Lee Mount Healthcare Limited

Lee Mount Residential Home

Inspection report

32-34 Lee Mount Road
Halifax
West Yorkshire
HX3 5BQ

Tel: 01422369081

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Summary of findings

Overall summary

We inspected Lee Mount Home on 12 December 2016 and the visit was unannounced.

Lee Mount is a 25-bed service and is registered to provide accommodation and personal care for older people, including people living with dementia. There are 25 single bedrooms; seven of these have en-suite toilets. There are two lounges and a dining room on the ground floor and an enclosed patio area at the rear of the building. On the day of the inspection there were 19 people living at the service.

There was no registered manager in post as they had left the service in November 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A new manager had been recruited but was not registered with CQC.

When we inspected the service in June 2015 we identified four breaches of regulations and the overall quality rating for the service was inadequate. When we returned in December 2015 we found some improvements had been made but the service remained in breach of two regulations and the overall quality rating was requires improvement.

On this inspection we found some of the improvements we saw on the last inspection had not been sustained and there had been a further decline in the service.

The home was mostly clean and tidy and odour free, except for the smell of cigarette smoke in one of the lounges. A fire officer from West Yorkshire Fire and Rescue Service had inspected the premises and had told the provider they needed to make a number of improvements to fire safety in the home.

Staff were not being recruited safely and there were not enough staff to provide adequate supervision to keep them safe or to keep them occupied. Staff training was not up to date and there was a lack of understanding about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards which meant the service was not always working within the principles of the MCA.

People's individual care plans varied in quality but we did see some good person-centred care. People's healthcare needs were being met, however, medicines were not being managed safely and this was the third inspection where this had been an issue.

Meals at the home were good and menus included people's particular preferences.

We observed staff to kind, caring and patient in their approach to people. Staff were bright and cheerful and this was clearly appreciated by the people who used the service. We found staff helpful and friendly during our visit. However, written information about people was not being kept confidential and we saw reports left

on one of the tables in the dining room.

Complaints and concerns were not being investigated or responded to properly.

We found there was a lack of effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. We found shortfalls in the care and service provided to people.

We identified six breaches in Regulations; Regulation 18 (staffing), Regulation 12 (safe care and treatment), Regulation 19 (fit and proper persons employed), Regulation 11 (need for consent), Regulation 16 (receiving and acting upon complaints) and Regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Staff were not being recruited safely and there were not enough staff deployed to provide people with supervision.

Medicines were not being managed safely.

The home was generally clean and odour free.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not up to date and there was a lack of understanding about the Mental Capacity Act and Deprivation of Liberty Safeguards.

The service was not always working within the principles of the MCA.

Meals at the home were good offering both choice and variety.

People's healthcare needs were being met.

Is the service caring?

Good

The service was caring.

Staff were kind, patient, caring and friendly. They knew about people in their care and individual preferences.

Information about people was not always been stored securely and we saw confidential reports about people on one of the dining tables.

Is the service responsive?

Inadequate

The service was not always responsive.

Care plans varied in quality but we did see some good person-centred support.

There were some group and individual activities on offer to keep people occupied.

Concerns and complaints were not being fully investigated or responded to.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager.

Effective quality assurance systems were not in place to assess, monitor and improve the quality of the service. The improvements we found at the last inspection had not been sustained and we identified six regulatory breaches on this visit.

Lee Mount Residential Home

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 was planned to check 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.

This inspection took place on 12 December 2016 and was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. We also 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 registered provider returned the PIR and we took this into account when we made judgements in this report.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included four people's care records, three staff recruitment records and records relating to the management of the service.

We spoke with five people who lived at Lee Mount Residential Home, one night care worker, four care workers (days), the housekeeper, the cook, the manager, the proprietor and the quality assurance manager.

Inadequate

Is the service safe?

Our findings

We arrived at the service at 7:00am and there was a senior care worker and care worker on duty. One of the housekeepers told us they came in at 6:00am so they could serve breakfast as people got up. On the day shift there were two senior care workers and a care worker. Staff told us these were the usual staffing levels.

We asked staff if there were enough staff. One staff member told us, "They need more staff, there aren't enough when people are sick or on holiday to cover. Last Saturday night they phoned me four times to ask me to cover the night shift." One of the night care workers told us the manager had worked this shift as no one else had been available. The quality assurance manager told us they wanted to recruit more staff to try and resolve this problem. Another member of staff said, "We just cope with three staff."

