Gibson's Lodge Limited

# Gibson's Lodge Limited

## Inspection report

Gibson's Hill
London
SW16 3ES

Tel: 02086704098

Date of inspection visit:
29 April 2016
03 May 2016

Date of publication:
01 July 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| 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

This inspection took place on 29 April and 3 May 2016, the first inspection day was unannounced.

Gibson's Lodge Limited is a residential nursing home that provides accommodation and personal support for up to 53 older people some of whom were living with dementia. There were 46 people using the service at the time of our inspection.

We inspected the service in February 2015, at the time we found the service required improvements in three areas. We returned in September 2015 and completed a focused inspection; the home had made the necessary improvements. At that inspection we found the service was meeting all the regulations that we assessed.

There was a registered manager in post at the time of our 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.

Although people received medicines prescribed there were aspects of the medicine practices that were unsafe. This constituted a breach of the regulation 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 the report.

People told us they felt safe, and relatives felt reassured their family members were well cared for. Staff were trained and knowledgeable in safeguarding adults and followed the policies and procedures in place. They responded appropriately to allegations or suspicions of abuse. The service ensured that people's human rights were respected and took action to identify and minimise risks to people.

Staffing levels promoted safety during the day and at night; these were based on the numbers and needs of the people who lived at the service and on the layout of the premises. People were cared for by motivated and well-trained staff that had completed essential training and responded to their individual training needs and the needs of the service. The learning opportunities were good and enabled staff to carry out their roles and responsibilities.

New staff completed an induction training programme and there was a training and development programme for staff. The support network in the home was good, staff felt supported, they had their practice appraised.

There was sufficient information in people's care records to guide staff on the care and support needs. Care

was arranged and delivered in a way that promoted equality and diversity.

Risks associated with people's health and well-being were identified and appropriate management plans were developed to help minimise these risks.

Staff had a good understanding of people's individual needs and the support they required. Care was delivered consistently by a team of workers who knew how to support people. New staff worked alongside experienced trained staff to get to know people and their individual ways.

We saw that arrangements were in place to assess whether people were able to consent to their care and treatment. We found the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People told us they were happy with the service and found staff kind and compassionate. Staff interacted with people in a patient and sensitive manner.
People were provided with a range of activities in the service but these were not well developed and did not fully consider the needs of people with cognitive impairment.

People felt assured by staff and were informed promptly of any changes to their relative's conditions. People were encouraged to continue to see friends and relatives and access the community with staff or relatives.

The service had systems in place to monitor the quality of the service provided and drive improvement. Some of the benefits of these were seen in a better developed workforce. The service benefited from good leadership, staff found the registered manager to be open and fair. She led by example and inspired staff to develop their skills through learning. Staff enjoyed the opportunities they got for learning and developing new skills.

Any complaints, incidents and accidents were managed well and measures were put in place so that they were less likely to reoccur. Management were vigilant in monitoring the quality of the service, they supported staff and completed out of hours checks on the welfare of people and on staff practice.

## 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**

Some aspects of the service were unsafe. People received the medicines they were prescribed but medicine procedures were not always safely managed.

There were arrangements in place to protect people from the risk of abuse and harm.The service followed safe recruitment procedures.
People felt safe and staff knew about their responsibility to follow protocols and protect people. We have made a recommendation about how staff support people who exhibit challenging behaviours.

Staffing levels deployed responded to individual and collective needs. Risks were identified and highlighted, and risk management plans were in place which staff were familiar with.

### Is the service effective?

**Good**

The service was effective. There was a clear emphasis on training and developing staff. Staff were provided with suitably training and supported in their roles to carry out their responsibilities.

People had sufficient to eat and drink and enjoyed the meals at the service. The service complied with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

People were able to make day to day decisions about their care, and their choices and wishes were respected. People received the support they needed to maintain good health.□

### Is the service caring?

**Good**

The service was caring. Staff treated people in a caring and compassionate manner that promoted their dignity and valued them as an individual.

Staff demonstrated real concerns for people, and spoke affectionately about the people they supported. Staff practice promoted people's values.

The service consulted with people about advanced care plans, they provided care for people in the final years of their life.

## Is the service responsive?

Good

The service was responsive. People had their needs assessed, they received care and support which met their individual needs.

People were able to follow their interests and participate in activities but their choice was limited.

Complaints were responded to appropriately and people were asked for their views of the service.

