Lilycross Homes Limited

Lilycross Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection was unannounced and took place on the 28 July 2015. An arranged visit to complete the inspection was then undertaken on the 3 August 2015.

The last inspection took place on the 21 and 30 January 2015 when Lilycross Care Centre was rated as an inadequate service. Following this inspection we issued the registered provider with a warning notice and four requirement actions. These were in relation to good governance, person centred care and staffing. The manager present during the inspection in January left the home in May and a new manager was appointed.

The new manager sent us an action plan explaining how the warning notice and requirement actions would be met and by when.

During this inspection we found that some issues had still not been addressed and further more serious concerns were identified.

The home is required to have a registered manager. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Although at the time of our inspection visit the home did not have a registered manager in post the new manager had applied for registration and their application was being processed by the Care quality Commission.

Lilycross Care Centre is a purpose built home offering people personal care with nursing for up to 60 people. The home is located close to Widnes and St Helens and is close to the local bus route. At the time of our previous inspection the care home had three units which the provider called suites, Lily, the general nursing care suite on the ground floor, Rose, the nursing dementia care suite on the first floor and Bluebell, the residential dementia care suite on the second floor. At this inspection only two suites were open, Rose unit on the first floor was closed and the people living there had moved upstairs into Bluebell suite which now provided nursing dementia care. Lily on the ground floor still provided general nursing care.

All bedrooms are en-suite with several rooms also having shower facilities. On the first day of our inspection there were 16 people living in Lily suite, two of whom were in hospital and 14 in Bluebell suite.

During this inspection we have identified a number of serious concerns relating to how the service was managed.

We found that the provider still had a large number of bank and agency staff members covering shifts, particularly at night. The potential consequence of this was that the bank staff working there may not know the care needs of the people they were caring for.

We found that there were issues with person centred care, consent, safe care and treatment, safeguarding, nutritional needs, good governance and staffing.

These were breaches of Regulations, 9, 10, 11, 12, 13, 14,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not safely managed which placed people's health at risk.

People were not being adequately safeguarded from harm.

Care plans did not reflect people's needs and the people living in the home were not receiving care that met their individual needs.

There were inadequate systems and processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.

The provider has been unable to demonstrate the skills, knowledge or ability to make the urgent changes that were required to make the service safe.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures would usually be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, would be inspected again within six months. In this instance however the CQC used its urgent powers to apply to the Magistrates Court on 11 August 2015 and received a court order to cancel the provider's registration to carry out the regulated activities at Lilycross Care Centre.

The provider had 28 days to appeal against this order to the First Tier Tribunal [Care Standards] under section 30 of the Health and Social Care Act 2008. The provider did not appeal and as a result the home's registration has now been cancelled.

Summary of findings

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.

There was a reliance on staff employed by external agencies to provide care to the people living at the home. This was a particular problem during the night and presented a risk that staff did not know and understand people's care needs sufficiently well.

We found that the arrangements for managing medicines were not safe and people were at risk of harm.

Is the service effective?

Inadequate

The service was not effective.

The training records available did not provide sufficient detail to enable us to confirm if staff had received the appropriate training or if it was up to date.

Some staff at the home did not demonstrate competency in their role and, as a consequence, the people using the service did not always receive care and treatment that was appropriate and met their needs.

Is the service caring?

Inadequate

The service was not caring.

There were a number of caring staff members working at Lilycross, particularly the permanent staff members, however, we found evidence that some staff had removed people's nurse call bells. Other staff had not administered pain relief appropriately, leaving people potentially in pain.

One person told us that a lot of the items of clothing in his wardrobe did not belong to him and we saw that they had other people's names and room numbers on them.

The majority of rooms on Bluebell suite did not have the name of the occupant on the door so new staff were less able to identify the individuals they were caring for.

When we asked the people living and visiting Lilycross about the home and the staff members working there, they all commented on how kind and caring all the staff were.

Is the service responsive?

Inadequate

The service was not responsive.

Written consent was not always being obtained from the person themselves and if this was not possible the person's family or representative had also not agreed to the care being provided.

In general, care plans were not always accurate and had not always been reviewed or updated regularly. Important health care issues for people had not always been followed up or addressed.

Summary of findings

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy.	
Is the service well-led? The service was not well led. There wasn't a robust quality assurance system in place within the home. The provider still didn't have a suitable system in place in order to assess the quality of care being provided. In addition there were no clinical governance or audit arrangements in place with regard to the manager and deputy manager.	**Inadequate** 

Lilycross Care Centre

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 checked 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.

We carried out an unannounced inspection on the 28 July 2015 and then undertook a second announced visit on the 3 August 2015. The first day of the inspection was carried out by an adult social care inspection manager, two adult social care inspectors, a pharmacist 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 announced visit on the second day was undertaken by two adult social care inspectors and a pharmacist inspector.

Before the inspection we reviewed all the information we held about the home including any notifications. Because there had been a variety of issues surrounding the home the local authorities who fund placements there [Halton and St Helens] had a support plan in operation. This had been in operation since April 2014. The CQC had been involved in this process and had been attending regular professionals meetings in order to monitor the situation in accordance with its regulatory responsibilities.

During our inspection we saw how the people who lived in the home were provided with care. We spoke with a total of 11 people living there, four visiting family members and approximately 17 staff members including the deputy manager [some staff members spoke to more that one member of the inspection team]. The people living in the home and their family members were able to tell us what they thought about the home and the staff members working there.

We used the Short Observational Framework for Inspection (SOFI) on both Lily and Bluebell suites during the lunchtime period. SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked around the home as well as checking records. We looked at care plans and a variety of other documents including policies and procedures and audit materials.

