Community Housing and Therapy

Lilias Gillies House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Lilias Gillies House is a residential service providing accommodation and therapeutic interventions to 10 people with mental health care needs at the time of the inspection. The service can support up to 20 people in one adapted building.

People's experience of using this service and what we found
People did not always experience a service that was safe, because the provider was not following national guidance to protect them from the risk of being infected with COVID-19. Although the provider had clear reasons for this, they were not able to provide us with evidence of an ongoing risk assessment process that took into account people's individual risks and preferences.

Medicines were not always managed safely. Stock counts were not always accurate, meaning there was a risk of medicines going missing or being used unsafely.

There was not always evidence that incidents and action plans from the provider's quality checks were appropriately followed up and action taken to improve the safety and quality of the service. Although this had improved since our last inspection, checks were still failing to identify some issues around safety and people told us things did not always improve after they raised concerns.

Other aspects of the service were safe. There were enough staff to support people safely. People had detailed and robust individual risk management plans that took into account how to restrict their freedom as little as possible while protecting them from harm. Although people told us they did not always feel safe, the provider had begun taking action to help people feel safer. Staff knew how to manage these risks, protect people from abuse and ensure the premises were safe to use. However, staff did not have training in emergency first aid so there was a risk they would not know how to respond to medical emergencies.

The service had an open, person-centred culture which meant people felt supported and listened to. People and staff had regular opportunities to feed back. The service had visible and flexible leadership and there was evidence of learning from the COVID-19 pandemic. Staff were clear about their roles. The provider shared information where appropriate in an open and transparent way with other agencies such as commissioners.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 requires improvement (published 19 July 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 29 and 31 May 2019. Two breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve governance and safe care and treatment.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

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

Enforcement
We have identified breaches in relation to safe care and treatment, in particular infection control and medicines management, and good governance at this inspection.

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. You can see what other action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-led findings below.

Lilias Gillies 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 carried out by two inspectors.

Service and service type
Lilias Gillies House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 did not have a manager registered with the Care Quality Commission. A registered manager, together with the provider, is legally responsible for how the service is run and for the quality and safety of the care provided. However, there was a service manager who was in the process of applying for registration.

Notice of inspection
This inspection was unannounced. However, we contacted the home by telephone on arrival to check whether it was safe for us to conduct the inspection due to COVID-19 risks.

What we did before the inspection
Before the inspection we looked at previous inspection reports and notifications the provider is required to send to us about significant events at the service. We reviewed information and concerns we had received from people using the service and local authorities. We discussed the service with the local safeguarding

team. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to 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.

During the inspection
We spoke with four people who used the service and observed some interactions between people and staff. We spoke with four members of care staff, the service manager and a senior manager. We looked at medicines records and toured the premises to check the safety of the environment.

After the inspection
We reviewed a range of records we had asked the service manager to send to us. This included individual and service-wide risk assessments, staff recruitment records, audits and quality assurance data.

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 requires improvement. At this inspection this key question has remained the same. 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.

Preventing and controlling infection

At our last inspection in May 2019 we found there were not adequate systems in place to ensure the premises were in a clean and hygienic condition and to prevent the spread of infection through poor kitchen hygiene. The provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found although the provider had improved these specific issues, there were still problems with infection control and the provider was still in breach of the regulation.

● Staff did not always follow national guidance to protect people from the risk of the COVID-19 virus spreading and the provider had not done all they could reasonably do to ensure people were protected from this risk. For example, we observed staff did not wear masks within the service and did not maintain social distancing at all times. Staff explained they had discussed risks with people using the service and had agreed not to use masks as this was likely to impact on therapeutic relationships and because people who used the service had said they did not want staff to wear masks. However, the provider did not have a policy covering the use of masks or how to keep people safe where they were not used, and people's individual risks and views in relation to COVID-19 had not been fully considered. We did not find evidence the provider had regularly reviewed the decision not to use masks. This meant the views and individual risks of people who had moved into the service since the start of the pandemic, some of whom had underlying health conditions that may put them at additional risk from COVID-19, had not been considered as part of this decision.
● The provider had introduced systems to help ensure cleaning tasks were completed. People said this had improved over the last year. The service was visibly clean and free from unpleasant odours and people told us staff supported them to clean their home daily.
● There were handwashing facilities and hand sanitiser available throughout the premises. To help prevent infection from spreading, staff only allowed visitors to meet people outdoors and people and staff had regular tests for COVID-19.

