

Borough Care Ltd

# Lisburne Court

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This was an unannounced inspection which took place on 12,14,18 and 19 October 2016.

We last inspected the service in October 2013. At that inspection we found the service was meeting all the regulations that we reviewed.

Lisburne Court is registered with the Care Quality Commission (CQC) to provide care and accommodation for up to 42 older people living with dementia. It is one of 11 residential care homes operated by Borough Care Limited which is a not for profit company providing residential accommodation. The home is located in Offerton Stockport and is situated on a bus route into Stockport town centre. Accommodation was provided over two floors which could be accessed via a passenger lift. All bedrooms were single without en-suite facilities. At the time of this inspection 42 people were living at the home. Day care was provided for up to four people each day.

Borough Care Limited specialise in dementia care. The company's head office is located at Heaton Lane, Stockport, Greater Manchester.

During the inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we asked the provider to take at the back of this report.

A registered manager was not in place. 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. At the time of the inspection an interim manager was in place. This manager was also the registered manager at another Borough Care Ltd location but was not the registered manager at Lisburne Court. The interim manager was assisted in managing the home by a deputy manager.

Written information for a person identified as being at medium risk of weight loss, had not been transferred to their risk management plan and was not shared in a timely way with the management team. Whilst the person had not come to any harm it was apparent their identified risks were not continually monitored to prevent the risk from increasing.

A care record we looked at lacked robust information to enable staff to continually identify and assess some of the risks to their health, safety and welfare. For example, although the district nurse was managing the person's skin integrity their care record did not contain enough information about the wound treatment or care to be provided by staff members.

Another person's daily record sheet was not detailed enough to demonstrate their care had been delivered in a person centred way. We also saw a care plan did not clearly instruct staff how to support a person with

mental health needs should they display paranoid behaviour. This meant these people were at risk of receiving unsafe and inappropriate care.

Daily record sheets relating to the care and treatment of people who used the service, such as changes to care plans following medical advice, had been archived prematurely. This meant information about decisions taken was not immediately accessible for staff to help them deliver people's care and treatment in a way that met their needs and kept them safe.

A medicine's emergency policy aims and guidance, and a policy to support service users consent to examination of treatment, both referred to obsolete care standards and regulations. Both policies had not been updated or reviewed since May 2014 which meant they were not managed in line with current legislation and guidance.

Records showed staff received infrequent supervision and they also told us they had not received an annual appraisal during 2016. The interim manager confirmed there have been no staff appraisals since April 2016. This meant the provider could not show that staff were supported in their role to make sure their competence was maintained and risks to people's health and wellbeing was minimised.

An up to date annual service user satisfaction survey had not been carried out since 2015. The interim manager was unable to provide us with the survey results. However a service user and relative meetings were in place to ascertain people's views and opinions about their satisfaction of the service provided. These systems enable the registered provider to identify where quality and safety are being compromised and to respond appropriately.

People who used the service and their relatives were complimentary and positive about the support provided and attitude of the care workers. They told us they were happy with the service provided and felt their needs were being met. They also told us care workers treated them caringly, sensitively and with respect and they tried to make sure that their independence was maintained wherever possible.

People were supported by sufficient numbers of suitably trained staff. We saw that recruitment procedures helped to make sure staff had the appropriate qualities to protect the safety of people who used the service.

Care workers we spoke with told us they had undergone a thorough recruitment process. They told us training appropriate to the work they carried out was always available to them and following their employee induction. This training helped to make sure the care provided was responsive to meet peoples identified needs.

When we looked at six individual staff training records we saw training certificates to show the care workers had received appropriate training to carry out their roles effectively. Care workers we spoke with confirmed they had received training in topics such as safeguarding and whistle blowing and knew who to report to if they suspected or witnessed abuse or poor practice.

The registered provider was working towards implementing The Care Certificate which is a professional qualification that aims to equip health and social care workers with the knowledge and skills they need to provide safe care and support to people using the service.

Medicines were stored safely. Information regarding people's dietary needs was included in their care records and clear guidance for care workers helped make sure these dietary requirements were met.

Information about how people wanted to be supported, their likes and dislikes, when support was required

and how this was to be delivered was also included in the care records we examined.

We saw written evidence of people and their relatives involvement in the decision making process at initial assessment stage and during their care needs review.

Complaints, comments and compliments were encouraged by the provider and any feedback from people using the service or their relatives was addressed by the registered manager. People spoken with knew how to make a complaint and felt confident to approach any member of the staff team if they needed to.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

Care records lacked enough detail to enable staff to continually identify and assess risks to people's health, safety and welfare.

