Care Quality Commission

Mrs C Chesyre

Lillibet House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good

Overall summary

This inspection took place on 15 September 2015 and was unannounced The inspection was carried out in response to information of concern which had been received.

At this inspection we looked at these specific areas to check if the provider was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Lillibet House provides care and support for up to 30 older people who are physically and mentally frail, some of whom may be living with dementia.

The registered manager at the service had recently resigned from the service. Therefore, the service did not 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 the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found that risk assessments for people whose behaviour could challenge others required more detail on the actions staff should take to reduce the potential risk of harm. We also found that one person's mobility had become impaired; however, their risk assessment had not been updated to reflect the changes.

There was insufficient guidance for staff to follow on the circumstances when staff should administer 'when required' medicines (PRN) to a person who use the service.

We found the staffing numbers were sufficient to meet the needs of the people who lived at the service.

Summary of findings

Staff ensured the principles of the Mental Capacity Act (MCA) 2005 were being followed when supporting people to make decisions.

We found people were provided with adequate amounts of food, drinks and snacks.

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?

Requires improvement

The service was not always safe

People's risk assessment lacked detail and clarity. They had not always been updated when there had been a change to their condition.

Clear guidance on the circumstances for 'when required' (PRN) medicines should be administered were not in place.

There were sufficient staffing numbers to meet people's needs.

Is the service effective?

Good

Staff ensured the principles of the Mental Capacity (MCA) 2005 were followed when supporting people to make decisions.

Adequate amounts of food, drinks and snacks were available for people to eat.

Lillibet 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 undertaken because of concerns raised about care practices at the service. We wanted to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 15 September 2015 and was unannounced. The inspection was undertaken by two inspectors.

Before we carried out this inspection we reviewed information we held about the service including data about safeguarding. We also had a discussion with the local safeguarding team. We reviewed statutory notifications we had received from the service. Statutory notifications are information about important events which the provider is required to send us by law.

We used a number of different methods to help us understand the experiences of people living in the service. We observed how staff interacted with people who used the service and how they were supported during individual tasks and activities.

We spoke with two people who used the service, three care workers, one senior carer, one domestic, the cook, the interim manager, deputy manager and the provider.

We reviewed care records relating to three people who used the service and other records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

We found that risk assessments relating to two people whose behaviours could challenge others, lacked detail and clarity on the actions staff should take to reduce the potential risk of harm. The actions recorded were for staff to walk away, or to apply the de-escalation techniques they had learnt in training. There was no information provided as to what these techniques were to ensure people's safety. We also found that one person's mobility had become more impaired; however, their risk assessment had not been updated to reflect the changes. This did not ensure that risks to people's safety and well-being were appropriately managed.

We looked at the way in which medicines were administered. We were told by the interim manager and staff responsible for administering medicines that under no circumstances were people's medicines administered covertly. We found where people had been prescribed for 'when required' medicines (PRN) such as sedatives to reduce their anxiety; there was not always sufficient guidance for staff on the circumstances when they should be administered. For example, in one person's care plan the guidance for staff was to give their PRN medicine for anxiety as a last resort. There was no explanation as to what the last resort was; and did not include information such as, applying positive techniques to manage the individual's anxiety.

We found that the temperature of the trolley where medicines were stored was not being monitored; however, we saw evidence that the drug refrigerator temperature was checked daily. Daily temperature checks of the medicine storage trolley or the room where they were kept would ensure that medicines were stored in the right conditions. Since our inspection the provider has confirmed that a record of the daily temperature was now being maintained. There was evidence seen to confirm that MAR sheets were being audited; however, where areas were identified as requiring attention, action plans had not been put in place to indicate how they would be addressed to ensure improvements.

We checked a sample of the Medication Administration Record (MAR) sheets and found that there were no unexplained gaps. We found that the service used an electronic medication system. Staff told us the system helped to reduce the risk of medication errors. One staff member said, "I like this system it helps to minimise the risk of us making mistakes. If all the prescribed medicines for a service user are not scanned. The system would not allow you to move on to another person." The staff member also told us that they had been trained in the safe handling of medicines and they were not allowed to administer medicines until they had been assessed as competent.

We observed the morning medicine round and found that the activity was carried out in line with best practice guidelines. We saw that the staff member involved in the medicine round wore a red tabard with writing 'not to be disturbed.' We found people were not rushed to take their medicines; and we observed that people were asked if they wished to take their medicines. For example, the staff member said to a person, "Would you like to take your medicine?" They ensured the person had taken all their medicines before moving on.

Prior to this inspection we received information of concern that the staffing numbers in the service were inadequate. We were informed that seven staff including the registered manager had left the service. The interim manager confirmed that seven staff had left the service. She also confirmed that the staffing numbers throughout the day consisted of seven care staff. This number was reduced to four staff at night. We checked the rota for the current week and the following two weeks and found that it reflected the agreed staffing numbers. The interim manager told us that agency staff were being used to make up the staffing numbers but this was only at night. She told us there was consistency and continuity in people's care. This was because the service ensured the agency workers providing care and support were doing so on a regular basis. Therefore, people were supported with staff who were familiar with their care needs. Staff told us that new staff had been employed.

Good

Is the service effective?

Our findings

We found that consent to care and treatment was sought by staff. People told us that staff asked them for their permission before they carried out a task or offered them support. Staff told us it was important to seek people's consent, and to provide care and support in line with their wishes. One staff member said, "We are geared up to make sure that the residents' rights are protected and they consent to everything."

We observed two staff members using the hoist to transfer a person to their armchair. Although there was not a lot of interaction in terms of providing reassurance to the individual; staff gained the person's consent to carry out the activity and explained how it would be done.

We found people were able to choose what they wanted to do on a daily basis, as well as where they wished to spend their time. Throughout our inspection we observed staff supporting people to make their own decisions and making choices for themselves. For example, we observed staff asking people if they wished to have a hot or cold drink. People's records seen confirmed that they had given consent to be supported with care and support.

We found staff also followed the principles of the Mental Capacity Act 2005 (MCA) when supporting people to make decisions. Staff described the actions they would take if they suspected a person might lack capacity and how they would support them to make a decision in their best interests. We saw that staff had received MCA training and that capacity assessments had been completed and recorded for people, where necessary. These assessments demonstrated that the individual had been put at the centre of the decision making process and we saw evidence how the outcome was reached, regardless of whether or not the person was deemed to have capacity.

Several people were under continuous supervision; and Deprivation of Liberty Safeguards (DoLS) applications had been made and approved by the statutory body. One person was receiving twenty-four hour one to one supervision to ensure their safety. We found that this was carried out in a sensitive manner and from a distance. This enabled the individual not to feel restricted.

Concerns were raised that the service ran out of bread, drinks and snacks, especially at night.

We spoke with the chef who said they were not aware of the service running out of essential supplies. We were shown the food cupboard. Although this was not stocked excessively there were sufficient supplies in place. One person told us they always had plenty to eat. They said, "Whenever I fancy a drink or snack I can have it." Two staff members we spoke with told us that on occasions at the weekends, the service had run out of snacks, tea and juice. They said this had not happened for some time, but had occurred when there was not a senior member of staff on duty who had access to the petty cash. From our observations on the day of the inspection, we found that people were provided with adequate amounts of food, drinks and snacks.