Inadequate

Is the service safe?

Our findings

When we visited Lilycross on the 21 and 30 January 2015 we found that the registered provider was not taking proper steps to ensure that the people who used the service were protected against the risks of unsafe or inappropriate care because records were not being maintained appropriately and they had failed to ensure that there were sufficient staff with the right knowledge and understanding of people living at the home. These were breaches of Regulation 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made two requirements regarding these issues.

Following the inspection the new manager sent us an action plan explaining how the requirements would be met and by when.

During this inspection we found that some of the issues had still not been addressed and people living in the home were still not being protected against the risks of unsafe or inappropriate care because accurate care records were not being maintained and the provider had also failed to ensure that there were sufficient staff with the right knowledge and understanding of people living at the home to ensure their health, safety and welfare.

We also identified some further issues of concern during this inspection.

We asked people if they felt safe and those that were able to told us they did. A visiting family member told us that they had had issues previously but that the family felt that they could not fault the safety since February. When asked if they felt that the staff were knowledgeable about using the hoists to assist them from the bed the people using the service told us, “All the staff know what they are doing, even if it is someone different than usual”, “There are always two staff to do it”. A visiting family member told us, “Very good when using the hoist and they are continually talking to [their relative] throughout”. All of the people using the service and the visitors we spoke with told us that they were confident that the staff understood people’s needs sufficiently to keep them safe and were always kind and respectful to them.

There had been on-going concerns, including a large number of safeguarding issues in the home prior to and since our previous inspection took place. For example information received from Halton borough council had identified 55 safeguarding issues, including medication errors and incidents of unexplained bruising that had occurred between 12 March 2015 and up to and including the second day of our inspection on the 3 August 2015. These have been investigated by the local authority. The fact that there have been so many clearly demonstrated that people were not being protected appropriately and the systems within the home for identifying and reporting issues was inadequate. The CQC have been working closely with other agencies involved with the home including the main two local authorities who place people there, Halton and St Helens. We were also aware that the home was still under an on-going support plan that started in April 2014 and was under constant quality assurance monitoring by both councils.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that the people using the service were protected from abuse.

Staff members told us that they had recently received training in protecting vulnerable adults and that they understood the process they would follow if a safeguarding incident occurred.

When looking at care plans we found that in general risk assessments were not always accurate and had not always been reviewed or updated regularly. On Bluebell suite we saw that there were often duplicates of forms and in some cases information on different forms was contradictory. For example one person had had two falls both dated 10 July 2015, one of these had a falls risk score of 20 and another had a score of 14. This score could directly affect the amount of staff assistance this person received because the higher the score indicated an increased risk of falling. If records were not completed accurately people were at a greater risk of harm. We also found that the same person had a risk assessment for the use of bed rails, this was not dated and there was no evidence of any review. There is a danger of injury if bed rails are not fitted and used appropriately so their use should be monitored and reviewed regularly.

There were a number of people on Bluebell suite with behaviour that could be challenging. We found that for lengthy periods during the inspection the unit was noisy and whilst staff were very kind and patient they appeared

Is the service safe?

to lack direction in how to manage the situation. We spoke with three staff from 5 Boroughs community mental health team [CMHT] who visited during the afternoon of the first day of the inspection. We asked if it would be usual to use ABC charts. These are charts to help staff determine triggers for challenging behaviour and identify actions that may help to engage people or help them feel calm and peaceful. The staff from the CMHT said yes they had asked for ABC charts to be completed but this had not been actioned by staff on the unit.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to adequately assess and monitor the risks to people's health and safety or take appropriate action to mitigate any risks.

Since the previous inspection individual Personal Emergency Evacuation Plans [PEEPS] had been put in place for people living in the home. This was good practice and would be used if the home had to be evacuated in an emergency such as a fire. It would provide details of any special circumstances affecting the person, for example if they were a wheelchair user.

We asked whether there were sufficient staff on duty and one person told us, "They sometimes have to rush as they are short staffed, they tell me that so and so is off". Visitors spoken with said, "There used to be too many agency staff but this has subsided now" and "They need more staff on at night, two at night is not enough. We have been here overnight when our relative was very poorly and five or six buzzers were going off".

The staff members we counted during the inspection and the rotas we looked at confirmed that during the day on the first day of our visit there was one nurse [the deputy manager] and three care staff members on Lily suite. There was also one nurse and three care staff members on Bluebell suite. At night there was one nurse and one carer on Lily and Bluebell suites plus an additional carer who worked between both floors.

The manager's hours were in addition to these numbers although we are aware that there were days when they had to cover the rota. In addition to the above there were separate ancillary staff including an administrator, kitchen, cleaning and laundry staff.

Whilst we didn't have any concerns regarding the actual staffing levels we still had concerns relating to the use of bank and agency staff. A high percentage of staff, particularly at night were not actually employed by the home. They were bank staff members employed by another provider. This had also been an issue of concern following the previous inspection that took place in January 2015. One staff member commented, "The major issue is staffing, a lot of bank staff".

Following our inspection we attended a meeting with officers from Halton Borough Council. They told us that they carried out a monitoring visit to the home from 5am until 9am on Sunday 2 August 2015 and had observed a staff handover between the night staff going off duty and the day staff coming on duty. They told us that the staff handover had been chaotic and that the agency nurse coming on duty, who had only worked one other day at the home, told them that he did not feel the information given to him during the handover had been sufficient for him to understand what people's individual care needs were. This meant that the people living in the home were at risk of not be getting the appropriate care when they had a high level of care needs or had behaviour that challenged, both requiring input from staff members that knew their needs.