Employee recruitment processes were in place. The required pre-employment checks had been undertaken prior to anybody starting work at the service to help make sure they were safe to work with vulnerable adults.

Appropriate arrangements were in place to help safeguard people from abuse. Care staff had received training and knew what action to take if abuse was suspected or witnessed.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Staff received infrequent supervision and appraisals to help make sure they had the appropriate skills to provide people with effective care and support.

Staff records showed care staff received an employment induction and regular training.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, who contributed to care records.

### Is the service caring?

**Good** ●

The service was caring.

People received care and support from care workers who knew them well and made positive comments about the caring and supportive nature of the staff.

Relatives of people using the service told us they were always included in decisions about all aspects of their relatives care, and care workers helped people to express their views.

Care workers knew how to use the service's confidentiality policy and understood how to work within its guidelines. People's care records were stored securely so their privacy and confidentiality was maintained.

### Is the service responsive?

The service was not always responsive. □

Daily record sheets relating to the care and treatment of people who used the service had been archived prematurely and were not immediately accessible for staff to help them deliver people's care and treatment in a responsive way.

People's needs were assessed prior to them receiving a service and person centred reviews were held on a regular basis or as necessary.

People told us they felt confident in raising concerns or complaints because they knew their concerns would be dealt with immediately and appropriately by management or care workers.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led

A manager registered with the Care Quality Commission (CQC) was not in place at the service. However an interim manager was in place and was assisted by the home's deputy manager.

Whilst systems were in place to monitor the quality of the service they had not been fully utilised by management at the home.

Service user and relatives meetings took place to ascertain people's views and opinions about their satisfaction of the service provided.

**Requires Improvement** ●

# Lisburne Court

## 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 the 12, 14, 18 and 19 October 2016 and the first day was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, the information provided in the PIR used at this inspection was completed in October 2015. A more recent PIR should have been returned to the Care Quality Commission (CQC) before this inspection, but was not received. We also reviewed information we had about the home including the previous inspection report and notifications that we had received from the service. We also contacted the local authority safeguarding and quality assurance team to obtain their views about the service. We did not receive any information of concern.

During our inspection we spoke with two people who used the service, two relatives of people who used the service, the interim manager, the deputy manager, the chief executive officer, the head of care, the newly appointed home manager, five care workers, the medicines improvement officer, the activity lifestyle facilitator and the office administrator.

We looked at the care records that belonged to six people who used the service, seven employee personnel files including individual staff training records, records relating to how the service was being managed such as safety audits and a sample of the services operational policies and procedures.

We looked around all areas of the home and how staff cared for and supported people. We also looked at food provided to people who used the service.

# Is the service safe?

## Our findings

Care records showed that risks to people's health and well-being had been identified using a generic risk management plan. For each person who used the service, assessments for a variety of physical and environmental risks were in place. For example, where there was a risk to a person of developing poor skin integrity their risk management plan clearly identified the cause or factors which might increase the likelihood of the risk occurring. The plan stated what action the care workers should take to minimise the risk, such as ensuring pressure relieving equipment was in place, the use of a profiling bed and full hoist transfer.

However we saw in another person's care records information that indicated they were at medium risk of weight loss, this information had not been transferred to their risk management plan and was not shared in a timely way with the deputy manager. The deputy manager told us they had not been made aware of this risk otherwise these details would have been included in the person's care records. Whilst these care records showed identified risk to the person were not continually monitored to prevent the risk from increasing, on visiting the person we saw they had not come to any harm and care provided met the person's needs.

We examined further care records that showed a lack of detailed information to enable staff to continually identify and assess risks to people's health, safety and welfare. For example a person's skin integrity record did not provide enough information about the wound treatment or care to be provided by staff. Another person's care plan did not clearly instruct staff how to support a person with mental health needs should they display paranoid behaviour.

The above examples demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Providers should do all that is reasonably practicable to mitigate any such risks.

A medicines policy was in place to instruct staff on the safekeeping and administration of medicines at the home. Only senior care workers had been trained in the safe handling of medicines and were not able to administer medicines until they had received appropriate training in this topic. The interim manager told us medicines were stored in locked cupboards within a locked room designated for that purpose. We saw this system was in place during a tour of the home. We saw a list of authorised staff that been signed and kept up to date. Medicines were dispensed in blister packs by the supplying pharmacist. This helped to make sure the correct dose was administered as prescribed.

We checked the medication administration records (MAR) in place and saw they provided a detailed list of all the medicines prescribed, and when they needed to be taken. We observed a senior care worker administering medicines and saw the staff member sign the MAR when people had taken their medicine. Each MAR we looked at had a photograph of the person attached and the record had been signed appropriately. Two senior care staff spoken with were able to demonstrate their knowledge of why people required their medicines, the dosage, the desired effect and the action they should take in the presentation of any potential side effects.



