manager was not aware of their responsibility of following the principles of the Mental Capacity Act 2005, restrictions were placed on people that had a significant impact on them.

Staff told us the registered manager was approachable and they held staff meetings to cascade information and enable staff to discuss concerns.

Requires improvement



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.

The inspection took place on the 27 and 28 July and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed information we held about the home including the previous inspection report and the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and

improvements they plan to make. We also viewed other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we spoke with the registered manager, two team leaders and three members of staff. People were unable to tell us their experiences of living at the home. We therefore 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. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for people. We reviewed three people's care records, three staff files and looked at other records relevant to the management of the service. We also spoke with two professionals and two relatives by telephone after our visit.

Is the service safe?

Our findings

We found some parts areas of the home required maintenance and repair. For example, we found the worktops in the kitchen had holes in it where the surface had worn, there were rips in the flooring and it was not sealed around the edges. There was dirt behind the freezer and the tiles behind the sink were cracked. We found other areas of the home also required maintenance. For example, the tiles around the shower area appeared dirty and the shower surround looked worn and dirty. We asked one of the team leaders if they would use the shower and we were told "No I would not." One person had taken all of the wallpaper off of their bedroom walls, the walls in the bedroom were bare with plaster. Staff told us this had happened in the past few weeks. Another persons bedroom was in need of decoration. A radiator cover in the lounge had the top of it missing and one of the sofa's in the lounge had rips in it.

In one of the bathrooms there were pipes exposed rather than being boxed in. Staff told us they were waiting for maintenance to complete the work to box the pipes in, they were unsure when this would be completed. One of the bathrooms had recently been decorated and the paint was already falling away from the ceiling.

We saw a mop and bucket in the kitchen; the mop looked old and dirty and was not labelled for use in the designated area of the kitchen. This meant robust cleaning of these areas could not be effectively undertaken and people were at increased risk of being exposed to infection.

Staff told us night staff carried out cleaning duties and this was recorded on the daily handover record. The registered manager was not carrying out infection control audits within the home to check the quality of the cleaning.

This was a breach of Regulation 15 (a) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

The registered manager told us the home had been undergoing a closure programme for the past three years. They stated the final decision had not been made regarding this and the outcome would be decided in September 2015. They acknowledged the home required work to be completed and said the pending closure had impacted on some of the maintenance and repairs being

completed on the home. They said if the home remained open the funding would be made available to complete a refurbishment of the property. We saw one bathroom had been recently refurbished.

We spoke to one of the team leaders who acknowledged the cleaning equipment should be labelled and a new mop and bucket was required.

There was a hand basin in the kitchen for staff to wash their hands, however during our inspection there was no soap available at this sink and no paper towel dispenser for staff to dry their hands.

Staff told us the soap was located at the kitchen sink and paper towels were stored in the cupboard rather than in a paper hand towel dispenser. Anyone using the towels to dry their hands could cross contaminate the pile of clean paper towels. This meant people and staff were at increased risk of cross infection when drying their hands.

There was an infection control risk assessment in place, this had not been reviewed since 2010.

Cleaning products were stored in the kitchen cupboard; the kitchen cupboard was not locked to protect people from accessing the products. One person's care plan stated they were at risk of potentially consuming cleaning products. We spoke with staff who told us the kitchen was locked and people were unable to access the area without staff support. There was no information available in the home regarding the cleaning products and how to respond if they were inappropriately used or in the event of an accident. There was a policy in place relating to the use of Control of Substances Hazardous to Health (COSHH). The policy stated data sheets should be obtained by the organisation and be available for staff. One of the team leaders told us they would ensure these would be put in place.

We recommend that the provider puts effective procedures in place for managing infection control in line with the Department of Health's Code of Practice on the prevention and control of infections.

There was an infection control risk assessment in place detailing actions required to reduce the spread of infection and staff had access to and were using appropriate personal protective equipment.

Is the service safe?

Relatives told us they thought their family members were safe at Gilbert Scott. Comments included “My relative is very safe” and “I’m happy my relative is safe.”

Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of the different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. Staff described how they would recognise potential signs of abuse through changes in people’s behaviour and unexplained marks or bruising. They told us this would be recorded and reported to one of the team leaders or the registered manager and they were confident it would be dealt with appropriately. One staff member told us “If I saw something I would confidently report it and the manager would deal with it” and another said “If someone is at risk you have to report it”. Staff were also aware of the whistle blowing policy and the option to take concerns to agencies outside of Gilbert Scott if they felt they were not being dealt with.

Relatives told us they were involved in decision making related to the risks associated with their family member’s care. One relative told us “We are aware of and involved in risk assessments, if we are concerned about anything we just talk to the staff.” Where risks had been identified, management plans were developed to minimise the risk. Plans were in place to support people where they may become anxious and display behaviour that could challenge staff or other people who lived at Gilbert Scott. A health professional told us they were involved in developing one person’s behavioural plan. Staff told us they very rarely used restraint as people were settled in the home and it was only ever used as a last resort to protect the person or others. Staff received training in approved restraint techniques. Where restraint was used staff were using the recommended techniques as detailed in their care plans.

Staff were aware of the importance of reporting incidents to the team leaders and registered manager. We saw one incident where it was recorded that staff had used physical restraint on a person, the staff members involved had not recorded the amount of time the restraint was used. The registered manager told us they had recognised staff recording as an issue and were working with the team to improve this. The registered manager reviewed incidents

and analysed them to identify any trends or themes. They gave us an example of how recently they had changed staff approach to supporting a person and how this had reduced the number of incidents the person was involved in. A health professional told us they were pleased with the support the home provided and the progress the person had made.

Relatives told us they thought there were enough staff available to meet people’s needs. One relative commented “There are always plenty of staff available.” Staff told us they thought there were enough staff on each shift, they described the staff as being “No problem, shifts are covered and we have plenty of bank staff available to cover shifts.” We saw enough staff were available during our inspection. Staff rotas reflected appropriate and consistent staffing levels were available to meet people’s needs.

A recruitment procedure was in place to ensure people were supported by staff with the appropriate experience and character. Staff told us they were not able to work with people until the appropriate pre-employment checks had been undertaken. We were unable to look at staff recruitment files during our inspection as they were held at a local office. Following our inspection the registered manager emailed us a copy of the checks undertaken by the organisation prior to staff starting in their role. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant’s past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people.

One relative told us they were happy with the medicines their family member was prescribed commenting “I know about the medicines my family member takes and staff tell me if things change.” Medicines held by the home were securely stored and people were supported to take the medicines they had been prescribed. We saw that a medicines administration record had been completed, which gave details of the medicines people had been supported to take. Medicine records held information on how people liked to take their medicines. We observed staff administering medicines and where a person refused to take their medication, the appropriate advice was sought from health professionals.

Is the service effective?

Our findings

We looked at how the Mental Capacity Act 2005 (MCA) was being implemented. This law sets out the requirements of the assessment and decision making process to protect people who do not have capacity to give their consent.

People's rights were not fully protected because the correct procedures had not always been followed where people lacked capacity to make decisions for themselves. We found restrictions were placed on people without evidence of a capacity assessment or if the restriction was in their best interest. For example, some people had restricted access to their clothing, their bedrooms, the bathrooms, the kitchen, food and drink and two people had restricted access to their belongings. Staff told us these practices were historical and had been implemented and agreed by the Gilbert Scott team; they told us they were in place to protect people and their belongings. There was no evidence of the restrictions being regularly reviewed. This meant people were at risk of receiving care and treatment which was not in their best interests. We spoke with the registered manager who told us they would review their processes for assessing people's capacity in line with the Mental Capacity Act 2005.

This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We found some evidence of the MCA being followed relating to decisions being made for people. For example, where one person required medical treatment and where they needed to wear a harness in a vehicle.

A health professional told us after our visit they were aware of some of the restrictions in place, however they were unaware of people having restricted access to their belongings.

Relatives told us they were involved in best interest decisions around aspects of their family members care. This included finance and decisions around medical interventions. Staff demonstrated an understanding of the importance of offering people choices such as choice of food and what people want to wear. We observed staff seeking consent before providing support to people such

as supporting a person to wear an apron. Staff told us if a person appeared unhappy with their support they would report this to the shift leader and another staff member would be offered to provide support for people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. At the time of the inspection the registered manager told us they had applied for three people to have their liberty restricted under DoLS. The registered manager told us they had not completed an application for one person as they were due to be moving out of the home. However they said this move was not now going ahead and they would be putting in a DoLS application for the person.