This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 because the registered person had failed to ensure that there were sufficient staff with the right knowledge and understanding of people living at the home to ensure their health, safety and welfare.

At the previous inspection visit we identified issues with the records of staff recruitment; at the time recently appointed staff were bank staff members, not Lilycross staff. The recruitment files for these staff members were at another home. We therefore could not confirm from the documentation within Lilycross that effective recruitment procedures had been completed. During this inspection we checked the records for five staff members and found that the relevant recruitment documentation was available in the home. We found that the appropriate checks had been made to ensure that they were suitable to work with vulnerable adults.

We received information prior to the inspection informing us that that there may be concerns about the way medicines were managed at the service. A Pharmacist

Inadequate

Is the service safe?

Inspector looked at medication stocks, Medication Administration Records (MARs) and other records for 12 people living in the home and found concerns and/or discrepancies in each case. We found that people were not protected against the risks associated with the unsafe use and management of medicines.

We looked at the way in which topical medicines such as creams and ointments were stored, used and recorded. We found that many products were kept in people's rooms, even though this practice had not been assessed. Some people's rooms contained creams which had not been prescribed for them. This placed people at risk of cross infection as well as being given the wrong product. Topical medicines were generally applied by care workers, but this was not recorded and there was no system in place for nurses to check whether or not the products had been used as prescribed. The lack of records and lack of control of use of these products placed people's skin integrity at risk of harm.

We found that devices used to crush tablets were filthy and heavily contaminated with grime and tablet residue. The devices were not named and were used to prepare medication for a number of people. This placed people at risk of both cross infection and of being given traces of medication they were not prescribed. We saw inhalers stored in a basket together with a tube of cream rectal applicator which was heavily contaminated with cream and what appeared to be faecal matter. Products with short shelf lives were not always stored at the correct temperature nor had they been dated on opening. It was impossible to determine whether or not some of these products remained fit for use. Waste medicines were not stored safely. These findings show that people living in the home were not protected against the risks associated with the unsafe storage of medication.

Medication records that we looked at were frequently inaccurate and incomplete. The quantities of medicine received, brought forward from the previous month and disposed of had not always been accurately recorded. This made it impossible to calculate how much medication should be present and therefore whether or not medicines had been given correctly. There were missing signatures on records and it was unclear if medicines had been given or omitted at those times. Where medicines were prescribed at a variable dose, the actual dose administered had not always been recorded. This meant that we were unable to tell whether or not some medicines had been used as prescribed. We looked at records for one person who had recently had changes made to their medication doses. We saw that the instructions had been recorded incorrectly and as a result, was being given double the dose of medication prescribed by the Consultant Psychiatrist. Failing to keep accurate records places the health and wellbeing of people living in the home at serious risk of harm.

We observed part of a medication round and saw one nurse administer medicines to three different people without referring to their MARs and without signing the records after the medicines were given. We also saw the same nurse signing records to indicate that medicines administered the previous day had been given. This is poor practice and contrary to both standards issued by the Nursing & Midwifery Council and current NICE guidelines for the administration and recording of medicines in care homes.

People did not always get their medicines at the correct times or when they needed them. On one day of our visit, the morning medicines round on Bluebell unit did not finish until after lunchtime. This meant that some people who were due their medicines at 8am did not receive them until 1pm. This had a knock-on effect of placing these people at increased risk of being given the rest of the day's medicines too close together.

Many people were prescribed creams and medicines, e.g. painkillers and laxatives that could be given at different doses i.e. one or two tablets or that only needed to be taken or used when required. We found that there was not enough information available to enable nurses to give these medicines safely, consistently and with regard to people's individual needs and preferences. This was of particularly concern as the service relied heavily on agency and bank nurses who were unfamiliar with people living in the home. We saw one person who was left in severe pain for over 30 minutes before being given a mild painkiller even though there were prescribed medication for the relief of moderate to severe pain. We intervened to ensure that the person was given appropriate medication. Another person should have been given painkillers four times a day, but records showed they were generally given them only once a day. We asked the nurse on duty how he determined whether or not people living with dementia were in pain. He told us "It's difficult, you can't always tell".

Inadequate

Is the service safe?

Nurses did not have any system in place to assess people's pain, such as recognised pain assessment tools and were unable to demonstrate how they ensured people received pain relief when they needed it. People were not given their medicines when they needed them and were seen to suffer unnecessary pain. This placed the health and wellbeing of people living in the home at severe risk of harm.

We looked at records for people who had been prescribed anticipatory medicines that were to be used via a device called a syringe driver at the end stage of life. There was no clear information for nurses to follow regarding when these medicines should start to be used. None of the nurses on duty during our visits were able to set up a syringe driver. This meant that people were at risk of not being given the vital medicines they needed at the end of their lives.

We looked at records for three people that were currently given their medicines covertly i.e. hidden in food or drinks without the person's knowledge or consent. Arrangements for giving medicines in this way had not been made in accordance with the Mental Capacity Act 2005 or current NICE guidance. There was no information within the care plans or MARs to tell nurses which medicines were to be given covertly or exactly how and in what circumstances they should be given. It was impossible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent. There was no evidence that a pharmacist had been consulted to ensure that crushing tablets or mixing them with food was safe and one of the nurses told us that some medicines were crushed even though they were clearly labelled 'Do not crush or chew'. Giving medicines in this way placed people's health and wellbeing at serious risk of harm.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People using the service were not protected against the risks associated with the administration, use and management of medicines.