We checked the medicines and found there were no excessive stocks of medicines. A check of the controlled drugs (CD) in place showed the provider had followed the procedure for administering CD's. Controlled drugs are prescribed medicines frequently used to treat conditions such as severe pain. These medicines are liable to abuse and for these reasons there are legislative controls for some drugs and these are set out in the Misuse of Drugs Act 1971 and related regulations. Part of the controls require services to make entries of any controlled drugs stored and administered in a separate register as well as on the MAR sheets. When we checked the CD register and counted a sample of remaining drugs, we found there were no errors and two designated staff had signed the register to confirm they were administered.

We examined systems in place to monitor the quality of medicines management in the home to ensure people received their medicines safely. A medicines improvement officer (MIO) had been appointed to audit the quality of medicines management at all homes within the organisation. The medicines improvement officer had carried out three visits to Lisburne Court in September 2016. This was to ensure compliance was maintained in medicines management, handling and administration. MIO visits to Lisburne Court had taken place on 19, 22 and 30 September 2016. At each of these visits the MIO identified shortfalls in the management of medicines at the home. Following the MIO visits an action plan was implemented to address the shortfalls identified.

Subsequent MIO visits to the home helped ensure the shortfalls were actioned by the deputy manager and staff team. An up to date British National Formulary was in place (The British National Formulary is a United Kingdom pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology) and the MIO met with designated staff to discuss efficiency in relation to changing the medicines ordering cycle to prevent over stocking.

A senior care worker told us about the process following a medication error should one occur and said, "If there has been a medicines error such as a medicine not signed for by staff, we have to tell the deputy manager who completes a medicines error report and they seek advice from the person's general practitioner (GP) or NHS 111(NHS non-emergency number where people can speak to a highly trained adviser; supported by healthcare professionals should they require any health or medical advice).

A system to help protect people from the risk of abuse was in place. The service had a safeguarding policy and procedure in place which was in line with the local authority's 'safeguarding adults at risk multi agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. Records we examined showed the provider had effective procedures to help make sure any concerns about a person's safety, was appropriately reported. Care staff we spoke with were able to give a satisfactory account of the risks to vulnerable older people and explain how they would recognise and report abuse.

Staff spoken with confirmed they had received safeguarding and whistleblowing training and staff training records showed this. They were able to share their understanding of the service's whistleblowing policy (the reporting of unsafe and or poor practice by staff) and told us they would speak to the deputy manager to inform them about any risk concerns. Some staff spoken with knew they could also report their concerns to CQC. Care staff told us they felt people who used the service were safe because they understood their responsibility to ensure people's safety should they witness or suspect abuse. A relative of a person who used the service said, "I have never seen any staff being unkind to people. The staff are vigilant about people's safety."

We looked in the laundry and saw it was well equipped with hand washing facilities, washing machines and tumble driers. We saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination. We checked the kitchen and saw that it was clean, the fridge

temperatures were monitored regularly and food stored safely to prevent any risks of cross contamination.

Communal toilets and bathrooms were clean, adequately stocked with hand de-sanitizers, and paper towels. Disposable aprons and gloves were available for staff to use which helped to protect them and people using the service from the risk of cross infection whilst delivering care. Staff were aware of the need to make sure they used the protective equipment available and told us there was always enough protective equipment in place. Pedal bins with appropriate colour coded bin liners further reduced the risk of cross contamination. Appropriate policies and procedures such as control of substances hazardous to health (COSHH) including the uses and storage of cleaning materials, fire safety risks and checks were in place.

At the time of the inspection the home was undergoing a major building refurbishment including the addition of six new bedrooms with en suite toilet facilities. We looked at the operational and environmental risk assessments in place, which were managed safely by the provider's estates management team and building contractors. This showed consideration to how people might be harmed, and actions in place to minimise the risk helped to ensure people who used the service, staff members and visitors were protected.

A maintenance team were in place at the service and staff compiled a list of any faults or broken equipment for the maintenance people to sign off and date as work were completed. When we inspected jobs to be completed, we found these were on going and included taking delivery of new furniture and replacing old furniture as appropriate. Electrical and gas equipment were checked regularly by external contractors who ensured these systems were safe. Records seen confirmed this. Documentation was in place for the passenger lift, hoist checks, the control of Legionella and portable appliance tests (PAT) this meant equipment was safe to use for staff and people who used the service.