Relatives told us they were happy with the food provided. One relative commented "The food is very good." We observed the lunchtime experience and staff had prepared meals for three people, these consisted of filled rolls and other cold snacks. People were not involved in choosing what they wanted as a filling for their rolls or involved in preparing the meal. Staff placed the meals on a serving hatch between the kitchen and dining room. Two people entered the dining room and took their food from the dining hatch. Staff remained in the kitchen whilst the two people were initially eating their meals. One person ate their food quickly and returned their empty plate to the serving hatch with food still in their mouth. We asked staff what support people required at mealtimes, staff said the person can rush their food and they need to keep an eye on them, they told us they had never choked on their food. Following this a staff member went into the dining room and sat with the other person whilst they ate their meal. Staff said during the evening meal they sat with people whilst they were eating.

Staff told us there was one option available on the menu and menus were based on their knowledge of people's likes and dislikes. They said if people did not like what was on the menu they would offer other choices. We discussed this with the registered manager if menus could be more individualised. The registered manager told us they thought the menus could be more individualised and in

Is the service effective?

their opinion the dining experience had a feel of a “Canteen” with staff serving people food. They told us this was something they would look into with staff and look at ways to improve the dining experience for people.

We recommend that the provider seek guidance on how to provide people with opportunities to enjoy a sociable meal time experience.

People were given options of where they could have their meal. For example, one person who did not want to eat their meal in the dining room was supported by staff to eat in the lounge.

Relatives told us they thought the staff team were well trained and knew their family members well. One relative told us “Staff are well trained and they are very good.” Staff told us they received training to meet people’s needs and keep them safe and they described their training as “Good.” Staff told us the home was good at keeping their training up to date and they were able to request training they felt they needed as long as it was relevant to their roles.

Staff told us they received an induction when they joined the service. They said the induction included a period of

shadowing experienced staff and looking through records, this could be extended if they needed more time to feel confident in the role. One staff member told us “There was lots of training on my induction and it prepared me for the role.”

Staff told us they had received supervision to enable them to receive support and guidance about their work. One staff member told us they received “Constructive feedback” during supervision and they went on to say it was a “Supportive experience.” Another staff member told us supervision was “Supportive and you can raise any issues, you are listened to.”

Relatives were happy their family member received support from health professionals when required. One relative said “They are very good with medical appointments and they always tell us if there is a problem.” People were also supported to see health professionals where required, such as their GP, chiropodist and dentist. The home requested support from the intensive support team where required for their input with writing individual guidelines for people.

Is the service caring?

Our findings

Staff did not always interact with people in a way that promoted dignity and respect. For example, we observed one person did not appear happy with how close a staff member was to them, the person pushed the staff member. The staff member responded by asking them to stop, the person pushed them again and the staff member responded by telling them if they did not stop they would have to leave the room. On another occasion a person was trying to interact with a staff member and held onto their arms, the staff member told the person if they did not stop they would have to leave the room. On both occasions the staff did not ask the people what they wanted. We observed another interaction where a person hit out at a staff member and the staff member mimicked the action back at them. We observed one person who had been incontinent came to the kitchen following their meal; staff invited the person into the kitchen and offered them a pudding rather than offering to support them with personal care. Later during the inspection we saw the person had been supported to receive personal care and change their clothes. We also heard staff making joking comments about a person relating to an unpleasant smell.

Staff completed monthly summaries to detail events relating to people for each month. We saw staff had recorded for one person that they had been 'demanding of staff' and another monthly summary noted a person had been 'sent to the quiet room to calm down'.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We discussed with the registered manager we felt there was a power imbalance between staff and people who used the service. The registered manager demonstrated they were concerned about what we had observed. They told us they had a relatively new staff team and this had

highlighted they needed to get on top of the team culture. They said they would achieve this by holding team training days, focusing on team culture, delivering expectations to staff and challenging poor practice.

