Livability

Livability Marion House

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Livability Marion House is a care home accommodating five people at the time of the inspection and providing care at home to a further two people. The service can accommodate up to eight people.

People's experience of using this service and what we found
Right Support
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 supported this practice.

People's support promoted their choices and their independence. Staff focused on what people could do and encouraged them to celebrate their achievements. They enabled people to do things for themselves and did not provide more support than people needed, which would compromise their independence. Support planning was based on people's hopes and aspirations. People were actively involved in planning their support and maintaining their own health and wellbeing, and staff supported them to make their own decisions about medicines wherever possible. People made choices for themselves about their day to day lives, as far as they were able.

Right Care
People and their relatives were pleased with their care and support. Staff were kind and respectful, upholding people's right to privacy and dignity. Care and support were tailored to people's individual needs. Staff knew people well and understood the support they needed, including any assistance they needed to communicate. People and their relatives were involved in designing and reviewing care and support plans. The registered manager understood the importance of independent advocacy to uphold people's rights and preferences and knew how to access advocacy services.

Right Culture:
The registered manager fostered a person-centred culture, where staff treated people as individuals, upholding their rights and encouraging and enabling them to live life as they wanted. People and staff liked the registered manager, finding her approachable and feeling confident that the service was well run. The registered manager had invested time and effort in developing staff skills and confidence, delegating tasks with support so staff felt more able to manage a range of situations in the registered manager's absence. This meant people's needs were met more promptly and effectively; it had also boosted staff morale.

People had opportunities to get updates and give their views about the service and any developments they would like to see. These included regular house meetings, monthly key worker meetings, support plan reviews and ad hoc conversations with the management team, as well as involvement in quality assurance audits.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was good (published 30 August 2018).

Why we inspected
We undertook this inspection as part of a random selection of services rated good and outstanding.

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.

Recommendations
We have made a recommendation about the management of medicines.

Follow up
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?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Livability Marion 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by an inspector, 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.

Service and service type
Livability Marion 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. Livability Marion 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.

This service is also a domiciliary care agency. It provides personal care to people living in their own homes.

This service is also registered to provide care and support to people living in 'supported living' settings, so that they can live as independently as possible. However, it was not providing supported living at the time of the inspection. People's care and housing for supported living are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager

This 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. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service a day's notice of the inspection. This was because people are often out and we wanted to be sure there would be people at home to speak with us, and also that the registered manager, who also manages another service locally, would be available.

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, although they did complete one during the inspection, which we took account of in reaching our judgments. 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.

Good

Is the service safe?

Our findings

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

The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Using medicines safely

● Staff supported people with their medicines. However, during the inspection we identified areas of the systems and processes to prescribe, administer, record and store medicines that could be improved. The registered manager took immediate action to rectify these.

● Whilst people's medicines were stored in locked cupboards, the cupboards we checked were not fixed securely. This had resulted from people recently moving to different rooms. The registered manager immediately arranged for the cupboards to be secured to walls.

● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured people's medicines were reviewed by prescribers in line with these principles. One person's behaviour support plan described when a medicine to support their behaviour could be administered. However, this medicine was not listed in their medicines administration records and the medicine was stored separately to the person's other medicines. When we raised this with the manager, they started a review of the need for the medicine, which had not been used for several months and had been discontinued; the behaviour support plan was updated.

● Other people at the service also had when required and variable dose medicines; guidance to support staff was not always available or consistent with the prescriber's directions. The management team promptly addressed this during the inspection.

● Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines. Staff made sure people received information about medicines in a way they could understand. Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.

● People had support from staff to make their own decisions about medicines wherever possible. Staff assessed whether it was safe for people to administer their own medicines. However, where this was not safe, people had not been encouraged or supported to take part in other medicines tasks that might have been suitable to promote their independence. This is an area where the approach of staff could be developed further.

We recommend the service keeps the management of people's medicines under review to ensure this remains safe and in line with national guidance and good practice.

Systems and processes to safeguard people from the risk of abuse

● People felt safe and comfortable at Livability Marion House.

● There was regular discussion at house meetings and with individual people about the safeguarding adults procedure and how to report any concerns.

● The registered manager and staff had training about safeguarding and knew how to recognise and report abuse.
● Where people needed support to look after their money, the service kept this securely and accounted for all transactions.