We observed one person who was sitting in one of the lounges called out loudly for long periods of time. Other people were clearly irritated by this and we saw one person put their head in their hands and say quietly, "Oh for goodness sake shut up." Staff were not available to support the person who was calling out or other people in the lounge.

We saw one person in the lounge knock their plate and cup off the coffee table and the plate broke. There were no staff present in the lounge and the broken crockery was only picked up when the cook came into the lounge with two jugs of juice.

We saw the three care workers on duty were busy throughout the morning and as a result had no time to provide any meaningful activities. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the service in June and December 2015 we found the medication system was not well managed and there was no assurance people were receiving all of their medication as prescribed by their doctor. We identified issues about the management of medicines again on this visit.

We saw medicines currently in use were stored in a locked trolley with minimal amounts of stock medicines stored in a locked cupboard in the dining room. We saw temperatures of storage were recorded but found these were often recorded as 25 degrees Celsius. We saw some of the medicines stored in the cupboard had manufacturer's instructions to be stored at below 25 degrees Celsius. The storage of medicines at temperatures higher than the manufacturers' guidelines might have compromised the efficacy of the medicine.

We observed the senior care staff responsible for administering medicines supported people well by explaining they had their medicines for them and, when people asked about their medicines, gave them explanation about why they needed to take them and the doctor had prescribed them to help them to keep well. We saw when one person refused their medicines the senior care staff returned to them after a short while and the person accepted the medicine.

We saw a protocol had been put in place for when people refused their medicines. The acting manager told us they intended to include this in people's care plans making it more individual to the person concerned.

We checked a sample of Medication Administration Records (MARs). We saw one person had been prescribed two different kinds of anti-inflammatory topical cream. The instructions for one of these were for it to be applied three to four times each day with the other to be applied three times each day. There were no instructions either on the MAR or in the person's care plan to say where on the body the creams should be applied. We were unable to see from the MAR when the creams had been applied and were concerned that both creams were being used at the same time as this can cause skin irritation. We spoke with the acting manager about this. They told us they had concerns about both creams being prescribed and had spoken with the prescriber about it. We did not see any record of this. During the inspection the acting manager contacted the prescriber and they confirmed the discontinuation of one of the creams in an email.

The acting manager told us they had changed storage arrangements of topical medicines so they were held in people's bedrooms in order for staff to apply them whilst giving personal care. However there were no accurate records of application of topical medicines or clear instructions of where they should be applied.

We saw medicines supplied in tablet form were supplied in dosette boxes with all the tablets for each administration time in a single sealed pod. We saw on one of the MARs that one of the tablets within the pod should be administered 30 to 60 minutes before food. We asked the acting manager and the senior care assistant if this tablet was administered as prescribed. Both confirmed it was not. We asked the acting manager if this tablet could be identified from others within the pod to enable staff to give it before food and before other tablets. We saw the tablet was described on the information on the dosette case as 'white oblong' however there were no tablets in the pod meeting this description. The acting manager identified the tablet as a yellow capsule. We asked if they could be sure this was the correct tablet and they said they couldn't.

We looked at the MAR for another person who required a tablet to be taken before food and saw the tablets had been supplied in a box. We asked if this person was given their tablet as prescribed before food. The senior care assistant said it was not.

This meant people were not always being administered their medicines as prescribed.

We saw tablets were not always recorded as received accurately. For example, we saw a box containing four tablets had been recorded as one received. The acting manager said this referred to the box. However, it is important the number of tablets is recorded so all medicines can be accounted for.

We saw a number of gaps in MARs where staff had failed to note a recording code to say whether the medicine had been taken. This meant it was difficult to reconcile the number of tablets recorded as received and taken against the amounts still available. The acting manager showed us medication audits they had completed which showed they had identified this as an issue. We also saw a record of a staff meeting where this had been discussed. The acting manager had also identified that the MARs in place were of poor quality and on the day of the inspection had obtained new MARs.

The acting manager showed us protocols for use of 'as required' (PRN) medicines which they had recently developed. However, these protocols were not available with the MARs and therefore not available to staff administering the medicines.