One relative told us staff were "A lovely bunch," and another said they were "Very good and have empathy." We observed some positive interactions during our inspection between people and staff. For example, there were workmen in the home fitting new electrics. This meant there were disruptions to people's usual routines such as the TV was not able to be on and certain areas of the home did not have access. We observed a person becoming anxious about this and the supporting staff member offered them reassurance and letting them know what was happening. This appeared to reassure the person.

Relatives told us staff knew their family member well; one relative commented "Staff know my family member well, some of the staff have been there a long time."

Staff told us they spent time getting to know people. One staff member told us "They know me fairly well as I am here a lot, if I was in a home I would want regular staff so that I would get to know them and feel safe." Another staff member said "For people to trust you takes time, it's about being there for them, continuity is important to build trust". One staff member described what was important to a person for example, their family, going out for walks and drives in the homes transport.

Staff described how they ensured people had privacy and how people's modesty was protected when providing personal care. For example, covering people when they were supporting them with personal care, closing doors and explaining to the person what they were doing. During our inspection we observed a staff member knocking on a person's bedroom door before entering.

Relatives told us they could visit at any time, there were no restrictions. One relative told us "We can visit any time we want; there has never been a problem". Another said "I can go when I like, I am going to visit on Sunday."

Is the service responsive?

Our findings

Staff did not always demonstrate a good knowledge of the people they were supporting and their needs. We asked one staff member about the needs of the people living in the home in relation to specific conditions such as autism. The staff member told us there were people who had autism living at the home, however they could not remember who. People were unable to verbally communicate and they relied on staff to support them to communicate their needs. One person had a communication book containing pictures to support their communication when they became anxious. Staff told us this had not been used for a while. We asked staff how they supported the person when they became anxious and one staff member said they redirect the person to an activity and if that didn't work they would send them out of the room. They told us "Normally they calm if you send them to do their activity." One staff member told us the person was good at communicating their needs by using Makaton signs. Makaton is a language programme using signs and symbols to help people communicate. The staff member went on to say the person "Communicates well."

We recommend that the provider embeds and ensures staff receive training relating to the individual needs of the people who use the service.

We discussed this with the registered manager who told us the team appeared to have "Lost the understanding of why people do things." They told us a lot of experienced staff members had left the team, they had a "Newish team" and "Needed to get on top of the culture." They said they would achieve this by arranging training days for the staff team relating to how to respond to people and their individual needs.

Relatives were involved in the planning and reviewing of their family members care. One relative told us "I am involved in meetings around care plans and staff tell us about changes or if there are any concerns." Each person had a care plan that was personal to them. Care plans included information on how to support the person and preferences around their support. Staff told us they thought the care plans were "Pretty good and reflect people's needs." People also had a person centred plan called 'planning for life'. This document included outcomes that people wanted to achieve and were developed by the staff team, relatives and agreed by the person's care

manager. One person's planning for life plan identified outcomes for them to go out into the community and reduce the amount of medicines they were taking. The registered manager told us these outcomes had been achieved in a short period of time and they were looking at setting further objectives for the person.

Relatives told us staff supported their family member to make contact on important dates such as family birthdays. One relative said "They are very good with birthdays; they send cards and think of the whole family." Another commented "They sent me flowers on my birthday, it was really nice."

Relatives thought there were enough activities available for their family members. One relative told us how they were pleased with the home and activities offered commenting "My relative goes out for walks to the local farm for a coffee and they also go out in the car." We saw another person who had recently moved to the home had refused to go out in their previous placement. Since living at Gilbert Scott they had been out in the home's transport on several occasions and on the day of our inspection they were going clothes shopping with staff. People were supported to engage in activities outside of the home such as going for a drive, walks and visiting local cafes. One person had a equipment in the garden and we observed them using this.

Relatives told us they felt confident raising any concerns with the teams leaders or the registered manager. They told us they had not had to do this but were confident they would be listened to and they would respond appropriately. The registered manager told us they were encouraging staff to log complaints on behalf of people. People had a document in their care plan called a 'complaints profile'. The registered manager told us this was in place for staff to identify people's actions and behaviours in order for staff to translate this into how the person was feeling and log a complaint on their behalf if required. For example, one person made loud noises, this could indicate they were unhappy about another person who uses the service and staff should make a complaint on their behalf.

