Lilena and Pentree Lodge Care Homes Limited

Lilena Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 December 2017 and was unannounced. Lilena Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lilena Residential Care Home accommodates up to 14 people with mental health needs. The service consists of a three story detached house with 13 bedrooms and bungalow where one person can be supported to develop the skills necessary for independent living. At the time of our inspection 14 people were using the service.

The service had 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.

People told us they felt safe living at Lilena and relatives said, "It is very safe" and "There is nothing at all to be worried about." Staff had received safeguarding training and understood their responsibilities in relation to protecting people from abuse and harm. Records showed the registered manager made appropriate safeguarding alerts to ensure people's safety.

The atmosphere in the service on the day of the inspection was friendly and calm. People were comfortable approaching staff for support and staff responded promptly to meet people needs. People told us they got on well with the care staff and commented, "I am well looked after here", "I like it here" and "I am well loved and cared for." Relatives were also complimentary of the service and told us, "It seems to be the best one so far" and "I am very pleased. It is the best place [Person's name] has been in. I could not wish for anything better."

The service was adapted to meet people's needs and maintained to a reasonable standard. Although, carpets in high traffic areas on the ground floor were discoloured. Fire fighting equipment had been regularly serviced and action taken to address resolve issue identified during a recent fire safety audit.

Risks both within the service and in relation to people's care needs had been assessed and staff were provided with guidance on how to protect people from identified risks. Where accidents or incidents occurred these had been investigated by the registered manager to identify any further actions that could be taken to improve people's safety.

People's medicines were managed safely. But we have recommended that the service review current practices in relation to the dispensing of medicine to ensure people's dignity was protected at all times.

There were enough skilled staff available to meet peoples' care needs and records showed planned staffing levels were routinely achieved. Necessary staff pre-employment checks had been completed and there were systems in place to provide new staff with an appropriate induction. Staff training needs had been met and supervision was provided regularly.

People needs were assessed before they moved into the service to ensure those needs could be met. People were encouraged to visit the service before deciding to move in to ensure they understood the service's routines, rules and policies. Based on information gathered during the assessment process individualised care plans had been developed. These documents provided staff with clear guidance on how to meet each person's individual needs. People's care plans had been updated regularly and staff told us, "[The care plans] are well thought out and detailed."

People were able to choose how to spend their time and to access the community independently if they wished. However, during our inspection we noted that there was a lack of activities for people to engage with within the service. We have recommended that the service reviews staff working practices with the aim of supporting and encouraging people to engage with more meaningful activities.

Management and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). We saw that staff sought people's consent before providing care and support. Where people had been identified as lacking capacity made certain decisions the service acted in accordance with legal requirements. Necessary DoLS applications had been made and subsequent conditions were complied with.

The registered manager normally worked one shift each week as a carer within the service. This meant the manager had a detailed understanding of both people's needs and staff working practices. Staff told us they were well supported by the registered manager and commented, "The registered manager] is excellent, very professional", "very nice, very helpful." A Health and Social care professional said, "[The registered manager] is a proactive manager, and keen to support residents to rebuild skills, with the hope of greater independence." The registered manager was expected to be absent from the service for a significant period following the inspection. The provider had made appropriate arrangements to ensure the service was led appropriately during this period.

The service's complaints procedures were displayed within the home and records showed all complaints received had been appropriately investigated. Residents meetings were held regularly and minutes showed changes had been made to the service's menu in response to people's feedback.

Information was stored securely and there were systems in place to monitor the service's performance and identify where improvements could be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains safe.

Is the service effective?

Good

The service remained effective.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Requires Improvement

The service not entirely responsive.

There were limited opportunities for people to engage with activities within the service and the provider did not fully recognise the importance of respecting people's protected characteristics.

People's care plans were accurate and informative and the registered manager had worked with professionals to ensure people needs were accurately identified.

Staff respected people choices and decisions.

Is the service well-led?

Good

The service remained well led.

Lilena Residential Care Home

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.

This inspection took place on 12 December 2017 and was unannounced. The inspection team consisted of two adult social care inspectors.

The service was previously inspected on 5 and 6 October 2015 when it was found to be fully compliant with the regulations. Prior to the inspection we reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we met and spoke with the four people who used the service, two members of care staff, the registered manager and the provider. Following the inspection we spoke with two people's relatives by telephone. In addition we observed staff supporting people throughout the service and inspected a range of records. These included two care plans, three staff files, training records, staff duty rotas, meeting minutes and the services policies and procedures.

Good

Is the service safe?