However, we did see a 'sleep plan' for a person who was struggling to sleep. The plan identified a number of

actions staff should take before resorting to use of PRN medicine.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD's). We saw these were stored appropriately but found some signatures of checking of administration were missing from the CD administration record book. We also saw a stock balance of pain relieving patches for one person was recorded as one patch in stock but found a box of another four patches for this person. This had not been recorded as received into the home. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the acting manager had recently produced a protocol for administration of medicines and staff competencies in administration of medicines were being completed.

The recruitment procedures were not robust and staff were not being properly checked before being employed. We saw the registered manager had employed someone they had worked with previously. We saw their application form was not dated, but they had been interviewed as soon as the registered manager had finished their induction. In one staff member's recruitment file we saw on both references the person had been subject to disciplinary action. There was no evidence on the file this had been explored at interview. We asked the acting manager for the interview record and this could not be produced. We also noted the references from their last employer showed they had only known them for five months. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked two members of staff about their understanding of safeguarding and what they would do if they thought people who lived at the home were at risk. Both of them told us they would not hesitate to report any concerns to the manager, Care Quality Commission or the Adult Protection Unit. This meant staff understood how to keep people safe.

We looked around the building and found most areas clean and tidy and fresh smelling. However, we did find some of the dining chairs had dried food on them as did some of the tables in the lounges. The lounge situated at the end of the ground floor corridor also smelt of cigarette smoke.

When the contracts officer from the Council visited in November 2016 they found the building smelt strongly of cigarette smoke. In the room adjacent to the lounge at the end of the corridor they found two full ashtrays and cigarette ends in the waste paper bin. They raised these issues with the manager and contacted the West Yorkshire Fire and Rescue Service with their concerns. A fire officer carried out an inspection of the premises on 6 December 2016 and issued an enforcement notice on 16 December 2016, telling the provider they must make improvements to the premises, fire risk assessment and evacuation procedures by 27 March 2017.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the electrical and gas systems. A system was in place for staff to report any repairs that were needed.

We saw boards in both lounges which had information about the day, date and weather. There was clear signage to assist people to find the lounges, dining room, toilets, bathroom and shower.

Care records for people who used the service contained identified areas of risk. Risk assessments were in place which covered for example, moving and handling, nutrition and tissue viability. We saw where risks had been identified action had been taken to mitigate those risks. For example, one person had been assessed as being at risk of skin damage. We saw they had a specialist mattress in place and were sitting on

a specialist cushion in their armchair. In another person's care file we saw a number of risk assessments had been put in place to mitigate the risk to the person in areas including aggression, moving and handling and the effects of a skin condition.

Inadequate

Is the service effective?

Our findings

We asked one person if they thought there were enough staff available. Initially they told us they did not think it was up to them to comment but after further conversation said, "They are always busy but they always come when I need them, maybe they could do with an extra one."
One member of staff told us when they started work at the service they had not received any induction training as the home had been short staffed.

We looked at the training matrix to see if staff had received up to date training to support them in their work. The training matrix covered a number of areas including Mental Capacity Act, Health and Safety, dementia awareness, pressure ulcer prevention and medication. The matrix showed dates where staff had undertaken training and where updates were required. However for a number of areas rather than a date the code 'IP' had been used. The acting manager told us this meant 'in progress.' We looked at the most recent training certificate for medication training for a member of staff where the code IP had been used. We found the person was not up to date with their training in this area. This increased the risk of people receiving support with their medicines from staff who did not have the knowledge and skills to do so safely.

Staff told us they had been given a list of on-line training they needed to complete via an outside training company. However, they told us they had not been able to access the training. This meant not all staff were up to date with essential training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The quality assurance manager told us that all new staff who did not have experience in care would undertake the Care Certificate training. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provider safe and compassionate care. It is aimed primarily at staff who do not have existing qualifications in care such as an NVQ (National Vocational Qualification).

We saw records to show the acting manager had had put a matrix in place for staff supervisions since they commenced work at the service a month prior to our inspection. Some supervisions had already taken place. The supervision policy was for staff to receive supervision every three months but the acting manager told us they intended for all staff to receive supervision every two months.

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. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS).

We spoke with the acting manager and they told us a number of applications for DoLS authorisations had

been made over a year ago but none had yet been granted.

We spoke with two members of staff who both told us they thought a number of people living at the home were subject to DoLS authorisations. When we asked staff how they might make sure they supported people in line with DoLS authorisations they were unsure.

