Lillibet Court Limited

Lillibet Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 1 September 2016. It was unannounced.

Lillibet Manor is comprised of 34 single occupancy studio apartments within one converted building.

The service provides a choice of assisted living, with Assured Shorthold Tenancy provision and a choice of support options, or full residential care with accommodation and personal care, for adults of all ages who may have a range of needs. These include mental health, learning disabilities, physical disabilities, sensory impairments and dementia.

There were 23 people using the service at the time of this inspection, approximately half of whom received a full residential care service whilst the remaining people had assisted living packages in place. The majority of the people receiving an assisted living package did not receive personal care, as regulated by us, the Care Quality Commission (CQC). Therefore information relating to them could not be included in this report.

We carried out an unannounced comprehensive inspection of this service on 27 July 2016, and found that eight legal requirements had been breached. After the inspection the manager submitted a report which outlined the improvements she planned to make to address these areas. We carried out this inspection to check her progress with the proposed improvements in three of the most urgent areas requiring improvement – safe care and risk management, staff training and skill mix and quality assurance and governance systems. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Lillibet Manor' on our website at www.cqc.org.uk.

During this inspection we found that a manager was in post and our records showed they had applied to register with us, the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations.

New systems had been introduced to ensure people were not being exposed to unnecessary risks, and that risks associated with people's care were managed appropriately.

Positive steps had been taken to ensure people received effective care from staff that had been equipped with the right skills and training to carry out their roles. Since our last inspection, the manager had reviewed internal processes to ensure staff skills and training reflected the diverse needs of the people living at the service. The manager had also allocated new champion roles to staff in key areas such as safeguarding, mental health, nutrition and falls. Specific training was being arranged for the champions, to support them in taking on their new lead roles and responsibilities.

The arrangements for monitoring the quality of the service provided had also been strengthened; to mitigate identified risks to people and ensure their health and wellbeing. The manager showed us a number of new checks she had introduced to improve the management and oversight of the service.

Although we found that improvements had been made during this inspection, it was clear that more time was needed to fully implement and embed the changes being introduced by the manager. We have therefore not changed the overall rating for the service on this occasion, because to do this would require consistent good practice over a sustained period of time. We plan to check these areas again, alongside the remaining outstanding breaches from the 27 July 2016 inspection, during our next planned comprehensive inspection.

The overall rating for this service therefore remains 'Inadequate' and the service is in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the provider to take at the back of the full version of the report.

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

Progress had been made towards making the service safe.

A number of actions had been taken to ensure identified risks to people were managed appropriately, and they had their care needs met in a safe way. However, further risks were identified during this inspection. This meant that the actions taken had not yet had time to fully embed, in order to bring about required improvements.

We could not improve the rating for 'safe' from 'inadequate' therefore, because to do so requires consistent good practice over time. We will check this again during our next planned comprehensive inspection.

Is the service effective?

Requires Improvement

Improvements had been made to ensure the service was effective.

The manager had made progress to ensure staff had the right skills and training to meet the needs of everyone living at the service.

We could not improve the rating for 'effective' from 'requires improvement' however, because to do so requires consistent good practice over time. We will check this again during our next planned comprehensive inspection.

Is the service well-led?

Inadequate

Progress had been made towards ensuring the service was well-led.

New systems had been introduced to monitor the service provided, in order to deliver good quality care to people living at the service. However, as further areas requiring improvement were identified during this inspection, this showed the actions taken to date had not yet had time to fully embed, to improve the quality of the service provided.

We could not improve the rating for 'well-led' from 'inadequate'

therefore, because to do so requires consistent good practice over time. We will check this again during our next planned comprehensive inspection.

Lillibet Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced focused inspection of Lillibet Manor which we undertook on 1 September 2016. The inspection was carried out to check that urgent improvements to meet legal requirements planned by the provider after our comprehensive inspection on 27 July 2016 had been made. The inspection was undertaken by two inspectors.

Before the inspection, we checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law.

In addition, we asked for feedback from the local authority who have a quality monitoring and commissioning role with the service.

During the inspection we focused on three of the five questions we ask about services: Is the service safe, is the service effective and is the service well led? This is because the service was not previously meeting legal requirements in relation to these areas.

During the inspection we used different methods to help us understand the experiences of people using the service. We spoke with two people living at the service and observed the care being provided to other people during key points of the day, including lunch time and when medication was being administered. We also spoke with the manager, deputy manager, two care members of staff and the cook.

We then looked at care records for four people, as well as other records relating to the running of the service - such as staff training records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Inadequate

Is the service safe?