Our findings

People said they were happy, safe and comfortable living at Lilena and relatives comments included, "It is very safe" and "There is nothing at all to be worried about."

Staff understood their responsibility in relation to protecting people from abuse. Records showed staff had received safeguarding training and information about how to raise safety concerns outside the service was displayed on notice board and readily available to people and staff. Staff said that if they had any concerns they would initially report them to the registered manager who, they were confident, would take any action necessary. One staff member told us, "I had a concern, I went straight to the registered manager and she handled it straight away." Records showed that the service had made safeguarding alerts to the local authority where appropriate to ensure people's safety while accessing the community independently.

Risks in relation to people's care and support needs had been identified and assessed. Individual risks had been categorised and staff were provided with guidance on how to mitigate and manage individual risks. For example, one person had been identified as being at risk while crossing roads independently and as a result staff were tasked to ensure the person wore a high visibility tabard when leaving the service independently.

The service's firefighting equipment had been regularly checked by external contractors to ensure it was ready for use and records showed regular alarm tests and evacuation drills had been completed. An emergency grab bag was located outside the manager's office and this ensured staff had immediate access to safety information and guidance when required.

An inspection by Cornwall Fire and Rescue Service in November 2017 had identified and number of fire safety concerns. In response the service had developed and action plan and appointed an external fire safety consultant to help the service achieve full compliance with the requirements. We reviewed the action plan and found plans were in place to promptly address and resolve each of the fire safety issues highlighted.

Where accidents and incident occurred these were documented in people care records and highlighted to the registered manager via an incident reporting form. The registered manger reviewed all incidents reported to identify any trends or changes that could be made to further improve people's safety. During our review of care records we identified one recent significant incident that had not been reported to the registered manager. We discussed this incident with the registered manager who subsequently completed an investigating into both the specifics of the incident and why it had not been correctly documented. Following the inspection changes to the service incident reporting procedures were introduced to ensure all incidents and accidents were fully documented. The registered manager encouraged staff to raise and report any safety concerns. Staff meeting minutes showed action had been taken in response to issues raised to improve people's safety.

There were sufficient staff available to meet people's care needs. Each day two staff were on duty until 23:00

and there was a sleeping night staff member available to provide care and support overnight if necessary. The staff team was shared with the provider's other local care service. This system had been introduced to enable staff to provide support in either service as required to meet people's needs. The provider told us, "Staffing is fine" and staff rotas demonstrated that planned staffing levels had been routinely achieved. Staff told us there were additional hours available but that they did not feel pressurised to pick up additional care shifts.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that staff employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate pre-employment checks including references from previous employers and a Disclosure and Barring Service (DBS) check. There were staff disciplinary procedures in place and these were used to ensure staff performed appropriately.

Staff received effective training in safety systems, processes and practices such as in moving and handling, fire safety and infection control. Personal emergency evacuation plans (PEEPS) had been developed to describe the support individuals would need to exit the building in an emergency.

The service had suitable arrangements for the ordering, storage, administration and disposal of medicines. Some medicines were being used that required cold storage, there was a medicine refrigerator at the service and the temperature was monitored daily. We noted that recently recorded fridge temperatures were towards the top end of the desired range and reported this issue to the registered manager. There were facilities available for the appropriate storage of medicines which required stricter controls by law. Information about known side effect of people's prescribed medic medicines was readily available to staff if required.

The service had a dedicated medicines room which people visited to collect their medicine at fixed times each day. Medicine Administration Records (MAR) were completed appropriately. Any handwritten entries were double signed to help prevent any errors. These records had been regularly audited to ensure people had been appropriately supported with their medicines. Where any errors were identified these were discussed with the staff involved and if necessary procedures were change and updated to prevent similar errors reoccurring. There were appropriate policies and procedures in place for the self-administration or covert provision of medicines if required. Where medicines had been prescribed 'as required' staff had been given guidance on how and when these medicines should be used.

Staff dispensed medicines to people in the medicines room and observed them being taken and swallowed. This meant people routinely observed others receiving support with their medicines and that queues could form while people were waiting to be called into the medicines room. This impacted negatively on people's dignity and did not reflect current best practice.

We recommend the service reviews it's procedures for supporting people with medicines to ensure their dignity is protected at all times.

The service had an infection control lead responsible for overseeing infection control processes. There were cleaning schedules in place for both communal areas and people's bedrooms. We found that the service was clean and tidy. People had been encouraged to take part in and appropriately supported with cleaning tasks.

Information and care records were stored securely when not in use to ensure people's privacy and dignity was protected.

