Lilycross Homes Limited

Lilycross Care Centre

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

The inspection was unannounced and took place on the 21 January 2015. An arranged visit to complete the inspection was then undertaken on the 30 January 2015.

The last inspection took place on the 20 May 2014 when Lilycross Care Centre was found to be meeting all the regulatory requirements looked at and which applied to this kind of home.

One of the conditions of registration for the home was that it must 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. At the time of our inspection although there was a manager in place they had not registered with the Care Quality Commission.

This is a breach of the Care Quality Commission [Registration] Regulations 2009 Regulation 5 relating to the registered manager.

Summary of findings

Lilycross Care Centre is a purpose built home offering people personal care with nursing for up to 60 people. The home is located close to Widnes and St Helens and is close to the local bus route. The care home has three units which the provider calls suites, Lily, the general nursing care suite on the ground floor, Rose, the nursing dementia care suite on the first floor and Bluebell, the residential dementia care suite on the second floor. All bedrooms are en-suite with several rooms also having shower facilities. On the first day of our inspection there were 17 people living in Lily suite, 15 in Rose suite and seven on Bluebell suite.

During this inspection we have identified a number of concerns relating to how the service was managed.

We found that the provider had appointed staff members on a bank basis which meant they were not actually employed by the home. The potential consequence of this was that the bank staff working there may not know the care needs of the people they were caring for.

We found that there were issues with the care and welfare of service users, recruitment and induction of bank staff, training and supervision for staff, obtaining consent from the people receiving a service, notifiable incidents not being sent to the Care Quality Commission as required under the regulations and a lack of any quality assurance or clinical governance for both the manager and unit managers being undertaken by the registered provider.

These were breaches of Regulations, 9, 10, 20, 22 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations, 9, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found breaches of Regulations 5, 16 and 18 of The Care Quality Commission [Registration] Regulations 2009.

You can see what action we told the provider to take at the back of the full report.

The Lilycross staff members we spoke with were generally positive about how the home was being managed but did have concerns regarding the working and pay arrangements. These were the responsibility of the provider and not the manager who was subject to the same terms and conditions of employment.

To give a balance to the above we have found many examples of good practice particularly when we asked the people living in Lilycross about the home and the staff members working there. We received mainly positive comments that included, “They are very good, they can’t do enough for you” and “It’s very good”. On one occasion whilst in the lounge talking to residents we saw one carer go up to a resident, give her a hug and kissed the top of her head in a very kind and caring manner. Another person who preferred to stay in their room said of the care staff, “They are fine, they treat me with respect and they always knock on the bathroom door”. They went on to tell us that when they had woken up early that morning the night staff had made a cup of tea, and a while later, because she had said she was hungry had brought her a plate of biscuits and more tea as it was still too early for breakfast. This person also said,” I’m looked after well, if I ask for something I will get it, I never have to wait long”.

A visiting relative said about their relative, “she didn’t want to come, but now she is happy”.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe because the recruitment processes were not robust and there was a reliance on staff not actually employed by the home to provide care to the people living there. This was a particular problem during the night.

We found that the people living in the home did not have an individual Personal Emergency Evacuation Plan [PEEPS] in place.

We found that the arrangements for managing medicines were safe.

Is the service effective?

Requires Improvement

The service was not always effective because although the home's staff members told us that they received regular training and had supervisions no evidence was provided to confirm that this was happening.

We were unable to confirm what induction and training bank staff members were receiving.

The home was well maintained and provided an environment that could meet the needs of the people that were living there.

Is the service caring?

Good

The service was caring and when we asked the people living and visiting Lilycross about the home and the staff members working there. They all commented on how kind and caring all the staff were.

The staff members we spoke to could show that they had a good understanding of the people they were supporting and they were able to meet their various needs.

Is the service responsive?

Requires Improvement

The service was not always responsive because written consent was not being obtained from the person themselves and if this was not possible the person's family or representative had also not agreed to the care being provided.

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy.

Is the service well-led?

Inadequate

The service was not well led because there was no registered manager in place.

Although the staff all said they could raise issues and discuss them with the manager they did comment that he was not allowed to manage.

Summary of findings

In order to gather feedback about the service being provided Lilycross handed out questionnaires to family members every six months.

There were no quality assurance checks undertaken by the provider in order to assess the quality of care being provided. In addition there were no clinical governance or audit arrangements in place with regard to the manager and unit managers.

Lilycross Care Centre

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.

We carried out an unannounced inspection on the 21 January 2015 and then undertook a second announced visit on the 30 January 2015. The first day of the inspection was carried out by two adult social care inspectors, a specialist advisor who had experience in working with people with dementia 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. The announced visit on the second day was undertaken by one adult social care inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The manager told us that this document had not been received.