Our findings

At our last inspection on 27 July 2016, we identified a number of concerns about the quality and safety of the care and support being provided, and found that improvements were urgently required. This was because the risks associated with people's care and support were not always managed in a safe way. For example, we found someone who had a history of falling and needed to wear a pendant alarm; to call for assistance if they fell. We saw that they were not wearing it and the manager confirmed it had been sent away for repair because it was broken. A number of people had also reported concerns about the use of call bells, and the length of time it took staff to come when they called for assistance.

One person, who staff had identified as being at risk of malnutrition, had not been weighed for three months. Another person was at risk from choking and required a soft diet. The cook had not been provided with written information about people requiring special diets, including soft options. When questioned, they had not been aware of the needs of the person in question. We observed the person choking during lunch and observed their pudding had only been roughly chopped instead of being pureed.

We also saw a member of staff administering medication, including a controlled drug. This was not carried out in accordance with best practice guidance from the National Institute for Health and Care Excellence (NICE). The staff member then asked for a second staff member to witness the administration of the medication. However, this member of staff had not actually seen the medication being given to the person in question so could not have known whether they had received it, or taken it.

In addition, we found concerns with the systems in place to ensure the premises and equipment was managed and maintained in a way that ensured the safety of people, staff and visitors. For example we noted that a fire exit on the top floor had been blocked by equipment, and the gas safety certificate for the service had expired over a month before the inspection.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the July inspection the manager submitted a report which outlined the improvements she planned to make to address these areas. We carried out this inspection to check her progress with the proposed improvements.

During this inspection, we saw the person who required a pendant alarm now had one in place. There was evidence that the manager was monitoring call bell response times. We also saw a call bell monitoring form which required staff to check the position and working order of call bells on a regular basis.

We checked for a sample of call bell response times over the last couple of weeks, at different times of the day. In general these had been responded to quickly; within two minutes. There was evidence that staff were taking longer to respond to one person's call bell however. The manager provided an explanation for this but told us she planned to discuss call bells at the next staff meeting; to reinforce the importance of meeting

everyone's needs in a timely way. People we spoke with confirmed that their call bells were responded to, although they still felt staff could be quicker at times. All the call bells we saw were within people's reach, and people confirmed they knew how to use them.

We looked at the care plan for someone identified as being at risk from falling. We found the care plan to be unclear in terms of describing the person's level of mobility. In addition, the plan had not been updated to reflect the number of falls the person had experienced in the last six months, and did not provide specific instructions for staff on how best to manage this and minimise the risk of another fall in future.

Falls risk assessments were in place, but they were not personalised and were basic in their content. For example, they did not contain information relating to potential fall causes such as a person's medical history, or the number of falls they had previously experienced. Assessments we saw recorded that a score of five or greater indicated a high level of risk. However, there was no further information to explain what action needed to be taken if a high level of risk was identified. We looked at the falls risk assessment for the person identified at risk of falling. This recorded a score of seven from March 2015 onwards, meaning the person had been assessed at high risk of falling. The assessment had been reviewed monthly up to July 2016 but had not been reviewed in August 2016, despite records showing an increase in the number of falls experienced by the person during that month. After the inspection the manager told us that she had reviewed the current risk assessment and determined that it was not fit for purpose. She told us that they had sourced a more suitable risk assessment tool and were in the process of introducing that.

A falls chart was in place, which staff used to record when a person had a fall; to help to identify potential patterns and causes of falls. The chart recorded that: 'If more than one fall is recorded in a month GP needs to be informed for Tenant health check and Falls Clinic Referral'. Staff we spoke with were aware of who was at risk of falls, but it was clear that they all currently had a different understanding of when to act on a fall. We also found a discrepancy in the number of falls recorded for one person. For example, accident records showed the person had experienced seven falls since March 2016 however, only two of these had been recorded on their falls chart; meaning there was a risk of staff not having a full picture of the person's possible changing needs.

We noted the person had experienced two falls in March 2016, but there was no evidence that staff had followed the instructions on the falls chart by calling the person's GP. In August 2016, the person had experienced a further three falls in one month. Although there was an entry in the person's records showing that a GP had seen the person, it was unclear of the outcome of the visit because parts of the handwritten entry in the person's records were illegible. Staff were also not able to tell us what the immediate plan was for this person in terms of minimising the risk of them falling. In addition, an ambulance crew had attended the person following one of their falls in August and recommended that blood and urine tests were carried out. We saw evidence that blood tests had been taken, but there was no evidence that a urine test had been carried out. Again, staff were unable to adequately explain why this had not happened. The manager told us after the inspection that she had made arrangements with the person's GP to do this.