The service had a business continuity plan to inform staff of how the home could function with a loss of facilities such as gas, electricity or bad weather. Each person who used the service had a personal emergency evacuation plan (PEEP) which informed any emergency services what support each person needed to leave the building safely. The fire alarm and call bell system was also checked monthly to ensure they were working correctly. There was a record of fire drills with staff being taught evacuation of the premises and the fire break points were checked on rotation to ensure they were working.

An accident and incident procedure was in place. We looked at the file used to record accidents and incidents and saw the appropriate documentation had been completed when an incident had occurred. The interim manager told us appropriate authorities, including the CQC, would be notified immediately of such events when they occurred. CQC had been appropriately notified of such occurrences.

A safe and effective recruitment and selection procedure was in place. We looked at seven staff recruitment files and found that all of the staff had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and a minimum of two recent references from previous employers. Such checks help the provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults.

Six staff spoken with described their recruitment process. They confirmed after completing an employee application form, they were invited to attend a face to face interview to assess their suitability for the job. Following a successful interview the manager carried out the necessary pre-employment checks which included proof of the employee's identification (ID) and two references, one from a recent employer. We saw evidence that care workers were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory. Staff records showed where issues of poor practice had been raised these issues had been addressed appropriately through the providers disciplinary

procedure.

Staff spoken said, "We had to complete an application form then attend an interview, it was a bit scary", and "At interview they asked me why I wanted to work with older people with dementia and what skills I would bring to the job."

Staff spoken with told us they felt there were enough staff to meet the needs of the people who used the service. From looking at the duty rosters and walking around the home we saw there was a consistent level of staff in place to deliver care and support to people who used the service. The interim manager informed us that whilst a staffing dependency tool was not in place, the staff duty rota was compiled according to the support needs and level of dependency of people who used the service and the specific skills of the staff. She said, "We are looking at implementing a dependency tool following the induction of the new home manager."

We saw staff worked closely with people to assist them to meet their specific needs and provide a consistent response to those needs. A relative of a person who used the service said about the staffing levels, "There always seems to be enough staff for [relative] and I visit [relative] daily."

# Is the service effective?

## Our findings

Care staff spoken with told us they were given a full mandatory induction that covered topics such as, fire awareness and evacuation, basic life support, food hygiene awareness, control of substances hazardous to health (COSHH), role and responsibilities, moving and handling, health and safety awareness. Individual staff training records indicated that care workers had received such training. The induction was followed by a period working under the supervision of a senior care worker at the home. This gave the new staff member the opportunity to get to know the people who use the service. A probationary period of three months could be extended if required for new staff members to ensure they were suitably skilled, confident and competent to deliver care and support to people using the service.

We saw additional induction training was provided via the Care Certificate and a nationally recognised qualification in care such as a National Vocational Qualification (NVQ) in health and social care. The Care Certificate is a professional qualification which aims to equip health and social care staff with the knowledge and skills they need to provide safe compassionate care to people using the service. When we looked at six individual staff training records we saw training certificates to show the care workers had received appropriate training to carry out their roles effectively. Care workers we spoke with confirmed they had received training in topics such as safeguarding and whistle blowing and knew who to report to if they suspected or witnessed abuse or poor practice.

So that we could determine the staff skill mix at Lisburne Court we asked the business learning and development (L&D) manager to confirm the scope and percentage of qualifications, competence and skill experience of the whole staff team. During the inspection we were provided with a skills audit report for nine staff members one of whom had since left.

Following the inspection we were provided with a 'Report for Lisburne Court Learning and Development'. The report informed us the provider online training Portal 'My Learning Cloud', was accredited by Skills for Care. A Corporate Induction Workshop delivered by the L&D Manager covered topics such as, values and mission statement, management structure, induction programme, development opportunities, roles and responsibilities, code of practice, Care Quality Commission, key lines of enquiry & inspection process and living with dementia. The report showed courses assigned to each job role and the number of online courses each job role needed to complete. We were provided with a team compliance report that outlined the mandatory training completed by staff which indicated staff had completed 95.7% of required training.

The report informed us that ongoing and refresher staff training was also available in topics such as, the Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS). The interim manager told us where it was identified staff required training in other areas to meet people's specific needs training would be arranged for all staff. Care workers spoken with said about the training provided, "If staff need more training, it's always available and this helps us to look after people better." A relative spoken with said about the staff training, "Yes I think the staff are trained very well, they know what they're doing."

An annual staff appraisal system was in place to discuss and evaluate the quality of staff individual

performance and where best practice or practice improvement was demonstrated. A system was in place for staff to receive one to one supervision every eight weeks. Staff we spoke with confirmed they received supervision but this was infrequent and none of the staff when asked could confirm the last time they received a formal supervision. They collectively said, "We usually discuss work, progress, learning and development, key working and if there are any specific issues. We use a discussion log which is fed back to the manager for them to address." They also told us they had not received an annual appraisal during 2016.