Our observations throughout the two suites during the inspection were of a clean, fresh smelling environment which allowed people to move around freely. The people living in the home told us that their rooms were cleaned daily.

Inadequate

Is the service effective?

Our findings

When we visited Lilycross on the 21 and 30 January 2015 we found that the registered provider did not have appropriate training records, had failed to ensure staff members received appropriate supervision and had also had failed to take proper steps to ensure that the people using the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe. These were further breaches of Regulations 17 and 18 and Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made three requirements regarding these issues.

Following the inspection the new manager sent us an action plan explaining how the requirements would be met and by when.

During this inspection we found that some of the issues had still not been addressed and we were unable to confirm if staff members had received the appropriate training or if people we protected against inappropriate or unsafe care.

We also identified further issues of concern during this inspection.

One of the people using the service told us that the home was "Alright", this person went on to say that the food hadn't been great; it had been coming up cold but had improved a bit recently. They also told us that they had moved rooms and were happy about that because their new room had a shower.

We were unable to confirm from the recruitment files we looked at if all staff members had completed a suitable induction. On one of the five files we looked at an induction record had been completed. There was an induction form on another but this had not been completed and there was no record in the remaining three files.

We asked staff members about training and they told all told us that they had done a lot of training since the new manager had started working at the home. This included Mental Capacity Act training, moving and handling, dementia awareness and safeguarding. Staff members we spoke with were all happy that the new manager had organised training and that they were now attending regular courses. They told us, "The training is planned better so that you can plan it around your shifts", "You feel that you can suggest training" and "Things have improved, training has been sorted". We asked to see the staff training record which was provided to us by the administrator. This was a new record which only showed the courses the staff had undertaken since the new manager had started at the home. We asked if any other records were available but were told no. The record available did not provide sufficient detail to enable us to confirm if staff had received the appropriate training or if it was up to date. We found evidence during the inspection that the nursing staff members were unable to carry out tasks such as the routine taking of blood, measuring pain relief using for example a recognised system such as the Abbey pain scale and were unable to use a syringe driver which is a device for administering pain relief to someone who is nearing the end of their life. These omissions brought into question the competency of the nursing staff being employed and the effectiveness of the service being provided to the people living in the home.

This was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that staff had received appropriate support, training and professional development.

At the time of the last inspection staff members were not receiving supervision and a requirement was made. At this inspection all of the staff members we spoke with told us that they had received supervision from the new manager. At the time of the visit only one session had taken place. Supervision is a regular meeting [regular is approximately every six to eight weeks]. between an employee and their line manager to discuss any issues that may affect the staff member; this may include a discussion of the training undertaken, whether it had been effective and if the staff member had any on-going training needs.

During the inspection we saw that there was good general interactions between staff and the people using the service and that staff took time to ensure that they were fully engaged with each person and checked that they had understood before carrying out any tasks with them. Staff explained what they needed or intended to do and asked if that was alright rather than assuming consent.

We saw that generally across the two suites written consent was not being obtained from the person themselves or if this was not possible the person's family or representative

had also not agreed to the care being provided. We did see that the new manager had devised a form for this to be done but it had not been put into practice at the time of our visit.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to obtain consent to care and treatment.

The provider should have policies and procedures in place to guide staff in how to safeguard the care and welfare of the people using the service. This includes guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). This is a legal requirement that is set out in an Act of Parliament called The Mental Capacity Act 2005 [MCA]. This was introduced to help ensure that the rights of people who had difficulty in making their own decisions were protected. The aim of DoLS is to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. Whilst we did not see these documents during the inspection we did identify some concerns in these areas.

Although we were aware that the new manager was completing any relevant DoLS applications and was submitting these to the local authorities we did identify some issues regarding this process. We saw that two requests for standard DoLS authorisation had been completed in the care plans we looked at but there was nothing to indicate if they had been granted. The request for one person had been faxed to social services on the 25 June 2015. The request was to cover the fact that the person was in a locked unit. Under other information it also said the person needed covert medication to be administered and that they needed assistance with personal hygiene/diet and fluids/mobility/ moving and handling. The form did not provide any details regarding what this assistance comprised of. We also saw a note in the personal care plan that the person, 'Will punch/kick/ hit/head butt staff – staff to hold his hands one on each side whilst third member of staff does washing etc'. We asked the nurse in charge on Bluebell suite about this because the actions indicated that restraint was being used and were told that the person wasn't as challenging now so it wasn't really like that. We saw that the care plan had been reviewed on the 26 March 2015 and the 2 July 2015 but had not been updated. We asked the nurse if the authorisation for the DoLS request had been granted and were told they thought so. However, we could not find any record in the file and neither could the nurse. The nurse said they weren't sure who, of the people they were caring for, had a DoLS in place.

This was a further breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that the people using the service were protected from abuse.

We saw that a mental capacity assessment had been completed for this person regarding the decision to administer covert medicines, which had been regularly reviewed. There was also a record of a best interest meeting regarding a Do Not Attempt Resuscitation directive (DNACPR). However, this wasn't fully completed as it was not recorded if the person's wishes regarding this had ever been known or what the different decisions or options being considered were.

The staff members we spoke with said they had recently had training on the MCA and DoLS.

The people using the service and their visitors we spoke with on all said that people's health needs were being met and visits from other health care professionals, such as GPs, speech and language therapists, dieticians, chiropodists and opticians were organised. However, we had concerns that nursing staff did not always monitor healthcare needs effectively or access appropriate other healthcare professionals when needed.

