Progressive Care (Derbyshire) Limited

Lilybank Hamlet Care Home

Inspection report

Lilybank Hamlet
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Lilybank Hamlet Care Home is a residential care home providing personal care for up to 63 people. The service provides support to people with dementia, older people and people with a learning disability. At the time of our inspection there were 31 older people living at the main house and a second home provided personal care and support for 4 people with a learning disability.

The main home is set over 3 floors with a lounge, dining room and conservatory on the ground floor and further communal spaces to the second floor. The smaller home was adjacent to the main house and had 2 communal areas and shared bathroom facilities. Both homes had access to outdoor space.

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.

People's experience of using this service and what we found
Medicines were not always safely managed. Systems were not used effectively to monitor stock levels and medicine storage was not secure and monitored. Routine safety checks were not in place putting people at risk of avoidable harm. Governance systems were not effective in monitoring and mitigating risks to the health, safety and welfare of people using the service.

Right Support: Improvements were required from the provider to ensure staff received the training they needed to meet people's needs, not all staff had received training in supporting people with a learning disability or autism.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service also did not support people to have choice and control over their own lives.

Right Care: Care plans did not always reflect the care that people received from the staff team and did not always demonstrate the underpinning principles of Right support, right care, right culture. People were not supported by staff who knew them well as some of the staff team were scheduled to work between the 2 homes. People had access to health care professionals. Family members felt that their relatives were safe at the service. Appropriate checks were carried out when recruiting new staff to support people.

Right Culture: People's accommodation and care was focused on keeping people safe and was not focused on effectively listening to them and the promotion of people having control over their lives and living an ordinary lifestyle. For example, people were not supported to access and participate in their local

community. People felt able to raise concerns and felt that the management team were approachable. Staff also felt supported in their role and felt able to raise concerns if necessary.

The provider acknowledged at the beginning of the inspection that they were exploring renovation options, although there was no schedule in place.

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

Rating at last inspection and update
The last rating for this service was Good (published 24 February 2020)

Why we inspected
We received concerns relating to staffing, activities and maintenance of the environment. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. We are assured the home manager has taken action following the inspection to address our concerns.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lilybank Hamlet Care Home on our website at www.cqc.org.uk.

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

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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?

Requires Improvement

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Lilybank Hamlet Care Home

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 completed by 2 Inspectors 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
Lilybank Hamlet Care Home 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. Lilybank Hamlet Care Home 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
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was no registered manager in post, however the home manager, who had been in post for 12 months, told us they were submitting an application to register as the 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 information gathered as part of monitoring activity that took place on 16 December 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 9 relatives about their experience of the care provided. We spoke with 5 members of staff including the home manager, senior care worker and care workers.

We reviewed a range of records. This included care records for 4 people and multiple medication records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

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 good. 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks were not being managed safely. Health and safety checks were not in place to identify hazards and monitor risks.
- Hot water temperatures were not monitored. One tap was found to be hotter than recommended maximum temperature and another felt hot to touch, this meant people were at risk of scalding.
- The water system in the home was not sufficiently maintained, there were no checks to prevent the build-up of Legionella. This meant people were exposed to the risk of Legionnaires disease.
- We identified 4 window openings above ground level which exceeded the recommended guidelines for care homes and a room where rope hanging from a high level window was a ligature risk.
- We identified a balustrade above a staircase was not secured and had excessive movement. This meant the staircase was not safe and created a risk to people.
- Two-way radios had been introduced by the home manager to support evacuation, one staff member on the 3rd floor told us they would collect a walkie talkie from the ground floor when the alarm sounded. This meant evacuation for people in the home may be delayed.
- Chemicals were found stored in a bathroom accessible to people. This meant people were at risk of harm.
- Environmental risks had not always been considered or assessed. We found tall furniture in people's rooms which had not been secured to the wall. This meant people were at risk of injury if furniture became unstable when opened.

Whilst no harm occurred, care and treatment was not being provided in a safe way for people. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Accidents and incidents were reviewed and investigated by the management team. We found appropriate actions had been taken to reduce the risk of re-occurrence.
- The home manager regularly analysed accidents and incidents to identify any emerging themes or patterns in order to improve the care provided.

Using medicines safely

- Systems and processes were not robust for managing medicines safely.
- We found the quantity of medicine stored and received was not recorded. One person had more medicine left than was required for the month, however all medicine had been signed as administered and additional medicine could not be accounted for. This meant people were at risk of not receiving their medicine.

● Medicines were not always stored safely. Temperatures were not monitored in rooms where medicines were stored. We found a person's cream required storage below 25 degrees and had been stored in an exceptionally warm room.
● A medicines trolley was found unattended in the corridor unlocked with the keys in. We raised this with the home manager who took action to ensure the medicines trolley was secured.
● We observed the senior carer administering medicines at both homes during the day, this meant some people had to wait longer for medicines. The home manager told us more staff would be trained to give medicines.