Staff recorded if there was an incident involving an altercation between people as a complaint on the person's behalf. There were 12 incidents recorded in the complaints book in 2015 relating to incidents between people, one of these had a recorded outcome of the person being more settled. The registered manager told us they reviewed the

Is the service responsive?

complaints books monthly and logged any action taken or outcomes. They said they had not reviewed the complaints book this month, however they were aware of the incidents that had occurred as these had been reported to them.

There was a system in place to collate and review feedback from people's relatives on the service received. Information

collated from the relatives survey completed in 2014 was complimentary of the service. The registered manager told us improving communication with family members on the future of the service was an action point they had identified as an outcome.

Is the service well-led?

Our findings

The provider had a system in place to monitor the quality of the service. The registered manager was responsible for completing bi-monthly quality audits of the service. The audits covered areas such as medicines, staff training, the MCA, infection control and care plans. We found the audit systems were not always effective in identifying breaches in regulations and shortfalls in the service. For example, the audit had not identified the home had not followed the principles of the MCA in relation to decision making for people and it had not identified the concerns we raised regarding infection control. We discussed this with the registered manager who told us they would be developing an action plan to cover these areas.

The environment was in a poor state of repair and appropriate resources were not made available by the provider to create a safe and appropriate environment. The registered manager had an action plan for 2014 and 2015 which identified areas of the service that needed to be improved. This included the improvements required to the environment. The registered manager told us this year's action plan was on hold due to the potential closure of the home.

The staff team had not been developed to ensure they display the right values and behaviours towards people and because of this outcomes for people were poor. Although staff competency observations were completed by staff these did not always identify where there were poor practices. The registered manager was not aware of the negative culture in the home.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

There was a registered manager in post at Gilbert Scott. The registered manager was also responsible for managing two of the providers other homes. One relative told us they thought the registered manager was approachable, they said although they were not always visible in the home they were contactable on the telephone. The relative went on to say the two team leaders were available in the home to respond to any queries. The registered manager told us

they had an open door policy and promoted an open and transparent culture where staff could approach them with concerns. Staff told us the registered manager was accessible and approachable, comments included "The manager is very accessible and 100% approachable" and "The manager is accessible and supportive."

The registered manager had recently completed an internal survey with the staff team to receive feedback on staff morale and their experience of working in the team. The results showed 80% of the team felt morale had improved and 100% felt supported by the registered manager.

Staff meetings were held which were used to keep staff up to date with relevant information. One staff member told us the meetings were used to "Voice any concerns." They went on to say their concerns were listened to and things were generally resolved although sometimes this "May take a bit of time." Another staff member told us "You can raise any issues, we are listened to." The registered manager told us safeguarding and whistle blowing were a standing agenda item for each meeting to raise awareness and for staff to raise concerns. Meeting minutes confirmed this.

We spoke with the registered manager about the values and vision for the service. They told us their vision was "For staff to be positive about risk and to support the people living at Gilbert Scott to lead a 'normal' life." Staff told us the vision of the service was to "Give people a quality of life and access the community" and "For people to lead a happy life." The registered manager recognised there were areas of the service that needed to be developed and they told us they were committed to delivering this.

The registered manager told us they felt supported by the organisation and they had regular contact with senior managers. They told us they kept up to date with best practice through organisational workshops and seminars where topics such as new legislation were covered. They also attended local provider forums led by the local authority to keep themselves up to date with current practice. The registered manager gave us an example of where good practice had been shared between managers in the organisation. This involved looking at developing complaints profiles for people to encourage staff to support them to raise concerns when they were not happy.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The premises were not clean and were not suitably maintained. Regulation 15 (a) and (c).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Effective systems and processes were not in place to assess, monitor and improve the quality of the experience of service users receiving services. Regulation 17 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Where restrictions were in place effective processes were not in place to support people to make best interest decisions in accordance with the Mental Capacity Act 2005. Regulation 11 (3).

The enforcement action we took:

We have issued a warning notice to the registered manager and the provider. They must become compliant by 13 November 2015.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

People were not always treated with dignity and respect.

The enforcement action we took:

We have issued a warning notice to the registered manager and the provider. They must become compliant by 13 November 2015.