People's weights should be monitored as part of the overall planning process to ensure they remain healthy and are not at risk of losing or gaining weight inappropriately.. This is normally undertaken using a tool called the Malnutrition Universal Screening Tool (MUST). We looked at these and saw that on the 12 July 2015 one person's weight had increased by 7.5kgs since 26 March 2015. Despite this weight gain the person's BMI [body mass index] was recorded as unchanged at 26, which was inaccurate given the weight gain. We asked the nurse in charge regarding this and they were not aware the person had gained so much weight. We checked the BMI and found it was now actually 30. We then asked if the person had been referred to either their GP or dietician as they were being hoisted and were also diabetic and it would not be in the person's

best interests to gain too much weight. The nurse said, "To be honest I think we thought we were doing quite well that he was putting weight on. We don't really consider it if they put weight on, only if they lose it".

On another person's MUST record we saw a letter from dietetics dated the 4 November 2014 confirming that a referral had been made due to weight loss. Ensure Plus to be given three times a day had been prescribed and the staff were advised to complete weekly weights and to keep a fluid balance chart. The care plan was reviewed on the 27 May 2015 with a note to review again in a month and to encourage snacks and ensure drinks. The person's weight had gone up in June but had dropped again in July and their care plan stated that they needed more prompting. On the first day of our inspection we observed this person in their room all morning. We checked at 10.00am, 10.50am and again at 11.45am. On each occasion the person was lying in bed, their position had not changed, the bedroom light was on and the curtains were closed. We did not see any staff going in to the room during the morning. At 11.45am one of the carers saw one of the inspection team coming out of the bedroom and then went in and helped the person to get out of bed. We saw the person at lunchtime with corned beef hash, carrots and chips in front of them and observed the person was not touching the food. We did not see any staff members attempting to encourage them and at 13.15pm we saw that the person had left the table and the plate of food was untouched. We asked one of the care staff if they had eaten breakfast and were told no. They told us, "She wouldn't get up". We then asked if any Ensures had been given and the the care staff member said the nurse did this. We then asked the nurse who said, "She's been refusing it". This lack of action contradicted the notes in the care plan and the advice given to the home.

In a third file we found that the person had a MUST nutritional risk assessment undertaken on the 13 May 2015; their BMI was 19 and their weight was recorded as 59.7kgs. Notes stated to continue with supplements. We found another weight monitoring form within a pile of other observation forms with a sticker on it saying to file. On that form the person's weight was recorded on the 26 February 2015 as 61kgs. On the 10 May 2015 it was recorded as 53.1kgs and a note stating, weekly weights to commence. These two forms showed a difference in weight of over 6kgs in a three day period. We found that weights were kept in a separate files so it was difficult to assess and evaluate the information in line with the care plan. Although the note stated that weekly weights were to commence the person was not weighed between the 13 May 2015 and the 7 July 2015 when the person's weight had dropped further to 59.1kgs. They were weighed again on the 12 July 2015 and the person's weight had fallen by 1.2kgs to 57.9kgs. We asked the nurse why the person had not been weighed between the 13 May and the 7 July when it was clear they were losing weight and she was supposed to be weighed weekly. The nurse said they thought the scales hadn't been working. We then asked if the person had been referred to the dietician and the nurse was unable to say.

From the fluid balance charts being maintained it appeared that most people did not get drinks overnight. Records seemed to stop at about 8-9pm when the day staff finished and started again as late as 11.45am the next day. For example on the 27 July one person's last drink was recorded as 20.40pm and their first drink the next day was 12.30pm. Another person's last drink on the same day was 21.00pm and their first the next day was 11.45am.

The chef explained that there was a three week menu and they confirmed that special diets such as liquidised and diabetic meals were provided if needed. They also told us that if someone wanted something else they could provide other choices that were in addition to those on the menu. We asked how they were informed if somebody had any special dietary needs and were told that the manager or deputy passed this information on to them. We did have concerns regarding this because one person living on Bluebell suite was a diet controlled diabetic. We found that although this was recorded in the personal summary in their care folder and there was an information sheet regarding diabetes in the same folder there was no care plan in place for any dietary needs and the kitchen staff were unaware of this. We passed this concern on to the deputy manager as soon as we realised it was an issue, they agreed to address this.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that people's nutritional and hydration needs were being met.

We did have some concerns regarding the choice of lunchtime food on the first day of our inspection. We felt

choice was limited because the meal was corned beef hash and the alternative meal was corned beef and chips. We asked kitchen staff what people could have if they didn't want this and we were told, "A sandwich".

A tour of the premises was undertaken; this included all communal areas including lounge and dining areas plus and with people's consent a number of bedrooms as well. The home was well maintained and provided an environment that met the needs of the people that were living there.

The home provided adaptations for use by people who needed additional assistance. These included bath and toilet aids, hoists, grab rails and other aids to help maintain independence. At the previous inspection we identified that suitable signs and pictures on doors and walls to ensure it was a suitable dementia friendly environment were needed. The action plan sent to us following the inspection stated that this had been done. During this inspection we found that the majority of rooms still did not have the names of the occupants on the doors nor was suitable signage present within Bluebell suite. The Department of Health recommends that signage should include visual clues of different types as well as notable landmarks which have special meaning to service users and can be used as reference points (e.g. pictures of local area) and use personal items to identify personal or private space (e.g. doors on bedrooms). None of this was apparent and the environment was not specifically designed to enhance the experience of people living with dementia.

The laundry within the home was well equipped and there were systems in place for the care of people's clothes. The laundry appeared to be well organised and we did not receive any negative comments regarding the laundry service during the inspection.

