

Community Housing and Therapy

Lilias Gillies House

Inspection report

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10 April 2018

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

Lilias Gillies House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Lilias Gillies House does not provide nursing care. Lilias Gillies House accommodates up to 20 people in one adapted building. At the time of our inspection 12 people were using the service.

At our last inspection on 11 and 12 April 2016 we rated the service Good overall and for each key question. At this inspection on 10 April 2018 we found improvements were required and we rated the service 'requires improvement' overall for the key questions 'safe' and 'well-led'.

The service did not have a registered manager in post. A new manager had been in post since September 2017 and their application to become the registered manager was in the process of being assessed. 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 about how the service is run.

Robust governance procedures were not in place and there were a lack of audits relating to care records, infection control and medicines management. This meant there was a risk that the provider was not consistently adhering to best practice guidance and there were not robust systems to monitor and improve the quality of all areas of service provision.

Individual risk assessments were undertaken and people were supported to manage and mitigate those risks. However, we found improvements were required to ensure robust health and safety procedures were consistently followed in line with best practice guidance.

The provider and service had been through a period of change since our last inspection including the introduction of a new chief executive officer and a new manager. The focus of the service had also changed to incorporate the principles of psychologically informed environments (PIE) and the introduction of respite and crisis admissions. PIE is an approach to improve the psychologically and emotional well-being of people accessing services.

There were processes in place to record and learn from incidents. Safe medicines management processes were in place and people were protected from the risk and spread of infections.

Staff supported people with their mental health recovery and to regain skills to develop their independence with the aim of moving towards less supported accommodation. People's care records were in the process of being updated to be structured around the five areas of mental well-being. Care records provided information about people's needs. Staff supported people with their health needs, including both their

mental and physical health. People had free access to the kitchen and there was a rota in place for communal meals.

Caring working relationships had been built between staff and people using the service. People said staff were friendly and they were able to share a joke and have a laugh together. Staff adhered to the Mental Capacity Act 2005 and conditions in place relating to people's care under the Mental Health Act 1983. People's views and involvement was integral to service delivery. People were central to their care decisions and how they spent their day.

Staff supported people to build and maintain relationships with friends and family. Staff provided any support required with people's cultural, religious or sexual preferences. People's privacy and dignity was maintained.

There were sufficient staff to keep people safe and meet their needs. Safe recruitment procedures continued to be followed. Staff had the knowledge, skills and experience to provide people with the support they required. Staff received regular training and supervision. This included reflective practice sessions to discuss staff's concerns, thoughts and any difficulties they were experiencing.

There were systems in place to analyse key performance data including incidents and complaints. Staff felt well supported and able to have open and honest conversations with the manager. People were invited to the provider's head office to meet senior managers and people who use the provider's other services. A complaints process remained in place and any complaints received were handled in line with the provider's procedures.

Nevertheless, the provider was in breach of the legal requirement relating to good governance. You can see what action we have asked the provider to take at the back of this 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?

Some aspects of the service were not safe. Robust health and safety procedures were not consistently followed to ensure a safe environment was provided in line with best practice guidance and taking into account people's individual risk behaviour.

There were processes in place to record and learn from incidents. Safe medicines management processes were in place and people were protected from the risk and spread of infections.

There were sufficient staff to keep people safe and meet their needs. Safe recruitment procedures continued to be followed.

Requires Improvement 

Is the service effective?

The service was effective. Staff had the knowledge, skills and experience to provide people with the support they required. Staff received regular training and supervision.

Staff adhered to the Mental Capacity Act 2005 and conditions in place on people's care under the Mental Health Act 1983.

Staff supported people with their health needs, including both their mental and physical health. People had free access to the kitchen and there was a rota in place for communal meals.

Good 

Is the service caring?

The service was caring. Caring working relationships had been built between staff and people using the service. People said staff were friendly and they were able to share a joke and have a laugh together.

People's views and involvement was integral to service delivery. People were central to their care decisions and how they spent their day.

Staff supported people to build and maintain relationships with friends and family. Staff provided any support required with people's cultural, religious or sexual preferences. People's

Good 

privacy and dignity was maintained.

Is the service responsive?

Good ●

The service was responsive. Staff supported people with their mental health recovery and to regain skills to develop their independence with the aim of moving towards less supported accommodation. People's care records were in the process of being updated to be structured around the five areas of mental well-being. Care records provided detailed information about people's needs.

