

# Jeesal Residential Care Services Limited

## Lilas House

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

### About the service

Lilas House is a residential care home providing accommodation and personal care to up to six people. The service is in a Victorian building with shared communal areas and a courtyard garden. The service provides support to people who are living with a learning disability or autistic spectrum disorder. At the time of our inspection there were five people using the service, and one person was in hospital.

### People's experience of using this service and what we found

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice as it was not clearly documented why decisions were being made in people's best interests and how their independence could be maximised. However observations and feedback showed staff understood how to promote people to have choice and control.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of key questions of safe, effective and well-led the service was not able to demonstrate they were meeting some of the underpinning principles of Right support, right care, right culture.

### Right support

People were supported to have choice and control over their lives, as well as pursue their interests. However, there was a lack of guidance around where people required decisions being made in their best interests. Despite the lack of written guidance, people were supported by staff who knew them well and who understood their care and support needs, and what was important to them.

### Right care

Risks were not always identified and therefore not adequately managed. People's care records lacked detail about how people communicated their wants and wishes, however, this was mitigated because of how well staff knew people.

### Right culture

Whilst the service promoted an inclusive culture, there still remained a lack of effective governance systems to monitor and assess the quality of service people received.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)  
Rating at last inspection and update

The last rating for this service was inadequate (published 13 October 2021) and there were breaches of regulation. We imposed conditions on the provider's registration, and they sent us action plans each month. At this inspection we found some improvements had been made, but the provider remained in breach of regulations.

#### Why we inspected

This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

#### Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

#### Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Is the service safe?**

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### **Is the service effective?**

The service was not always effective.

Details are in our effective findings below.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Lilas House

## Detailed findings

### Background to this inspection

#### The inspection

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

#### Inspection team

This inspection was carried out by two inspectors.

#### Service and service type

Lilas House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Lilas House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

At the time of our inspection there was a registered manager in post. The registered manager was in the process of deregistering and the service was being overseen by an acting manager.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

#### During the inspection

We spoke with two people who used the service, the acting manager, deputy manager, one senior support worker and two support workers. We also contacted two health and social care professionals for feedback.

We reviewed a range of records. These included the care records and medicine records for two people, and three staff recruitment files. We also reviewed a range of records in relation to the management and auditing of the service.

After the inspection

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

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection we found that people were not protected from avoidable harm. These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

### Assessing risk, safety monitoring and management

- Risks were not always planned for or mitigated. We saw one person using the stairs, whilst doing so, they would stop on the stairs and bend down to touch the stairs. They were also not wearing appropriate footwear. This posed a risk of tripping or falling. The acting manager told us a risk assessment had been put in place after our inspection, but not all staff we spoke with were aware of this.
- A second person's care records showed they had a pressure ulcer. There was no further guidance in their care records regarding the care and treatment required in relation to this care need.
- Environmental risks were not safely managed. The door to the laundry room was unlocked, people could have potentially accessed hot water which posed a scalding risk, and an unsecured drill. We also found an uncovered radiator and unsecured topical medicines.

Improvements were still required to ensure risks to people's safety, including risks within the environment, were adequately identified, planned for and managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After our inspection, the acting manager told us a risk assessment was put in place to mitigate the risk to the person using the stairs and a referral had been made to occupational therapy. However, not all staff were aware this new risk assessment was in place.
- Since our last inspection, there was an improvement in staffs' understanding in relation to people's individual risks.

### Systems and processes to safeguard people from the risk of abuse

- Safeguarding incidents were reported to the relevant bodies. However, review of safeguarding records showed that outcomes had not always been updated.
- Staff understood their responsibilities in relation to safeguarding people and were able to tell us the process they would follow to report any concerns.

### Staffing and recruitment

- Recruitment processes were in place. However, a check of staff files showed there were some gaps in the records. These included employment histories and references.
- A review of staffing rotas showed there were enough staff deployed to meet people's needs. Staff we spoke with told us there were enough staff to allow for supporting people with accessing interests outside of their home.

### Using medicines safely

- A review of medicines records found that one person was on a number of sedative medicines. A review of the person's medicines in relation to use of sedatives had not taken place. This was not in line with guidance specifically in relation to the over medication of people with a learning disability and or autism. The acting manager confirmed after our inspection they had requested a medicines review for this person. Since our inspection this person has attended a review of their medicines.
- We found some gaps on topical medicines charts and a medicine for one person had the wrong time to be given written on their medicine administration record.
- Topical medicines such as creams were not always stored securely.
- One person's care plan did not detail why they were prescribed a sedative medicine twice a day. The dosage of the medicine on the care plan did not correspond with what was on the MAR chart.
- Staff we spoke with confirmed their competency in administering medicines had been assessed and records we reviewed confirmed this.

### Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections. The inspection team were not asked screening questions to ascertain if we had experienced any symptoms of COVID-19.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. This was because staff worked across two of the provider's services.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider's infection prevention and control policy was up to date.

### Visiting in care homes

- There were no restrictions on visiting, and people living in the service were supported to have visitors.

### Learning lessons when things go wrong

- Whilst analysis of accidents and incidents took place, there was a lack of identifying themes and trends. This meant possible antecedents to incidents could not be fully assessed and action taken to reduce further occurrences.



# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection we found that the provider failed to ensure people lived in a safe and well-maintained environment. These findings constituted a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made, and the provider was no longer in breach of this regulation, however, some further improvements were still required.

Adapting service, design, decoration to meet people's needs

- Some people's furniture was tired looking and required replacing. Floors in people's rooms had debris on and toilets were not cleaned regularly.
- Most of the exposed piping had been covered as a result of our previous inspection with the exception of a radiator.
- Communal areas were free from clutter. One member of staff commented how the home was looking more "homely."
- People's rooms were personalised with their belongings and items of interest to them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At the previous inspection, we found people did not receive person-centred care which respected their independence. These findings constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements were found, but further work was required.

- Since our last inspection we saw that people were supported to pursue things of interest to them. One person told us how they liked drawing and showed us some of their pictures. A second person told us how they had been out that morning to do some shopping.
- One member of staff explained how they can support people with going out on a day to day basis rather than relying on planned activities.
- A healthcare professional we spoke with told us the two people they regularly have contact with were happy living in the service and had choice and control over their lives.
- Our observations showed people were supported to have choice over their care and treatment. For example, we saw one person was supported to have their meals at a time they wished.

- Whilst staff had a good understanding of people's interests, and how they communicated their needs and wishes, this was not clearly documented in people's care records.

#### Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Mental capacity assessments were not always in place where people did not have the capacity to make a particular decision. However, people's care records stated what areas of their lives they needed support in, for example, managing money.
- It was not clear why staff would be making decisions on behalf of people in their best interests and what the least restrictive option would be.
- Staff we spoke with had a good understanding of the MCA and when they would make a decision in a person's best interests.

We recommend people's care records are reviewed to clearly detail when a decision is required to be made in a person's best interest and show the least restrictive option has been considered.

#### Staff support: induction, training, skills and experience

- Staff we spoke with told us they were able to access training relevant to their role. Training was delivered either face to face or via e-learning.
- Staff told us they had regular supervisions with a member of the management team, and felt supported in their role.
- A review of the training matrix showed there were still some gaps in staff training, however, this had improved since our last inspection.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- There was a lack of detail in people's care records about how to support them to maintain a healthy weight and people's weights were not consistently monitored.
- There was inconsistent practice around referral to healthcare professionals. Whilst records showed referrals were made in some circumstances, we saw referrals were not made in a timely way to get further advice regarding supporting people to maintain a healthy weight.

- Staff told us the acting manager had implemented a healthy eating plan for people, and records we looked at showed people were offered healthy choices of food.
- People were consulted about the meal choices and were able to have their meals at a time of their choosing.

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our previous inspection we found there were ineffective governance systems in place to monitor and assess the quality of the service. These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Whilst some audits had been introduced, these did not always identify where improvements were required. For example, the medicines audits did not highlight the errors we found during our inspection.
- The provider did not undertake any audits of the service to assess and review the quality and safety of care being delivered.
- There were still gaps in staff training and people's care records still required updating to ensure these were fully reflective of their most current care and support needs.

Improvements were still required in relation to implementing robust governance systems which assess and monitor the quality of service being delivered. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The acting manager understood which incidents they were required to notify us of, and our records showed we were notified of reportable incidents in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were able to attend weekly resident's meetings where they discussed highlights of their past week and what they would like to see on the menu.
- There were regular staff meetings, and staff we spoke with told us they felt comfortable in making suggestions about how the service could be improved.
- People were supported by staff who understood their individual care needs, and who spoke

enthusiastically about working with the people they supported.

- People's interests were encouraged by staff and staff told us there were adequate staffing levels. This meant people could be supported to pursue their interests with staff on a one to one basis.

Working in partnership with others

- One professional who has been working closely with the service said staff were open and accommodating during these visits. A second professional told us how the management team were always helpful and updated them with any changes to people's care needs.