Inadequate

Is the service caring?

Our findings

We asked the people living in Lilycross about the home and the staff members working there. Comments were generally positive and included, "The girls come in to see me before they start work, they say good morning and give me a kiss", "the atmosphere is getting back to when I first came here", "the girls come in for a chat and watch TV with me", "the staff are good, they don't just taken anyone on", "Everyone knocks on the door to come in, even if it is just to pop in to get something quickly" and "They (staff) try to do their best, trying to get staff, that's the hardest part. Staff smashing, blooming good crowd here".

A visitor we spoke with told us, "[The staff] are kind and joking, know all his visitors and welcome [me] at any time". Another told us; "Very happy with the care here, never had reason to complain, look after her well". A third visitor we spoke with said that there had been an attitude problem with one staff member but that this had been reported and dealt with.

We also received some negative comments. These were about bank staff members rather than Lilycross staff. These included a comment from one person who said she had told a staff member, "I'm not a piece of meat, he was a bit rough, he was a man with a name I can't pronounce but I think he was on bank" and "Often new staff who do not know her treat her as if she has Alzheimer's but they soon realise that she has not". One person we spoke with said, "Stuff vanishes", when we asked the person said slippers, three woolly hats and clothes. This person said most of the stuff in the wardrobe wasn't his. We checked and whilst some belonged to the person and were labelled, other items had different room numbers and initials in. Not being provided with one's own clothing and having to wear other people's does not promote dignity and is disrespectful to the person.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that people's were treated with dignity and respect.

On Bluebell suite we saw a couple of people with no socks or shoes on; although this was their choice it would have been better to see something warm placed under their feet rather than walking on a cold floor.

One of the permanent staff members we spoke with on Bluebell suite said that things had improved since the new manager had started, "Probably about five out of seven days are Lilycross staff", they went on to say, "All night staff are agency, lazy, residents are not given buzzers always". This person went on to say that in her opinion the suite, "Needs some authority, nobody has taken responsibility because nurses only work odd shifts". Another staff member on the same suite told us, "It is better with Lilycross staff". This person also went on to say they had concerns regarding the buzzers and one of the people living in the home, "Sometimes his buzzer is removed" we asked if this occurred regularly and were told, "I don't think it has happened for a couple of weeks". This staff member then told us that they intended to check when they came on duty in the morning that everyone had a buzzer within reach so they could use it. This staff member also said that the permanent day staff on the suite had noticed when arriving for duty in the morning that some people had unexplained bruises on them. They weren't there when they had left the previous evening. They went on to say that in her opinion it was how night staff approached people, they told us, "They don't get to know people".

We also found evidence on Bluebell suite during the first day of our inspection that some staff had removed people's nurse call bells.

We passed the concerns regarding the call bells [buzzers] to Halton Borough Council who undertook an early morning visit on Sunday 2 August. They found a total of ten people across both suites who could not reach their call bell to summon assistance. .

Other staff had not administered pain relief appropriately, leaving people potentially in pain.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People using the service were not protected against the risks associated with unsafe care and treatment.

The quality of décor, furnishings and fittings provide people with a homely and comfortable environment to live in. The bedrooms seen during the visit were personalised, comfortable, well furnished and contained items belonging to the person. However, we found that the majority of rooms did not have the names of the occupants on the doors nor was suitable signage present within Bluebell

Inadequate

Is the service caring?

suite. This would not help people living at the home or staff new to the home and raises concerns that ensuring that staff have the means to know the names of people they are caring for is not seen as a high priority.

Inadequate

Is the service responsive?

Our findings

When we visited Lilycross on the 21 and 30 January 2015 we found that the registered provider did not meet the individual needs of the people using the service because appropriate activities were not being provided. This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made a requirement regarding this issue.

Following the inspection the new manager sent us an action plan explaining how the requirement would be met and by when.

During this inspection we found that this issue had been partially addressed. We also identified further issues of concern during this inspection.

We asked people if they had choices with regard to daily living activities and could they choose what to do, where to spend their time and who with. One person told us they were a bit bored; "They (other people living in the home) are old fashioned, no conversation. I led a different life, was 40 years at sea".

During the first day of the inspection we heard one person on Bluebell suite shouting for help at 10am whilst in bed. They were able to communicate to us that that they wanted the nurse call bell which had been left out of reach behind her bed. When we gave it her she pressed it and the staff came straight away. In discussion with Halton Borough Council following the inspection we were informed that they had visited the home on Sunday 2 August 2010 and had found that 10 people on Bluebell suite did not have nurse call bells at hand..

On Bluebell suite we found one person had a care plan written on the 15 April 2015 and a risk assessment stating they were unable to use the call bell. The plan then stated that the person was in a bedroom near to the nurses the station so staff could hear if he needed help. We found the person was actually in the room furthest from the nurses station. The care plan stated that staff, 'Will check when in room and document'. We asked the nurse in charge of the unit where the record of this monitoring was kept and was told that he thought the night staff were doing them at night and he would try and find them. We asked whether staff kept records for when the person was in his room during the day and were told, "We were – to be honest I think it's dropped off a bit since we've been up here". We found that there had been a number of incidents where there were unwitnessed injuries to the person. These incidents would indicate that the person had suffered falls.

We looked at other care plans to see what support people needed and how this was recorded. On Lily suite we saw that improvements were needed. On one care plan we saw notes to say the person's needs had changed but the monthly evaluations stated, no change. We found that the care plan for wound care was confusing; it contained a note stating; 'further pressure sore evident'. It did not however explain where the sore was or its size. This same plan explained that the person needed a soft diet with thickened fluids, it did not though explain what consistency of food was required or how thick the drinks needed to be.