There were systems and procedures in place to support people with their finances. Where the service held people's money it was stored securely and routinely audited. Staff supported people with some shopping tasks when requested. The manager had encouraged one person to take on responsibility for purchasing the service's bread to help their development of independent living skills but this had not yet been entirely successful.

Good

Is the service effective?

Our findings

Assessments of people's needs were completed before they moved into the service. This was done to ensure that the service could meet their needs. Before people moved in they were also encouraged to visit the service, look around and meet the other people currently using the service. This ensured people had a good understanding of how the service operated before choosing to move in. It also gave people an opportunity to observe staff interacting with people and gain and understanding of how the service operated, its rules and procedures.

Staff had the skills, knowledge and experience necessary to deliver effective care and support. All new employees completed an induction programme when they joined the service. This consisted of a mix of formal training, shadowing experienced staff and reviewing the services policies and procedures. In addition, staff new to the care sector were supported to complete the care certificate during their probationary period. The care certificate is designed to help ensure all staff have an understanding of current good working practices in care. Staff competence was assessed by the manager before they were permitted to provide support independently. Staff who had recently completed the induction told us, "The induction was through, I felt confident when I started" and "I went through the paper work to get a feel for the organisation."

Staff received regular training updates in topics the provider considered necessary including, safeguarding adults, infection control, first aid and the Mental Capacity Act. Staff told us, "There is plenty of training" and "Last was fire training, manual handling awareness and first aid." Training was provide in a mixture of face to face and online formats and the registered manager completed regular audits to ensure staff training needs had been met.

There were systems in place to support staff working at Lilena. This included regular support through one-to-one supervision from managers and annual performance appraisals. These meetings gave staff opportunities to discuss working practices, identify any additional training or support needs and to discuss any other issue that may impact on the staff member's performance. In addition, staff team meetings were held quite regularly. Records of these meetings showed they provided staff with additional opportunities to discuss training needs and any changes within the service. Staff told us, "We have supervision and staff meetings" and "They like practically everyone here for staff meetings. We can raise anything."

The service supported people to access the health service and worked effectively with health and social care professionals to ensure people's needs were met. For example, staff had become concerned about one person's food intake. The manager had reported these concerns to the general practitioner and sought guidance from specialist health professionals on how to meet the individual's specific needs.

The service's policy was not to use any forms of physical restraint. People's care plans included guidance for staff on how to support people if they became upset and anxious. This included information about incidents likely to cause the person anxiety and details of techniques that had previously been used successfully to support people while upset. One person had capacity but was likely to put themselves at increased risk if the

left the service for an extended period without support. Staff were provided with details of previous incidents, information about where the person was likely to go and guidance on how to access additional support if they were concerned about the person's safety. Staff told us they had received training in conflict resolution and felt they had the skills necessary to support people during periods of increased anxiety.

People told us, "The food is pretty good" while relatives said "The food is very good." Staff had a good understanding of people's dietary needs and preferences. Where risks in relation to weight loss had been identified this had been discussed with individuals and agreements reached detailing how the service would support the person to manage their weight. One person had a very restricted menu. Staff worked with this person to try new foods and to agree to introduce some variation into their diet. Records showed the service had sought guidance from professionals when necessary to ensure people's dietary needs were met. People were able to access snacks and drinks from a small kitchen area throughout the day. There was a cooking rota in place and people were regularly encouraged to participate in meal preparation. However, access to the main kitchen was limited to when staff were available to support people.

The design, layout and decoration of the building met people's needs and it was maintained to a reasonable standard. However, the carpets in high traffic areas of the lounge and downstairs corridor were showing signs of wear and discoloration. There was a maintenance person based at the service three days per week to complete routine repairs and external contractors were used appropriately when larger works were needed. Most people had their own bedrooms with shared bathroom and toilet facilities. However, one person lived in a self-contained flat with its own bathroom and kitchen facilities designed to enable the person to live independently. In the main house there were two lounge areas, a dining room and two kitchens. There was a designated smoking conservatory and outdoor seating areas that people could access when they wished.

There were system in place to record people's consent to their planned care and support. One person had not consented to their photograph being taken. This was well document and respected by staff.

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 Act 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. The registered manager had a good understanding of this legislation and appropriate assessments of people's ability to make decisions had been completed. Were people's capacity to make specific decision could be variable this had been recorded and staff were provided with guidance on how to support people to make meaningful choices.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although the service's doors were not locked and people were able to access the community independently the manager had identified that some people who lacked capacity in relation to certain decision were the subject of restrictive care plans. Necessary applications to the local authority for the authorisation of these care plans had been made. Where authorisations had been granted the service had complied with any associated conditions.

