Leicestershire County Care Limited

Tillson House

Inspection report

Bradgate Drive
Coalville
Leicestershire
LE67 4HF

Tel: 01530832793

Date of inspection visit:
08 April 2021

Date of publication:
29 October 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service

Tillson House provides accommodation, nursing and personal care for up to 40 people who have need relating to dementia, physical disabilities, learning disabilities, mental health, and sensory impairments. At the time of our inspection there were 32 people using the service.

People's experience of using this service and what we found
People were not always safe when being hoisted. A person had been injured and we observed poor hoisting practice. This had led to a breach in regulations.

The provider's quality assurance audits had not identified issues with medicines records, the environment, and risk assessments.

We have made a recommendation about the provider's quality assurance system.

Staffing levels had improved, and people received support when the needed it. The staff were kind and caring and relatives made many positive comments about them. People were encouraged to take part in activities to increase their well-being.

People and staff had the opportunity to share their views on the service and managers acted on their suggestions. Relatives said the registered manager and staff were approachable and helpful.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Why we inspected
This was a focused inspection based on concerns we had received about the service. These were in relation to people's care and governance. As a result, we undertook this focused inspection to review the key questions of safe and well-led only.

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 remained the same. This is based on the findings at this inspection.

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.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Tillson

House on our website at www.cqc.org.uk

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

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Tillson House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors 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.

Service and service type
Tillson House 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used this

information to plan our inspection.

During the inspection
We spoke to three people using the service, 17 relatives, the deputy manager, the provider's compliance and care standards officer, a senior care worker, two care workers, the health and safety lead, and the maintenance person.

We reviewed a range of records. This included six people's care records and a sample of medicines records. We also looked at a variety of records relating to the management of the service including audits, policies and procedures, and infection control documentation.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

At the last comprehensive inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate

Inadequate: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not always safe when being hoisted. A person was seriously injured in a hoisting incident. The provider was unable to determine how the injuries occurred. The person was not risk-assessed for hoisting. Staff used the wrong type of sling and failed to complete a sling assessment to ensure the correct size sling was used.
- A person returning from hospital was hoisted in the reception area. The person's dignity was not maintained as this was a 'public' area and no screens were used. Staff did not speak with the person during the manoeuvre or explain what they were doing. The wheelchair was not located close enough to hoist. This meant the person had to undergo two manoeuvres, rather than one, due to the incorrect position of the wheelchair.
- A person was hoisted in an upstairs lounge. The hoisting equipment became tangled during the manoeuvre and the staff had to reapply the sling. Again, staff did not speak with the person they were hoisting to explain what was happening. Not communicating with people when they are hoisted increases the risk of incidents and accidents as people may not understand what is happening and are more likely to panic when the transfer takes place.
- Some people's risk assessment were not fit for purpose. For example, one person's risk assessment for moving and handling stated they were 'unable to mobilise' and needed a 'Rotunda for all transfers with two staff.' There was no other information or instructions for staff to follow to ensure the person was transferred safely according to their needs. The deputy manager said more personalised information was in the person's care plan. However, the risk assessment did not make this clear by directing staff to other documentation. This could compromise people's safety if staff were not aware of this.
- A person and a relative had concerns about hoisting at the service. A person said when they arrived at the service, "Staff said I should be hoisted, even though I have an [injury making this impossible]. I had to explain my needs to the staff." A relative said, "Staff seem unaware of the up to date situation regarding hoisting.
- After the serious moving and handling incident, a local authority occupational therapist visited the service. They found not all staff were familiar with people's moving and handling needs, and improvements were needed to moving and handling care plans and risk assessments, including what to do in the event of an emergency.

The provider had not ensured risks in relation to people's care were properly managed to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visit, the registered manager contacted us to report all staff were being re-trained in moving and handling, and moving and handling risks assessments improved, to ensure staff had up to date personalised information about how to support people to transfer safely.

Learning lessons when things go wrong

● At our last comprehensive inspection new staff had used hoists to support people before they'd been trained to do this safely. Although all staff were trained in moving and handling at this inspection, moving and handling practices were unsafe. This meant that lessons regarding the importance of safe moving and handling had not been learnt.

● Followed the incident when a person was seriously injured in a moving and handling incident there was no staff debrief, and only the staff who were involved in the incident had their competency checked. We discussed this with the managers and following our inspection visit the registered manager contacted us to report that all staff were being re-trained in moving and handling and would have their competency checked by the end of April 2021.

Systems and processes to safeguard people from the risk of abuse

● Most relatives said they thought people were safe at the service. A relative said, "I feel it is safe. The home informs me of any incidents."

