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Liam House

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Liam House is a residential care service that provides 24-hour care and support to people with a learning disability and autistic people. Eight people were living at the service at the time of the inspection. The service can support up to 10 people.

People's experience of using this service and what we found
The service was not always able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support
People's rights were not always protected as there was a lack of understanding of the MCA from the provider and staff and, where restrictions were in place, we did not see evidence of best interest decisions to support this.

People received care and support in an environment that was not always safe, clean, stimulating and well-maintained.

People had a choice about their living environment and were able to personalise their rooms. Two people proudly showed us their rooms which they had decorated to reflect their tastes and hobbies.

Right care
The service did not have enough appropriately trained staff to meet all people's needs and keep them safe.

Some people were at risk of harm as care plans and risk assessments were not always complete and up to date.

Staff had attended safeguarding training and when we spoke with them demonstrated they knew how to apply it. However, we did find referrals for one person were not always made by the provider to the local authority safeguarding team.

Staff worked well with other services and professionals to prevent people needing admission to hospital.

Right culture

There had been changes in management with the home now overseen by the provider who worked remotely at the time of the inspection. This had affected the quality of auditing and oversight of the service.

Although the provider promoted the importance of person-centred care people were not consistently involved with planning and reviewing their care.

The provider demonstrated a good understanding of their legal responsibilities for sharing information with CQC.

The provider had reached out to leaders in the health and social care sector to express their concern and that, as a small provider, they were struggling during the pandemic.

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 27 September 2018).

Why we inspected
We received concerns in relation to record keeping, governance and oversight. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.
The provider is being supported by the local authority and management support has been offered and accepted. Management support has been provided to support the service to further assess and mitigate known risks with an aim to drive improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Liam 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 have identified breaches in relation to the safe care and treatment of people, need for consent, safeguarding, staffing and governance of the service at this inspection. We have made a recommendation around staff training.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our well-led findings below.

Liam 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 Health and Social Care Act 2008.

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
Two inspectors, a member of the CQC medicines team and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Liam 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers 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 sought feedback from a local authority that commissions care from the service. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and three relatives about their experience of the care provided. We observed a staff member using signing to communicate with a person who did not communicate with words.

We spoke with four members of staff including the provider, accounts manager, a senior support worker, and a support worker.

We spent time observing the mood and engagement of people at Liam House and the quality of staff interactions. These observations were conducted throughout the inspection.

We reviewed a range of records. This included four people's care records and six people's medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We liaised with the provider to discuss actions they had taken in response to the issues identified during our inspection. We received feedback from two professionals who regularly visit the service.

Requires Improvement

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 the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- Some people were at risk of harm as care plans and risk assessments were not always complete and up to date. When we raised this with the provider they stated, "It is a work in progress, I have not had the time. Most risk assessments are going to be done by me until my team are more confident and educated to be able to do that." Although the provider told us they set themselves dates to review care plans there was no evidence of an established risk review and management process.
- There was a lack of health and safety monitoring which put people at risk of harm. For example, there was no lock on a laundry building with cleaning detergent accessible on the top of washing machines and we also observed bottles of disinfectant accessible on the top of a locked 'hazardous substances' cupboard in this building. One person living at the service was at risk of putting non-edible items in their mouth. We raised this with the provider who spoke with staff to help ensure these issues were resolved. They also liaised with an external contractor to schedule health and safety checks.
- Improvements were required to the home environment. It had not been maintained to a standard to ensure people's safety and enjoyment. For example, the garden was cluttered; in some areas it was inaccessible, had trip hazards and was not secure. The rear fence was broken allowing access to the adjoining property. One person said, "I used to go out there. I don't now. It's messy." A staff member commented, "Everywhere you look, there's mess. It's not a space anyone can use. Bits here and there." We raised this with the provider who told us this would be resolved.
- People were at increased risk of fire as the home did not have a fire risk assessment, fire drills had not included night staff, some fire equipment had not been serviced recently and two fire extinguishers were not easily accessible. We raised this with the provider during the inspection and they liaised with an external contractor to resolve these issues. The items blocking the fire extinguishers were removed during the inspection. After the inspection we shared our observations with the local fire service.
- The service did not have a business continuity plan. This meant people and staff were at increased risk in the event of an emergency such as flooding or utility failure. The provider told us, "I had a continuity plan for the pandemic, but it is not useable now. It would be good to have something written down."
- We discussed with the provider occasions where they had decided not to report unexplained bruising for one person to the local authority. Risk information was not in place to explain why these referrals were not necessary.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate risks to people were identified, assessed and effectively managed. This 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.

● We observed all eight people during the inspection. They smiled, interacted naturally and appeared content in the company of staff. Four people who were able to communicate using words told us they felt safe.
● Staff demonstrated an understanding of signs that might indicate abuse and had attended safeguarding training.