## Is the service well-led?

Good

The service was well-led. The manager and senior staff provided staff with appropriate support to enable them carry to out their roles.

There were quality assurance systems in place to monitor the quality of care provided and drive improvements.

Management was open, fair and transparent. They together with staff continued to work collaboratively with other healthcare professionals to ensure people's health and care needs were met.

# Gibson's Lodge Limited

**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 checked 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.

Before the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by.

The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service did well and improvements they planned to make. The PIR was well completed and provided us with information about how the provider ensured Gibson's Lodge was safe, effective, caring, responsive and well-led.

We visited the home on 29 April and 3 May 2016. Our first visit was unannounced; we told the manager we would return on the next working day of 3 May to complete the inspection. The inspection team consisted of one inspector and an expert by experience. The expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The team also included two specialist professional advisors, one was a registered mental health nurse, the second professional advisor had expertise in people's medicines.

During our inspection we spoke with 20 people using the service, five visitors, seven care staff and two nurses, and the registered manager. We spoke with two trainers delivering training to staff. We examined recruitment records for five staff. We observed care and support in communal areas, spoke with people in private and looked at the care records for eight people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also looked at records that related to how the home was managed. Before the inspection visit we contacted and spoke with two health professionals who had involvement in the care of people who lived at Gibson's Lodge, we also spoke with two social care professionals.

Requires Improvement

# Is the service safe?

## Our findings

There was a general air of calm about the environment, people told of feeling safe and felt reassured by staff presence. Relatives told of their trust in staff, one person visiting told us, "I come here every day to spend time with my relative, my spouse has settled well and is safe, staff are always popping in to the room to check he is okay." Another relative present told us "It is relaxed here and staff make sure the place is safe, there is always a staff presence in lounges."

People using the service did not raise any issues about their medicines, and there were no concerns reported from health professionals who visited the home. Audits were completed both internally and externally of medicine procedures. Allergies recorded on the resident's front profiles matched those recorded on the MAR charts. Medicines requiring dates of opening were found to be appropriately marked, but attention was needed to correctly store all medicines. For example we saw that a topical cream to treat skin infection was stored next to the person's tablets. Controlled drugs (CD) were reviewed and all stock balances were found to match those in the records. There was evidence of the use of the pain assessment tool, this was stored with MAR charts to assess the person's pain.

Internal audits of medicines did not pick up on the shortfalls identified during the inspection. One of the concerns we identified about medicine management was the secondary dispensing of medicines for a person. Secondary dispensing is when the medicine is removed from its original container and put into another pot in advance of the time of administration. This process removes the safety net to check the medicine strength and dose with the medicine record. There were a number of other discrepancies which we highlighted to the manager, for example the stock contents for three of the people did not reconcile with paper records. Where one person's medicine did not reconcile staff had administered the medicine prescribed for another person which caused the balance to be incorrect. The registered manager confirmed with us the action taken following the inspection to address the medicine concerns, These included using NICE guidance and a new tool to audit medicine procedures.

A number of people were receiving medicines covertly due to their specific support needs. (Covert is the term used when medicine is administered and disguised in a way without the knowledge or consent of the person receiving them.) Although there was on occasions involvement by the prescribing GP records did not show that guidelines for the covert administration of their medicines were developed by the pharmacist and the person's GP and agreed through a 'best interests' decision-making process. It was not clear what advice if any the pharmacist had given on how people's medicine should be prepared, and which medicine was to be given covertly. One person was receiving anticoagulant medicine covertly and no advice from the pharmacist had been sought. It is important to record the advice of a pharmacist because adding certain medicines to food or liquids, breaking and crushing medicines to hide them can alter the way they work. These incidents constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable and trained about protecting people from abuse. They knew what to do if they had concerns about a person.Incidents had taken place whereby staff had alerted safeguarding authorities

and the police when necessary. One staff member told us, "We understand how to protect the vulnerable, we raise any concerns with the social worker and with our manager if something is not right." The service had processes to manage and report whistleblowing, safeguarding, accidents and incidents. The whistleblowing policy gave instructions and staff were clear and knew what to do if they had concerns and who to report their concerns to. Details of incidents were recorded together with action taken at the time, and who was notified, for example the relevant healthcare professional and what action was needed to reduce triggers and the likelihood of further incidents. One external health professional involved with visiting people using the service told us staff were good at listening to advice and followed their professional guidance. We saw that information shared with health professionals by telephone was not always recorded in detail. We discussed with the registered manager the importance of staff fully documenting discussions between staff and health professionals and the outcome of these.