Before the inspection we reviewed all the information we held about the home including any notifications they had made and any comments we had received from other sources such a members of the public. Because there had been a variety of issues surrounding the home the local authorities who fund placements there [Halton and St Helens] had had a 12 month support plan in operation. This was due to finish in April 2015. The CQC have been involved in this process and have been attending regular professionals meetings in order to monitor the situation in accordance with its regulatory responsibilities.

During our inspection we saw how the people who lived in the home were provided with care. We spoke with a total of nine people living there, four visiting family members and approximately 15 staff members including the manager [some staff members spoke to more that one member of the inspection team]. The people living in the home and their family members were able to tell us what they thought about the home and the staff members working there.

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

We looked around the home as well as checking records. We looked at care plans and a variety of other documents including policies and procedures and audit materials.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe and they told us, **"**The staff are in and out all day", "They do come when I ring. It depends. They come as quick as they can" and "In the night there is two or three to look after you".

We saw that the service had a safeguarding procedure in place. This was designed to ensure that any possible concerns that arose were dealt with openly and people were protected from possible harm. The manager was aware of the relevant process to follow.

There had been on-going concerns regarding the home since our previous inspection took place and the CQC have been working closely with other agencies involved with the home including the main two local authorities who place people there, Halton and St Helens. We were also aware that the home was still under a 12 month support plan that started in April 2014 and under constant quality assurance monitoring by both councils.

During the inspection we were made aware of an issue regarding one of the people living on Rose suite that had occurred during the previous night. Although this was dealt with appropriately at the time we did identify some concerns regarding the circumstances. The unit manager told us there had been previous recent cause for concern regarding this person. We asked if we could see the records relating to this incident and the subsequent monitoring of the person. The unit manager said she could not find any related records so assumed the night staff had not completed them. Appropriate accident/incident paperwork for this person was not completed and there was no record in the person's file that this had happened. The manager was made aware of this and a safeguarding referral was made to Halton safeguarding team.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had failed to ensure that the people using the service were protected against the risks of unsafe or inappropriate care because accurate records were not being maintained. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members told us that they had received training in protecting vulnerable adults and that this was updated on a regular basis. The staff members we spoke with told us they understood the process they would follow if a safeguarding incident occurred and they were aware of their responsibilities when caring for vulnerable adults. One person said, "The safeguarding team are quick to respond and are very supportive." From our observations we found the staff on the three suites caring and attentive to the residents. The care staff on Rose suite all told us they enjoyed working on the suite and were aware how to raise a safeguarding concern. We also saw information concerning this on the notice boards across the three suites with relevant telephone numbers for whistle blowing. The staff members we spoke with were also familiar with the term 'whistle blowing' and that the home had a policy regarding this. They said they would use it if necessary.

Relevant risk assessments, for example, moving and handling, risk of falls and mobility contained clear instructions for staff regarding the support and care required and were kept within the care plan folder. This helped to ensure that people were able to live a fulfilling lifestyle without unnecessary restriction.

Bluebell suite is comparatively small and at the time of the inspection there were only seven people living there. There was one staff member on duty throughout the day and night. Whilst this was not a concern because the people's dependency needs were relatively low we were told that there were times when the staff member needed to provide personal care to people, for example, help with a bath or shower. This meant that there was no staff member available for the other people on the suite. There was no risk assessment in place to confirm if this was a safe practice.

Staff members were kept up to date with any changes during the handovers that took place at every staff change. This helped to ensure they were aware of issues and could provide safe care.

We found that the people living in the home did not have an individual Personal Emergency Evacuation Plan [PEEPS] in place. This was good practice and would be used if the home had to be evacuated in an emergency such as a fire. It would provide details of any special circumstances affecting the person, for example if they were a wheelchair user. We did see that people had a hospital admission procedure in place including a dedicated admission form should they need to be admitted to hospital.

Inadequate

Is the service safe?

Apart from the administrator all of the staff who had been appointed recently were bank staff members, not Lilycross staff. The recruitment files for these staff members were at another home.