Preventing and controlling infection; Using medicines safely
● Despite the home only having one case of COVID-19 during the pandemic, we were not assured that all was being done to protect people from the risk of COVID-19. For example, hand hygiene auditing records had stopped in April 2021. The provider explained to us how they felt they went above and beyond infection prevention and control guidance at the height of the pandemic, for example, by purchasing additional equipment such as air filtration systems.
● People were not always being protected from the risk of infection as the home did not have a cleaning schedule. A staff member told us, "We used to have cleaning two hours a day which I always said wasn't enough, but now that's stopped so it is just what you can do on a nightshift."
● Staff did not always follow effective processes to assess and provide the support people needed to take their medicines safely. This included where staff were responsible for making decisions that a person required medicines.
● Following administration of when required medicines there were records of the reason for administration and the outcome of the administration. However, there was not always clear information to support staff decision making processes. The provider should ensure there are processes in place to develop and use clear guidance on the use of medicines prescribed to be used in this way.
● Where people were prescribed when required medicines to support them at times of emotional distress there was not a clear care plan to guide staff around the interventions required to de-escalate before administering any medicine.

We found no evidence that people had been harmed. However, the provider had failed to ensure medicines were managed safely and failed to ensure infection prevention and control processes were in place with regards to audits and cleaning. This 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.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● People were supported by staff who mostly followed systems and processes to administer, record and store medicines safely.
● Staff had received appropriate medicines training and were aware when they needed refresher training. Staff competence was assessed.

Staffing and recruitment
● The numbers and skills of staff did not match the needs of people using the service. This meant people were not always kept safe and did not always have their needs met. Staff told us, "Night is where we are dangerously short of staff" and, "We are constantly short staffed and have to rely on people from agencies who often don't know enough to work efficiently." The provider said, "We have lost a middle section of staff." The provider told us they considered staffing levels as one of the key challenges for the service.
● The lack of staff meant people were not always able to take part in activities they wished to. Staff

commented, "When we say no, it stops them doing what they want and it frustrates them" and "This is the main issue here, we urgently need more staff to cover annual leave and sick leave, also this impacts on the residents' activities since we don't have enough staff to do it." The provider acknowledged people at Liam House would benefit from extra staff as this would enable them to go out more.

● The service used agency staff to supplement staff vacancies. When we asked the provider about current vacancies they responded, "So many, we are using two or three agency a day, we need a third of our staff if we are going to extend for more community access then we would need half the staff again."

● The service had a recruitment process in place.

We found no evidence that people had been harmed however, the provider had failed to ensure there were sufficient numbers of suitably trained staff to meet people's needs and keep them safe. This 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.

Learning lessons when things go wrong

● Accidents and incidents were recorded on an electronic care system. Although this system had a function that provides the provider with "an instant update of what needs actions", they added that "a glitch in the software [means I'm] having to manually check all the time."

● With regards to incidents in the home a staff member commented, "It's [name of provider] who follows up these things but with [name of provider] so far away and not in the building you don't always know what's happened."

● There was some evidence that analysis of incidents had helped to reduce the risk of them happening again. For example, a person had been supported to purchase special footwear following a fall in the shower. This had improved their safety and independence.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- People's rights were not always being protected as there was a lack of understanding of the MCA from the provider and staff and, where restrictions were in place, we did not see evidence of best interest decisions to support this.
- When we asked the provider whether they felt staff understood consent and the principles of the MCA they responded, "Not as in depth as I would like."
- Where people lacked capacity to make certain decisions the service had no record of who had representatives with the legal authority to make decisions on their behalf, nor of the legal scope of this authority.

We found no evidence that people had been harmed. However, the provider did not have an understanding of the Mental Capacity Act and people were being deprived, or were at risk of being deprived, of their liberty without legal authorisation. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Appropriate legal authorisations for deprivations of liberty had not always been sought when people who

lacked the capacity to choose where they resided were subject to continuous supervision and control and were not free to leave. This meant that people were not safeguarded against being unlawfully deprived of their liberty.
● Seven of the eight people were subject to restrictions, such as door and bed alarms, or were not allowed to go out unaccompanied. It was not always clear what people were able to make particular decisions. In all such cases the service could not evidence they had considered applications where required. We raised this with the provider during the inspection. They contacted the DoLS team and then submitted a DoLS application to the local authority for one person.

We found no evidence that people had been harmed. However, the provider failed to ensure that service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. 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.

● Staff understood the importance of seeking consent from people before supporting them. During the inspection we observed staff asking people for their consent, offering choice and carefully explaining how they were looking to support them. We observed people being given the opportunity to decline support.
● Staff knew about people's capacity to make decisions through verbal or non-verbal means and this was well documented.

Adapting service, design, decoration to meet people's needs
● Not all areas of the home were equally accessible to the people who lived there. For example, some people with mobility issues would find accessing the raised lawn more challenging.
● People had been supported to personalise their bedrooms and other areas around the home. These reflected their lifestyle choices, interests and hobbies. A person smiled as they showed us their room which included memorabilia from their favourite sports team. There were pictures on walls around Liam House documenting various activities people had done. A professional confirmed this when recalling the "warm and welcoming environment for residents, personalised to their individual needs in areas such as their bedrooms".
● People moved around freely, spending time as they pleased within the home.