On Bluebell suite we found that the evaluations in the care plans we looked at were limited and did not always reflect the changes that had occurred. Some care plans and risk assessments had not been reviewed as regularly as required given people's level of risk. For example, one person's care plan for mobility was not up to date and stated that the person was independently mobile when in fact they needed to be hoisted. This particular plan had been written on the 15 April 2014 and had been reviewed on the 25 February 2015, 26 March 2015 and 2 July 2015. There was no note to state that the person's needs had changed.

Without accurate care plans and appropriate evaluations people were at risk of receiving inappropriate care.

We had concerns about the response to people's changing needs, for example one person had a care plan dated 13 July 2015 explaining that the person may have toothache as through non verbal signs they appeared to be in pain. The care plan said to give regular paracetamol and that the person had been referred to the dentist. The care plan had not been reviewed since being written and the inspection of the MAR sheet showed they had not been given the paracetamol. We asked the nurse in charge about this and were told that it was difficult to assess whether the person was in pain or not. We asked if a recognised pain scale such as the Abbey pain chart to help assess this was completed and the nurse said no. We then asked when he would give the paracetamol and were told, "I give it when his sister tells me to". We found that this person was admitted to hospital on the 27 May 2015 following a seizure. The hospital couldn't find a definite cause but made a dental

referral. This care plan had also not been reviewed since being written. On another care plan we saw that the moving and handling profile which was last reviewed on the 6 May 2015 stated that they were awaiting assessment by an occupational therapist [OT] for the use of a hoist. The handling assessment had not been completed so we asked the nurse in charge if an OT assessment had taken place. This couldn't be found and then we were told the OT had said they wouldn't assess as the person wasn't for rehabilitation. The assessment could be done by someone competent to do it within the home. The nurse told us he didn't know if it had been done.

We noted that the daily care notes written by the nurses were kept in a separate file to each person's care plans. This meant that when the nurse wrote their records of each person's health and welfare that day they did not necessarily write them with reference to their care plan. We had already noted that many of the care plans were not up to date or accurate and it was not possible to see how effective evaluation and assessment of people's care needs could be carried out without looking at care plans and daily care notes together. Furthermore when we looked at some care notes at 5pm we saw that the nurse had written them but put the time of entry as 7pm. This meant the nurse was writing records in advance and they could not be relied on to give an accurate picture of specific events and when they had occurred.

At 12.35pm on the first day of the inspection we started to look at people's fluid balance charts and positioning charts on Bluebell suite. One member of staff told us that they were not up to date as they had not had a chance to write them up until then. When we reviewed them later we saw that care staff had written entries for 9am, 10am and 11am all at the same time, giving specific amounts that people had drunk and details of what they had eaten and when they had been asleep. When records are not written contemporaneously staff have to remember specific details about a number of people which means there is a risk that they will not be accurate.

In general across both suites we found care plans were not always accurate and had not always been reviewed or updated regularly. We saw that there were often more than one care plan and information in them was contradictory. For example in one file a person had a care plan stating they appeared to take good diet and fluids but the accompanying risk assessment showed the person had lost a considerable amount of weight. This had occurred even though the plan had only been reviewed in July.

These were breaches of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to safeguard people from the use of improper treatment and to ensure that the care and treatment people were receiving was provided in a way that met their needs.

We asked about care plans and a visiting relative told us that she and her husband looked at the care plan every time they came, but that the main carer at the home for always kept them up to date, even phoning them at home if there was a major change.

The home had recently employed an activities co-ordinator for five hours a day between Monday to Friday. Their job was to help plan and organise social and other events for people, either on an individual basis, in someone's bedroom if needed or in groups. The co-ordinator spent time in both lounges during the first day of our inspection and we saw them carry out a reminiscence session in Lily lounge during the day. Whilst the organising of activities and events is generally a positive aspect we did have some concerns because we did not observe the co-ordinator asking people if they wanted to participate in the reminiscence activity or if they had an interest in the Royal family which was the topic. We are aware that the activities co-ordinator was due to leave the home within a few days of our inspection.

We did see some evidence of craft work taking place and one person had been encouraged to continue knitting which was her hobby. Knitting materials had been provided to enable them to do this.

We also observed a visitor carrying out an activity in Lily lounge on the first day. This was a chair based activities session. We were told that this was a recent activity and the person was going to visit the home once a week for the exercise classes. Again we did not see any evidence of people who were already in the lounge being given a choice of whether they wished to take part in this.

Inadequate

Is the service responsive?

Staff members told us that they were expected to organise activities when the co-ordinator was not on their unit or at weekends and a plan of activities was posted on the notice board as a guide. Activities included, sing a long, skittles, film and jigsaws.

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. Complaints were recorded on a file along with records of the investigations which took place and the outcome achieved. The most recent complaint had been made prior to our inspection in January, this had been dealt with appropriately at the time by the previous manage. We asked people living at the home and their visitors whether or not they had ever had cause to raise a complaint and one visitor told us they had but were happy with how it was handled and that the issue had been resolved. Another visitor also told us that a small issue had been resolved.

There was a complaints procedure posted on the back of each bedroom door.

Inadequate

Is the service well-led?

Our findings

When we visited Lilycross on the 21 and 30 January 2015 we found that the registered provider did not have appropriate quality assurance systems in place. This was a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served a warning notice regarding this issue.