We therefore could not confirm from the documentation within Lilycross that effective recruitment procedures had been completed. The manager explained that he was not involved in the recruitment of these staff and that this was done by the registered provider. We asked what information was held in the home and were given the file for a bank nurse who worked there on a Monday and Tuesday. This contained a health declaration and an emergency contact details form that the administrator and manager had asked them to compete. In addition there was a home induction sheet that contained information such as the location of the fire exits and a Disclosure and Barring Service (DBS) disclosure number. This check aims to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. There was no documentation whatsoever for any of the other bank staff employed. We asked the manager to contact the provider who then brought the recruitment documentation for the bank nurse to Lilycross. When we looked at these we saw there was an application form, CV, health questionnaire, an authorisation form to obtain references and two references. The CV clearly stated that the current employer was a recruitment agency from 2004 to date. This differed from the information on the application form. There was no reference from the current employer and the two references obtained appeared to be from other care services where the employee had or was still working as an agency staff member. Because the manager was not involved in the recruitment process he could not provide an explanation for this.

This is a further breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010. The records relating to recruitment were not being maintained appropriately. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that policies and procedures were in place to help ensure that people's medication was being managed appropriately. Medicines were administered by the nurses or senior care staff working on each of the three suites. We saw that both the medicine trolleys and the treatment rooms on each of the three units were securely locked. We checked the medication arrangements on all of the suites and observed medicines being dispensed on two of them [Lily and Rose]. Whilst we found that the practices for administering were safe on Lily we did see an unsafe practice on Rose suite. One person was given their medicine inappropriately. The person's preference was that the tablets were placed directly into their mouth. We watched the unit manager do this with their fingers however they did not wash their hands either before or after completing the task. We passed this on to the manager who confirmed that he would deal with the matter. Notwithstanding the above we did find that on all three suites that medications were stored correctly and Medicine Administration Records [MAR} sheets were also correctly completed. Although no concerns regarding medicines were noted on the days of the inspection we are now aware that a safeguarding referral regarding medicines has now been made and was being dealt with as a separate issue by Halton Borough Council's safeguarding team.

We observed throughout the first day of the inspection that there were times when no staff member was in the lounge on Lily suite despite the fact that there were five or six people sitting in there, none of whom could move without assistance. This occurred three times in the morning and on one occasion we went to find a carer as one person needed to use the toilet. The carer came quickly and took the person in question to the toilet. The person we were talking to at the time said, "That was lucky, we sometimes have to wait a while" and went on to say this sometimes meant that people had "accidents". This person also said, "I don't think there are enough people to look after us". In the afternoon on three separate occasions we again found that five people were sitting in the lounge and no carers were either in the lounge or in the immediate vicinity. On all occasions people did not have any means, for example a call bell to call a carer.

We did not identify the same issue occurring on either of the other two suites and on Rose suite a member of staff was always present in the lounge and office area, we never observed peoples left unattended. We passed our concerns on to the home manager and when we returned on the second day he explained that he had addressed this issue. He had put a table in to one corner of the lounge and care staff members had their breaks in there and also completed any daily notes. This ensured that staff members maintained a presence in the lounge.

Inadequate

Is the service safe?

Although our observations during the inspection indicated that there were sufficient staff on duty we did receive a comment that there should be more staff. A person using the service living in one of the suites told us that in their opinion, "I think they are understaffed at times".

The staff members we counted during the inspection and the rotas we looked at confirmed that during the day on the first day of our visit there was one nurse [the unit manager] and three care staff members on Lily suite. One nurse [also the unit manager] and three care staff members plus a one to one carer on Rose suite and one senior care staff member on Bluebell suite. At night there was one nurse and one carer on Lily and Rose suites and one care staff member on Bluebell suite.

The manager's hours were in addition to these numbers although we are aware that there are days when they have to cover the rota. In addition to the above there were separate ancillary staff including an administrator, kitchen, cleaning and laundry staff plus the home's maintenance staff.

Whilst we didn't have any concerns regarding the actual staffing level we did have concerns relating to the use of bank staff and the lack of control over the rota that the manager has. A high percentage of staff, particularly at night were not actually employed by the home. They were bank staff members employed by another provider. Comments from staff members included, "All night staff are bank", "The home director brings pool [bank] staff from [another home] when we are short". This meant that the people living in the home may not be getting the appropriate care particularly on Lily and Rose suites where people had a high level of care needs or could have behaviour that challenged both requiring input from staff members that knew their needs. We also had concerns that the home manager was not responsible for the rota, this was now done by the provider who appointed and supplied the bank staff. The consequence of this was that there were times when the home manager did not know who was due on shift and if a staff member phoned in sick the manager was not allowed to get cover.

This is a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 because the registered person had failed to ensure that there were sufficient staff with the right knowledge and understanding of people living at the home to ensure their health, safety and welfare. This corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records of monies held by the home on behalf of the people living there and could see that good records were being kept and the balances were being audited on a regular basis by the manager. This meant that people's monies were being handled safely.