Assessing risk, safety monitoring and management
● People's health risks were assessed and managed and they were involved in decisions about how to keep safe. Risk assessments were individual to the person and covered areas such as managing long-term health conditions like epilepsy, moving and handling, malnutrition and developing pressure ulcers.
● People had the support they needed when they were experiencing distress. Staff were alert to signs of concern and followed behaviour support plans that reflected how people wanted to be supported at such times. Restrictions, such as medication to help someone to calm, were kept to a minimum.
● There were regular health and safety checks by people and staff, and periodic checks by specialist contractors of gas, electrical, fire and water safety. Any items of concern were rectified.
● There were regular fire safety checks and fire drills, which involved both staff and people who lived in the house. People had personal emergency evacuation plans to guide staff and emergency services personnel on how to help them to safety in an emergency.

Staffing and recruitment
● Staff were readily available to provide the care and support people needed. One person said they sometimes had to wait for staff to finish what they were doing before supporting them.
● Minimum safe staffing levels were calculated using a staffing dependency tool. The number of staff on duty was at least equal to the minimum, and usually exceeded it during daytime hours.
● Staff had the skills they needed to support people safely and effectively. They had training in essential topics when they first started employment and at intervals after this; during the pandemic the training had mostly been online. A relative commented how they had "come to trust the people who care for [person]".
● Staff training covered key topics such as health and safety, moving and handling, food hygiene, fire safety, infection control and data protection, as well as Makaton (a sign language used by some people with a learning disability). Staff took time to familiarise themselves with people's communication styles.
● Staff vacancies had arisen during the pandemic, but only two posts were unfilled at the time of the inspection. The service used agency staff who knew the service to cover shifts that could not be filled by the existing staff team.
● There were recruitment checks to help ensure new staff were of good character and suited to work in a care setting. These included obtaining a full employment history, references and Disclosure and Barring Service (DBS) clearance before they started work. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises. Flip-top waste bins were replaced by pedal bins during the inspection.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured the provider's infection prevention and control policy was up to date.
● The service's approach to visiting aligned to government guidance. People were usually able to have visitors as they chose, with precautions for visitors including temperature screening, symptom questionnaires, lateral flow testing, hand cleansing and mask wearing. In event of a COVID-19 outbreak, people could receive visits from their designated 'essential care givers', who followed the same twice-weekly lateral flow testing regime as staff.

Learning lessons when things go wrong
● Staff reported and recorded accidents, incidents and near misses. The registered manager reviewed these and took any action required immediately, such as making a safeguarding adults referral. Any higher risk matters were escalated to senior management.
● The registered manager and senior management team had regular oversight of accidents, incidents and near misses. This included a monthly analysis to identify emerging trends.
● Where appropriate, the learning from things that went wrong was shared with people and staff and measures put in place to help prevent a re-occurrence. This was illustrated during the inspection when a professional visitor tripped down a well-marked step and hurt themselves. At the time, staff followed a well-rehearsed post-falls protocol. Although the service could in no way be blamed for what had happened, procedures were adapted to help avoid this happening in future.

Good

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.

The rating for this key question has remained good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People were actively involved in maintaining their own health and wellbeing. They were supported to have contact with health professionals for existing health conditions and any new concerns about their health.
- People were encouraged and supported to access age and gender-related health screening, as well as annual health checks.
- People routinely accessed dental and eye care, and foot care where needed.
- People's care was consistent with instructions and guidance from health professionals. For example, instructions from a person's occupational therapist, physiotherapist and speech and language therapist were reflected in their care and support plan.
- People who needed assistance with toothbrushing and oral hygiene received this from staff who were confident in supporting them. However, oral health was not assessed and planned for in line with guidance on oral health for adults in care homes from the National Institute for Health and Care Excellence. The registered manager arranged to put this in place when drawn to their attention.

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

- Although the premises were safe, communal areas were tatty and in need of redecoration. Although people had not complained about it, the registered manager recognised this could adversely affect their quality of life. Forthcoming changes to the service were imminent, including plans for the renovation and redecoration of the whole building.
- People liked their bedrooms, which were styled according to their individual choice. Some people had recently moved rooms, by agreement, because of their altered mobility and risk of falling.
- Staff supported people to spend their time where they wanted to be, including in an accessible garden and in the former day-centre annexe. This meant people who preferred to spend time on their own outside their rooms were able to do so.