We also identified breaches of Regulation, 5, 16 and 18 of the Care Quality Commission [Registration] Regulations 2009 relating to the registered manager and to notifications. We wrote to the provider following the inspection advising that we expected immediate action to be taken.

Since the previous inspection the manager in post at the time has left the home and a new manager has been appointed. They have now submitted an application to the CQC for registration. The new manager has also completed any notifications due retrospectively and has been submitting any new ones required since.

Following the inspection the new manager sent us an action plan explaining how the warning notice and requirements would be met and by when. During this inspection we found that whilst some of the issues had been addressed others had not been despite the action plan stating they had. This included systems for auditing care plans and medication which although supposed to be in place were either not available or were clearly not working.

During this inspection visiting family members told us, “Definite improvement since the new manager”, “The new manager is great” and “The manager is lovely, she introduced herself and told us if there were any problems to come and see her”.

The deputy manager told us, “The new manager is like a breath of fresh air”. Other staff members told us, Emma is lovely, best thing that has happened since I have been here”, “The manager is very helpful”, Emma is brilliant, things have improved, training has been sorted” and “She is approachable, sorts out any concerns, she appreciates the work staff do, always says good morning and ask if one is ok and thanks people for their hard work”.

The new manager was in the process of implementing an internal quality assurance system and trying to raise standards within the home. Although we did see some evidence of medication and care plan reviews having taken place the issues we have identified in both of these areas demonstrate that this system was not working. We also saw a medicine competency assessment for one nurse that stated their practices were competent. Although this had only been completed recently we observed the same nurse administering medicine inappropriately and in an unsafe way.

We found that in general on Bluebell unit care files were in disarray. There were a number of duplicated records with differing information so staff didn’t have clear direction of the care they were supposed to deliver. Observation and monitoring records were not kept in a consistent manner and there was no clear system of storage so they could not be easily be found and used to evaluate the care being given. Different files were kept for nursing and care notes, weights and observations which made it difficult to find relevant information about people using the service or to track what the current situation was. Records were not kept contemporaneously so we could not be confident they were accurate.

We saw that a weekly clinical review had taken place on 16 July 2015 between the home manager and the nurse in charge on Bluebell suite to discuss each person receiving care. The nurse had been asked to complete certain actions. However, these had not always been carried out; for example the review said to complete a weekly weight care plan and refer to dietician for one person but this had not been done.

Representatives from the provider did visit the home but from the feedback provided by staff members this was only to undertake administrative tasks. They did not routinely visit the two suites and according to the staff members we spoke with did not talk to the people using the service. One person said, “[Name of owners] do not speak to people on the unit”. We were given two documents to show that the providers had visited the home on the 18 May 2015 and had undertaken two visits in June. These however provided little evidence that they had undertaken any meaningful checks on the quality of service provided, for example although care plans were discussed with the new manager during one visit; there was no evidence to indicate the provider had actually checked these.

Inadequate

Is the service well-led?

In addition there were still no clinical governance or audit arrangements in place with regard to the manager and unit managers on Lily suites in order for the provider to assess their competency.

This is a further breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. There were inadequate systems in place relating to the assessing and monitoring of the quality of service provision.

Although staff members told us that they liked working in the home they did raise some concerns particularly regarding their working and pay arrangements. It was clear from talking with staff that the current arrangements caused anxiety and low morale because there had been occasions when their pay had not been cleared into their bank accounts on the correct day causing problems with the payments of direct debits and other bills. We have commented on this area in both of the previous inspection visits and whilst these issues were outside of the CQC's remit of responsibility we were concerned about the continued effect they were having on the morale of staff members and the possible consequences on care standards if more staff left the home and there was an ever increasing reliance on bank or agency staff members.

We saw that the new manager had been trying to improve communication within the home and had organised a relatives meeting since her appointment, this had been held in June. She had provided information on the notice board explaining that she operated an 'open door' policy and to 'please pop in and say hello. I welcome any ideas, suggestions and anything that you feel needs improving'. She had also implemented 'drop in' sessions that would be taking place on the 4th Wednesday of every month. This would enable people to raise any concerns they may have had.

The staff members told us that since the new manager had started work at the home staff meetings were being held and the last one had been held in June. These enabled the manager and staff to share information and/or raise concerns. All the staff we spoke with felt that the new manager had a positive approach, had a drop-in policy for staff concerns and were all feeling optimistic.

We looked at the maintenance certificates and saw that there were contracts in place for the fire extinguishers, fire alarm system and emergency lighting, the lift, mobile and bath hoists.

On-going weekly and monthly maintenance checks on the fire alarm system, emergency lighting, operation of fire doors, hot water temperatures and the call bell system were being undertaken by an employee of another home because the person previously employed by Lilycross had left.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had failed to ensure that the people using the service were protected from abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to adequately assess and monitor the risks to people's health and safety or take appropriate action to mitigate any risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had failed to ensure that there were sufficient staff with the right knowledge and understanding of people living at the home to ensure their health, safety and welfare.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People using the service were not protected against the risks associated with the administration, use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	The registered person had failed to ensure that staff had received appropriate support, training and professional development.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had failed to obtain consent to care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person had failed to ensure that people's nutritional and hydration needs were being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had failed to ensure that people's were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People using the service were not protected against the risks associated with unsafe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	This is also a breach of Regulation 17 HSCA [RA] Regulations 2014 Good Governance. The registered person had failed to safeguard people from the use of improper treatment and to ensure that the care and treatment people were receiving was provided in a way that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were inadequate systems in place relating to the assessing and monitoring of the quality of service provision.