Although our observations throughout the three suites during the inspection were of a clean, fresh smelling environment which allowed people to move around freely we found the general bathroom door on the corridor within Rose suite unlocked. We felt this could be dangerous if people living on that unit wandered into the bathroom unsupervised.

We also found on Rose suite that the kitchen fridge had an opened tin of rice pudding with half of the contents missing. We were told that this belonged to a resident however there was no label stating when it had been opened and the contents should have been transferred into a clean covered container. There were no records kept on the fridge temperature in the kitchen.

Staff members told us there was plenty of specialist equipment available to meet people's needs including airflow mattresses and cushions to reduce the likelihood of pressure sores.

Requires Improvement

Is the service effective?

Our findings

One relative we spoke with on Rose suite told us "Staff are sensitive to my dad's needs although I feel they could interact with him a little more, just because he prefers to spend time in his room doesn`t mean he doesn`t want to do anything.

The manager told us that no induction for the bank staff was carried out at Lilycross and he did not know what induction they had received when they had been appointed. The manager did say that there was an orientation file for agency staff that was used to explain basic information such as the fire exits, this had been used with the bank nurse on duty that day but had not been used for any other of the bank staff members.

We asked two care staff members about training and they told us that they were completing a course on dementia care using booklets to be completed each month. They also said that training was advertised and that it would take place several times over a couple of weeks to enable people to attend. The staff members we spoke with told us, "I'm due moving and handling as It's due every 12 months", "We had basic safeguarding a couple of months ago and I've started doing the dementia booklets. A notice has gone up downstairs about infection control, end of life and quite a few others" and "At the moment I am doing a dementia course which is in six units, one each month".

We have requested a copy of the staff training records but have not received it. As a consequence and although staff members told us that they were receiving regular training we cannot confirm what has taken place or if it was up to date.

This is a further breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 because the registered person had failed to provide training records in relation to the staff employed at the home. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nursing staff told us that they received supervision every six weeks from the home manager and appraisals were being introduced. We were also told that the manager undertook the supervision of the care staff members too. One staff member we spoke with said, **"**I'm waiting for a date for my appraisal. It will be the first one I've ever had". The care staff we spoke with also told us that they received supervision but we have been unable to confirm if all staff members were receiving regular supervision. The bank staff members were not receiving any supervision from any staff members working at Lilycross. Supervision is a regular meeting [regular is approximately every six to eight weeks]. between an employee and their line manager to discuss any issues that may affect the staff member; this may include a discussion of the training undertaken, whether it had been effective and if the staff member had any on-going training needs.

This is a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 because the registered person had failed to ensure staff members were receiving appropriate supervision. This corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that whilst there was good general interactions between staff and the people using the service we did not see much interaction during the mealtime observed on Lily suite. We did however see that staff took time to ensure that they were fully engaged with each person and checked that they had understood before carrying out any tasks with them. Staff explained what they needed or intended to do and asked if that was alright rather than assuming consent. Whilst in the lounge talking to the people using the service we saw two staff members moving someone in a hoist. We observed that throughout the process they were talking to the person and explaining exactly what they were doing.

Policies and procedures had been developed by the provider to provide guidance for staff on how to safeguard the care and welfare of the people using the service. This included guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). This is a legal requirement that is set out in an Act of Parliament called The Mental Capacity Act 2005 [MCA]. This was introduced to help ensure that the rights of people who had difficulty in making their own decisions were protected. The aim of DoLS is to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

We saw that mental capacity assessments were being completed by the qualified nurses on Lily and Rose suites or the senior carers on Bluebell suite and where necessary best interest decisions were made involving a social worker. If applicable a DoLS application was completed.

Requires Improvement

Is the service effective?

These were only completed if the person was deemed to be at risk and it was in their best interests to restrict an element of their liberty. The application was submitted to the local social services department who were responsible for agreeing to any DoLS imposed and for ensuring they were kept under review. We saw that two of the residents on Rose suite were subject to a DoLS order.

On Rose suite we saw that one of the people that was subject to a DoLS authorisation was being supported on a one to one basis. We observed the bank member of staff doing this sitting near to the person, however despite this person's care plan stating that stimulation and interaction was required, we did not observe this taking place. We also observed this same staff member standing next to the person they were supporting whilst they were eating their lunch. This did not look dignified and we asked the unit manager to speak to them regarding this. This was done immediately am the staff member sat down; even though this had happened there was still little interaction taking place.

The staff members we spoke with felt they needed more training on the MCA and DoLS but they did have access to a useful guide given to them by Halton Borough Council.