When we examined staff supervision records there was little evidence to show staff had received a recent formal supervision session. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. A lack of supervision meant staff were not supported in their role to make sure their skill competence was maintained and risks to people's health and wellbeing was minimised.

The interim manager told us there have been no appraisals for staff. Whilst a new staff appraisal form was introduced at the home in August 2016, no staff from Lisburne Court had undergone an annual appraisal. When we asked the interim manager they could not tell us why this had not occurred. However, staff had all received training in the new appraisal process." They also said, "I have carried out a systems audit to establish when staff last received individual supervision, and found some staff have not been supervised since April 2016. Since then, there have been no further individual supervision sessions for the staff team." When we examined staff records we found no evidence that staff had received an annual appraisal in 2016.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff should be appropriately supervised and supported.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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.

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. We saw risk assessments and service user mental capacity assessment forms had been completed when any interventions might be restrictive and these assessments showed that the least restrictive practices had been considered and implemented. Where necessary best interest decisions had been recorded including any consultation undertaken and a rationale for reaching the decision made.

However further checks showed the registered provider was not working within the MCA and DoLS principles in relation to a person who used the service. The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This legislation sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this.

We found the person was unlawfully restricted despite the registered provider having received a local authority (LA) DoLS renewal reminder letter for the person, in June 2016. Following our findings the interim manager contacted the local authority to check if a DoLS re-submission request had been made for the person. The LA confirmed this had not been done by the provider. In light of this information the provider

immediately made an urgent DoLS application to the LA.

The service supported people with varying degrees of dementia ranging from mostly independent to requiring increased levels of support. Some people were able to select their food choices with assistance from care workers from the menu board displayed in the home or were asked their meal choice face to face by staff. We saw people had choice about what they wanted to eat and we saw that where necessary people were supported by staff to eat and drink. On examining the care records we saw attention was paid to what people ate and drank. For example, a care record stated, "Encourage the resident to have three meals a day with between snacks. Consider to weigh the resident weekly and evidence this by completing the weekly or monthly weight chart." We saw that these instructions had been carried out and results recorded by staff as required. Daily record sheets indicated the type and amount of food people had eaten and nutrition and hydration assessments had been carried out by appropriate professionals. This meant people's nutrition and hydration was monitored to support their on going good health. A relative of a person who used the service said, "The staff are very discreet when they're helping people to eat."

Care records showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and GPs, and the notes were included in people's care plans. Where people had been assessed as having a risk associated with eating and drinking, such as choking, people had received specialist assessment and advice from the speech and language therapist (SALT) and the advice was followed. Other care files showed attention was paid to general physical and mental well-being, including health care records which recorded people's weight, dental and optical checks, and gender specific annual health checks to support the agreed care and treatment.

We spoke with a relative of a person who used the service who told us they were actively involved in making decisions about their relatives care and support and where possible the person's consent was sought and documented. This was confirmed when we examined peoples care records and saw appropriate consent to care and treatment forms had been signed by the person or their relative where they had the legal authority to do so.

A care worker we spoke with had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support. Staff spoken with said, "We ask people's relatives for their consent if people can't tell us themselves. We work with them because they know their relative better than us in areas such as their daily routines."

When we walked around the home we saw the home's design and layout were suitable to accommodate the number of people using the service. There was sufficient equipment in place, such as hoists and wheelchairs to support people using the service. Toilets, bathrooms, lounge areas with appropriate seating and waiting space in the reception area, were sufficient and relevant to the service being provided. Whilst the home was not particularly dementia friendly because of the building refurbishment, the service maintained a homely environment, people's planned activities and routines continued to be supported effectively by staff members.

Any alterations/adaptations being made to the premises had been securely locked or cordoned off and signs in place highlighted any hazardous areas in relation to the building work being carried out. This helped to mitigate any risks to staff, visitors and people using the service.

## Is the service caring?

### Our findings

We saw the culture of the service was geared to the needs of the people who lived at Lisburne Court. Respect and regard was central to the delivery of care and support, and we observed good interpersonal relationships between staff and people who used the service.

Two relatives of people who used the service said, "The staff are lovely and kind. Mum's always singing. Staff [X] can always get my mum to have a shower and there is always two staff to make sure she doesn't fall. I'm very happy my mum is here" and "Staff [X] is a little darling. She ticks all the boxes. All the other staff are lovely too. They always keep me informed about my mum's care and safety. The staff are absolutely dedicated."