There were risk assessments in place for people's behaviour that may challenge. Staff told us training gave them valuable guidance in promoting positive behaviour for people who had behaviours that posed a risk of harm to people or the person themselves. One person who was a wheelchair user was quite irate because another person kept invading their personal space. Staff were sensitive and gently encouraged the person to change their routine and sit at the table away from the person and have a drink. Staff told us they liaised well with individual's care coordinator or social worker to discuss any specific concerns. Staff were seen responding appropriately, if people were comforted by specific actions this information was recorded in care plans and staff knew how best to support the person. We observed some staff (new carers) were less confident in responding to situations. We recommend the manager reviews how individual behaviours are managed within the service and seeks further advice and guidance from relevant professionals.

People's records showed staff had identified the hazards people might face and what action they needed to take to minimise them and keep people safe. This included information on how to keep people safe in the event of an emergency and risks associated with people's medical conditions, mobility/falls, nutrition, moving and handling, skin integrity. One person had a mattress placed on the floor for night time as it was assessed as the safest option to keep them safe from falls. Their spouse said this worked well. Each person had a personal evacuation plan in case of an emergency.

Staffing levels were based on the numbers and needs of the people who lived at the service. A staff rota was planned to provide sufficient numbers of staff in both of the units during the day and at night. One unit was not purpose built which made it more difficult to monitor, this was considered in staffing levels. There were eight care staff and two nurses on duty during the day caring for 29 people. One person visiting commented, "I think they could do with more staff, especially at weekends and when new members join the team."

On the staff files we looked at we saw that robust recruitment procedures were followed. There was confirmation of a check conducted by the Disclosure and Barring Service (DBS) to show staff were not barred from working in adult social care and to inform the provider of any criminal record that staff might have. Staff files were audited by the administrator.

The home had a full-time maintenance person who took responsibility for undertaking the health and safety checks, records of these including fire drills maintained. The registered manager assured us these were monitored as part of the quality assurance process. Redecorating and refurbishment was still taking place, all areas were clean but décor in corridors and communal lounges was damaged from constant friction from wheelchairs. The service had poorly maintained exterior gardens that were inaccessible due to uneven surfaces – we were told that there are plans to landscape and make use of the outside areas. These areas offer a lot of scope and could be a great asset and resource for people in the home. The fire authority completed an inspection recently in 2016 and asked the provider to remedy minor deficiencies by July 2016,

which included fire evacuation procedures. Work was underway on completing these within timescales.

Good

# Is the service effective?

## Our findings

Despite a high turnover of staff in the past twelve months we saw the majority of staff on duty were familiar with people in their care and interacted positively with them. Vacant posts were being recruited to and new staff were provided with an induction, and substantial training and development. One relative told us they noticed staff turnover was high but were pleased that many of the senior staff and management were consistent and helped train the new employees. A family member commented, they had confidence in the system as they were always made aware of any changes in their family member's condition. Another person complimented the staff and management on the quality of care delivered; stating that it was the right choice, and their family member's state of health and wellbeing had improved since moving to the home a year earlier. Pictures they showed us also confirmed the person's progress.

Staff had access to a range of training to develop the skills and knowledge they needed to meet people's needs. The home's training records showed details of the training staff had completed, and what was due and planned for. The training matrix showed staff had completed training in relation to topics such the safeguarding of adults, manual handling, infection control, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and dementia care. The training needs of staff were monitored and any gaps in knowledge or provision were planned for. Nursing staff had completed professional development, but there were some concerns that qualified nurses had not completed medicine refresher courses, the registered manager acknowledged this would be prioritised in training plans. The provider had introduced a new role of health care assistant within the staff team. These are senior experienced staff selected using a relevant selection assessment tool. Four of these staff were in post; they were receiving training to undertake such roles as taking blood and medicine management. Staff showed a genuine enthusiasm for their roles and for the opportunity of career development.

Staff were supported well by management structures within the home. Staff told us supervision meetings were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff told us there was a great level of support and they found management staff acted as good role models. New staff completed an induction process and Skills For Care Certificate; this included shadowing an experienced carer and all mandatory training. Staff found that training opportunities were very good, both from in-house trainers and from the local authority trainers. One of the trainers told us of undertaking direct practice observations to help ensure staff put into practice all the learning and best practice advice.