The information we looked at in the care plans showed that staff had the information they needed to enable them to respect people's wishes regarding their chosen lifestyle. We saw that care plans described people's likes and dislikes and how these might influence their routine. For example on one file we saw notes regarding a wish to be woken up if visitors arrived. This was recorded in the Care Plan.

We looked at some of the additional records maintained by staff members, these included key worker comments that were completed and included updates on any communication with families. These were signed and dated. We also saw summary of care notes being completed by care staff members; these included observation charts, daily tasks completed and a record of food and fluid intake. These were also signed and dated

Visits from other health care professionals, such as GPs, speech and language therapists, dieticians, chiropodists and opticians were recorded so staff members would know when these visits had taken place and why.

The chef explained that there was a three week menu and they confirmed that special diets such as liquidised and diabetic meals were provided if needed. They also told us that if someone wanted something else they could provide other choices that were in addition to those on the menu. We saw that there were specific instructions about the consistency of food required by people with swallowing problems. A staff member we spoke with told us, **"**There is a list of food preferences in the kitchen". There were three people on Lily suite who had swallowing problems. They were being cared for in their beds. We were told that assessments by Speech and Language Therapists [SALT] were carried out (we saw one such assessment) with their recommendations seen in the care plans. The catering staff then received information from the nursing staff in order to provide the appropriate consistency of food. One carer on Lily suite told us they had received training from a SALT on safe swallowing, the other two on duty had not. We saw three people in bed being supported to eat in poor positions and one person was coughing whilst this occurred. When we commented we were told that the cough was the person avoiding food they did not like.

This a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had failed to take proper steps to ensure that the people using the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe. This corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On Lily suite we saw that people had their meals in the dining room, in the lounge or in their own rooms at lunch time. We saw little variety of hot food served, the choice on the first day of our inspection was corn beef hash and cabbage or corn beef and chips with a hot dessert to follow.

On Rose suite we did observe one person saying they did not want corned beef. They were offered a choice of two soups and bread & butter which they appeared to enjoy. Although we observed that people were supported and encouraged to eat meals we did hear one staff member say to someone on Lily suite, "We don't want you to make a mess do we". This person had a bib around her neck to which she had not consented.

We received a variety of differing comments about the food being provided and the people using the service told us, "Some days it's quite good, I'm learning to put up with it. The porridge was lumpy but the toast was awful and only cooked on one side". This person went on to say that they

Is the service effective?

had not been keen on the lunch served because there had only had a choice of two corned beef dishes. However some of the other people we spoke with had different comments to make, “The food is like home cooking, very good food”, ”The meals are very good, tasty. They ask what we want the day before. We get quite a bit of fish, which I like, and we get two hot meals a day” and “I’ve always said since I’ve been here that the meals have been good”.

A family member who was visiting said, “I think the food is alright, last week they made a gorgeous cake and for breakfast he can have whatever he wants. Last night he didn’t want dinner so they made him soup and sandwiches, the kitchen staff are lovely”. Another relative said, “It’s just ok, there is a choice, it’s usually a bit cold”.

We saw throughout the day on all floors that staff members were asking people if they wanted a drink and providing them what they wanted. We also saw that a record was kept of fluid intake where necessary.

We saw that the staff monitored people’s weights as part of the overall planning process on a monthly basis and used the Malnutrition Universal Screening Tool (MUST) to identify whether people were at nutritional risk. This was done to ensure that people were not losing or gaining weight inappropriately.

A tour of the premises was undertaken; this included all communal areas including lounge and dining areas plus and with people’s consent a number of bedrooms as well. The home was well maintained and provided an environment that met the needs of the people that were living there. We saw that where needed people had the use of airflow mattresses and cushions to reduce the likelihood of pressure sores.

The home provided adaptations for use by people who needed additional assistance. These included bath and toilet aids, hoists, grab rails and other aids to help maintain independence. Although the unit manager on Rose suite told us that if she required any additional equipment for people she contacted the owners of the home and the request was usually fulfilled quickly our observations were of a suite that although well-lit, required decorating. It also needed suitable signs and pictures on doors and walls to ensure it was a suitable dementia friendly environment. When we asked about this we were told staff were fundraising to purchase materials to assist with this.

The laundry within the home was well equipped and there were systems in place for the care of people's clothes. The laundry appeared to be well organised and we did not receive any negative comments regarding the laundry service during the inspection.

We recommend that additional training in the MCA and DoLS is provided for staff members.

We recommend that given the differing comments regarding the food provided the registered provider consults with the people living in the home regarding this so that if necessary improvements to the menu could be made.

Good

Is the service caring?

Our findings

We asked the people living in Lilycross about the home and the staff members working there. One person said regarding the carers, "They are very good, they can't do enough for you" and "It's very good". On one occasion whilst in the lounge talking to people we saw one carer go up to someone, give her a hug and kissed the top of her head in a very kind and caring manner.

