Larchwood Care Homes (South) Limited

Lily House

Inspection report

Lynn Road
Ely
Cambridgeshire
CB6 1SD

Tel: 01353666444

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Lily House is registered to provide accommodation and personal care for up to 44 people, some of whom live with dementia. The home is located in a residential area on the outskirts of the city of Ely. When we visited there were 31 people living at the home.

The inspection took place on 5 April 2016 and was unannounced. The last unannounced comprehensive inspection was carried out on 21 April 2015 when the provider was not meeting regulations associated with application of the Mental Capacity Act 2005 [MCA] and quality assurance of the home.

A registered manager was in post when we inspected the home and had been registered since 8 September 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 about how the service is run. The registered manager was not managing the home when we inspected; interim management arrangements were in place pending the return of the registered manager from leave.

People were safe living at the home as staff were knowledgeable about reporting any abuse. There were a sufficient number of staff employed and recruitment procedures ensured that only suitable staff were employed. Arrangements were in place to ensure that people were protected with the safe management of their medicines.

The CQC is required by law to monitor MCA and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was acting in accordance with the requirements of the MCA so that people had their rights protected by the law. Assessments were in place to determine if people had the capacity to make decisions in relation to their care. When people were assessed to lack capacity, their care was provided in their best interests. In addition, the provider had notified the responsible authorities when some of the people had restrictions imposed on them for safety reasons. The provider was waiting to hear the results of the actions that these authorities may be taking.

Staff were trained to do their job and demonstrated how their training was applied to their practice. Staff supported each other but felt that, due to the interim management arrangements, they felt less supported by the current leadership arrangements of the home. The provider was aware of this concern and was taking action to address this.

People were supported to access a range of health care professionals. Health risk assessments were in place to ensure that people were supported to maintain their health. People were provided with adequate amounts of food and drink to meet their individual likes and nutritional and hydration needs.

People's privacy and dignity were respected and their care was provided in a caring and attentive way.

People's hobbies and interests had been identified and a range of activities supported people with these. People's care records and risk assessments were kept up-to-date. A complaints procedure was in place and this was followed by staff. However, people and visitors were unclear who they could raise their concerns with but said that they had no complaints to make.

The provider had quality assurance processes and procedures in place to improve, if needed, the quality and safety of people's support and care. Improvements were made in relation to recruitment of permanent staff; the environment and auditing of people's care records.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's needs were met by sufficient staffing numbers and by staff who were suitable to provide people with safe care.

Measures were in place to reduce people's risk of harm to their health, safety and well-being.

People received their medicines as prescribed by staff who were trained and assessed to be competent.

Is the service effective?

Good

The service was effective.

People's rights were protected from unlawful decision making processes.

Staff were supported and trained to do their job.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People received care that was attentive and their individual needs were met.

People's rights to privacy, dignity and independence were valued.

People's decisions about how they wanted to be looked after were valued.

Is the service responsive?

Good

The service was responsive.

People were actively involved in reviewing their care needs and received care to meet their individual needs

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The provision of hobbies and interests supported people to take part in a range of activities that were important to them.

There was a procedure in place which would be used to respond to people's concerns and complaints. However, some people were not made aware of the complaints procedure.

Is the service well-led?

Good

The service was well-led.

There were links with the local community to create an open and inclusive culture within the home.

Arrangements were in place for people and staff to make suggestions and comments.

There were quality assurance systems in place to ensure that people were kept safe from the risk of harm.

Lily House

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 inspection took place on 5 April 2016 and was unannounced. It was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had expertise regarding older people and people who live with dementia.

Before the inspection we received information from a local contracts and placement officer: this was to help with our planning of the inspection. We also looked at all of the information that we had about the home. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with eight people who used the service and one relative. We also spoke with the deputy manager; a deputy manager from another of the registered provider's homes; a regional manager; the head chef; one senior carer; one acting senior carer, who worked also as an activities co-ordinator; three members of care staff and one member of domestic staff.

We looked at three people's care records and records in relation to the management of the service and the management of staff. We observed people's care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

People said that they felt safe because of how staff treated them. One person said, "I can't think of a better place to live than this." Another person said, "There are good people [staff] here." We were told by a third person that they felt safer living at Lily House than when they lived at home.

