Mrs C Chesyre

# Lillibet House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service caring? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Lillibet House is a residential care home providing accommodation and personal care to 28 people in one adapted building. Most of whom were living with different types of dementia. The home can support up to 30 people.

People's experience of using this service and what we found
The home supported people living with dementia who had complex needs who could become distressed and inadvertently can cause harm to others. We found the management of the home did not always have the right processes and systems to manage this risk effectively. There were also shortfalls with how the registered manager, management team and provider assessed the quality of their service.

We saw examples of potentially abusive care with how people were treated and supported in the home. We raised two safeguarding referrals with the local authority about what we saw. Staff needed more support to care for people in a safe and thoughtful way. Following situations when people living with dementia became distressed and who inadvertently harmed others, the registered manager and provider had not considered if there was enough staff or if these staff were in the right places at the right times, in order to support people, and to defuse situations when some people became distressed.

There was a lack of a social, fun and happy atmosphere in the home. People were waiting around in the lounge and hallway all day with nothing to do. Staff were often not present in the lounges and, when they were, they did not chat or try and do something interesting or fun with people.

We found issues with how the registered manager and provider were managing the risk of COVID-19. There were unvaccinated staff in the home. Relaxed processes for supporting visitors and professionals into the home. Staff did not always maintain social distance amongst themselves.

There were shortfalls with how the registered manager, provider and management team assessed and checked how other risks which people faced were being managed. Processes, risk assessments, care plans, and reviews of safety checks were not effective in supporting the management of these risks. This put people at potential risk of harm.

When we could communicate with people, they spoke fondly of the registered manager. Relatives and professionals also spoke well of the registered manager. They felt there was good communication and the home was doing everything they could to support their relatives and the people in the home, in very challenging situations.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Good (published 13 December 2017).

Why we inspected
We received concerns in relation to the management of COVID-19. As a result, we undertook a focused inspection to review the key questions of safe, caring and well led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lillibet House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We issued a warning notice to the provider in response to a breach of regulation 12 (safe care and treatment) and we have imposed a timescale for the required improvements to be completed. Please see the action we have told the provider to take at the end of this report.

We have identified breaches in relation to keeping people safe, promoting people's dignity, and how effective the leadership of the service was. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service caring?**

Inadequate

The service was not caring.

Details are in our caring findings below.

**Is the service well-led?**

Inadequate

The service was not well led.

Details are in our well-led findings below.

# Lillibet House

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors. One inspector carried out the site visit, whilst the second inspector assisted with reviewing documents off site.

Service and service type
Lillibet House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service. We spoke with the local authority and sought their views of the service. The provider was not asked to complete a provider information return prior for this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.
We used all of this information to plan our inspection.

During the inspection
We spent the day at the home and completed many observations. We were unable to communicate with most people, but we did speak with four people at the home. A medicine check was also completed. We reviewed six people's risk assessments, care plans, daily notes, and records of medicines. We reviewed various records in relation to the safety of the building such as fire safety and COVID-19 management. We spoke with a six members of care staff the registered manager, quality manager and provider. We also spoke with three people's relatives.

After the inspection
We contacted a sample of professionals for their feedback about the service. We also sought further clarification about unvaccinated staff working at the home.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- During the inspection visit we made two safeguarding referrals to the local authority about two people being treated in an unsafe way.
- We saw one person had been incontinent and was being pulled to the bathroom by two members of staff holding their hands. The person was screaming saying they did not want to go to the bathroom. They looked extremely distressed. Staff did not stop and review the situation. From this person's daily notes, which we reviewed later, it did not state staff had explained why they were supporting this person to stand to use the bathroom. Given their reluctance to go to the bathroom, we were not confident staff had explained what they were doing when they used equipment to support this person to stand.
- We saw another person who was on the floor experiencing an incontinence episode. A member of staff was heard shouting and swearing about this person. A member of staff had left this person, to attend to their own needs, leaving this person alone as they were trying to stand up. We needed to ask for a member of staff to stay with the person, so they did not hurt themselves as they tried to stand. When additional staff came to support this person to stand up, they did not assess the situation or ask questions, to see if this person was injured or not, before they used the hoist.
- We identified a person had recently harmed another person. This was not referred to the local authority's safeguarding team. This meant there had been no investigation to see if this situation could have been prevented, to check if the other person was safe, and to see if staff needed to do something different to keep other people safe. Without an investigation into this, it was possible this could happen again to this person and to others.

We found these were events were not managed in a safe way. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager also raised two safeguarding referrals with the local authority about these two events. They also started an internal investigation into what happened which included a disciplinary process for staff. They have created a new plan to monitor one of these people's needs and held staff meetings about the importance of this. They have also sought further professional support to manage one person's needs. .

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- There were incidents when people living with dementia had caused harm to other people during times of distress. These events were not meaningfully reviewed by the management team. They did not check actions had effectively been taken to reduce the repeat of these events and support these people.