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

- People and relatives were pleased with the quality of care and support. A person who had lived in other care homes previously described how Livability Marion House suited them "perfectly for now", recognising that their wishes might change in the future.
- People's care and support needs were kept under review and their support plans were updated accordingly. This was a holistic process that looked at what was important to them in all areas of their life.
- The registered manager and staff identified and made referrals to outside health and social care

organisations as required to ensure people's needs were met.
● A computerised care planning and recording system was being introduced. Important information about people's care was readily available for staff, although efficient filing was still being organised. Staff were maintaining care records but were still in the process of becoming comfortable with recording care on the computerised system.

Staff support: induction, training, skills and experience
● Staff felt well supported by the registered manager and received the supervision and training they needed to work effectively.
● New staff had an induction and were expected to attain the Care Certificate if they were new to care work. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● The registered manager was arranging for all staff to attend mandatory training on autism and learning disability

Supporting people to eat and drink enough to maintain a balanced diet
● Mealtimes were relaxed, enjoyable experiences. Some people chose to socialise at mealtimes; others preferred to eat alone.
● People talked with staff and to each other about how much they enjoyed what they were eating. People told us they had a choice of food and liked their meals at Livability Marion House.
● Staff understood people's dietary needs and ensured these were met. Support plans set out clearly any support staff needed in this regard.
● Staff prepared most meals, although people were encouraged to be involved in shopping and food preparation if they wished. Menus were agreed in consultation with people.

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). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

● People's consent to their care was recorded, if they understood what they were consenting to. Staff respected this.
● Where there were concerns a person might not understand the implications of consenting to something, staff assessed their mental capacity to consent following the principles of the MCA.
● Where a mental capacity assessment showed a person was unable to give informed consent in relation to some aspect of their care, staff made a best interests decision regarding the care to be provided. The person

and their family and professionals who knew them well were involved in deciding on how to provide the care the person needed in the least restrictive way.

- The registered manager and staff had identified people who were deprived of their liberty and had applied to the relevant local authority to authorise this.
- Staff had training about the MCA, including DoLS.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

The rating for this key question has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and relatives told us they liked the staff, who they found kind and respectful. A relative commented, "The staff seem caring and they are welcoming when I visit."
- Throughout the inspection, staff treated people with respect, encouraging and nurturing them. This came across as natural and routine, as opposed to awkward and staged.
- The registered manager and staff knew each person well, understanding their support needs and preferences, including their communication styles.
- Staff understood and respected people's privacy. They supported people sensitively to understand and get on with their partners and to enjoy their intimate relationships.
- Staff promoted people's independence and encouraged people to celebrate their achievements. People confirmed that staff encouraged them to do things for themselves and did not provide too much support.
- Support plans included details of people's spiritual and cultural needs. Religious faith was important to most people using the service. Staff supported people to practice their faith, by attending physical or on-line church services.

Supporting people to express their views and be involved in making decisions about their care

- From day to day, staff encouraged people to make choices for themselves, for example, about what they wanted to do that day or what they fancied to eat.
- People had access to a staff rota photo board, which showed who was working. They valued knowing which staff were and would be on duty.
- Activity planning was based on people's aspirations. There were regular discussions with individuals and during house meetings about what they wanted to do and to try.
- People and their relatives were involved in reviewing care plans. A relative told us, "The care plan review I am always invited to; I get sent the paperwork and everything I read is fine."
- Some people using the service had their own independent advocate to support them to have their voice heard in relation to their care and support. The registered manager understood the importance of advocacy and knew how to access advocacy services.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

The rating for this key question has remained good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People told us the support they were getting was at the right level for them, so they had the support they needed without being robbed of their independence. A relative commented, "I am happy with the care given."
- Each person had an individualised support plan, designed and reviewed in consultation with them and the people important to them. They had regular meetings with their key worker to discuss their hopes for the future, how their plan was working and any changes they wanted to make.
- Support plans were written in people's preferred language and were easy to read. They included summaries so staff and other professionals had the most important information readily to hand.
- Staff supported people in a way that was consistent with the instructions in people's support plans. They were clear about how people needed and wanted to be supported, including when they were experiencing distress.
- Daily recordings varied in the level of detail, although key information was included. Some staff made the effort to record in people's words how things had been for them that day. This variation was associated with staff learning and becoming comfortable with the new computerised recording system.
- The service was expected soon to become a supported living service rather than a care home. The registered manager and deputy anticipated this would further promote individualised care and support focused on what people wanted to work towards and achieve.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People received the support they needed to communicate and be understood, including being involved in decisions about their care. This support was from staff who had a clear understanding of their communication styles.
- Support plans clearly set out people's communication needs, and how staff were to assist them with these.
- People received information in a format that was accessible for them, such as easy to read illustrated documents.
- Communication needs were shared as necessary, for example when people were admitted to hospital or

had health appointments.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People maintained hobbies and interests, with any support they needed to do this. The pandemic had restricted outside activities as some social and activity groups had not resumed and some people were cautious about mixing outside the household. Despite this, people took part in things they enjoyed and were searching for new opportunities.