There were procedures in place to minimise the risks of harm to people. This included the training of staff in protecting people from such risks. Members of care staff told us what they would do if they suspected people were being placed at any risk of harm. They were able to describe the types of harm and the actions they would take, which included reporting the incident to the police and local authority. Staff were also aware of the signs of a person being harmed. They described the possible changes in people's behaviours and condition of their skin. One member of care staff said, "There could be physical marks or changes in their [person's] behaviour. They may not be acting themselves or become withdrawn."

Recruitment systems were in place to ensure that all checks were carried out before prospective employees were deemed suitable to do the job that they had applied for. Members of staff described their experience of when they were applying and recruited to the job. One member of the domestic staff said, "I remember filling in an application form. I did have a DBS [Disclosure and Barring Service]. I did have one written reference from my previous job and one from a neighbour. I came in for an interview." The head chef also told us that they had the required checks carried out and added that the provider had received these before they were able to start their employment. They said, "I sent in my C.V. [curriculum vita]; had an interview about a week later and there were two references. I was told to wait to start work until my DBS and other checks came through as they [the provider] have to protect the residents [people]."

People told us that there were sufficient numbers of staff to look after them. One person said, "If it takes longer than a minute [before staff respond to their call for assistance] it is very rare." We timed staff responses to people's call bells and these were less than one minute. Staff told us that there was a sufficient number of staff. Measures were taken to cover staff vacancies or absences with the use of agency staff. However, due to successful recruitment of permanent staff, this had reduced the numbers of agency staff.

The regional manager told us that agency staff were used for night duty only as there was enough staff working on day duty. However, due to recent recruitment of staff for night duty, this would reduce the number of agency staff used. The regional manager advised us that the agency staff used were supplied from the same agency; this was to reduce the risk of people receiving inconsistent care. Permanent members of care staff were positive about the recruitment of new staff and the reduction in the use of agency staff. They told us that this had created a more stable and supportive team of staff. The acting senior carer said, "When I first started working here, there was a lot of agency staff working here, which was quite difficult. Now we are getting to know how each other [member of permanent staff] works. It is a lot easier."

A dependency tool was used to determine the number of staff required to meet people's individual needs. We saw that people were looked after by staff in an unhurried way; their medicines were given at the times they were prescribed; there was enough staff to provide people with individual support with eating and

drinking. In addition, staff members had the time to talk to people in a sociable way.

Risk assessments were in place and these included risks of falls. Measures were in place to manage the risks; these included the use of monitoring equipment and ensuring staff reminded people to use their walking aids. The registered manager had sent us information about people's falls and the action taken to reduce the number of falls that people had experienced. The information showed that people's independence was maintained whilst ensuring that measures taken were least restrictive. This included the use of bed rails or contacting a GP to treat a person for a previously undiagnosed underlying infection.

There were satisfactory systems in place for the receipt, administering and storage of people's prescribed medicines. People told us that they were satisfied with how their prescribed medicines were managed. One person told us that staff stayed to make sure that they had safely taken their medicines. We observed one senior member of care staff offering people their prescribed medicines. We saw that they checked that the person had safely taken them before signing the medication administration records [MARs]. Medicines were securely stored when left unattended. MARs demonstrated that people were supported to taken their medicines as prescribed. Members of senior care staff were responsible in the management of people's prescribed medicines. Senior care staff told us that they had attended training in this topic and were assessed to be competent to do so. One member of senior care staff said, "I had my competency check sometime in the middle of last year. They [deputy manager] go round with you, watching that medicines are administered; that you are checking and recording the MARs."

Good

Is the service effective?

Our findings

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.

During our inspection of 21 April 2015 the provider was found to be in a breach of a regulation because people's mental capacity had not been formally assessed. The provider wrote to tell us what plans they intended to take to meet the requirements of the breached regulation. The plans were to be completed by no later than 30 September 2015. During the inspection of 5 April 2016 we found that the provider had taken remedial action to meet the requirements of the breached regulation. People living with dementia had their mental capacity assessed and care was provided within their best interest. This included support with taking their prescribed medicines and use of monitoring equipment to alert staff to the person's whereabouts, such as alarmed mats and external doors. Best interest decisions were also in place for some of the people's end-of-life treatment. Decisions made by the medical practitioner involved discussions with the person's legal appointee. The provider had submitted DoLS applications to the local authority to consider and was in the process of making further enquiries as to the progress of these; this was to ensure that any restrictions imposed to keep people safe, were authorised and in line with the MCA framework.