During the morning handover we heard one of the night care workers say they had crushed one person's tablet and put in a cake for them to eat but the person had knocked the cake on the floor. The care worker told us it was alright to do this and it was in the care plan. We looked at the person's MAR and care plan to see if this had been discussed using a best interest process in line with the principles of the MCA. There was no record of this having taken place but we did see a letter from the person's GP which said the tablet could be crushed and put in water.

This meant the service was not always working within the principles of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service about the meals at Lee Mount Residential Home and people told us they were good. One person told us they had a particular interest in food science and enjoyed speaking with the quality assurance manager about the menus. We saw people had been consulted individually about the autumn/winter menus and their requests had been incorporated into the menus.

We saw relatives had given the following feedback on their surveys, "Before going into Lee Mount they hardly ate anything – now they [staff] tell me [name] really enjoys their meals." A second relative had written, "They do great with their choosey food to accommodate."

The quality assurance manager had also used published guidance about nutrition in residential homes to make sure the menus were appropriate. For example, the guidance advised green leafy vegetables should be offered three times a week. We saw this had been discussed in October 2016 at the kitchen staff meeting and kale was served with lunch on the day of our visit.

We saw people's weights were being monitored and these were relatively stable. If anyone was at risk of losing weight food and fluid charts were introduced so staff could check they were receiving adequate nutrition.

We saw jugs of juice and beakers were available in the lounges and hot drinks and snacks were served mid-morning and mid-afternoon. We heard people being offered drinks by the cook when they came into the dining room. We concluded people's nutritional needs were being met.

At the handover meeting between the night and day staff we heard them discuss the need to get a urine sample from someone they thought might have an infection. During the afternoon one person went to sit down, missed the chair, and fell to the floor. We saw staff provide them with reassurance whist they called for an ambulance. This was done calmly and efficiently and the paramedics found no injury.

In the four care records we looked at we saw people had been seen by a range of health care professionals, including GPs, community matrons, district nurses, opticians and podiatrists. We concluded people's healthcare needs were being met.

Good

Is the service caring?

Our findings

We observed staff to kind, caring and patient in their approach to people. Staff were bright and cheerful and this was clearly appreciated by the people who used the service.

We saw one care worker sitting with one person and was reading their Christmas cards to them and using these to try and engage them in conversation. We also saw staff using a white board and pen so they could have a conversation with someone who was very hard of hearing.

One person told us, "They are all marvellous, they really care. I've been in different homes and the staff here are the best."

We heard care workers ask staff discreetly if they wanted to use the bathroom on their way to the dining room.

We saw people's bedrooms were neat and tidy and that personal effects such as photographs, Christmas cards and ornaments were on display and had been looked after. We also saw people's clothing had been neatly put away in wardrobes and drawers. This meant staff respected people's belongings.

We saw staff encouraging one person to eat independently giving them some prompts every time they passed. When this person had finished their breakfast a care worker asked them if they wanted to go to the lounge. The care worker stated to sing a Christmas song as they left the dining room and the person joined in and had a big smile on their face.

We saw the care plans for people who used the service contained 'Life history' information and details of their interests and hobbies. We saw staff knew people well and understood their likes and dislikes.

We found staff were helpful and friendly during our visit. We did not speak with any relatives but saw the following feedback in the completed surveys, "I think it's a great home, lovely staff and you are made to feel welcome," and, "Top marks for the staff who always greet us with a smile."

Inadequate

Is the service responsive?

Our findings

We saw from the audits two complaints had been received from people who used the service regarding a member of staff's attitude and laundry.

We asked to look at records relating to complaints and were provided with papers on which were recorded some information relating to two complaints. The information was difficult to understand and we were unable to establish how the complaints had been investigated and responded to. We did not see any information to show any discussion had taken place with the complainant to see if they had been satisfied with the outcome.

We also saw a concern had been made by a relative about the service's recruitment procedures. The managers response was that staff files were robust, but there was no investigation in relation to the specific concerns which had been raised about the suitability of staff. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw assessments of people's needs had been completed and care plans put in place to meet those needs. Care plans were detailed but sometimes lacked a person centred approach with little about the person's preferences recorded. We also noted some care plans were generic and errors such as referring to a gentleman as 'she' suggested some detail had been copied and pasted from other people's care plans.

We did see some good examples of responsive personal care. For example, we saw from one person's care records they had, in the past played the piano and had an interest in model buses. We saw the person had a cushion in the shape of a bus which the quality assurance manager told us they had bought for them as they knew about their interest. The quality assurance manager also told us they had brought in a key board to see if the person would like to play it.