Using medicines safely

At our last inspection in May 2019 we found people were at risk of harm from unsafe management of medicines. The systems to check medicine stock numbers and ensure people received their medicines as prescribed were not sufficiently robust. The provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection

we found the provider had made improvements, but was still in breach of the regulation.

● Although the provider had improved their system to record and track stocks of medicines, we found errors were still being made and in three cases the number of tablets in stock did not match what was recorded. This meant there was a risk the provider would not be aware if people were not receiving their medicines as prescribed.
● At our last inspection we found the provider had not fully considered how to support people safely if they missed doses of their medicine. They had since revised their policies to take this into account, but this still did not fully consider that missed doses of some medicines might require more immediate action than others. The service did not always consider flexibly supporting people to fit their prescribed medicines into their daily routine. For example, staff told us people would sometimes miss doses because they were asleep or in meetings.
● We observed medicines being administered safely. Staff checked they were giving people the right medicines and stayed with people to ensure they swallowed tablets before recording the medicines had been administered.
● There was an appropriately secure storage room for medicines and this was kept locked when not in use. However, three people told us the room was sometimes left unlocked. We discussed this with the service manager, who told us they were aware of one such incident and had since had alterations made so the door would always lock when closed and could no longer be left on the latch.

Learning lessons when things go wrong
● We reviewed a sample of incident records from the three months leading up to our inspection. While the incidents themselves and the immediate actions of staff were clearly reported, it was not clear from the records how the provider intended to manage the risks that had led to the incidents in future or what lessons they had learned.

The provider did not have robust enough systems and processes to manage some risks, particularly in relation to infection control and safe management of medicines. This placed people at risk of harm and was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People's risk assessments took into account the risks of abuse and neglect. Staff therefore had adequate knowledge of how to safeguard individual people from foreseeable abuse and neglect, including from other people who used the service.
● Staff understood how to recognise and report abuse. The service had a clear safeguarding policy and procedures, which staff were aware of.
● Three people told us they did not always feel safe, mainly because of other people using the service who presented behaviour that challenged. One person said, "I feel risk isn't always dealt with appropriately. The police are always being called." Staff were aware of this issue and knew how to manage behaviour that challenged and protect people from abuse. The service manager told us what they were doing to help people feel safe, including a new group where people could talk about this. People knew who they could talk to if they felt unsafe, and the person who was concerned about risk management also told us, "I can go to my room if I need to. I feel safe there."

Assessing risk, safety monitoring and management
● People had risk management plans based on a thorough assessment of their needs, risk history and preferences. These were detailed and contained the necessary information for staff to understand the

person, the reasons for the risks and how to manage them safely while maximising people's freedom and independence.

● Staff carried out monthly checks to make sure the premises were safe, including checks of fire safety, electrical equipment, water safety and general maintenance.

● However, training records showed all but two members of staff had not received training in basic life support or emergency first aid. Because of this, there was a risk that staff would not know how to administer potentially lifesaving treatment in an emergency situation.

Staffing and recruitment

● There were enough staff on duty to provide people with the care they needed. Rotas showed and people and staff confirmed that there were enough staff deployed daily to meet people's needs and these levels could be flexible if people needed extra support.

● Some people told us they felt less safe with agency staff on duty because they felt these staff did not know them or their risks so well. We discussed this with the service manager who explained agency staff were chosen based on their skills and training and would never work without permanent staff on the same shift.