A complaints process remained in place and any complaints received were handled in line with the provider's procedures.

Is the service well-led?

Requires Improvement ●

Some aspects of the service were not well-led. Robust governance procedures were not in place and there were a lack of audits in place relating to care records, infection control or medicines management. This meant there was a risk that the provider was not consistently adhering to best practice guidance and there were not robust systems to monitor and improve the quality of all areas of service provision.

There were systems in place to analyse key performance data including incidents and complaints. Staff felt well supported and able to have open and honest conversations with the manager. People were invited to the provider's head office to meet senior managers and people who use the provider's other services.

Lilias Gillies 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 10 April 2018 and was unannounced. One inspector undertook the inspection.

Prior to the inspection we reviewed the information we held about the service, this included any statutory notifications received about key events that occurred at the service. We also attended a joint meeting with representatives from the local commissioning service, the local authority safeguarding and quality monitoring teams and from the provider of the service - Community Housing and Therapy to discuss the remit of the service and action taken since the previous quality visit by the local authority.

During the inspection we spoke with four people using the service, three staff including the manager, reviewed three people's care records and three staff records. We also reviewed records relating to the management of the service and the management of medicines. We observed staff handover and part of the community business meeting.

Is the service safe?

Our findings

One person told us, "This place is top notch...I feel safe here." Another person said, "I do feel safe." A third person told us they had a discussion with the manager about how to maintain their safety in the community. They said, "He worries about us."

Nevertheless, the staff did not always adhere to their responsibilities regarding health and safety of the premises and had not ensured they adhered to the Health and Safety Executives' 'Health and safety in care homes' guidance. The service had window restrictors in place, however, there were not processes in place at the time of inspection to regularly check and monitor the compliance of these window restrictors with best practice and one restrictor was set outside the recommended width. Water temperatures were within a recommended safe temperature for people not at risk of scalding themselves. Risk assessments covering risk to self did not specifically address the issue of hot water or whether people were at risk of scalding or burning themselves. We saw that an environmental health and safety assessment was undertaken, which had identified potential risks to people mainly from kitchen equipment. However, there was no risk management plan in regards to these risks and how they were to be mitigated. We discussed these concerns with the provider and they informed us they would make the necessary changes to ensure their environmental risk management processes were aligned with best practice guidance.

Staff liaised with referring agencies and the person using the service to assess individual risks to their safety and welfare, including current risk behaviour, historical risks and how the risks to their health varied depending on their mental state. The provider was proud of their approach to risk management and supporting people in line with positive risk taking. This enabled people to take on more responsibilities within their recovery and rehabilitation, whilst having staff available to support as and when required. Risk management plans were developed and regularly reviewed with people's involvement. This gave people ownership over their risk management and supported them to develop strategies to manage those risks as they progressed with their recovery. Staff had identified that some people found it difficult to approach staff when their mental health was deteriorating. Staff had developed 'crisis cards' with them so they could let staff know they needed additional support. Staff were aware of people's risk behaviours relating to substance misuse and provided support with these.

Staff undertook weekly room checks, as much as possible with the person present, to ensure people's rooms were well-maintained and in working order, as well as checking for any contraband or materials that may cause harm to the person or others.

There were processes in place regarding the management and reporting of incidents. We viewed incident records and saw people were supported appropriately at the time of the incident and follow up action was taken to prevent recurrence. People had capacity in regards to their risk behaviour, so whilst staff provided people with information about how to manage and mitigate those risks, the risk could not be completely removed. Staff discussed with people their behaviour after an incident occurred and offered further emotional support and therapy.

Staff continued to follow safeguarding adults' procedures. Staff were knowledgeable in recognising signs of abuse. As part of the assessment process staff gathered information about any abuse people had experienced in their childhood or earlier in their adult life. They were aware of any protective factors that should be in place to prevent any further abuse. Staff had discussions with people about how to protect themselves when in the community from abuse and discrimination. If staff had concerns about a person's safety or welfare they escalated them to the management team and reported them to the local authority safeguarding team following appropriate procedures.