Good

Is the service caring?

Our findings

People told us they were happy living at Lilena and well cared for. Their comments included, "I am well looked after here", "I like it here", "The staff are very good" and "I am well loved and cared for." People's relatives said, "The staff are very good, My relative gets on very well with them" and "Everyone is so friendly, I can't fault it in any way."

Staff knew people well and told us that they enjoyed spending time with the people they supported. Their comments included, "I actually Love it" and "I get on well with the staff and the residents." During our inspection we saw that people approached staff for support without hesitation and that staff responded promptly to people's requests.

Staff protected and respected people's human rights and promoted individuality. Where people had expressed preferences in relation to the form of address used by staff these preferences had been documented with in care plans. During the inspection these preferences were explained to inspectors and we observed that staff and the registered manager consistently used people's preferred form of address.

People were able to make choices and decisions about both how their care was provided and how to spend their time. People chose what time they got up in the morning and when they went to bed. People moved around the service without restriction and were able to independently access the community when they wished. During the morning of our inspection most people choose to spend time in the rooms or in the service's lounge and designated smoking area. In the afternoon most people choose to access the community independently. Relatives told us, "They treat [my relative] like a proper adult" while one person told us, "I am happy."

People had keys for their rooms and chose to lock their doors while out. Staff consistently acted to ensure people's privacy and dignity was protected. For example, while sharing information about specific needs with inspectors staff lowered their voices to ensure they were not overheard. One person's relative told us, "[My relative] has his own room and they respect his privacy."

People were encouraged to become more independent. Cooking facilities were provided to enable people to prepare meals independently if they wished. Some people had expressed an interest in having a pet at the service. The registered manager had recognised that's as an opportunity to support people to become more independent. The idea was discussed in detail and a pet rabbit was chosen. People had agreed to help look after the rabbit which had subsequently been purchased. The registered manager reported people had initially looked after the rabbit but had now begun to lose interest. As a result the manager had met with people and agreed a rota identifying which person was responsible for caring for the rabbit each day.

People said they were involved in their care and decisions about how they wanted to receive support. Staff sought consent before providing care and support and there were formal systems for recording people's consent both in relation to their planned care and other issues. For example, people had been asked to consent to photographs being taken during activities and trips away from the service being uploaded onto

the provider's web site. One person had refused to consent for photographs and this decision had been respected.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the service. This was done to ensure the service could meet the person's individual needs and expectations. In addition, people were encouraged to visit the service before they moved in to meet people living there and see what it was like. Information gathered during the assessment process was used in the development of the person's initial care plan.

People's care plans were detailed and informative. They included information about the person's background, interests, family history as well as information about their mental health needs. This included details of topics of conversation people were known to enjoy. This helped staff new to the service to quickly build relationships with the people they were supporting.

Staff were provided with guidance on how to meet people's care needs and details of the person's preferences in relation to how their support was provided. Where people were known to be likely to decline or refuse support, staff were provided with specific information on techniques that had previously been effective in encouraging people to accept help. For example, one person regularly declined support with personal care. Their care plan said, "Under no circumstance to confront [Person's name] in the presence of others. Staff to take [the person] to the side and approach it discreetly. Be friendly but firm" and "[Person's name] responds well to sewing the seed – allow [them] time to think about an upcoming task."

Care plans had been reviewed and updated regularly to ensure they accurately reflected people's current care and support needs. Staff told us, "[The care plans] are well thought out and detailed."

Each day staff completed records with details of the care and support each person had received. Including, observation on the person's mood, and information about how the person had chosen to spend their time.

On the day of our inspection we saw no evidence of people being supported or encouraged to participate in activities with staff. During the morning most people chose to spend time sleeping and relaxing in their rooms while staff focused on meeting people's personal care needs. During the afternoon the majority of people accessed the community independently, while staff focused on cleaning and other domestic tasks with limited interaction with people other than to provide cigarettes when requested. Most people had agreed to limit their cigarette consumption to one per hour and spent significant periods of the day waiting for their next cigarette, rather than engaging with activities. However, people told us, "There is enough to do, I am happy here" and "We play cards and things like that." While relatives said, "There are activities, [my relative] does not participate but they do try" and "There seems to be enough to do, [My relative] is always doing something."

We recommend that the provider and registered manager review current working practices in the afternoon with the aim of supporting and encouraging people to engage with a greater variety of meaningful activities.