Another person told us how the acting manager had noticed they were not feeling very well and had made immediate referral to appropriate healthcare professionals to support the person.

We asked people who used the service what activities were on offer. One person told us they had thoroughly enjoyed a Christmas party at a local club. They said, "No expense was spared; they paid for our taxis and even bought our raffle tickets." Another person told us they enjoyed chatting to the staff but preferred to spend time in their bedroom watching television and reading.

We spoke with a member of staff who told us they worked as both a care assistant and an activities organiser. They told they had completed an eight week activities course which they had thoroughly enjoyed and had given them good ideas about activities for people living at the home. They told us they wanted to focus on people getting out more, not just in good weather but throughout the year. They told us, "There's nothing a coat and hat can't take care of."

Another member of staff had also been employed to spend time with people on a one to one basis and they

were working four hours per week. We saw they were spending time doing a variety of things with people including reading to them. The records of these sessions also recorded if people had enjoyed them and suggestions for future activities.

Staff told us about one person who went out to church every week. They said they arranged taxis to make sure the person was safe in their journeys to and from church.

We saw information about an entertainer who visited the home on a fortnightly basis.

We were also told about a play that was to take place in the home. The play was to be performed by a company who had based the play on information given to them by staff about the life experiences of people who used the service, particularly around Christmas time.

On the day of our inspection we saw little, other than the television, available to occupy people. We saw the television was playing an American situation comedy and asked people if they were enjoying it. The three people who responded said they were not. We asked a member of staff about it who changed the channel but did not ask people what they would like to watch.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in June 2015 we had found there was a lack of provider oversight and very few checks completed on the overall operation and quality of the service. When we returned in December 2015 we found a number of audits had been put in place but concluded these needed to be tested over time to see how effective they were. At this inspection we found the improvements seen previously had not been sustained and there had been a decline in the quality of the service.

The registered manager left the service in November 2016. A new manager had been recruited and they had only been at the service for four weeks. This had not been long enough to make an assessment of their management and leadership skills. However, staff told us they were approachable and had an 'open door' policy.

We saw there were a number of monthly manager's audit documents available covering health and safety, weights, medicines, accidents, spot checks, bed rail, complaints and pressure sores. We looked at the completed audits from June 2016 and found only four audits had been completed in June, July and August, one audit in September, none in October and only six in November 2016. The provider told us the previous manager had not been responding to their requests for these to be completed.

We were concerned the company secretary had interviewed a prospective member of staff with the new manager and appointed them without fully exploring their application form, references and work history.

Although we saw medicines audits had been completed each month, with the exception of October 2016 these had failed to bring about improvements in the management of the system. On this inspection we identified problems with the management of medicines, which meant the service had been in breach of the associated Regulation for the third inspection in succession. This demonstrated an inability to bring about improvement and operation of a safe system.

Information about people who used the service was not always held confidentially. The cabinet in the dining room where the care files were kept was unlocked and we saw report sheets had been left by the fridge in the dining room. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The audits carried out by the quality assurance manager had been more effective and we saw these areas had sustained improvement; for example, infection prevention. In December 2015 we had found the home was not clean and infection prevention practices were poor. We found these areas had improved in June 2016 and on this visit found the improvements had been sustained. We saw the housekeepers meeting minutes for October 2016 and saw they had been praised as hardly any problems had been noted over the last few months.

We also saw the quality assurance manager had put systems in place to ensure gas, electrical and fire safety services were kept up to date.

We saw the quality assurance manager had spoken with people who used the service on an individual basis to get their views and from these discussions was making plans to improve and individualise the service they received.

We saw satisfaction questionnaires had been sent to relatives in April 2016 and seven had been returned. These indicated those relatives were happy with the service and a number of positive comments had been recorded.

Staff surveys had also been distributed and returned in October 2016, which were also very positive. One person commented, "I am happy to work at Lee Mount. I feel welcome, the training is fantastic. I am supervised and I can freely ask for help and it is given. The staff are friendly and extremely helpful."

We saw minutes of meetings that had taken place since the acting manager had come to the home. Meetings had been held for staff and for people who lived at the home. These had given an opportunity for people to give their views about the service and what they would like to happen. The residents meeting had resulted in a 'You said – We did' to show how staff had responded to requests and suggestions.

Staff told us meetings were held in which they felt able to raise any issues.