There were sufficient numbers of staff to keep people safe. There was a combination of recovery practitioners at different seniorities, as well as 'live in' support workers. There was a minimum of two staff on duty to keep people safe, as well as the 'live in' staff in an emergency. In reality we saw often there were more than two staff on duty to provide people with the level of support they required in line with their recovery. People also benefitted from regular sessions from clinical and therapy staff who the provider directly employed.

Safe recruitment practices continued to be followed, including checking staff's eligibility to work in the UK, obtaining references from previous employers and undertaking criminal record checks.

People received their medicines as prescribed. Staff ensured medicines were stored securely, including for those people who were self-administering. There were detailed procedures in place to assess whether a person was safe to administer their own medicines and we saw these were followed. For those medicines that staff were administering for people we saw accurate records were maintained and stocks of medicines were as expected. There were processes in place to regularly review the accuracy of medicine administration records and stocks of medicines. There were processes in place in regards to the ordering and disposal of medicines.

People were protected from the spread of infection. Staff had daily cleaning schedules in place and we observed staff encouraging and helping people to maintain the cleanliness of their bedrooms. There were posters displaying information about good hand hygiene and we saw soap and antibacterial hand wash was available. Cleaning equipment was available and cleaning chemicals were stored securely.

Is the service effective?

Our findings

People were supported by staff that had the skills, knowledge and experience to deliver effective care and support. We viewed the provider's training matrix which showed the majority of staff were up to date with the provider's mandatory training and those courses that were not yet complete were in the process of being completed. The training included; food hygiene, health and safety, first aid, infection control, medicines administration, equality and diversity, fire safety, safeguarding adults, risk assessments and managing aggression, Mental Capacity Act 2005, and the control of hazardous substances. In addition, staff also completed training relating to people's specific needs including diabetes, working with people who misuse substances, working with people who self-harm and recovery planning. The provider had a clear training plan in place to ensure staff had the opportunity to continuously develop their knowledge and skills.

Staff received monthly management supervision as well as attending weekly reflective practice sessions. These sessions were structured around the needs of the staff at the time to ensure they were appropriately supported and had the opportunity to discuss any concerns, worries or questions they had.

The provider ensured their staff stayed up to date with good practice guidance regarding mental health care and we saw reference guides were available for staff to access. However, we saw there were not as robust systems in place to ensure staff stayed up to date with good practice guidance relating to social care and care homes. This included issues relating to health and safety processes and governance procedures.

Staff adhered to the Mental Capacity Act 2005. People were assessed as having capacity to make decisions about their care and treatment and staff respected people's decisions. Staff gave people information about any risks to their behaviour so they could make informed decisions. Staff and people were aware of any restrictions they were subject to under the Mental Health Act 1983, this included in regards to some people's compliance with their medicines and engagement with the therapy programme in place. No-one at the time of inspection had any further restrictions in place and there were no curfews in place. One person said they appreciated the "freedom" they had and being able to lock their own bedroom.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager was aware of DoLS procedures and the processes to follow. At the time of inspection each person using the service had capacity to understand the risks to their safety and were not deprived of their liberty. Each person had a key to their bedroom and were aware of the codes on the front door so they could come and go from the service as they pleased.

People met to discuss and plan the weekly food menu. People, with staff support, undertook the food shopping and there were twice weekly stock checks to ensure there were sufficient ingredients at the service. People were welcome to help themselves to the food in the kitchen throughout the day. A communal evening meal was cooked by people, with staff support, on a rota basis. People and staff were

aware of any food allergies people had and were considerate to people's needs when storing, preparing and cooking meals. Some people had more complex relationships with food, associated with their mental health, and staff regularly observed people to ensure they were eating sufficient amounts for their needs. During staff handover we observed staff updating each other about people's eating habits so they were all aware if people's eating habits changed indicating a sign of people's mental health deteriorating.

Staff worked with people's community mental health teams to ensure they received consistent and coordinated care. Staff regularly liaised with people's care coordinators and their responsible clinicians to ensure people's mental health was regularly reviewed and if staff identified that a person's mental health was beginning to deteriorate they could arrange additional support for the person to minimise risk of further deterioration. For people subject to sections of the Mental Health Act 1983 staff supported the person in line with any stipulated requirements. Most of the people using the service were out of area placements, meaning their community mental health team was not local and this was impacting on the accessibility of these services. However, staff were in regular telephone conversations with the teams and were able to take on some of the care coordination role where appropriate so this geographical distance did not impact on people using the service.