Care records examined had been written with understanding of people's individual needs. For example a different care record examined described a person's daily routine and gave detailed instructions about the person's personal care needs and included their night care personal plan. A daily record sheet was completed at specific intervals during the day and night to show their identified care needs were being addressed and met.

Care staff we spoke with said, "Our role is to support the resident's to meet their needs. We try to make their life as enjoyable as possible" and "We achieve this through good training, colleagues and teamwork. We have good communication with the resident's families and that helps us to understand the resident's needs better" and "We all have to work the same way with people, consistency is important."

We saw that staff had developed a good rapport and understanding of the people who used the service and treated the people with respect. We saw staff members understood people's particular communication styles and how to interact positively with them. Where people had difficulty communicating staff remained patient and took time to listen, acknowledge what they were saying and responded appropriately. For example, we overheard a care staff comforting a person who was disoriented around the home and the care staff listened patiently to the person, then verbally reassured them whilst gradually leading them to the area of the home they wanted to be in.

The home conveyed an open, relaxed and friendly atmosphere. Conversation between people and staff was respectful and demonstrated their friendship and interest in people's daily routines. For example a staff member was heard complimenting a lady who had just had her hair washed and styled by the visiting hairdresser.

Care records showed and we saw people were encouraged to remain as independent as possible, and staff supported people to manage tasks such as personal hygiene within their capabilities. It was apparent from the look of contentment displayed by people they enjoyed the responsibility this afforded.

Whilst nobody was using an advocate at the time of the inspection discussion with the interim manager and the head of care confirmed they were aware of how to access advocates for people. An advocate is a person who represents people independently of any government body. They are able to assist people in many



ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

We were told the cultural and religious backgrounds of people were always respected, and when we talked with staff members they were able to demonstrate their understanding of people's diverse needs cultures and religion.

We saw that all records and documents were kept securely in a locked room. This ensured confidentiality of information was maintained.

The interim manager told us that whilst nobody using the service required end of life care, staff training would always be provided in this topic and the relevant professionals such as district nurse and GP would be involved. Any programme of learning for care staff to develop awareness and knowledge about end of life care would be put in place and an appropriate care and support plan would be implemented to consider how best to meet the person's needs at that time.

We looked at the procedure on the 'rights of privacy' and the 'end of life care policy'. Both documents centred on the individual person and were geared towards helping the person to have as much control as possible about decisions relating to future care and end of life needs. The document also made reference to the support that may be required for the person's family and friends.



## Is the service responsive?

### Our findings

The interim manager told us that detailed needs assessments were undertaken by the manager or deputy manager before a person began to use the service. Following the initial assessment a more comprehensive assessment would be completed and plans put in place to make sure the home had the appropriate equipment and staff to meet people's identified needs. Consideration of social, communication, mobility skills and interactions was prioritised along with people's physical and mental health needs. We saw evidence in the care records to show this and where support would be given at the next stage of care intervention.

We looked at six care records four of which contained comprehensive information about each person and sufficient detail to guide staff on the care and support to be provided. They included the person's emergency contact details such as their next of kin, and GP, risk assessments, current support needs and the support to be provided and the desired outcome from the care and support provided. They contained relevant information about people's diagnosis and associated needs, mobility, leisure and communication.

All other care records we examined included a care record index sheet, a person centred plan, map of life events, where moving and handling assessment needs were identified as requiring two staff, the reasons why were clearly documented in each care plan. A generic risk management plan highlighted 'Things I can do' and where extra support for the person was required was included. A generic hydration plan, nutritional risk trigger form, referral to district nurse trigger form, my favourite food, favourite activities and a monthly review sheet and night care personal plan were fully completed. Specialist information and guidance from the relevant professionals involved in their care, such as physiotherapists, incident forms following an incident where risk was apparent were also contained within the care records. This meant information within this particular care record helped to make sure the person's needs were being met.

One of the six care records examined identified a person who used the service as requiring antibiotics on 7 October 2016 to treat a recurring wound infection. Written instructions advised staff to monitor the wound and to contact the person's GP if the problem continued. Whilst a short term care management plan had been completed to address this problem and antibiotic treatment prescribed, information about the recurring wound infection had not been included in the person's longer term risk management plan. The short term care plan had not been signed or dated by staff and daily records to show staff had consistently monitored the wound as instructed were not available in the person's care record and their daily care records had been prematurely archived.

When we looked at the unarchived daily record sheet we found there was a lack of information to describe the actual care and treatment provided. When we discussed our findings with the deputy manager they told us whilst the person's wound had since healed they had not been informed by the staff team about the wound, the wound treatment, the action taken and why the person had been prescribed antibiotics until 11 October 2016. This meant the systems in place to record the care and treatment provided to people were not fully utilised.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Maintain an accurate, complete and contemporaneous record in respect of each service user.