Members of staff told us that they had attended training in the application of the MCA and some were able to demonstrate their understanding of this. One member of care staff said, "[The MCA] is about if people have the mental capacity to make day-to-day decisions about their care." Another member of care staff said, "The MCA is for somebody who lacks [mental] capacity. It gives them their rights and protects them [from unlawful care]. The care plans say who has mental capacity and who has Power of Attorney."

Members of care staff were able to demonstrate how they offered people choices about their day-to-day care and valued their rights to make decisions. The acting senior carer told us that one person had declined to take their medicines as prescribed. They said, "I went back several times [to the person] and they still declined to take their medicines. Another senior [member of care staff] went to [person] and [person] still declined. And this has been recorded." (We were given assurances that the person was comfortable and well irrespective of their decision to decline their medicines on this occasion).

Staff told us that they received training, which included induction training. One member of care staff told us that, in their view, the training was "a lot better" as they preferred face-to-face training rather than computer on-line ['e-learning'] training. Another member of care staff said, "The training has always been good here." The acting senior member of care staff said, "The training has gone back to face-to-face training, which is good, compared to 'e-learning'." Staff told us that they had attended training in a number of topics which included moving and handling, infection control, food hygiene and fire safety. Records showed that staff had also attended training in looking after people with behaviours that challenge. Forthcoming training in

the application of the MCA was arranged for 7 April 2016.

Staff told us that they felt supported by their colleagues and this had increasingly improved due to a more stable team of permanent staff. However, due to the current management arrangements of the home, they did not feel so well-supported, although they did have one-to-one supervision. One member of care staff told us that they felt "supported by colleagues rather than by management." Another member of senior care staff also told us that they were supported by their colleagues but less so by the management of the home. One person had observed how the staff supported and worked with each other and said, "[It's] definitely team work."

People told us that they liked the food and always had a choice and plenty of what they wanted to eat and drink. One person said, "[The meals] are fine. We have a choice. I pick what I want [to eat]." Another person said, "My breakfast was lovely. [I get] plenty to eat and drink." A third person said, "The lunches are so filling, that by the time I've finished, I have to go and have a lie down."

People's individual nutritional needs were catered for, based on the advice provided by individual health care professionals. This included soft diets prescribed by the speech and language therapist for people at risk of choking and 'healthy' diets for people living with diabetes. People were offered a choice of cooked breakfasts and alternative hot and cold lunch and tea-time options, which included 'finger foods' and vegetarian options. The head chef advised us that people were also provided with nutritional supplements, such as milk shakes.

During lunch time we saw that people were encouraged and supported to eat and drink if they needed this level of assistance. People were also offered extra helpings, a choice of hot and cold drinks and also a choice of dessert.

We saw people were supported to maintain their nutritional health and weight records demonstrated that these actions were effective. When people had unintentional weight loss, they were referred to a dietician/nutritionist for their advice. In addition, the frequency of when people were weighed was dependent on their up-dated risk assessments. Weight records showed that the measures taken had enabled people to slowly gain weight.

During our inspection we saw some of the people had visits by a GP and district nurse. People's records showed that they were supported to access a range of health care professionals. These included opticians, community psychiatric services and hospitals. Notifications told us that when people required medical attention, appropriate action was taken in response to the level of seriousness of the person's medical condition. Effective preventative measures were in place in response to people's risk of developing pressure ulcers. This included the provision of pressure-relieving equipment; meeting people's continence needs and assisting people to change their position when in bed. At the time of our inspection none of the people had acquired a pressure ulcer whilst living at Lily House.

Good

Is the service caring?

Our findings

People had positive things to say about how well they were looked after. One person said, "Staff are very good and they always have a smile." Another person said, "They [staff] are very welcoming." We saw that staff were kind and attentive when they interacted with people. This included when helping them with their eating and drinking and walking with them in the corridors.

People told us about how they were enabled to choose how they wanted to spend their day. One person said, "I have my own day and it's not necessarily a conventional day." They explained that they were able to go to sleep late and their choice of when they wanted to have a lie down was also respected. People's care records detailed the times of when people preferred to go to bed and get up. However, we saw that these were guidelines only as some people were left to sleep and were relaxed and comfortable.