People were supported to access physical healthcare services, including their GP, dentist and opticians. Staff focussed on people's physical healthcare needs as well as their mental health, and supported people to access specialist healthcare services when required. Staff were aware of when people's mental health needs presented as physical symptoms and supported them appropriately. For people who had ongoing physical health needs staff supported them with pain relief and to access appointments. This included supporting people who had diabetes and supporting them to attend regular checks with their diabetic nurse and specialist screening services.

The building provided people with en-suite bedrooms which gave people privacy and space to have time on their own. In addition there was a large communal kitchen, dining room and lounge. A large garden was at the service, which we saw was well used by people. The staff considered people's mobility needs during assessment and offered them a downstairs bedroom if they were unable to use the stairs, as the lift at the service was not in working order. Some areas of the service had not been refurbished and were quite sparse and there was little use of colour throughout the service. The manager told us a redecoration plan was in place to make some of the bedroom areas more appealing and aesthetically pleasing.

Is the service caring?

Our findings

People had built caring and friendly working relationships with staff. One person told us, "Staff really care... we had a spontaneous barbeque. It was a great laugh." Another person said, "The staff are very nice and very helpful." A third person told us, "I like it because everyone's friendly." A staff member said they worked hard with people "establishing working relationships and building trust. [It] enables you to have those difficult conversations".

People's views and involvement was integral to service delivery. People were encouraged to express their views and opinions, and be involved in service decisions. People contributed to service delivery and had control over elements of daily living, including menu development and how people structured their day. The manager told us recently there had been a change to service delivery in line with the principles of psychologically informed environments, which put more emphasis on people being in control of their recovery and approaching staff if they wanted support or to discuss their thoughts, feelings and emotions.

Staff supported people to develop and maintain relationships. Staff discussed with people the type of relationships they had, including relationships that may be considered unwise so people could protect themselves from exploitation. Visitors were welcomed at the service including friends and family. If visitors were unknown to the staff this occurred in communal areas only so staff could ensure the person's safety. Many of the people using the service at the time of our inspection had regular social leave. People were requested to inform staff if they were staying at friends or families overnight and were asked to make contact with staff every 24 hours so staff could ensure they were safe and well.

Staff asked people about their cultural and religious preferences and provided them with any support they required. Staff also asked people about their sexuality, relationships and supported people to attend sexual health checks.

Staff respected people's privacy and dignity. People had keys to their individual bedrooms and staff did not enter people's rooms without their permission, unless they had concerns about their safety. Staff were aware of the importance of keeping confidential information secure.

Is the service responsive?

Our findings

One person told us, "It's the best place...I'm so grateful here gave me a chance as otherwise I'd be in hospital." They also said, "We're getting ready to move onto the community. Staff offer to help. If we're cooking they're willing to help." Another person told us, "This place has really helped me."

Staff supported people with their mental health recovery and to regain skills to develop their independence with the aim of moving towards less supported accommodation. People's care and support was structured around setting short and long term goals relating to their mental health, physical health, activities/employment/education, relationships and social network, self-esteem and confidence, and anything specific regarding moving on to less supported accommodation.

Each person had an allocated key worker (a dedicated member of staff to lead on and coordinate their care and support). One person said, "My key worker is really good and helped with my finances...[My key worker] helps me understand what's happening." They met with this staff member at regular intervals to discuss their recovery support plan and progress towards their agreed goals. People were involved in their care and they worked with staff to develop their recovery plans. This ensured people took ownership of their recovery and they were supported to work on what was important to the person. A staff member told us, "I help [people] to achieve what they want from the placement and their life."

The manager informed us people's care records (both their recovery plans and risk assessments) were in the process of being reviewed to make them more accessible to people. This involved changing the structure of the records to focus on the five areas of mental well-being. Whilst we saw some people's care records had been updated into the new format and others were still to be done, we saw all care records provided detailed information about people's needs and how they were to be supported to help them to manage their mental health and to become more independent.

There was a group programme in place which enabled people to get involved in the running of the service and to discuss the dynamics within the group. People were encouraged to express what they wanted to do and staff were available to offer support. This included undertaking activities of daily living, accessing the community or undertaking interests and hobbies. In addition to the group programme, people received individual psychodynamic based therapy with the provider's psychologist. This enabled people to talk about their feelings, emotions and discuss coping strategies related to their mental health. The service had begun to move away from an overly structured programme to provide more autonomy and engagement from people and enable them to take control of their recovery. This shift in focus was in its early stages and people and staff were still in the process of getting used to the new way of working. We will continue to review the impact of the change in how the service is structured and support delivered at our next inspection.