● Staff supported people one-to-one to take part in things they enjoyed. For example, one person particularly liked taking car trips and did this with staff during the inspection.

● There was an ethos of a sense of belonging being central to people's support. Staff therefore encouraged people to get involved in their local community involvement, for example, through attending church and using other local facilities.

● During lockdowns, the provider had organised group video calls for activities such as exercises, games and quizzes. These had continued due to their popularity; people described them enthusiastically and took part in various such activities while we were in the house.

● People kept in contact with friends and relatives, with staff supporting them as needed to arrange visits and phone or video calls.

● People talked at house meetings about what they had been doing, events they wanted to plan and things they wanted to try.

Improving care quality in response to complaints or concerns

● People felt they could tell the registered manager and senior staff if they were concerned about any aspect of their care and support.

● The service used the provider's complaints and concerns procedure, which required acknowledgement and response to complaints within a short timeframe.

● Complaints and concerns were addressed openly and honestly. They were used as an opportunity for learning and improvement.

End of life care and support

● The service was working on "When I die" plans with individual people and their families. These included where people wanted to be cared for if they were very ill, their wishes and plans for burial or cremation, any wishes regarding a funeral service and who they would like their possessions to go to.

● This had been prompted by a death earlier in the year of someone who was seriously ill. The person had been supported, by the service working in partnership with health professionals, to remain at Livability Marion House as they wished, rather than go into hospital.

Good

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.

The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a homely, relaxed atmosphere at Livability Marion House. The registered manager had fostered a person-centred culture, where staff treated people as individuals, upholding their rights and encouraging and enabling them to live life as they wanted.
- People knew the registered manager well and frequently approached her during the inspection. They spoke positively about the registered manager, referring to her by name.
- Staff found the registered manager and senior staff to be approachable and supportive. They felt able to raise concerns with them.
- The registered manager routinely spent time with people and staff whenever she was on site, observing and hearing about how the mood was around the service and about any concerns people raised.

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 provider and registered manager exercised their duty of candour through their openness and honesty with people and their relatives in the event of something going wrong or a near miss. This included making an apology for what had happened.

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

- People and staff voiced confidence in the leadership of the service.
- The registered manager had invested time and effort in developing staff skills and confidence, delegating tasks with support so staff felt more able to manage a range of situations in the registered manager's absence. Consequently, staff had become skilled in supporting people when they were distressed; staff had previously seen this as the manager's role alone. This meant people's needs were met more promptly and effectively; it had also boosted staff morale.
- Care staff understood their roles and responsibilities. Regular staff supervision made clear what was expected of them and gave them feedback about how they were doing.
- Quality assurance processes gave the registered manager and provider an overview of the service, helping ensure people received safe, good quality care and support. This included audits of various aspects of the service, such as medicines, health and safety and infection control. Any issues identified were listed on the service's action plan, for the registered manager and provider to monitor that they had been rectified.
- The service had notified CQC of significant events and incidents, which is a legal requirement. The rating from the previous inspection was displayed on the provider's website.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People had opportunities to get updates and give their views about the service and any developments they would like to see. These included regular house meetings, monthly key worker meetings, support plan reviews and ad hoc conversations with the management team.

● People were also able to contribute their views through involvement in quality assurance audits, such as taking part in regular health and safety checks. This enabled people to raise matters that staff might not see as important.

● Surveys of people, relatives and staff were under way. The findings, if they required any action, would be included in the service's action plan.

● Monthly staff team meetings provided updates for staff about current developments and changes at the service. There were discussions about people's care, areas for improvement and any matters raised by staff.

● The service worked in partnership with health and social care professionals, such as GPs and members of community learning disability teams, to optimise people's care and wellbeing. For example, the service had been liaising with a range of professionals to get the right moving and handling equipment for a person and to fund additional staff time, enabling the person to retain as much independence as possible whilst remaining safe.