Preventing and controlling infection
● The provider did not always promote safety through the layout and hygiene practices of the premises.
● We found flooring did not fully cover the surface in a toilet area, cleaning of the exposed wooden surface would be ineffective.
● Surfaces in the laundry room were not clean.
● Infection control checklists were completed, however these did not cover the laundry room or identify the flooring in the toilet.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. Staff had received training in how to safeguard people from abuse. Staff understood how to report any concerns they had to relevant professionals.
● Safeguarding incidents had been correctly reported, recorded and investigated. We found that appropriate actions and referrals to relevant professionals had been made to reduce the risk of reoccurrence.
● People and their relatives told us they felt the service was safe. One relative told us, "[Relative] is safe and well looked after."

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal

authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment

● There were enough staff available, however they did not always have the training to support people's specific needs. For example, staff had not always received specific training to support people with a Learning Disability or how to meet people's specific communication needs. For example, one staff member told us a person they supported had taught them how to use their method of communication.

● Staffing of the smaller home was not always consistent, one relative told us, 'There are no longer dedicated staff for where my [relative] lives, they come over from the main house.'

● We observed staff responding to people's needs quickly, however, one relative told us, 'I don't think they have enough staff.', another told us 'Staff are fantastic, but there are not enough.'

● The provider followed safe recruitment practices. The provider carried out checks such as Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Staff received regular supervision meetings. We found the home manager discussed the induction experience with staff and offered future training and development opportunities.

Visiting in care homes

● Relatives and friends were able to visit people in the home without restriction, this was kept under review, the home manager told us visitors only needed to wear a mask. We saw relatives calling in during the inspection.

Requires Improvement

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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance and risk management was not always reliable and effective.
- Systems to monitor health and safety were not robust. Regular health and safety checks were not taking place.
- Audits had failed to identify the environmental risk to people as identified in the safe domain of this report.
- Audits had failed to identify and address staff training, so that staff had the training they needed to meet people's needs.
- Where audits had identified areas for improvement, these were not always carried out in a timely way. For example, an audit identified a malodour to communal carpets, an action to replace had been noted in September 2022, however carpets were not replaced, and the malodour was present during our inspection. One relative told us, "The place is very tired. It could do with some renovations."
- The provider's monitoring systems and processes were not robust as they had not identified the risks to people found by inspectors.
- Audits of medicine records had failed to recognise unsafe practice reported on in the safe domain of this report.
- Feedback was sought from relatives, but actions were not always taken. This meant the provider had failed to use the feedback they had received to drive improvements in the service.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1), (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Outcomes for people were not always achieved. One person's care plan said they would like to go out more, however this had not been supported. A relative told us "[Relative] likes to go out shopping, lunch, garden centre…. Last manageress used to take them out in a minibus, but not anymore".
- We also found another person's care plan said they wished to access the community occasionally at quieter times and quieter places. No evidence was found to support this had taken place. We found

alternative activities had been offered to people, however these had not been to people's preference and therefore they had chosen not to participate.
● One relative told us, 'I think they are wonderful. They always have time to chat to [relative], I can't speak highly enough about them."

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.
● There was no registered manager in post at the time of our inspection. The home manager told us they were planning to submit an application to register.
● The provider had met the duty of candour and was open and honest with people and their families.
● The provider is legally required to notify us when certain incidents occur. The home manager understood how and when to notify us and sent in notifications appropriately.
● The provider displayed the previous inspection ratings poster in the home in a prominent position, so people and visitors had access to it.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received mixed feedback from relatives. One relative told us, "I speak to [manager] regularly." Another told us "the last one left 12 months ago ….. I have no contact with [manager]."
● The provider said furniture to make the conservatory more inviting and cosier had been requested following feedback from a relative survey in October 2022. The conservatory had minimal furniture at the time of our inspection.
● Where people had given feedback about how they wished to be supported, evidence did not support that people had been listened to. For example, one person had expressed a personal goal however there was no evidence to show this had been recognised.
● The home manager ensured staff were kept informed of any changes in the service. Staff meetings had taken place and important information was regularly shared with the team.

Continuous learning and improving care
● Improvements identified by the provider were not always actioned.
● The home manager told us improvement works had been identified, however no works had been scheduled.
● One staff member told us, "[manager] will listen and tell staff what they have changed"

Working in partnership with others
● The home manager and staff worked closely with other professionals such as social workers and GP's to ensure people's care needs were met.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Whilst no harm occurred, care and treatment was not being provided in a safe way for people. This placed people at risk of harm.

The enforcement action we took:

We issued the provider with a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people were harmed, however, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

We issued the provider with a warning notice