A complaints process remained in place. We saw all complaints made were investigated and dealt with in line with the provider's procedures. People told us they felt comfortable speaking with staff and found staff approachable if they had any concerns or worries. Any complaints made were raised to the senior

management team so further analysis could be undertaken on any trends or themes.

The service had received compliments about the service provided. Comments included, "I found the care the staff provides to be very good and supportive" and "It's fantastic to be able to 'escape' normal life and experience supported living whilst being able to concentrate on my recovery".

Is the service well-led?

Our findings

There was not a robust governance system in place to review and monitor the quality of service delivery. At the time of inspection there were not robust systems in place to regularly audit care records, infection control procedures or issues relating to the kitchen, such as cleanliness, food hygiene and safety. Whilst the service undertook regular medicines stock checks and checked the quality of medicine administration records, apart from an annual audit by the pharmacy, there was not a process in place to regularly audit the full medicines management procedures. This meant there were not processes to monitor the quality of all areas of service delivery and compliance with good practice guidance.

The manager informed us there were processes in place for the senior management team to monitor staff's compliance with training, supervision and appraisals. However, this information was not available at the time of inspection and it was not currently shared with the manager at frequent intervals to enable them to have oversight of their staff's compliance with their mandatory requirements. The manager informed us there were plans for them to hold this information.

The manager informed us they had also started to introduce a peer review process where the manager of another of the provider's service visited to review and audit elements of service delivery. However, at the time of inspection a formal audit tool had not been developed and this process was not yet operational meaning there were insufficient processes in place to review the quality of all areas of service delivery.

Since our previous inspection the staff had started using the Health of the Nation Outcome Scale (HoNOS) mental health clustering scoresheet and the Warwick Edinburgh Mental Well-being scale to assess outcomes for people. However, we saw these data collection tools were not always completed correctly and the data was not totalled or dated meaning it was difficult to interpret the data into meaningful information. When asking the manager about how this information was used they said currently the information was being sent to the senior management team, but they were not yet using the information with people to evidence the progress they were making and the outcomes they had achieved.

The paragraphs above show the provider was in breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Over the last year a new chief executive had come into post and in turn this meant there were some changes occurring at provider and at service level. For example, the service was in the process of extending their remit to include offering respite beds and beds for people in crisis in the community who needed short term intensive support. The service had also changed their approach moving towards a psychologically informed environment (PIE). PIE is an approach to improve the psychologically and emotional well-being of people accessing services. As well as a new manager coming into post in September 2017. This had all had an impact on the vision and values for the service. We had asked the provider prior to our inspection for an up to date statement of purpose, however this had not been provided. An up to date statement of purpose is required to be shared with the Care Quality Commission (CQC) as part of the provider's registration responsibilities. This information was shared with the CQC shortly after the inspection.

There were processes in place to capture data about incidents, complaints and key service data. This information was shared with the senior management team and produced an annual report highlighting the findings. The manager shared the 2017/2018 draft report with us which showed the number of incidents had reduced compared to the previous year. The majority of incidents were in relation to episodes of self-harm and additional support was being provided to people and staff. The report also showed greater co-production and involvement of people using the service in development of their recovery plans. The focus for the upcoming year was in relation to supporting people to explore employment and education opportunities, and make greater links with the local community.

The management team had an open culture and we observed staff and people speaking to each other freely. One staff member said, "The place is fantastic, very open door. They're open in answering my questions." There was clear communication amongst the team and good team working. Staff felt well supported by their manager and their colleagues. A staff member told us, "Any issues that arise have always been dealt with very well."

Every six weeks people were invited to visit the head office, together with people from the provider's other services, to meet the senior management team. People were also given the opportunity to visit the provider's other services to meet other people and to learn from them. This was an opportunity to see what worked well for others and give people the choice of introducing it at Liliias Gillies House.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered person had not ensured effective systems were in place to assess, monitor and improve the quality of care and to assess, monitor and mitigate the risks to service users.</p> <p>Regulation 17 (1) (2) (a) (b)</p>