● One person had tried to hurt staff with a piece of equipment. They later hurt a person with the same equipment. This may have been prevented if a review of the first incident had taken place, and lessons had been learnt from this.
● Risk assessments were not always updated or complete. The registered manager told us one person could refuse support when they were incontinent, but they did not have a risk assessment about this risk or a care plan to show staff what to do to support them. This was only updated on the day of inspection, after we had found issues with this person's care and treatment by staff and told the registered manager about this.
● We were told one person could "barricade" themselves in the lounge. However, this risk was not explored to promote their own and other people's safety when this happened. This person could also become aggressive and refuse support when they were incontinent. This risk was also not identified or explored so staff knew what to do in this situation, to ensure this person was safe.
● Where it had been identified that some people could become aggressive when distressed or confused, they did not have care plans which explained step by step to staff how they should manage these situations, and ensure everyone involved was safe.
● There were people living at the home who were at risk of choking. But there were no systems to ensure those who were at risk of choking were safe. The kitchen staff did not have records or a system highlighting those people who were at risk of choking and required a modified diet. It was reliant on the cook's memory. It was possible if an agency cook was needed this information would not be available to them. These people also did not have effective risk assessments or care plans which fully explored this risk and told staff what they must do. These factors could put these people at risk of coming to harm.

Preventing and controlling infection
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There were times when staff were not promoting social distance with each other. Staff were seen in the staff room which was small with no ventilation. A relative told us there was no ventilation when they saw their relative in a room for visitors. Two visitors also told us they were not asked to wear face masks on one occasion, when they visited the home.
● Wearing face masks and checking visitors and staff's temperatures can also reduce the risk of spreading COVID-19, especially when there is close contact between people in enclosed or crowded spaces. People's temperatures were also not being taken as per government guidance.
● When a person was incontinent this was not managed in a safe way. The soiled chair and cushion were not removed or cleaned and a person living with dementia sat in it. We needed to ask staff to address this issue. People's incontinence equipment was also stored outside in a large container which had been left open by staff, there was a potential risk, pests could contaminate these items.
● Parts of the kitchen were not clean. In the kitchen there were cobwebs and areas which looked unclean. Frequently touched areas of the home were not being cleaned. This was observed during our visit and no cleaning records showed this work was being completed.

We found these issues placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were three unvaccinated care staff who were providing care and support. We were informed by the registered manager and provider they did not have a medical exemption, so they had been transferred to the role of an essential care giver and were supporting people under the guidance for this. However, the provider and registered manager had not followed new legislation about staff (apart from those exempt) being COVID-19 vaccinated. They had not referred to the regulatory requirements for this matter.
●These unvaccinated staff continued to work as they had before in close contact with vulnerable people. They were on the staff rota; they gave medicines to people in the home; they used computerised records

with access to all people's records. They were allocated to 12 people in the home and one attended on night shifts. Relatives who were also designated essential care givers did not have this same level of involvement with their relatives' care needs.

● In addition, we needed to prompt staff to check our COVID-19 vaccination status and tests when we entered the home. A visiting health professional also needed to prompt the recording of their COVID-19 entry checks.

This has placed people at the risk of harm. We found the use of unvaccinated staff was a breach of regulation 12(3) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Although there was evidence of safe staff recruitment checks, we found staff were poorly deployed around the home.

● We saw some people were becoming angry or frustrated with each other in the main lounge, staff were not present to calm the situation. Some people living with dementia could also not call for help if this was needed.

● There were some occasions when people hurt one another in the main lounge and hallway, but staff were not present in these rooms when this happened. Despite the fact people spent a lot of time in these rooms during the day and some of these people had become distressed and harmed others before.

We found these staffing issues placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● A person's care plan about their mood controlling medicines was in contradiction to their 'as required' medicine plan. It poorly directed staff when they should administer this medicine. This increased the risk of staff providing this medicine routinely and not as and when required.

● We completed a check of people's medicines and found the correct amounts had been given to these individuals.

Inadequate

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- There were times when people were not treated in a caring way.
- We saw two events where people were not treated in a respectful and caring way. Even though these people were clearly distressed or in a compromised situation, staff did not offer support or re-assurance towards them.
- Another person needed support with their food, but staff did not provide or offer this support. Which meant they took an hour and a half to eat their food, so it was likely to be cold. Staff did not ask if they wanted it heated up, as they were taking a long time to eat it. When we spoke with the registered manager about this, they said it was this person's preference to eat cold food. But their care plan did not say this. Nor were staff providing support as outlined in this person's detailed food care plan.
- The lounge, hallway and dining room were cold. The front door (which was behind an inner door) was kept open despite it being late November. Some people said they were cold, others looked like they were cold, wearing coats in the lounge, pulling their cardigans around themselves. One person had put a disposable apron they had on at lunch time, around them which looked like a scarf. Staff and the management were not considering if people were comfortable at these times and taking the appropriate action.
- We needed to draw the temperature of these rooms to the management's attention. They instructed staff to close the front door and enquired about the lack of heat in the dining room. But no additional heat sources were brought into these rooms.

