Borough Care Ltd

Lisburne Court

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 well-led?	Good

Summary of findings

Overall summary

About the service
Lisburne Court is a residential care home providing personal and nursing care to 47 people aged 65 and over at the time of the inspection. The service can support up to 48 people.

Accommodation is provided across two floors which can be accessed via a stair-well and passenger lift. There are communal bathrooms, toilets and kitchen facilities as well as social, dining and garden areas that people can access.

People's experience of using this service and what we found
People felt safe at Lisburne Court. People and relatives told us staff were kind and attentive. Risk assessments were carried out and incidents and accidents were investigated. Medicines were managed safely. We have made a recommendation about the provider's 'medication' policy.

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 needs were assessed, and care was delivered in line with their preferences and choices. Staff had completed additional training to support people's nutritional needs. We have made a recommendation about the provider's 'nutritional and hydration needs' policy.

The provider had developed a robust policy to strengthen the infection prevention and control (IPC) practices in the home. Staff complied with the requirements to wear protective personal equipment (PPE) and regularly washed their hands. The home was clean and tidy.

The management team completed effective audits and systems to monitor the quality of care at Lisburne Court. People, relatives and staff said the management team engaged with them positively.

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 11 February 2020).

Why we inspected
The inspection was prompted by concerns raised by Her Majesty's Coroner. A Regulation 28 Report was issued to the CQC on 26 April 2021 relating to processes to identify risk and escalate care, pre-assessment processes and how effectively Lisburne Court worked with other agencies. The Coroners and Justice Act 2009 allows a Coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the Coroner believes that action should be taken to prevent further deaths. A decision was made for us to inspect Lisburne Court and examine those risks.

We found no evidence during this inspection that people were at risk of harm from this concern.

Please see the safe, effective and well-led sections of this full report.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Lisburne Court

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 Care Act 2014.

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
This inspection was carried out by one inspector.

Service and service type
Lisburne Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We asked the local authority and Healthwatch if they had any information to

share about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and seven relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, the operations manager, the deputy manager, senior care workers, care workers, the housekeeping team and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two 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 reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three professionals who regularly visit the service.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Using medicines safely

- People's medicines were managed safely. Staff who administered medicines were competent for this role and supported people in a caring and patient way. Records showed that people received their medicines as prescribed.
- Medicines that are controlled drugs (subject to stricter control because of the risk of misuse) were stored and handled safely.
- Medicines prescribed 'when required' to relieve pain or agitation were used appropriately. Protocols describing when to administer any medicines prescribed 'when required' were kept with people's medication administration records (MARs). Protocols were up to date.
- Staff knew how to escalate care for people who did not always adhere to taking their prescribed medicines. However, the provider's medicines policy did not include a defined pathway of escalation in such cases.

We recommend the provider consider current guidance on supporting people who may refuse their medicines and take action to update their policy accordingly.

Assessing risk, safety monitoring and management;

- People and their relatives told us they felt Lisburne Court provided a safe service. Staff received a daily handover before supporting people to ensure they were kept up to date about people's needs.
- Staff were vigilant to people's needs and took appropriate action when risk was identified. One person had recently been referred to the speech and language therapist because staff had identified risk in relation to eating.
- People's care records contained up to date and appropriate risk assessments, to guide staff on how to manage and mitigate any identified risks to people. For example, risks from falls and pressure wounds.

Learning lessons when things go wrong

- The management team were receptive and responsive to the feedback given during the inspection.
- Accidents and incidents were documented and recorded. Staff understood the importance of recording all incidents and accidents and were encouraged to report these. Incidents were reviewed by the registered manager and the provider to ensure appropriate follow up action was taken. This included an update to risk assessments and care plans to reduce the risk of future accidents.
- The registered manager reported incidents with transparency and liaised with other organisations where required. Relatives told us they had been updated about any incidents that had occurred where appropriate.

Systems and processes to safeguard people from the risk of abuse; Staffing and recruitment

● People said they felt safe at Lisburne Court and staff knew how to report concerns appropriately.

● Staffing levels were good on the day of the inspection and there were plenty of staff to meet people's needs. People told us they did not have to wait for care. A relative said, "There seem to be enough staff. Many of them go above and beyond with what they do for the residents."