Other care record we examined contained sufficient instructions to support the person with specific tasks, such as eating and drinking. Care plans that were written in a person centred way demonstrated a good understanding of the person and in one care plan we looked at we saw information about a person's skin integrity highlighted the areas of concern or risk stating the equipment and diet required to minimise the risk of the person developing pressure sores. For example, 'pressure relieving equipment, profiling bed, does not mobilise, full hoist transfers. Simvastatin prescribed therefore not to have cranberry or grapefruit juice. Pain relief every 72 hours by patch, low risk of falls, maintain high skin integrity, two hourly night checks'. Specific instructions under each heading provided staff members with sufficient information to help meet the person's identified needs.

When asked, the relatives of people who used the service told us that the service was responsive and met their relative's needs. One relative said, "She [service user] has been at Lisburne Court for four years after suffering a fall at home. I [relative] visited the home before she was admitted and there was a six week probationary period before she moved in permanently. It's a nice place and she has a lovely bedroom."

The interim manager, deputy manager and care staff were aware of the importance of the care plan review system. They told us any information about the person was reviewed to make sure it fully reflected the person's current support needs, and when any changes were made all staff were made aware of the changes to reduce the risk of improper care being provided. Person centred reviews were held every six months or sooner if required and involved the person who used the service where they had the capacity to be involved in the planning of their care. Family members or advocates, and their social worker, would also attend the review meeting. Where issues were identified this was noted and follow up action was recorded.

Care staff spoken with told us about their roles and responsibilities and stated, "We have daily handovers at each shift change and we discuss people's support plans. We have to complete a daily handover sheet and share the information with our staff team", and "We have a keyworker system and we are responsible for two residents each. Keyworkers are responsible for making sure the residents have regular baths, showers. We liaise with the relative's, update all of the treatments, weight, optician, GP and district nurse health appointment records. Sometimes we have to do this several times a day." We asked the care workers about their method of recording and sharing care interventions with the interim and deputy manager and one staff member said, "I write everything anywhere, like handover sheets, diary, and daily record sheets. It's just safer that way. There is a lot of paperwork to complete." This enabled the continuity of care for people who used the service.

Daily activity session sheets were completed following activities that were led by the activity lifestyle facilitator (ALF). They told us external entertainers visited the home and we looked at a comprehensive list of the activities offered to people and planned for the coming weeks. The ALF said about her role, "I'm getting there now the residents seem to love the activities in place, they're getting to know me and I'm loving the job." People were supported to continue taking part in their hobbies and interests or seek new pursuits and this information was recorded in their care records. Individual and group activity plans for people who used the service were kept in people's individual care records and included different daily leisure activities. During the inspection we saw the ALF providing individual targeted activities to people outside of the home such as, walking to the local shop to purchase small personal items and visiting places of interest.

A complaints policy was in place and we looked at how the service managed complaints. The head of care told us that complaints were addressed following the services complaints procedure. Complaints were

logged and allocated to the head of care to investigate. These complaints would be monitored by the HR director and records kept of actions taken. The service kept a computerised log of any complaints made and the action taken to resolve the issues. We examined the services complaints log and found any complaints made had been resolved to the satisfaction of the complainants. We were satisfied that the policy in place allowed for a full investigation and all complaints were taken seriously. The policy allows complaints to be escalated to the local government ombudsman if the complainant remains dissatisfied with the outcome.

Where possible, action was taken from complaints to improve the quality of service delivery. The head of care acknowledged that not all complaints could be dealt with satisfactorily and accepted that positive criticism was a useful way to ensure a good standard of care was maintained.

A relative spoken with said, "I have no need to complain, but I know I could always speak to the manager if I have any concerns."

## Is the service well-led?

### Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Lisburne Court is registered with the Care Quality Commission (CQC). At the time of the inspection a registered manager was not in place as required under the conditions of their registration with the CQC however an interim manager was in place. This manager was also the registered manager at another Borough Care Ltd location but was not the registered manager at Lisburne Court. The interim manager was assisted in managing the home by a deputy manager.

A new home manager had been recruited however an application to register with CQC had not been submitted at the time of the inspection.

Borough Care published business information states "The company has over twenty years' experience in supporting people living with dementia and is committed to providing excellent support through a range of services that include residential care. The company's aim is to offer the people control and choice in how they live their life as well as a feeling of safety and security." They aim to ensure their living environments are suitable for meeting the living needs of each individual and people's lives are enhanced by activities according to the person's interests and abilities. The service was in the process of developing and reorganising the way in which it was managed.