Members of care and catering staff showed their commitment to looking after people who were at the heart of their work. One member of care staff said, "I enjoy my job because the residents [people] are chatty and I like talking to them." An acting member of senior care staff said, "I love my job and I try and understand how people [living with dementia] see their world. My job is also developing a good relationship with them [people]. Sitting down and talking with them. It's about them feeling valued." The head chef said, "I talk to the residents [people] about what's for lunch. My job is worthwhile. To me, the food has to be right."

People's privacy, dignity and independence were valued. One person said, "They [staff] never walk in [to my room without permission]. They respect my privacy." We saw staff members knock on people's doors and waited for permission to enter. We also saw that staff helped people with their personal care behind closed doors. People's independence with eating and drinking was maintained and encouraged. We saw that some people were provided with specialised bowls to enable them to independently eat their food. Napkins were used to help people keep clean from the risk spillage of drink and food.

The premises maximised people's privacy and dignity as all bedrooms were used for single occupancy only. Communal bathing and toilet facilities were provided with lockable doors. In addition, since our last inspection of 9 September 2015, improvements had been made to make the environment more 'homely'. This included the provision of pictures, arts and crafts and photographs in corridors and communal areas. People's rooms were also individually decorated to meet their preferences. We saw that the seating arrangements, in communal rooms and dining areas, encouraged and enabled social interaction between people and promote their comfort. We saw that some of the people had made friends with other people living in the home.

People received their guests when they liked and we saw some of the people received visitors in the privacy of their rooms. One person told us that they also went to dine out in the company of their relatives.

Advocacy services were made available and these enabled people to be supported in managing their affairs by an independent agent. Advocates are people who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People told us that the staff knew them as individuals and understood how to meet their needs. We found that staff knew people's individual needs, which included what they liked to eat and what they liked to do. Information about people's life histories and about what was important to them was detailed in their care plans. One member of care staff said, "I've read all of the [people's] care plans and I can go back to what the person liked." They gave the example of supporting a person living with dementia to make choices about what clothing they would like to wear.

People's individual needs were met which included continence, hearing and mobility needs. People's continence aids were checked and changed when required; people had their hearing aids in; equipment was available and trained staff assisted people with their moving and handling needs by means of a hoist, when this was needed.

Members of staff were also aware of people's individual communication needs. Care staff offered people choices of what they would like to drink in a way that they could understand. This included providing verbal information in measured way; repeated the question if it was needed and waited for a response.

People told us that they had enough to do and could choose how they wished to spend their time. One person said that they enjoyed watching the television in the privacy of their own room. Another person told us that they had opportunities to take part in the arranged activities, but preferred their own company. We watched some of the people listening to an external entertainer singing 1950's and 1960's music.

There were designated 'activities' rooms which had arts and crafts displayed and large piece jig-saws to meet people's visual and finger/hand dexterity needs. We saw one person enjoying their role of looking after the indoor pet birds; they cleaned the cages and filled the seed containers. People's records demonstrated that there was a range of hobbies and interest that people were enabled to take part in ; these included attending religious services; arts and crafts and 'pamper' sessions. The acting senior member of care staff told us that they were also the activities co-ordinator. They described the activities that people took part in to help with the tidying of the enclosed garden. However, they said that they sometimes had to compromise people's day-to-day activities when they were working in their other role as an acting senior carer. They said, "The carers are really good at helping with these [activities] but when I'm working [in a caring role] it is not always possible."

Care records demonstrated that people's needs were assessed before they moved into the home to ensure that their needs would be met. People, if possible, and their relatives were part of this assessment process. Although it was unclear if people were involved in the on-going reviews of their care plans, we found that their relatives had been involved in this process.

People's individual needs were assessed and these and risk assessments were reviewed at least once a month, if not sooner. In addition to these reviews, daily meetings enabled staff and management teams to review the needs of people. The acting senior member of care staff told us that the daily meetings enabled

staff from all departments to respond to people's changed needs. For example, a changed health need which required a person to be assessed by a health care professional.