● Staff were trained in safeguarding and knew what to do if they had concerns about the welfare of any of the people using the service. The provider had policies and procedures in place for safeguarding and whistleblowing.

● The registered manager worked with the local authority and other agencies if a safeguarding incident occurred, sharing information as necessary.

Staffing and recruitment

● At our last comprehensive inspection the service did not always have sufficient numbers of staff on duty to meet people's assessed needs.

● At this inspection staffing levels had improved. If people needed assistance staff provided this promptly. Staff provided one-to-one and two-to-one personal care when required, and were available and in communal areas to ensure people were safe.

● Managers calculated staffing levels using the provider's 'dependency tool' which worked out how many staff were needed per shift in relation to people's care and other needs. Records showed staffing levels were flexible as people's needs changed.

● Staff were safely recruited following the providers recruitment process. This ensured staff had appropriate criminal records checks and supplied references prior to starting work with the people using the service.

Using medicines safely

● Relatives said their family members received their medicines safely and on time. A relative said, "Medications are regular, and staff will check to see if [person] has swallowed it."

● A person said their morning medicines had been arriving late, causing problems with the medicine's efficacy, but they had spoken with the managers who had resolved this issue.

● Medicines were stored safely in a temperature-controlled room. Staff were trained in medicines administration and had regular competency checks.

● Medicines records were mostly in good order. However, some 'as required' medicines protocols were undated. This could be confusing for staff when protocols were reviewed. Following our inspection visit the registered manager contacted us to say all PRN protocols had since been reviewed and dated.

Preventing and controlling infection

● 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 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 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 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 comprehensive inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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

- At our last comprehensive inspection audits had not identified that staffing levels were unsatisfactory. This was addressed by the provider and improvements made. However, at this inspection, audits had again failed to identify shortfalls in the service.
- Premises audits had failed to identify that three upstairs bathroom doors had gaps around them, so it was possible to see inside. This compromised people's privacy and dignity. We reported this to the managers who said seals would be put around the doors to address this issue.
- Care records audits had failed to identify that risk assessments were ineffective, unless linked to care plans, and did not include the information staff needed to move to support people safely. Managers said staff knew to read risk assessments in conjunction with risk assessments, however, agency staff might not, and this could put people at risk. Managers said this would be addressed.
- Medicines records audits had failed to identify that some 'as required' medicines protocols were undated. The registered manager addressed this following our inspection visit.

It is recommended that the service's audit system is reviewed and improved to ensure it is effective in identifying shortfalls in the service.

- After our inspection visit, the registered manager said the provider had already identified improvements were needed to its care recording system. They said the provider was piloting a new, computerised system which would enable managers and staff to access, review, and update records more effectively.
- Staff had failed to follow the provider's moving and handling policy which stated that moving and handling risk assessments must be carried out to ensure people are being transferred safely. Managers were addressing this with further staff training and competency checks.

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

- Managers understood their responsibilities in relation to the duty of candour.
- Managers notified the appropriate agencies, including the local authority and CQC, of reportable incidents.

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

● Relatives said the staff team were friendly and kind which made for a good atmosphere at the service. A relative said, "Staff are always joking and smiling and don't cut [person] out when talking. They keep [person] involved."

● People had the opportunity to take part in a range of activities including music, games, crafts and gardening. This improved people's well-being. A relative said, "Staff are getting [person] to do things and make friends."

● If people were feeling lonely staff arranged regular one-to-one sessions with them so they had someone to talk with in private.

● People made choices about their care and support. A relative said, "The carers came to put [person] to bed and [person] wanted to finish watching a tv programme so they came back later."

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

● People and staff had regular meetings when they could share their views about the service. Relatives said staff kept them up to date with their family member's progress. A relative said, "I ring them, and they ring me. They let me know what is going on. The [registered] manager listens.".

● There was a 'you said we did' board on the ground floor to show what actions staff took in response to people's requests. For example, one person wanted a large clock on display so they could tell the time more easily and this was provided.

● The service's compliance and care standards officer carried out regular audits of people's views of the service. The last audit, which covered January and February 2021, looked at complaints/commendations, meetings minutes, and staff and people's feedback.

Continuous learning and improving care

● Managers and staff were supported to develop their professional skills through training and other learning opportunities. Some training was paused due to pressures on the service because of COVID-19, but had since resumed.

Working in partnership with others

● Staff worked with health and social care professionals to help ensure people's needs were met. Records showed people were referred to GPs, community nurses, the SALT (speech and language therapy) team, and others when required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks in relation to people's care were properly managed to prevent avoidable harm.