Another person who preferred to stay in their room said of the care staff, "They are fine, they treat me with respect and they always knock on the bathroom door". They went on to tell us that when they had woken up early that morning the night staff had made a cup of tea, and a while later, because she had said she was hungry had brought her a plate of biscuits and more tea as it was still too early for breakfast. This person also said," I'm looked after well, if I ask for something I will get it, I never have to wait long".

A visiting relative said about their relative, "she didn't want to come, but now she is happy".

Although visitors were free to visit at any time they were requested via notices throughout the home to respect mealtimes and not to visit during these times, particularly if the person living in the home ate their meal in the dining room. This was called 'protected mealtimes' and is common practice in homes such as Lilycross. The reason for this was to minimise disruption and to allow staff members to support people with their meal. The only exceptions to this occurred when we saw visitors sitting with people who ate in their own rooms. A staff member we spoke with said, "Staffing levels meet people's needs. It helps to have protected mealtimes".

The staff members we spoke with on all of the three suites showed that they had a good understanding of the people they were supporting and they were able to meet their various needs. We saw that all staff were very caring and attentive with all of the people living at the home and respected their privacy and dignity, for example knocking on bedroom doors before entering. The staff members we spoke with told us that they enjoyed working at Lilycross and had positive relationships with the people they cared for. Comments included, "I absolutely love it here" and "The patients are part of our family".

We saw that the relationships between the people living in the home and the staff supporting them was caring and compassionate and on occasions we saw staff members showing genuine affection for the residents, in the manner in which they spoke to them. Everyone in the service looked relaxed and comfortable with the staff and vice versa. During our inspection we saw there was good communication and understanding between the members of staff and the people who were receiving care and support from them.

We undertook a SOFI observation on Rose suite over lunch and saw that people were being supported appropriately and that staff members were moving around the dining room attending to people's needs, offering choices and encouraging people to eat their lunch.

The quality of décor, furnishings and fittings provide people with a homely and comfortable environment to live in. The bedrooms seen during the visit were all personalised, comfortable, well furnished and contained items of furniture belonging to the person.

There appeared to be no obvious attempt to encourage people to continue with any hobbies or interests they had had prior to coming to Lilycross. This included any spiritual needs they may have. The staff members we spoke with said it was very difficult to meet people's spiritual needs as priests and ministers seemed reluctant to come to the home to see people. One staff member we spoke with told us, "I have not been aware of any religious services". One of the people living in Bluebell suite did make a comment regarding religion and a bank staff member working at the home. During the previous evening, one of the carers who was described as religious had wanted to watch a religious programme on television so she had turned the television to the programme she wanted and watched it. The person told us he had spoken to the staff member at the time saying, "It shouldn't be your choice what I watch on television" and went on to say she talks to them about religion quite a lot and he felt that it was inappropriate, "I feel she preaches religion at us when she talks to us". We have passed this concern on to the home manager for them to look into and address.

We saw that personal information about people was stored securely which meant that they could be sure that information about them was kept confidentially.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they had choices with regard to daily living activities and could they choose what to do, where to spend their time and who with. One person when asked about her opportunity to make choices about her care said, "I choose when I go to bed, but it doesn't always work out, sometimes I have to wait".

Everyone in the home at the time of our inspection had received a pre-admission assessment to ascertain whether their needs could be met. As part of the assessment process the home asked the person's family, social worker or other professionals, who may be involved to add to the assessment if it was necessary at the time. We looked at the pre-admission paperwork that had been completed for people currently living in the home and could see that the assessments had been completed.

We looked at care plans to see what support people needed and how this was recorded. We saw that each plan was personalised and reflected the needs of the individual. We also saw that the plans were written in a style that would enable any staff member reading it to have a good idea of what help and assistance someone needed at a particular time.

If people needed specialist help, for example assistance with swallowing the home contacted the relevant health professionals who would then be able to offer assistance and guidance. A care plan to meet this need would then be put into place. Although we saw that this was happening within the plans we looked at during the inspection we did observe people being fed in poor positions and coughing whilst this occurred.

The seven care files we looked at throughout the three suites contained relevant information regarding background history to ensure the staff had the information they needed to respect the person's preferred wishes, likes and dislikes. We asked staff members about several people's choices, like and dislikes within care plans and the staff we spoke with were knowledgeable about them. They also told us that care plans were being looked at so that they could be made more person centred. None of the family members we spoke with appeared to have been involved in formulating or amending care plans other than prior to coming to Lilycross. One family member said she had been involved in discussing her husband's care plan but that it had been when someone from outside the home had visited the previous week, she was unable to tell us she had been involved in his care plan other than to say, "staff will talk to me about his care". We saw that generally across the three suites written consent was not being obtained from the person themselves and if this was not possible the person's family or representative had also not agreed to the care being provided.