The provider head of care monitored the home's progress against any action plans to improve the quality and safety of the service. The interim manager and provider head of care understood their role and responsibility to the people who used the service and demonstrated their commitment to the company by having clear visions and values about the service. Staff spoke positively about the deputy manager and told us they enjoyed their work and thought management responded well to the needs of staff and of the people who used the service.

At the time of the inspection the interim manager was assisted in managing the home by a deputy manager. A business compliance officer was in place to carry out regular audits of services within the organisation, help identify non-compliance and analyse and action any findings to improve the quality and safety of the service. We were told the process was for all findings to be escalated to senior management and the board of directors. However, this had not been done in relation to the lack of deputy manager medicines audits and shortfalls in the documentation in some care records.

At the time of the inspection, a new home manager (proposed registered manager) had been in place at the service for one week and was undergoing their employment induction. They told us their immediate responsibility was to ensure there was no disruption to the care provided to people during the management transition and building refurbishment. They said, "There are a lot of changes taking place within the organisation, we are in the process of introducing more staff training which will need time to embed, but we have a clear vision moving forward."

The absence of a registered manager in the home was apparent throughout the inspection. Processes that

enable the registered provider to identify, assess, mitigate risks and monitor the quality of the service had not been fully utilised by management at the home. Systems in place had not been robust enough to identify the shortfalls identified during this inspection as detailed throughout this report.

We were unable to obtain up to date records of bi monthly audits undertaken by the compliance officer. The interim manager told us they would check the dates when these audits were last carried out. However during and following the inspection the dates and audit copies were not provided to us. The lack of bi monthly audits identifying shortfalls in good practice meant the provider was not able to identify where quality and/ or safety were being compromised, therefore they were unable to respond appropriately and without delay.

The interim manager provided us with copies of the services policies and procedures such as, complaints and suggestions, safeguarding adults, accidents and incidents, medicines, staff recruitment and whistle blowing. Other policies in relation to medicines were last reviewed in 2014 and the next policy review date being 2015 had not taken place.

The provider's head of care was aware that some policies had not been reviewed annually and told us the business was considering purchasing new policies and procedures for the whole organisation.

The above examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Assess monitor and improve the quality and safety of the services provided.

We saw comments and compliment cards and a suggestion box were made available in the reception area of the home for people to complete and provide feedback at any time. However it was not clear who was responsible for collecting and monitoring the comments and if any recent comments had been made. An annual service user satisfaction survey helped the provider seek the views of people who used the service, relatives and representatives and stakeholders. However an up to date annual service user survey had not been carried out since 2015. Whilst the service did not have a recent annual survey in place, relatives spoken with confirmed meetings were held with people who used the service and their representative or relatives. People were given an opportunity to say what they liked about the service but also what, if any, improvements could be made. Notes of the meetings were kept to ensure an accurate account of people's verbal contribution.

Accidents and incidents were recorded and had been regularly monitored by an internal compliance officer to ensure any trends were identified and addressed. We were told there had been no identifiable patterns in the last 12 months. Similarly, any safeguarding alerts were recorded and checked for any patterns which might emerge. We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

Regular staff meetings took place to ensure that staff had an opportunity to discuss any issues arising, including good practice guidelines, service user updates, changes to the organisation and personal issues relevant to staff, for example, holidays were discussed and actioned. We saw that recent staff meetings had discussed the building refurbishment plans for Borough Care and the proposals from the local authority to complete a full refurbishment or rebuild of buildings in line with their 'Vision 2020'.

In 2014 the provider was awarded the Investors In People (IIP) silver award. The standard defines what it takes to lead, support and manage people for sustained business success. This award is valid for three years.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People who use services were not protected against the risk of receiving unsafe and inappropriate care because people's care records and risk assessments did not contain enough detailed information to enable staff to continually identify and assess risks to people's health, safety and welfare.</p> <p>Regulation 12(1)(a)(b)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>People who used the service were not protected against the risks associated to their health, safety and welfare because processes that enable the registered provider to identify, assess, mitigate risks and monitor the quality of the service had not been fully utilised by management at the home.</p> <p>Regulation 17(2)(b)</p> <p>People who use services were not protected against the risk of receiving unsafe and inappropriate care because written information in care records had been prematurely archived and did not show that care provided was consistently monitored and recorded.</p> <p>Regulation 17(2)(c)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

People who use services were not protected against the risk of receiving unsafe and inappropriate care because staff had not received an annual appraisal in 2016 to make sure their competence was maintained.  
Regulation 18(2)(a)