Staff support: induction, training, skills and experience
● Staff were not always trained in how to meet people's specific needs, for example not all staff had been trained in supporting people with autism. The provider told us, "To a degree staff have had the training to meet people's needs but it is a work in progress."
● Staff comments on training included: "We haven't had any training in mental health, there's been no training at all. And the [person] with autism is supposed to have someone with [them] 24 hours a day. Most of the team have never worked with that level of autism and we had a two hour talk and that was it."
● At the time of the inspection there was no evidence of agency staff receiving robust induction. When we asked for these documents during our site visit these were not available. This increased the risk of inconsistency in care delivery and issues not being identified and shared in a timely way.
● Staff had an induction which included shadowing of more experienced staff and probationary meetings to check on their progress. Staff with no previous experience in a care setting were supported to do the Care Certificate. The Care Certificate aims to equip health and social care staff with the knowledge and skills needed to provide safe and compassionate care.

We recommend the provider reviews training to ensure staff have the required training to meet people's needs.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not always involved in choosing their food, shopping, and planning their meals. Despite it being late May when we inspected, an autumn/winter menu was displayed on the fridge. We raised this with a staff member who said a spring/summer menu was being created.

● There was a menu board in the dining room, but despite there being picture cards available, the board only had one picture of a meal on it during the inspection.

● Although staff supported people to be involved in preparing and cooking their own meals there were no risk assessments to cover people accessing the kitchen. These were put in place after we raised this with the provider.

● People received support to eat and drink enough to maintain a balanced diet. A professional confirmed that people were given "support with making healthy food options". One person told us, "I made my own sandwiches, my favourite. I like the food here."

● Where appropriate, the service had liaised with relevant professionals to ensure people's dietary needs were met in a way that reduced risks. For example, where people had swallowing difficulties staff had worked with speech and language therapists to develop personalised eating and drinking plans. We observed people being supported in line with these plans. A thickener product used to reduce the risk of a person choking was safely stored.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Although people had initial assessments that had supported their move to Liam House, not all of these had been reviewed when people's needs changed to ensure care plans included the most up to date information. The provider told us, "A lot needs my attention, so sections are either historic hard copy, completed or need my time."

● Staff liaised with people's respective funding authorities to ensure they had sufficient care and support hours to meet their needs.□

● The importance of good oral hygiene was recognised at the service. Each person had a detailed and up to date oral health assessment.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People had detailed health passports which were used by health and social care professionals to support them in the way they needed.

● People were supported to attend annual health checks, screening and health care appointments as and when required.

● Staff worked well with other services and professionals to prevent people needing admission to hospital. A professional who had liaised with the service in providing support to a person at Liam House said, "When there have been any issues these are communicated to us quickly, so we are able to intervene when needed."

Requires Improvement

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 the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Although the provider had a good understanding of their role, they were currently working remotely which had affected oversight. Contact with staff was limited to video calls and telephone. The service had also been adversely affected by the manager and deputy manager leaving without notice in 2021. This had affected the provider's ability to delegate tasks. A staff member commented, "My major concern is that there is no manager on site, and this is the big failing of the place."
- Governance and quality assurance systems were not robust. The provider's systems and processes had not identified the issues we found on inspection with MCA, environmental risks, medicines and care plans and risk assessments not being up to date.
- Auditing was out of date and not completed in a structured way. This made it difficult for the provider and staff to track what had been done and what needed doing. The provider told us they were in the process of moving from paper-based auditing to electronic.
- Poor record keeping meant there was potential for people's support needs not being met.

The provider had failed to ensure governance systems were established and operating effectively to ensure oversight was robust, procedures were followed, and the service improved. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection the provider had introduced electronic recording systems. These were yet to be embedded.
- The provider demonstrated a good understanding of their legal responsibilities for sharing information with CQC. The provider had met their legal obligations to tell us about any changes to their regulated services or incidents that had taken place.
- The provider understood the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to treatment and care. Following incidents, the provider had been open and honest with the people affected and, where appropriate, their relatives.

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

- There had been a lack of future planning in terms of people's care due to the provider's focus on keeping

people safe during the COVID-19 pandemic, negotiating additional funding and staffing.
● The provider spoke of the importance of person-centred care. A professional told us, "I believe that Liam House works in a person-centred way and this is reflected in the sense of community and family that is present when you visit there." Our observations confirmed this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● There were no formal listening events to enable people and relatives to share their views to help drive improvements in the service. The provider said monthly reviews had stopped "a few months ago" but would restart. The provider told us they stayed in contact with families using a messaging application.
● There was no evidence that people, including those who do not communicate using words, were consistently given the opportunity to collaborate and lead decision making with regards their care planning.
● There were ongoing communications between the provider and local authority to provide management presence and support within the home.
● The provider was ambitious and had vision for the service dependent on securing more resources.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not have an understanding of the Mental Capacity Act and people were being deprived of their liberty without legal authorisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate risks to people were identified, assessed and effectively managed. Medicines were not always managed safely. Infection prevention and control processes were not always in place with regards to audits and cleaning.

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 The provider failed to ensure that service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were established and operating effectively to ensure oversight was robust, procedures were followed, and the service improved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably trained staff to meet people's needs and keep them safe.