The home had employed an activities co-ordinator in December. Their job was to help plan and organise social and other events for people, either on an individual basis, in someone's bedroom if needed or in groups. We spoke to the person and they explained that they worked from 8am until 2pm for four days per week. The co-ordinator told us that they were planning a number of activities, including Valentine's Day, St Patrick's day with Irish Guard singers, Easter activities including an Easter Egg hunt and a WW11 singer, black and white films and painting. Whilst the appointment of an activities co-ordinator was a positive step in reality though they had to spend two hours in the morning completing care tasks and from 12 noon until 14.00 had to help with the lunch. This meant that there were only two hours a day to spend on activities across all three suites and on a day to day basis there were few activities for the majority of people to participate in. We did see the activity co-ordinator on Rose suite for 60 minutes doing some painting with a few people however this was the only activity we observed. We received a variety of comments from the people using the service, these included, "There is an activity person on paper, she is entertainment, but she never does anything with me, I'm bored stiff", "There are some but I don't join in, they are more for the people in the main room [Lily Suite lounge] who can't have a conversation. I just watch TV" and "I like being by myself. I would sooner be here and watch TV". A visitor told us that his relative had had her nails painted and had been dancing with the activities co-ordinator that morning. Staff members told us, "People (staff) are getting excited by the new activities" and "she does nail painting, we have been asked to think what the residents might like, like jigsaws and I have been asked to pick up some painting and craft stuff up, on my day off".

This was further evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Requires Improvement

Is the service responsive?

Regulations 2010 which we have also referred to in the section in the report asking 'Is the service effective'. This corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. Complaints were recorded on a file along with records of the investigations which took place and the outcome achieved. We looked at the most recent complaint made in December 2014 and could see that this had been dealt with appropriately.

We asked people living at the home and their visitors whether or not they had ever had cause to raise a complaint and none of them said that they had. When asked what they would do if they did have a complaint answers varied from, "Tell my daughter and she would deal with it" and "Speak to the person concerned or speak to the manager." None of the responses said that they would speak to the unit manager.

We recommend that written consent is obtained whenever possible.

Inadequate

Is the service well-led?

Our findings

Although the home had a manager they had not registered with the CQC, we discussed this with the manager during the inspection. They explained that they had not registered because they did not have control of the recruitment of new staff including the appointment of the unit managers, the rota and the staff holiday authorisation. The manager felt that all of these were important to ensure the smooth day to day running of the home and because they did not have control in these areas they were uncomfortable about applying for registration as they understood that the management of the home then became their legal responsibility . .

It is a condition of registration that a registered manager is appointed. This is a breach of the Care Quality Commission [Registration] Regulations 2009 Regulation 5 relating to the registered manager. We have written to the provider regarding this matter and expect immediate action.

We have found that the provider had not been notifying the CQC of any deaths or incidents as detailed in the regulations. This was discussed with the manager during the inspection and a total of 13 notifications have been submitted retrospectively.

This is a breach of Regulations 16 and 18 of the Care Quality Commission [Registration] Regulations 2009 relating to notifications. We have written to the provider regarding this matter and expect immediate action.

The manager had an internal quality assurance system in place. This included audits on medication. We looked at the most recent ones undertaken in December 2014 and could see that they had been completed in all three of the suites. The audits covered areas such as a controlled drug check, checks on individual stocks and MAR sheets, expiry dates and the room where the medication was stored. We also saw a competency assessment that the manager had completed with one of the unit managers as part of the supervision process. We also saw care plan audits seen on some of the files.

The unit manager on Rose suite showed us the accident book and said that when an incident occurred the completed sheet was to be photocopied and a copy sent to the manager. We saw that the book contained three accident records for December that had not been processed. This meant that the system for monitoring and analysing falls was not working.

We saw that a variety of other audits had been completed recently, these included a bedroom and infection control audit both recently completed on the 6 January 2015. A health and safety audit was undertaken on the 18 October 2014. This covered areas such as, First Aid, COSHH, clinical waste, ventilation and windows and protective equipment. There were other audits but these were not taking place regularly, for example, audits on the kitchen and laundry were undertaken in August 2014 but they had not been done since.