During this inspection, the manager talked about a number of changes she had introduced since our last inspection; to improve people's safety and minimise the risk of people falling. She told us she had identified a member of staff to take a lead role in the prevention of falls, called a falls champion. She explained that training had been arranged for later that month, to equip the staff member with the right skills and knowledge to take on the role of managing and overseeing falls. Staff we spoke with confirmed they were aware of the introduction of a new falls champion.

The manager told us that the new falls champion would take the lead on recording and reporting on falls in

future. She showed us that a new falls protocol that had been developed, which stated that if a fall occurred, the fall chart and accident book should be completed, and the falls team and GP should be contacted. The manager confirmed the new protocol was not yet live because she was waiting to discuss this with staff at the next staff meeting. She also showed us a new electronic summary, which had been designed to record the number of falls experienced by people. The manager explained the falls champion would ensure that accurate information was sent to the local falls team on a monthly basis for further external analysis and overview. This would support the service in managing risks identified with falls more appropriately, and help to keep people safe.

We looked at weight records for the person previously identified by staff as being at high risk of malnutrition and needing to be weighed weekly. At the last inspection we found the person had not been weighed for three months. During this inspection, the manager showed us a new MUST (Malnutrition Universal Screening Tool) protocol, which had been introduced since our last inspection. This stated that if a person was deemed as high risk, they should be weighed weekly. However, the person's records only contained one more entry since the last inspection. This meant that staff had not followed the internal policy of checking the person's weight weekly and we brought this to the attention of the manager. The manager updated following our inspection that she had rechecked the person's records and found that the last two entries had been calculated incorrectly by staff. She told us that the person had now been reassessed as low risk and would only need to be weighed monthly. In addition, the manager advised that she had identified a staff member to take on the role of MUST champion. She told us the staff member had received relevant training, and would now take on the role of monitoring people's weight electronically. This would support the service in assessing and supporting people at risk of malnutrition in a more consistent way.

We looked at records for the person previously identified as being at risk of choking who needed a soft diet. A 'prospective tenant / resident assessment form' had been completed prior to them moving in, but there was nothing on the assessment regarding the fact the person needed to have a pureed diet. We noted that several parts of the assessment form were incomplete; raising concerns about whether the service had had sufficient information to determine whether they were able to fully meet the person's needs before they moved in. We did note that additional information had been supplied by the person's funding authority which did refer to the need for a pureed diet and also recorded that the person was diabetic. We found that this information however, had not been transferred to the person's care plan, meaning that they may have been placed at risk of not receiving appropriate care and support to manage risks associated with diabetes. The manager confirmed after the inspection that this information had been added to the person's care plan and that improvements had also been made to the assessment process, to ensure more accurate and robust information was recorded regarding people's needs in future.

We saw that the person's care plan did clearly refer to them having difficulty with swallowing, and that a referral had been made to the local SALT (speech and language therapy) team for advice. There were no further updates regarding progress with this, and when asked staff were not aware what was happening. The manager updated after the inspection that they had chased up the referral and found it had not been received by the SALT team; therefore action was being taken to make the referral again.

The person's care plan stated their food should be blended and all drinks thickened; to minimise the risk of choking. The manager told us that new information had been developed for kitchen staff about people's specific nutritional needs. We saw the new list, but this did not include the person in question, although the member of staff cooking was aware the person required a soft diet. After the inspection, the manager told us the person had been on the list, but a page had fallen down the back of a cupboard.

The manager confirmed that a new care planning system was about to be introduced which would

incorporate a more thorough and integrated approach to care planning and risk management. The deputy manager told us he had now received training for the new electronic system, so they were ready to begin this work. The manager told us that senior care staff would receive the same training, to assist the deputy manager in carrying out this task. She also told us that everyone's care records would be reviewed and updated on a priority basis, which she would determine alongside the deputy manager. She told us this work would be completed by the end of November 2016.

During this inspection, we observed a member of staff administering medication using the new electronic system introduced just before our last inspection. Although we did not observe the staff member administering controlled drugs on this occasion, as none were required, they were able to describe the process of administering correctly. We also observed them administering other medication to people in a safe way too.

We checked corridors during this inspection and found them to be clear of obstruction and fire escapes were easily accessible. The manager told us the local fire authority had visited since our last inspection and confirmed the service was meeting required standards. We contacted the fire authority after the inspection who verified this.

The manager also told us that a gas safety check had taken place since the last inspection. We were not able to verify this as the manager told us the certificate had not yet arrived.