● The provider had recruitment procedures designed to ensure the staff they recruited were safe to work with people. This included criminal record checks and references from previous employers.

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 requires improvement. At this inspection this key question has remained the same. 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.

Continuous learning and improving care

At our last inspection in May 2019 we found the provider's governance system was not effective in driving improvements. Audits and checks did not always identify when improvements were needed and when they did, there was not always a clear plan to take action. The provider was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements but was still in breach of the regulation.

- The provider carried out a range of regular checks of the quality of the service. However, the effectiveness of these varied. Despite significant improvements in some areas such as cleanliness since our last inspection, other issues had arisen which the provider's checks had not identified. The measures the provider took to improve medicines management since our last inspection were not effective as there were still similar problems with this.
- It was not always clear what action the provider was taking to improve on any problems identified by their audits and checks. For example, the monthly health and safety check from two months before our visit identified some items that needed addressing, but did not always specify what action would be taken, by whom or by when. In several cases follow-up action was clearer and this had improved since our last inspection but there were still gaps.
- People fed back that action was not consistently taken when improvements were needed. Two people told us staff listened when they raised issues that needed improving, but one person added "nothing changes" and the other said, "there are no consequences." A third person said jobs would always be completed if they added them to the maintenance log book. However, they added that if they raised items other than maintenance issues, "nothing changes and you just give up."

The governance system was not robust enough to ensure continuous improvement of the service. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

- There was evidence of learning and improvement as a result of the COVID-19 pandemic. This included a shift away from paper-based documentation to electronic, which helped the provider organise, store and share information in better ways. There was also work around protecting people from social isolation and a better cleanliness regime, which the service manager told us they would continue using after the pandemic.

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

● The provider's chief executive sent regular communications to staff to maintain visible leadership, offer support and show appreciation to staff.

● People knew who the service manager was and said he was supportive. One person said, "He's good. He listens." Another person told us, "[Manager] is good. We have a good rapport and he always makes time for everyone."

● There were systems to ensure debriefing happened after incidents and everyone who was involved had the opportunity to discuss what had happened in a fair and open way. People confirmed they were able to do this.

● The service had an open and inclusive culture. People attended regular community meetings where they could talk about any issues they wanted to. This included conversations about incidents and discussions about the culture of the service, such as any allegations of bullying or discrimination. Staff told us they felt the service had a very open culture.

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

● There were arrangements to ensure the service was led when the service manager was not there. A senior manager visited the service more often than usual when the manager was required to spend time working from home. The manager told us they made use of video calls and other technology to maintain contact with people and staff during that time.

● Managers and staff were clear about their roles. Managers and senior staff had regular meetings to discuss this, for example to share procedures and strategies for new ways of working during the COVID-19 pandemic. They communicated clearly with other staff about their roles and responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People had regular opportunities to feed back and share ideas, including community meetings and surveys. Staff encouraged this and involved people in making decisions about how the service was run.

● People told us they were able to have input into decisions about the service. One person told us about choosing colours for a redecoration project. Another person said everyone had opportunities to participate in menu and activity planning.

● The provider consulted staff for their opinions on important issues. There were meetings for staff to discuss their work and express their views.

Working in partnership with others

● The provider made adjustments to the service in a timely way to manage risks and other difficulties resulting from the COVID-19 pandemic. This included purchasing new IT equipment to facilitate communication with other providers.

● The provider shared information with other relevant parties in a transparent way to make it easier to work well together. This included reporting incidents people were involved in to their community mental health teams and commissioners to keep them up to date with people's changing needs.

● The service manager told us how they had been working with the local authority to monitor and improve the quality of the service. They told us they had improved communication and transparency to help the local authority understand the purpose of the service and how it worked. This made it easier to work together efficiently.

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 17 HSCA RA Regulations 2014 Good governance The provider did not effectively operate systems and processes to assess, monitor and improve the safety and quality of the service. Regulation 17(1)(2)(a)(b)(f).