The majority of people using the service had varying degrees of cognitive impairment. The service ensured that people where possible gave consent to care and treatment in line with the principles of the Mental Capacity Act 2005. Staff understood the principles and explained to us how they put it into practice daily when providing care and support to people. Staff told us they always involved people and asked for their permission before supporting them. One care worker said "It's the person's decision that determines how we proceed."

We saw that mental capacity assessment had been carried out in relation to specific decisions where there were doubts about the person's ability to make that decision. Where a person had been assessed as lacking

capacity to make certain decisions, the relatives had been involved to ensure decisions were made in the person's best interests. The service ensured the people's rights were respected in line with relevant legislation. At the time of the inspection a number of people were subjected to the Deprivation of Liberty Safeguards (DoLS) and records confirmed that appropriate processes were followed in relation to this. This ensured that people who lacked mental capacity were not unlawfully deprived of their liberty.

The nutritional needs of people were monitored and considered. People were supported to choose where they wanted to have their meals. Some people had lunch in their bedrooms and we saw that staff were attentive to their needs. For example, one person had their food brought to them and a care worker noticed that they were not eating by themselves, so they offered help and sat with them, which ensured they enjoyed their lunch. A visitor told us their relative enjoyed the meals, saying, "The food is good, they have encouraged [my relative] to eat, and they look so much better than when they came here." People's nutritional and dietary needs were assessed and
the support they required was noted in their care plans. For example, a person's care plan documented they required pureed food to reduce the risk of choking. People had access to food and drink throughout the day, supplements and snacks were provided to those who found it difficult to sit for long at mealtimes. We observed a good approach and technique by staff at meal times. People told us they enjoyed their meals and they found the food was of a good standard. We spoke with kitchen staff who were aware of people who needed fortified food, and they provided this when requested. The administrator printed an up to date list of people with special dietary needs.

Staff were familiar with those at risk of poor nutrition or dehydration, they identified 26 people were at risk of poor nutrition, and appropriate care plans were in place to address this. There were referrals made to speech and language specialist (SALT) when there were swallowing concerns. There were delays encountered in getting responses, a SALT we spoke with told of delays to referrals received from the home due to staff availability. A care worker explained that a number of people were unable to take liquids safely unless a thickener was used in their drinks. There were some inconsistencies in how screening tools and there was no supporting information used which we brought to the attention of the nurse in charge. One person had experienced a pattern of instability and fluctuations in weight bearing due to a neurological condition but the assessment tool did not demonstrate why these fluctuations were recorded.

We saw from care records and daily appointment books the staff engaged with a range of health care professionals, these included three GPs, community psychiatric nurses, tissue viability nurses, and care coordinators. The home had a good relationship with GP practices. Feedback from health professionals confirmed the service was effective and that guidance and advice was generally followed. We received positive feedback from a specialist nurse who advised the staff about tissue viability issues in the home. They told us the home staff were managing tissue viability issues appropriately saying, "There are no issues staff are doing well". Body maps were maintained in each person's file, these provided evidence of the management and promotion of good skin integrity for all.

The service provided appropriate equipment such as pressure relieving mattresses and hoisting equipment, these enabled staff to carry out their duties and meet the people's' needs. One health professional described the access facilities from the ambulance bay as not totally satisfactory when people had to enter the building. We observed that the layout of the home was quite restrictive; internal corridors in the old unit were too narrow, and signage was poor for people with dementia. We saw that maintenance work was still in progress which accounted for some of the lack of signage. The manager acknowledged the difficulties with the layout of the premises and agreed to share these with the provider.

Good

# Is the service caring?

## Our findings

Comments from people using the service, from people's relatives and health professionals visiting were positive about the qualities of staff. One mental health professional who visits people placed there said, "Overall I think the care my clients receives is fairly good. The staff appear caring and attentive."

We saw staff interacting with people in a sensitive caring manner, when providing support to people at mealtimes, and when working with people whose behaviour was challenging the service. We saw a care worker reassuring an individual in a warm and patient manner using their arm to comfort the person. The impact of this on the person was seen to be positive and calming.

People liked the staff who cared for them. One person said, "Staff here are great, I have just a small family who visit when they can, but staff all do their best to chat with me and take me to the lounge to meet others." A person's relative said, "I am so comforted knowing staff look after my parent well, it is important that I find staff are patient and I always feel welcome at the home." People told us that they could have visitors anytime up to 8pm, and we saw this to be the case. All staff employed including domestic and catering staff interacted with people in a caring and patient way. Staff approached people in a sensitive way and supported them to do things that they wanted to do.