People and one relative told us that they did not know who to speak with if they wanted to raise a concern or complaint. This was due to the management arrangements of the home at the time of our inspection. One person said, "I never see a manager." The relative said that the only concern that they did have was who to speak to about their family member, "I'm never quite sure who I should approach about my father's well-being [or to complain to]." Members of staff were aware of supporting people to make a complaint and told us that this would be following the provider's complaint procedure. Information about reporting abuse, whistle blowing procedures and reporting complaints to the Care Quality Commission was available on entry to the home for people and visitors to access. However, a copy of the provider's complaints procedure was not publicly available. The regional manager assured us that remedial action would be taken in relation to the missing information.

Good

Is the service well-led?

Our findings

During our inspection of 21 April 2015 the provider was found to be in a breach of a regulation. This was because the quality monitoring systems were ineffective in protecting people's rights and from preventing people receiving care that was based on out-of-date information. The provider wrote to tell us what plans they intended to take to meet the requirements of the breached regulation. The plans were to be completed by no later than 30 September 2015. During the inspection of 5 April 2016 we found that the provider had taken remedial action to meet the requirements of the breached regulation. Audits had been carried out and action was taken so that staff had the correct care plan guidance to be able to safely meet people's individual needs. In addition, MCA assessments were now in place and staff had attended training in MCA and DoLS. One senior member of care staff said, "The care plans have improved and we have better training in MCA and DoLS."

A registered manager was in post at the time of our inspection and was supported by a range of care, ancillary and managerial staff. When we visited the registered manager was not working; interim management arrangements were in place to cover the registered manager's absence. Members of staff told us that they found the interim management arrangements had left them without the support and strong leadership that they considered the home needed. One member of care staff said, "[Staff] morale is better than what is has been and we are moving in the right direction. But it still could be better by having a good leader and a captain of the ship." However, they added that they welcomed the appointment of a new deputy manager. A member of senior care said, "It's hard working here without having a [permanent] manager." They told us that they felt that they did not get the guidance or support from the current management arrangements. People also told us that they were unclear who was managing the home. The provider's monthly monitoring report for February 2016 read, "The home is effectively led at this time but unstable."

Although staff had concerns about how Lily House was being currently being managed, they told us that this did not have a negative impact on the quality and safety of people's care. One member of care staff said, "There is reduced direction by management. But it is not affecting people's care. Not at all." A member of senior care staff also told us that the quality and safety of people's care were maintained and gave their reason for this: they said, "We do have a good team here and we help each other out." We saw how staff helped each other between different work places and between different grades of staff.

Staff were enabled to make suggestions in improving the standard of people's care. This included during the daily meetings when people's individual needs were reviewed and actions taken as a result, such as changes in menus. Staff were also enabled to make suggestions about their training. One member of senior care staff told us that they requested training to develop their career and that this request had been actioned. A member of care staff told us that they attended staff meetings: they described the proposed changes to the pattern of rostered hours of work. They told us that they felt "a lot better" when staff had made their views known and were listened to. They told us that there were minimal changes made based on what staff had said during the staff meeting. The acting senior member of care staff told us that they were able to "influence" the proposed changes to the staff rosters and this had helped to maintain flexible working for

staff members.

By the visitors' signing in book, people were provided with comment cards to complete and tell the provider their views about Lily House. People and visitors were also provided with other opportunities to share their views about the home. The regional manager told us that relatives 'and residents' meetings had been held since 2015 although minutes of these were not available. Arrangements were in place for future meetings for people and their relatives/friends to attend.

Members of care staff were aware of the whistle blowing policy and procedure. The acting senior member of care staff said, "If I see something I am not happy with, I need to say something to my manager or go to CQC or the local authority." They told us that there identity would remain "confidential." A member of care staff said, "If you see a colleague doing something that isn't correct, you would report it to the manager in the first instance. It [whistle blowing policy] gives me protection against anything coming back at me [i.e. reprisal]."

There was an open culture operating in the home with Lily House being situated close to the centre of Ely. People were enabled to visit the city. In addition, representatives of religious organisations conducted services within the home at least once a month.

The registered manager had submitted notifications as required which demonstrated their understanding of their legal obligations of a registered manager.

There were quality assurance systems in place other than provider monthly visits and care plan audits. These included observing people's dining experiences and audits of people's medicines. Records confirmed that the standard of people's care met the provider's standard. Furthermore, since 2015, the provider has sent us copies of their detailed action plans, which were kept under review. Improvements were made to the standard and quality of people's care.