Respecting and promoting people's privacy, dignity and independence

- Staff and the management team did not always take action to promote people's privacy.
- One person had a safety gate fitted to stop people living with dementia walking into their bedroom as they found this frustrating, because they told us these people would take their things. But this gate was broken so people came into their room a lot. From speaking with the registered manager, no action had been taken to replace or fix this gate.
- Another person's care plan was written at times in a disrespectful way about their needs.

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

- We were not confident people, when they could be, were involved in making key decisions about their lives.
- A person's actions who had capacity, were being restricted to manage a risk which they faced. However, the records relating to this did not show they had been involved in this process. Nor did it show they had

agreed with this decision. The management team had not considered if other actions were needed here, as this could have an adverse effect on their well-being.

● One person who had capacity said they would not want unvaccinated people caring for them. However, they were receiving this support at the home. A meeting recorded their agreement for this support, but it lacked evidence to show the risks had been discussed with them. We were not confident they had understood what they had agreed to. This decision was also not reviewed to check if these people had changed their minds.

We found people were not always treated with respect. This could have a negative impact on their wellbeing and undermine their rights. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we brought these issues to the registered manager, they told us they have started an investigation and had a meeting with staff.

Inadequate

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were clear shortfalls in how the leadership of the home kept people safe. Especially those people living with dementia, who could become distressed and inadvertently harm others. This was because there was a lack of safe care and treatment to support and manage these people's needs.
- Management and staff did not understand the principles of good quality assurance and the service lacked drivers for improvement. When people harmed other people, these events were not reviewed to see if the management team could try and prevent these from happening again. They could not evidence they had considered if there was enough staff, in the right places, who knew how to spot the signs of people getting frustrated. They did not consider if people were acting in this way because they were bored. This put people at an increased risk of harm.
- Some key risks which people faced were not being adequately assessed and checked by the management team to ensure care plans and risk management documents were up to date and effective in directing staff with what they needed to do to keep them safe.
- We were not assured the management team were effectively managing the risk of COVID-19. They were not always following the guidance and legislation to try and prevent it from entering the home. This placed people at risk of becoming ill with COVID-19.
- Audits were either not taking place or were ineffective when assessing people's experience of living at the home. There were no provider level audits into key aspects of the care such as safeguarding events, and when people have harmed others. To test the quality of the care and consider what improvements could be made, to support the management team to carry out their role.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was not a culture of the staff and the leadership being attentive to people's needs and providing compassionate care.
- When some people living with dementia became distressed, when their dignity was compromised, and when they became frustrated, staff were either not present or they did not offer thoughtful respectful and caring support.
- There was a lack of focus on people's experiences in the home, to make people's experiences social, fun, and interesting. We were told specialist dementia input was not considered to improve people's time at the home. This could affect people's mental wellbeing and result in some people becoming frustrated.
- We saw examples of outdated potentially abusive care in relation to how people were treated and referred

to in documents. One person who had a learning need was referred to in a derogatory way and staff were directed in their care plan to treat them in this way. We noted aspects of the environment which looked institutionalised such as the window into the lounge from the office, which had wired fire safety glass in it.

We found there were issues with how the leadership of the home promoted people's safety and experiences. There were key shortfalls in how the leadership also assessed the quality of the service. This put people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- A complaint had been raised by a relative about a person experiencing harm when they stayed at the home. The documents relating to this complaint did not show it had been managed in an open way, with the complainant being told about the outcome, an apology for what went wrong and what they can do if they were unhappy with this.
- The registered manager and provider had not contacted the local authority, department of health, or the CQC to discuss and seek agreement about the essential care giver role for unvaccinated staff. Other professionals were also not contacted to seek their involvement in this decision.
- A safeguarding event was also not raised with the local authority.

We found there were issues with the transparency of the leadership of the home. This put people at risk of harm. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- It was challenging to involve people in the development of the home. But attempts were not made to understand their experiences of the care for example, through observations of people's experiences.
- Relatives told us they were asked for feedback if something went wrong with how their relative was being supported. Three professionals we spoke with also said the registered manager communicated well with them and kept them up to date. They also told us they had found no issues with how certain individuals were being supported at the home.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Service users were not always treated with dignity and respect. The registered manager and provider had failed to ensure this was part of the culture of the home. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The registered manager and provider did not safeguard service users from institutionalised abuse and harm. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA RA Regulations 2014 Duty of candour<br><br>The registered manager and provider had not always been transparent and open when responding to a complaint and with outside organisations. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were shortfalls with how staff were being deployed about the service. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There were shortfalls in how the registered manager and provider promoted service users' safety in the home.<br><br>Not all staff were vaccinated against COVID-19 or able to demonstrate an exemption.<br><br>The provider did not have a system in place to check the COVID-19 vaccination status of professional visitors to the home as required since 11 November 2021. The failure to have this system in place meant people living in the home had been put unnecessarily at risk.<br><br>This was a breach of regulation 12(3) safe care and treatment. |

**The enforcement action we took:**

We warned the provider they were breach of safe care and treatment at the service. Instructing the provider to correct these failures.