The Grange Care Centre (Cheltenham) Limited

Lilleybrook Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inspected but not rated**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service

Lilleybrook Care Home is a 'care home' registered to provide accommodation and personal care to 60 older people and people living with a diagnosis of dementia. At the time of our inspection 51 people were receiving support at the service.

People receive care in one of four units in the home. Each unit had communal spaces for people to use. There was also a secure garden which people could use.

People's experience of using this service and what we found
At the time of our inspection the management of the service had just changed. The provider told us they would notify us of this management change.

People told us they had built good relationships with staff and we found staff were committed to provide care that met people's needs. However, feedback received from people, relatives and staff meant that we could not be assured that everyone in the home experienced person-centred care where choices and preferences were respected.

People and their relatives had raised complaints and the provider told us these would have been investigated. However, as they were still familiarising themselves with the previous registered manager's systems at Lilleybrook there was a delay to providing requested information.

We have made a recommendation about the provider taking action to ensure management information is readily available in the absence of a registered manager.

The provider had systems in place to monitor the quality and risk in the service. However, the provider had not identified through their own monitoring systems that people were not always satisfied with their care and that records in the service were not reliable in supporting the provider's monitoring activities.

We were somewhat assured the service was following safe and correct infection control processes. We have signposted the provider to resources to develop their approach in relation to monitoring of cleaning practices and use of PPE.

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 26 February 2020).

Why we inspected

We received concerns in relation to people's experience of their care. As a result, we undertook a focused inspection to review the key questions of responsive and well-led only.

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.

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.

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

We have found evidence that the provider needs to make improvement. Please see the responsive and well-led sections of this full report. We shared these improvements with the provider at inspection and they have told us they are taking action to review their systems.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lilleybrook Care Home 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 have identified breaches in relation to regulation 9 (Person-centred care) and Regulation 17 (good governance).

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 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?

Inspected but not rated

We have signposted the provider to resources to develop their approach in relation to monitoring of cleaning practices and use of PPE.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Lilleybrook Care Home

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
The inspection was carried out by two inspectors and an Expert by Experiences. 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
Lilleybrook Care Home 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 the inspection
We reviewed information we had received about the service since the last 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. We used all of this information to plan our inspection.

During the inspection

We spoke with five people who used the service and 17 relatives about their experience of the care provided. We spoke with 23 members of staff including the regional manager, deputy manager, senior care workers, care workers, night care workers, domestic staff, wellbeing and community liaison, activities co-ordinator, nurses and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and multiple medication records. 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 gathered feedback from three professionals who regularly visit the service.

Inspected but not rated

Is the service safe?

Our findings

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat 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.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People's care had been clearly planned, and their likes, dislikes and preferences had been reviewed and updated. Staff knew people well and could tell us about people's preferences and the delivery of their care.

● However, people did not always receive timely individualised care. Our observations during the inspection and feedback from staff, people and relatives confirmed this. Two of the five people we spoke with told us that they had to wait for staff, and that care was not delivered in line with their wishes. One person said, "I had a bath yesterday, but before that I can't remember. They don't always remember to put my teeth in".

● Relatives also provided mixed views about the care people received and commented that sometimes basic care needs were not being met; such as, "Over here on this [unit] he's not getting the basics…he has the wrong clothes on, his hair is dishevelled. I have to come in to help him out." Another relative said, "A couple of times I've come in and [my relatives] pad hasn't been changed and she's wet."

● Of the 23 staff that we spoke with, 19 staff told us that people had to wait and did not always have care delivered in accordance with their care plans. One staff member said, "We do our best but can't give people the care they deserve. We can't spend any time with people."

● During our observations we saw that staff had to leave the unit to visit another unit. During this time people were left waiting for staff support such as hoisting.

● People's experience of the activities available to them was also mixed. Of the five people that we spoke with, three people told us that they were not supported to follow their interests or take part in activities to avoid social isolation. One person said, "No one spends time with me. I'm bed bound and spend my time in my room watching TV. Staff come in and turn my bell off and they're gone."

People did not always receive timely, personalised care. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's relatives were able to visit them at Lilleybrook Care Home in accordance with COVID-19 safe visiting guidance. One relative told us, "'I ring and book a visit, they allow four people a day. I go once or twice a week". We received overwhelming feedback that sometimes relatives had to wait long times for the door or telephone to be answered. We fed this back to the provider who told us they were reviewing their systems during unprecedented times.