We saw that staff addressed people by their preferred names, and spoke to them in an unassuming way, making eye contact and touch when appropriate. One care worker told us, "Sometimes I see people become sad, and I recognise this and give them reassurance or a hug."

We saw that people were well-dressed, and assisted with good grooming. The service had a visiting hairdresser and a private area was provided for this purpose. Doors were closed when staff assisted with personal care. Staff knocked on doors and waited for permission to enter, which helped respect people's privacy. People got appropriate support from staff who ensured they were suitably dressed and comfortable; this helped promote their self-esteem and dignity. People were able to choose what they liked to wear, individual's culture was promoted, for example some people wore clothes and had their hair styled in a way that reflected their cultural heritage and staff had the expertise to do this. Staff paid attention to detail, such as prompting and helping people be suitably attired in a way that promoted their modesty. One care worker said, "In our training and at team meetings we are constantly reminded of the little but important tasks such as helping people do up buttons and fasteners, and provide people who need them with hearings aids and glasses."

The staff team was reflective of the community they cared for. They were able to meet the diverse needs of people who use the service because they had the knowledge and understanding of individual's religious and cultural needs. Staff spoke various languages, this provided opportunities for people to speak with someone in their first language. People's religion was noted in care plans seen and staff were aware of specific needs and preferences. Church ministers came to see people who requested their presence and held religious worship.

Although staff understood the importance of person centred care this was not always reflected fully in care planning records. Staff and the manager told us there were plans to improve the care planning records.

People displayed personal items in their rooms; a person told us their treasured ornaments took them back to their earliest memories of family life. Most rooms seen had photographs of people and relatives and important events. This helped with conversation with staff especially when people became anxious, and it also helped give people a sense of identity.

The service provided end of life care to people who were at that stage of their life. This home was accredited with the Gold Standards Framework (GSF) which is a system of training and accreditation in end of life care that enables front line staff to provide a 'gold standard' of care for people nearing the end of life. Staff worked closely with the facilitator from a local hospice. People's care records detailed the care and support people wanted, their discussions with the GP, and also discussions between the GP and relatives where applicable as they approached the end of life. This included people's decisions about Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and whether they want to be sent to hospital if they became unwell. Records showed that people and their relatives had been involved in planning their care in detail and that staff respected their wishes. Staff told us they were aware and understood people's care and the choices made in relation to their end of life care.

Good

# Is the service responsive?

## Our findings

People received the care and support they needed, and their views were listened to. The responses we received from people and relatives demonstrated the service was generally responsive. One person said, "I asked to see a doctor about a pain in my arm and staff listened and the doctor came." A person visiting said, "My relative complained of the room being too cold, and maintenance staff were called in and took prompt action and fixed it, mostly anything wrong is rectified once you let them know."

People's care and support was planned and delivered in a way that met their individual needs, their independence was promoted. A care worker told us, "We encourage those who can care for themselves and help in areas they need support- this helps make sure we do not de-skill them."
Prior to admission senior staff met with the person to carry out an assessment of needs. Staff showed us the information gathered during this process was used to determine if the service could meet the person's needs. Care records gathered information about the person's background, histories, preferences, and health, medical and social needs. Staff told us where possible they were able to visit the home for a trial visit before they moved in. A family member we spoke with told us they had taken their relative to view the home, the relative loved the homely environment. There was evidence that people's care plans were evaluated and reviewed monthly, and more frequently if necessary to respond to changes that arose.

During our observations we noted staff were responsive, people were assisted promptly when they requested assistance. Those who remained in their rooms had called bells located close by them. The communal areas had a staff member present at all times. Staff recognised and responded appropriately helping reduce the anxiety of a person who became restless and was looking for their relative. A person visiting said, "I see how well staff manage some difficult situations when people become anxious." We saw examples of staff promptly seeking advice from health professionals such as psychiatrists when needed. A mental health professional reported positively on staff listening to their advice and guidance and reflecting this in practice. The majority of staff knew people well and were able to describe people's personal preferences. They also knew what made people happy and what could trigger anxiety or challenging behaviour.

Family members told us they were asked to contribute to the development of care plans when their relative was unable, (the majority of people had relative involvement). A care co-ordinator told us the service responded well to people's needs and they found they got the support they needed. We saw that information exchange was good; all relevant information was passed between staff during shift handover times. This helped to make sure staff were fully informed about individuals and able to respond appropriately and in a timely manner to people's changing needs.