Findings from this inspection have shown that a number of steps had been taken to strengthen the arrangements in place to manage identified risks to people. However, more time was needed to fully implement and embed the planned changes; in order to improve the quality and safety of the care and support being provided to people using the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 27 July 2016, we identified concerns about staff skills and knowledge, and found that improvements were urgently required. This was because there was a diverse range of conditions and associated needs amongst the people living at the service; including some people who were living with complex mental health conditions. Staff members lacked knowledge and expertise in each of these conditions and had not received specific training to equip them with this knowledge. For example, all the staff we spoke with confirmed they had not received training regarding mental health, and records we looked at supported this.

Staff told us they had learnt how to work with the people with mental health conditions over time however; they talked about managing risk and challenging behaviours as they occurred. They did not demonstrate a good understanding of how to manage these needs in a proactive way; identifying potential triggers and signs that could help to deescalate a situation before it arose.

In addition, we found inconsistencies in the number and subject matter of training courses completed by each staff member, and there was no clear overview of training provided to staff.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the July inspection the manager submitted a report which outlined the improvements she planned to make to address these areas. We carried out this inspection to check her progress with the proposed improvements.

During this inspection, we found that a number of positive steps had been taken to address our previous concerns. The manager showed us that she had introduced a system to identify the assessed needs of people living at the service such as mental health, dementia, Parkinson's, diabetes and epilepsy. She had then matched these with staff who had received relevant training in those areas. We noted that not all staff had been trained in all areas as yet, but there was evidence of new training being completed since the last inspection, and further training being booked.

The manager also showed us a daily shift allocation sheet, which incorporated a breakdown of people's needs and the names of the staff trained in those areas. The manager explained that staff rotas would be drawn up to ensure staff skills matched people's assessed needs in future, starting from the following week.

A notice for staff highlighted that staff had also recently been allocated new champion roles in areas such as safeguarding, mental health, nutrition, falls etc. Staff we spoke with were aware of who had which role, but the manager confirmed these roles were not yet live. She explained that training was being sourced, or had been booked, for the champions; to support them in carrying out their new roles and responsibilities. We saw that training had already been booked for the nutrition and falls champions.

The manager had also created training records for various areas such as medication, safeguarding and mental health; to enable her to see when training had been completed by staff and when refresher training was next due. From this, we could see fewer gaps in training than we saw at the last inspection. The manager explained that the service was supported by an external training company and we saw training had been planned to fill the training and knowledge gaps identified as a concern at the last inspection. The manager told us she planned to develop this system to include all training, but she had focused on the areas of concern initially.

In addition, there was evidence that the manager had sourced an eight week mental health on line training package for staff, and she informed us that all staff had enrolled on this and were ready to begin this training.

Findings from this inspection have shown that a number of steps had been taken to strengthen the arrangements in place to ensure people receive effective care from staff with the right knowledge and skills to carry out their roles and responsibilities. However, more time was needed to fully implement and embed the planned changes. We therefore plan to check these areas again during our next planned comprehensive inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 27 July 2016, we identified a number of concerns about the quality and safety of the care and support being provided, and found that improvements were required. This was because quality monitoring systems and assurance processes had failed to identify a number of shortfalls in the service provided. This resulted in people not receiving a high quality, person centred service, with some people also being placed at risk of harm as a result.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the July inspection the manager submitted a report which outlined the improvements she planned to make to address these areas. We carried out this inspection to check her progress with the proposed improvements.

During this inspection, the manager showed us that she had introduced a number of new tools to assist her in monitoring the service and providing better oversight. This included daily, weekly, monthly and three monthly checks. We noted that all the concerns we had identified at our last inspection had been incorporated into the new auditing tools. This included checking people's care records as well as monitoring staffing levels and skill mix.

The manager had only just started to use the new auditing tools, so there was little to assess on this occasion. We did however see that she had begun to make checks in key areas, for example call bell response times.

The manager showed us that satisfaction surveys had also been sent out to people using the service and their relatives since the last inspection. Some had been returned, but not all, so there was no overall analysis as yet. The manager told us this would be done once all the completed surveys had been returned. Completed surveys we saw showed that people were generally satisfied or very satisfied with the service. One person had described staff as: 'They are very nice.' Some people however had identified areas for improvement.

Findings from this inspection have shown that steps had been taken to strengthen the arrangements in place to ensure the service delivers high quality care. However, more time was needed to fully implement and embed the planned changes; in order for quality assurance and governance systems to be effective and used to drive continuous improvement.