The registered manager had become concerned that one person's needs had not been correctly identified by commissioners and professionals. These concerns had been appropriately raised with health and social

care professionals and the person needs were subsequently reviewed. In order to facilitate this staff had completed detailed records of the care provided by staff and details of the person's behaviour both within the service and while accessing the community. The information gathered by staff had resulted in professionals recognising the person's additional needs. At the time of our inspection commissioners were in the process of identifying an alternative service provider able to meet the person's recently identified specialist needs.

Staff consistently respected people's choices and decisions in relation to activities and tasks within the service. For example, it was one person's birthday on the day of our inspection and the registered manager and staff team had arranged a surprise treat for the person away from the service. The person was grateful for this gift but decided not to participate in the arranged activity. This caused obvious disappointment to both staff and the manager as they had hoped the person would have enjoyed their gift. However, staff respected the person's choice, ensured the person was unaware of their own disappointment and moved on so the person did not feel pressured to change their mind. One person's relative told us, "[Person's name] does not like to be pressurised and they manage this well."

The service had appropriate systems in place for the investigation of any complaints received. Information about the complaints policy was readily available to people and visitors in the hall way. Records showed that where complaints had been received these had been fully investigated by the registered manager and that the service aimed to use any complaints received as opportunities for learning and to improve the service's performance

Both the registered manager and staff had a good understanding of equality and diversity issues and acted to ensure people were protected from all forms of discrimination. However, the provider was less clear on these issues and did not consistently ensure protected characteristics were respected.

There were systems in place to enable information about people's preference in relation to end of life care to be recorded. However, most people had chosen not to provide these details.

Good

Is the service well-led?

Our findings

The service 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 the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had a registered manager in post.

The registered manager provided the staff team with leadership and support. Each week the manager normally completed one care shift and was supernumerary for approximately 30 hours. This meant the manager had a good understanding of people's care and support needs and working practices within the home. Staff told us they felt well supported and commented, "You can go to the registered manager or provider with anything even if not at work. They help with anything." People's relatives and were also complimentary of the manager's leadership style. They told us, "[The registered manager] is excellent, very professional" and "Very nice, very helpful." A Health and Social care professionals said, "[The registered manager] is a proactive manager, and keen to support residents to rebuild skills, with the hope of greater independence."

The provider operates two care homes in Newquay and each week a management meeting, with both registered managers and the provider, was held to review each service's performance and discuss any ongoing issues. The registered manager told us she was well supported by the provider who was present in the service throughout our inspection. The registered manager told us this was not unusual and commented, "[The provider] is always popping in to support us."

Since our previous inspection significant changes had been made to the staffing arrangements at both services. The registered manager and senior cared worked full time in their individual services while care staff were now shared between both services. This approach was designed to increase flexibility in relation to staff availability, while maintaining dedicated leadership roles and their detailed understanding of people's individual needs. There were on call systems in place to enable staff to access management support whenever required and staff reported that these systems worked well.

Relatives were complimentary of the service and told us, "It seems to be the best one so far" and "I am very pleased. It is the best place [Person's name] has been in. I could not wish for anything better." Staff told us they worked well together as a team and commented, "All the staff are good" and "I like it, I am enjoying it." While the provider told us they had confidence in the registered manager commenting, "It's all trundling along quite nicely."

The registered manager was expected to be absent from the service for a period following our inspection. The provider had attempted to recruit and interim manager to cover this period but had been unsuccessful. As a result temporary changes to the service's management arrangements were planned. An additional carer had been appointed and the senior carer was to be allocated additional office time each week. The registered manager from the provider's other local service was to be based at Lilena two days per week

during the manager's absence to provide staff with appropriate leadership and support.

Staff told us they worked well together as a team and commented, "Anything you're not sure of you can ask and they will help out." The registered manager used team meetings and the staff notice board to highlight good practice and individual staff commitment to meeting people's needs.

The service had procedures in place to monitor the quality of the care provided. Audits had been routinely completed. Where any issue had been identified the manager had taken appropriate action to improve the service's performance.

The service worked in partnership with other organisations to make sure people's needs were met in accordance with current practice. Records showed the service had made referrals to and sought advice from health and social care professionals including social workers, mental health professional and General Practitioners.

Residents meetings were held regularly at the service to ensure people were involved in decisions about changes to how the service operated. Records showed at previous meetings people had discussed and agreed changed to the service's menu.

The service care records were kept securely and confidentially when not in use. All necessary routine maintenance checks had been completed by appropriately qualified contractors.