Representatives from the provider did visit the home but this was only to undertake administrative tasks in the office in the entrance area. There were no quality assurance checks undertaken by the provider in order to assess the quality of care being provided. In addition there were no clinical governance or audit arrangements in place with regard to the manager and unit managers on both Lily and Rose suites in order for the provider to assess their competency.

This is a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 relating to the assessing and monitoring the quality of service provision. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action regarding this.

The manager told us that information about the safety and quality of service provided was gathered on a continuous and on-going basis via feedback from the people who used the service and their representatives, including their relatives and friends, where appropriate. They 'walked the floor' daily in order to check that the home was running smoothly and that people were being cared for properly. They also worked as the nurse in charge regularly on Lily suite so had the opportunity to speak to the people using the service and their families on a regular basis.

In order to gather feedback about the service being provided Lilycross handed out or posted out questionnaires to families every six months. This had just been done and we saw the list of people who had received one. We were able to look at the one form that had been returned from the family of someone who lived in Lily

Is the service well-led?

suite. This contained the following comments, "I cannot believe the difference in [my relative] since she has been here. She is more alert and happy. I feel that I have got [my relative] back and cannot thank the care home staff enough. They treat her with respect and dignity and she sees them all as her friends". We were also able to see the results of the previous survey from May 2014 that had been completed on the 30 June 2014. This stated that a total of 18 questionnaires had been returned and 13 people were very happy, four were fairly happy and one person was neither satisfied or dissatisfied. We were not able to determine which suites they were referring to.

Staff members we spoke with had a good understanding of their roles and responsibilities and were generally positive about how the home was being managed. Comments included, The manager is really good", "The home is much calmer, more settled", "I could go to him [the manager] with any problem and it would be dealt with straight away. I feel confident in going to him", "The manager is there if I ask him anything", "We work very well as a team", "The morale of staff has risen now", "It has been better since [the manager] came. He is very approachable and helps as much as he possibly can" and "The way the floor [Lily suite] is run is very good. It's very routine and very organised and management [the home and unit managers] are both very approachable".

On the other hand we did receive some comments regarding the overall management of the home too, these included, "I get on fine with the manager [but he] is not allowed to manage", "X is the manager but he is not allowed to manage" and "I do feel the owners interfere too much and won't let him [the manager] do his job, like the rota and holidays". The manager and staff members told us that they could request holidays and the manager could sign the approval form but these were subject to the agreement of the provider who could refuse to grant them.

One of the unit managers was due to finish work for an operation shortly after our inspection took place and would be away from work for four to six weeks. We asked the manager what arrangements had been put in to place to cover this and they told us they did not know.

Although staff members told us that they liked working in the home they did raise some concerns particularly regarding their working and pay arrangements. It was clear from talking with staff that the current arrangements caused anxiety and low morale because there had been occasions when their pay had not been cleared into their bank accounts on the correct day causing problems with the payments of direct debits and other bills. We have commented on this area in a previous inspection visit and whilst these issues were outside of the CQC's remit of responsibility we were concerned about the continued effect they were having on the morale of staff members and the possible consequences on care standards if more staff left the home and there was an ever increasing reliance on bank or agency staff members.

Staff members told us that residents and relatives meetings were held by the manager and that one had been planned to take place on both the 28 January 2015 and the 2 November 2014 but these had been cancelled because nobody arrived.

The staff members told us that staff meetings were being held and the last one had been held at the beginning of the month [January]. These enabled the manager and staff to share information and/or raise concerns. The minutes from this meeting were not available yet so we looked at the minutes from the meeting held on the 19 November 2014 and could see that issues such as the grievance procedure, holidays, rotas, wages, sickness, whistle blowing and staff training, including NVQ's had been discussed.

We looked at the maintenance certificates and saw that there were contracts in place for the fire extinguishers, fire alarm system and emergency lighting, the lift, mobile and bath hoists. We could not see the most recent gas safety check and according to the index maintained it had expired on the 31 October 2014.

In addition to the above we saw that appropriate employers liability insurance was in place.

On-going weekly and monthly maintenance checks on the fire alarm system, emergency lighting, operation of fire doors, hot water temperatures and the call bell system were all being undertaken regularly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used the service were not protected against the risks of ineffective or unsafe care because accurate records were not being maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected against the risks of unsafe or ineffective care because the registered person was not ensuring at all times that there were sufficient numbers of suitably qualified, skilled and experienced persons employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure staff members were receiving appropriate supervision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had failed to ensure that care was delivered in a way that ensured the welfare and safety of service users.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have an effective quality assurance system procedure in place. This included the arrangements for the on-going monitoring of falls and the clinical governance and audit of the manager and the unit managers.

The enforcement action we took:
We have issued a warning notice regarding this.