Mr Christopher David Green

Lunesdale House

Inspection report

Lunesdale House
Hale
Milnthorpe
Cumbria
LA7 7BN

Tel: 01539563293

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11 March 2016

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07 June 2016

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 31 March and 7 April 2015. In January and February 2016 we received concerns in relation to moving and handling practices within the service. As a result we undertook a focused inspection on 11 March 2016 to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lunesdale House on our website at www.cqc.org.uk

Lunesdale House is a residential care home providing accommodation and personal care for up to 19 older people. All the accommodation is in single bedrooms with ensuite facilities. There is car parking to the front of the home and well-kept gardens.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that staff had received sufficient training in moving and handling.

The service had equipment to meet people's identified needs.

The provider pre-admission assessment ensured that only people with minimal moving and handling needs were cared for in the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – regulation 17 – Good Governance (2) (c) Maintain securely and accurate, complete and contemporaneous record in respect of each service user.

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 always safe.

Care plans did not always reflect people's support needs in relation to moving and handling correctly.

People told us that they had no concerns about the ability of staff to support them.

Staff told us that they were well trained in moving and handling techniques. Training records we saw supported this.

Lunesdale House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Lunesdale House on 11 March 2016. This was because we received concerns in relation to moving and handling practices within the service. We inspected the service against one of the five questions we ask about services: is the service safe?

The inspection was carried out by one adult social care inspector.

During the inspection we spoke with three people who lived in the home, two care staff, a member of kitchen staff, the provider and the registered manager.
As part of the inspection we looked at four care records and care plans relating to moving and handling. We looked at people's individual care records and risk assessments to help us see how their care was being planned with them and delivered by the staff.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about accidents and incidents affecting the service and the people living there. We looked at the information we held on safeguarding referrals and concerns raised with us.

Requires Improvement

Is the service safe?

Our findings

We spoke with the people who used the service and asked if they had any concerns relating to the way the staff supported them to stand up and move around the home. One person told us, "We are all able to get around!" Another person said, "I have not seen anyone fall." Another commented, "We have great pride in looking after ourselves."

We spoke with care staff who told us that they believed they had sufficient training in moving and handling. We asked them if they had ever seen anyone carry out a 'drag lift'. A drag lift involves hooking an arm beneath someone's armpit and lifting. It is seen as poor practice and abusive as it can cause harm or injury to both the person being lifted and the person doing the lifting. One member of staff said, "I haven't seen anyone perform a drag lift, no-one here requires that level of assistance anyway." They then added, "We are using a slide sheet at the moment though."

We spoke with the provider and the registered manager. They showed us their pre-admission assessment that demonstrated that people who required high levels of assistance with moving and handling were not admitted to the home. They stated that if a person's needs increased in this area they were re-assessed to see if the service could continue to meet their needs. For example one person in the home was being nursed in their bed as they were frail and unwell. The registered manager was able to evidence that a slide sheet was in use to help this person move around the bed when required.

We looked at the equipment available within the home and compared it to people's moving and handling needs highlighted in their written records of care. We saw that the home had the necessary equipment to meet people's needs and that, where required, the equipment had been properly serviced.

We looked at staff training records. We noted that all staff had received moving and handling training. The training was due to be updated but we found evidence that this training was booked in for staff within the next month.

We looked at people's written records of care. There were moving and handling plans in place for each person that required them. We spoke with staff who were able to tell us who required what support. The staff were able to provide more detailed information than the care plan. This meant that care plans relating to people's moving and handling needs did not always contain sufficient detail. The impact on people who used the service was low as staff were aware of people's needs and used approved moving and handling techniques in order to support people appropriately.

This represented a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – regulation 17 – Good Governance (2) (c) Maintain securely and accurate, complete and contemporaneous record in respect of each service user.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not keeping accurate, complete and contemporaneous record in respect of each service user.