Care was delivered in a flexible way that enabled staff to dedicate the time people required. Staff described the approach used for one person to reduce challenging behaviour episodes. Staff engaged the person with a conversation about their job when they were young to help reduce the person's increasing anxieties. The home had large communal areas that most people used. There was a cinema room and people were seen enjoying and responding well to old black and white movies. The home had two activities coordinators and

both of them were new to the role, a training plan was in place to provide them with the skills needed. There was a weekly programme in place but this was in its infancy stages. We saw that activities were limited as a number of people with cognitive impairment were unable to participate in many group activities and required more one to one stimulation. We saw people engage in activities that provided pleasure and engaged people, these included singing and music. A number of people went out to a museum in South London which was arranged by one of the coordinators with a number of care staff to assisting; during this period those remaining had little to engage them other than watching films showing in the cinema room. The manager spoke of improvement plans which included developing an activities programme that responds more appropriately to the needs of people with dementia.

Visitors were welcomed and able to stay in the home for meals and join in the entertainment if they wished. People were encouraged to continue to see friends and relatives and access the community with staff or relatives. The home held a recent barbeque for people and their friends and families. Staff were familiar with visiting relatives and maintained effective relationships with them to the benefit of people living in the home.

A meeting was held quarterly for people who lived at the service and their relatives, the provider attended the meeting for a short period. People were asked their opinions about the service and were always asked about the care, the menu, activities and the laundry service. We noted in the minutes the chair of the meeting had listened to views and agreed to look into the problems to resolve laundry issues. People were reminded at the meetings that they may make a complaint if they wished and we saw leaflets about the procedure on display. People were aware they could complain and said they felt they could approach any of the staff and they would be listened to. We looked at the complaints logs, Records showed the complaints had been managed in line with the provider's policy, responded to within timescales and resolved to people's satisfaction.

Good

# Is the service well-led?

## Our findings

The registered manager promoted a positive culture that was open, inclusive and empowering. Staff morale was good. Staff told us they enjoyed working at Gibson's Lodge and felt supported, listened to and could raise any issue with the manager. Staff had a clear understanding of their role and responsibilities and were aware of their responsibility to pass on any concerns about the care being provided. They told us that there was a whistleblowing policy and felt supported to use this if necessary. Care staff were clear about who was in charge and were given areas of responsibility and tasks to perform at the beginning of each shift. The manager when on duty attended and directed handovers. The most notable change and improvements noted were seen in staff attitude and keenness to learn. They told us the manager had inspired them to learn and develop new skills, they took pride in their work and worked towards personal development.

Staff had a well-developed understanding of equality, diversity and human rights and put these into practice. Staff told us that the manager was visible around the home and was approachable. Staff said they were kept informed about any matters that affected the service through supervision meetings, talking directly to the manager and at team meetings. During our observations it was clear that the people who lived at the service knew who the manager was; people and their visitors told us the service was well-led.

A healthcare professional who visited the service told us that the manager was approachable and would listen to what they had to say, they took on board recommendations and reflected this in improved practice evident in the home. The service worked in partnership with other healthcare professionals such as district nurses and GPs. The registered manager had notified us about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

Quality monitoring systems were in place to monitor the quality of the care and support that people received. The service had made progress in this area and developed more effective systems to monitor the quality of the service. Staff records were audited, and checks were undertaken on the environment and health and safety processes. However we found progress was slow in addressing areas of the environment requiring attention such as the corridors and garden. Senior staff undertook internal audits. However, the internal audits were not always robust in identifying shortfalls such as those found in medicine management. The manager told us the provider was supportive and visited the service once to twice weekly. The provider had also attended people and their relative's meetings. When the provider visited there were reports made of their findings but these had limited information.

The manager made unannounced visits to the service to check on staff practice at night and weekends. The home had an appropriate whistle blowing policy in place which encouraged staff to raise concerns. There were regular team meetings, and staff had the opportunity to participate in.
The home helped drive improvements and consistency in the service. Surveys were used annually to evaluate the service. We saw one area where the service has responded positively to people's views, for example when hospital appointments were scheduled and no relatives were available staff were assigned in advance to provide the escort duties.

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 did not take formal enforcement action at this stage. 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<br><br>Medicine procedures were unsafe and placed people at risk. People's medicines were not always being managed in line with policy, procedure, current legislation and guidance. |