● An activities co-ordinator had recently been recruited to provide meaningful activity to people in accordance with their likes and preferences. During the inspection we saw some people engaging in colouring. The activities co-ordinator told us they were enjoying the role and were developing their skills, "I don't just want to do crafts and colouring. I want to do more when I learn." The provider was looking to

recruit an additional activities co-ordinator to provide a greater coverage of hours for people.

Improving care quality in response to complaints or concerns

● People and their relatives had raised complaints to the provider. The provider told us that all complaints would have been thoroughly investigated. They were unable to promptly locate the information to evidence that complaints and concerns had been investigated in accordance with their policy and that learning from complaints had been used to improve the service.

We recommend that the provider reviews their process for making management information readily available in the absence of a registered manager.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were identified, assessed, and recorded in care plans. These referred to how people communicated their needs and any support required.

● Reasonable adjustments were made where appropriate to meet the information and communication needs of people with a disability or sensory loss, as required by the Accessible Information Standard.

End of life care and support

● People were supported at the end of their life by care staff and other healthcare professionals where required. There were arrangements in place to ensure healthcare support was available for people to maintain comfort. COVID-19 safe visiting guidance had been followed to ensure people could receive visits at the end of their life.

● Staff were aware of national good practice guidance and professional guidelines for end of life care and provided care in accordance with this.

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 this key question has now 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; Continuous learning and improving care;

- The registered manager was not in post at the time of the inspection and had very recently left the service. The provider told us they would submit a notification to inform us that the registered manager was absent from the service.
- The nominated individual and temporary manager supported the inspection. The nominated individual explained that they were still familiarising themselves with the service's management systems. Some information we requested were not readily available such as complaints, enhanced cleaning records for the individual units, call bell records and relative meeting minutes.
- The provider had identified improvements were needed and an improvement plan was in place, although this did not include the concerns we found in relation to people not always receiving timely individualised care.
- Monitoring systems were not always effective as the records supporting the management of the service were not always reliable. The provider had not through their own monitoring systems identified that the information in complaints, cleaning schedules, health and safety audits and people's fluid records and stakeholder feedback where not always available, complete or accurate. The provider therefore did not have all the information they needed to monitor whether staff and managers had followed the provider's policies.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Feedback received from people, relatives and staff meant that we could not be assured that everyone in the home experienced person-centred care where choices and preferences were respected.
- Staff told us, and we saw that despite their best efforts, people did not always receive the care they felt they deserved. One staff member said, "It's difficult to get everyone up before lunch. The bells are going constantly; it's chaotic." Another staff member said, "We are not [always] giving people the care they need. People are waiting for us to get them up, eat and drink etc."
- The nominated individual told us that they were not aware that people, their relatives and staff had concerns about people's care. We asked them how the service gathered feedback; they told us that they spoke with people and staff, however records of these conversations were not available.

● There was limited opportunity provided to staff, people and their relatives to share their experience and have their say about the service. Staff, relative and residents meetings were not taking place regularly. The provider told us this was due to the pandemic. The provider could not locate all meeting minutes and satisfaction surveys. They could therefore not monitor how people had been engaged, and whether action had been taken and any improvements made in response to the feedback.

Systems were in place to identify concerns and drive improvements; however these had not always identified quality concerns. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were praised by people and their relatives for their hard work and dedication. We were mindful the pandemic had been difficult for everyone who worked in an adult social care setting. All staff we spoke with were professional, although many told us they were tired but remained committed to the people they cared for. A relative said, "Care is good…but the staff are all tired." One staff member said, "Everyone is tired and exhausted. At least that's how I feel." Despite this people mostly remained positive about care staff during challenging times. One person said, "Generally the [staff] are lovely. Mostly quite delightful."
● There were good relationships between people, relatives and staff, and this supported effective communication on a day to day basis. Systems were in place to help promote effective discussions between staff so that they were aware of any changes for people in their care. This included daily handovers and written daily records.

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 was aware of their responsibilities under the duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm.
● The provider displayed their CQC rating within the service and on their website.

Working in partnership with others
● Staff had formed positive relationships with health and social care professionals. One visiting healthcare professional commented, "The care staff are caring and hard working." Another visiting healthcare professional said, "Care staff have always taken time to assist me with information I need about the people I work with and I haven't had any issues with 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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and support which was tailored to their individual needs. Staff did not provide care in accordance with people's choices and taken into consideration their wellbeing needs. Regulation 9 (1)(a)(b)(c)(3)(a)(b)(h)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had system in place to monitor the quality and risk in the service. However, the provider had not through their own monitoring identified that people were not always satisfied with their care and that records in the service were not reliable in supporting monitoring activities. Regulation 17 (1)(2)(a)(b)(c)(e)