

Lillibet Court Limited

Lillibet Court

Inspection report

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19 July 2016

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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

Lillibet Court comprises of 27 individual self-contained flats. The service provides support and / or personal care as required, for adults of all ages who may have a range of care needs, including dementia, mental health, learning disabilities, physical disabilities and sensory impairments.

There were 27 people living at the service on the day of this inspection.

The service is also registered to provide care and support to people in their own homes (off site), as part of an agreed care package. However, this was not happening at the time of this inspection.

We carried out an unannounced comprehensive inspection of this service on 12 May 2016, and found that four legal requirements had been breached. The provider sent us an action plan after the inspection, setting out what they would do to meet legal requirements and address these concerns. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met the legal requirements.

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 Court Limited' on our website at www.cqc.org.uk.

During this inspection on 19 July 2016, we found that improvements had been made in all areas.

There was a registered manager in post. Like registered providers, registered managers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

New systems had been introduced to improve the management and oversight of identified risks to people, such as weight loss or weight gain.

Steps had also been taken to ensure that legally required information, such as an incident involving the police, was reported to us, the Care Quality Commission (CQC), as required.

The arrangements for monitoring the quality of service provided had also been strengthened; to mitigate identified risks to people and ensure their health and wellbeing.

Although we found that the service was no longer in breach of legal requirements, we have not changed the overall rating for the service on this occasion, because to do this this would require consistent good practice over a sustained period of time. We therefore plan to check these areas again during our next planned comprehensive inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Improvements had been made to ensure the service was safe.

Improvements had been made to ensure identified risks to people were managed appropriately, and they had their care needs met in a safe way.

We could not improve the rating for 'safe' 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.

Requires Improvement ●

Is the service well-led?

Improvements had been made to ensure the service was well-led.

Steps had been taken to report notifiable events to CQC.

New systems had also been introduced to monitor the quality of care provided to people living at the service.

We could not improve the rating for 'well-led' 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.

Requires Improvement ●

Lillibet Court

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 Court which we undertook on 19 July 2016. The inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 12 May 2016 had been made. The inspection was undertaken by one inspector.

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 two of the five questions we ask about services: Is the service safe and is the service well led? This is because the service was not previously meeting legal requirements in relation to these two areas.

Because the areas requiring improvement were records based, we did not need to speak with people using the service about them on this occasion. We did however speak with the registered manager and a care member of staff.

We also looked at care records for one person, as well as other records relating to the running of the service, such as audits and meeting minutes; to corroborate our findings, and to check that the required improvements had been made.

Is the service safe?

Our findings

Following our last inspection on 12 May 2016, we found that improvements were required in this domain. This was because the arrangements to manage individual risks to people were not always adequate. For example, most people had been weighed regularly; to identify potential problems associated with weight loss or gain. However, one person had not been weighed since January 2015, because they were not able to use the weighing scales provided at the service. Records showed that the person had previously lost weight however; staff confirmed they had not sought advice from relevant healthcare professionals at the time.

Following the inspection, the registered manager confirmed that a referral had been made to the local dietetic service for the person and that sit on weighing scales had also been purchased. However, the delay in taking this action had meant the person had been placed at possible risk of malnutrition and poor health for almost 18 months.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

After the inspection the provider submitted an action plan which outlined the improvements they planned to make to address these areas. We carried out this inspection to check they had followed their plan, and found that improvements had been made.

During this inspection, the registered manager informed us that dietetic appointments had been confirmed for the person in question and three other people living at the service, who had been identified as being at risk in terms of weight loss or gain. In addition, she showed us a new folder that had been introduced to record people's weights on a weekly or monthly basis; depending on their identified level of risk. We did note there were some gaps in recording where people had been out or away from the service. The registered manager acknowledged this and advised that staff were still getting used to the new system, but told us that further changes would be made to ensure people were weighed on return to the service, to avoid gaps in the future. Despite this, there was evidence that the majority of people living at the service had maintained a stable weight during the period between the two inspections. We saw that a different person had lost weight, but the registered manager was able to advise us on the actions being taken to address this.

The registered manager showed us records of individual discussions with staff members regarding the importance of monitoring people's weight. These records showed that staff had been provided with information about the reasons that might lead to someone gaining or losing weight. We saw that the registered manager had also instructed staff to take relevant action in the event of someone's weight varying by 2kg, either up or down, in the future. Staff had signed the records to demonstrate their awareness and understanding of the new changes.

This showed that steps had been taken to strengthen the arrangements in place to manage identified risks to people.

Is the service well-led?

Our findings

Following our last inspection on 12 May 2016, we found that improvements were required in this area. This was because the arrangements to ensure notifications were submitted to us, the Care Quality Commission (CQC), in a timely way were not adequate. A notification is information about important events which the provider is required to send us by law. However, our records showed that this was not happening consistently and some notifiable events such as a death of person and incidents reported to the police had not been reported to us as required.

These were breaches of Regulation 16 (1) (a) and Regulation 18 (1) (2) (f) of the Care Quality Commission (Registration) Regulations 2009.

In addition, we found the monitoring systems in place to check the quality of service provided, and the arrangements to mitigate the risks to people's health, safety and welfare, had been inadequate. This was because internal auditing systems had failed to identify and act upon the fact that one person had not been weighed since January 2015. According to their records, they had previously lost weight.

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

After the inspection the provider submitted an action plan which outlined the improvements they planned to make to address these areas. We carried out this inspection to check they had followed their plan, and found that improvements had been made.

During this inspection, the registered manager showed us records of individual discussions with staff members regarding the actions to be taken in the event of someone dying or there being an incident that involved the police. These records clearly set out the need for staff to notify relevant external bodies including CQC. We saw that staff had signed the records to demonstrate their awareness and understanding of the new changes.

The registered manager updated that there had been an incident involving the police a week before this inspection. She explained that a tablet computer had been stolen from the service. Although this was reported to CQC, there was a small delay in this happening. The registered manager acknowledged this and confirmed her understanding that notifiable events should be reported without delay in future.

This showed that steps had been taken to ensure CQC registration requirements, including the submission of notifications, were met.

The registered manager showed us a number of new monitoring charts and records that she had introduced since the last inspection. She told us that these would enable her to have a better oversight in areas such as people's weights and the outcome of their healthcare appointments; to be able to identify any concerns more easily. Previously, some of this information had been recorded within people's daily records, making it

difficult to audit and pick out the salient points. For example, when someone living with diabetes had last had their blood sugar levels checked, and when they were due again.

The registered manager also showed us new contact sheets that she had introduced since the last inspection; to ensure a clear record of her communication with people and staff was maintained, including any actions required as a result of those interactions. She explained that she was not always on site when she spoke with people, so this new system would support her in maintaining accurate records and a clear audit trail of actions taken. We were able to see an example where she had recently followed up on a concern that had come to light and had made contact with a relevant external professional, in order to support someone in managing their finances.

This showed that action had been taken to monitor and review the delivery of care to people more closely.