● Staff recruitment was robust. Staff were subject to screening to ensure they were suitable candidates to work in the care sector.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet;
● People told us they enjoyed the food and they had a wide variety of drinks available. The menu changed daily, and people could choose from several options. People were regularly visited by the chef who explored their preferences. For example, a 'vegan for life' programme catered for people who preferred a meat free diet.
● The registered manager had appointed a member of staff as the 'nutrition champion' who ensured that staff consistently monitored the food and fluid intake of people who were at risk of malnutrition or dehydration.
● Care plans contained appropriate information about people's nutritional needs and preferences. Staff monitored people's weights regularly and referrals were made to appropriate health and social care professionals if additional advice was required.
● Staff had recently completed additional nutrition training via an external training provider in partnership with the local authority.
● Staff knew how to screen for malnutrition and escalate care for people who declined to take food and fluids. However, the provider's nutrition policy did not capture a defined pathway of escalation in such cases.

We recommend the provider consider current guidance on supporting people who decline to take food and fluids and take action to update their policy accordingly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
preassessment
● People's needs and choices were assessed to ensure their care, treatment and support was delivered in line with current legislation, standards and evidence-based practice to achieve effective outcomes. The management team visited prospective residents in person to carry out an assessment of need.
● We observed positive interactions between staff and people being supported. Staff knew the needs of the people they were supporting well. A relative told us, "[Name] can struggle to communicate but staff are patient and anticipate their needs."
● People's care records reflected their current care and support requirements and contained any guidance or advice which had been provided by external health care professionals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Appropriate partnership working took place. All the professionals we spoke with told us about their

positive working relationship with the home. One professional told us, "I feel we have a good professional relationship the staff at the home. We have regular meetings with the management team. I also like the fact that Lisburne Court have a designated general practitioner (GP) who visits weekly to address any medical issues."

● People were referred to external health care professionals where required to ensure people's needs were met in a timely way. Another professional told us, "I have found the staff to be proactive and very engaging. They have a good relationship with the GP and any advice given has been acted on."

● People were supported appropriately with personal care, oral healthcare, pressure care and continence care.

Staff support: induction, training, skills and experience

● Staff had received training relevant to their role. New starters completed a thorough induction whilst shadowing more experienced staff members. New staff demonstrated their competence before they started to work autonomously.

● Staff completed annual competencies in areas such as moving and handling and medicines management. Staff had bespoke training plans in place and could set their personal goals. The registered manager said, "Every staff member has the opportunity to develop their skills through national vocational qualifications in care."

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

● People were supported to receive visitors in line with government advice which helped them stay connected to loved ones.

● The home had been decorated with dementia friendly decoration and signage. For example, bedroom doors were easily identifiable in different colours and were numbered, and a lounge area had become a 'pub' for residents to enjoy.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The management team ensured that people were not unduly restricted. They had made the necessary applications for people subject to DoLS restrictions.

● Care plans contained detailed and individualised information about people's capacity to make decisions about their care and support. Best interest meetings had taken place for people who were unable to consent to treatment. People, family members and health and social care professionals had been involved in decision making.

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Working in partnership with others

- The service worked effectively with others such as commissioners, safeguarding teams and health and other social care professionals.
- The service worked in partnership with relevant external stakeholders and agencies to support care provision consistent care for people. The registered manager and staff team had positive relationships with GP's and other external professionals. This meant people received appropriate support when they needed it.

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

- The registered manager wanted to promote a culture where staff felt valued. They recognised that caring for people in a person-centred way was a highly skilled and responsible role.
- Systems and processes to monitor the safety and quality of care were in place. Any identified issues were acted upon.
- The provider had quality assurance systems and audits in place and worked closely with the service to offer support. Regular meetings were held with the registered manager which enabled the provider to continuously monitor and improve people's experiences of the care and support provided.
- Systems to analyse and learn from incidents were in place. This helped identify any themes or trends and this information was shared with staff to help reduce re-occurrences.

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 registered manager was visible in the home, completing a daily walk rounds to speak to people and staff and have oversight of the environment.
- The registered manager was aware of, and they and the provider had systems to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- The registered manager had notified us, as required, of significant events which had happened in the home. This meant we could check they had taken appropriate action in response to incidents. The notifications showed the provider had acted on their responsibilities under the duty of candour, sharing information about incidents with appropriate people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager involved people who used the service and their relatives in decisions about the home. The management team also kept relatives updated. A relative said, "The communication during the [Covid-19] pandemic has been very good."

● We received positive feedback about the home from the local authority quality assurance team about the care at Lisburne Court.

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

● Staff completed detailed records about people's care which were audited by the management team. Actions identified through the audit system were addressed appropriately and in a timely way.

● The registered manager was passionate, and the staff team were fully committed to working towards becoming an outstanding care home.