Lee Mount Healthcare Limited

Lee Mount Residential Home

Inspection report

32-34 Lee Mount Road
Halifax
West Yorkshire
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Tel: 01422369081

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 6 August 2018 and was unannounced. At the previous inspection we found the provider had not submitted all relevant notifications to the CQC. We found this was a breach of the CQC (Registration) Regulations 2009 Notification of other incidents. We found improvements had been made and the provider was no longer in breach of this regulation.

Lee Mount Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lee Mount Residential Home accommodates up to 25 people in one adapted building. 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. There were 20 people who used the service at the time of inspection.

There was a registered manager in post at the time of inspection. 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.

The provider had systems in place to safely manage medicines within the home. Risk assessments were in place and kept up to date. We made a recommendation for the provider to produce an overview of people's health needs, including equipment to ensure an overview of their current needs was easily accessible to staff.

We made a recommendation for the provider to have a clear inventory of all equipment including, cushions, wheelchairs and shower chairs. This was to ensure equipment servicing and checks were not overlooked.

Some areas of the home were in need of refurbishment. We saw redecoration was taking place and the registered manager had a refurbishment schedule in place.

There were enough staff to meet people's needs. There was a robust recruitment process in place and staff received appropriate training and supervision.

People's care and support was assessed and reviewed on a regular basis. We saw people had access to healthcare professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People had a choice of food and drink. People were physically shown the food on a plate to help them make a choice,

where appropriate.

People's privacy, dignity and independence was respected and promoted.

The provider had a service user guide. However we found the guide was not easy to read or user friendly, particularly for people with dementia. We made a recommendation that information is available to people who use the service in a format that is easy for them to read.

Links had been made with the local community. A school worked with the home around healthy eating and a college was providing assistance with activities.

The provider had an up to date complaints policy displayed within the home. We saw complaints were logged, investigated and responded to appropriately. The provider had systems in place to assess and monitor the quality of the service. There were audits in place for areas such as, medicines, infection control and supervisions.

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.

Risks associated with people's care were identified and managed. Although a clear inventory of all equipment was not maintained.

Medicines were managed safely within the home.

The home had cleaning schedules in place but parts of the home required attention.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and training.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met.

People had a choice of food and drink.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People's independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care plans were up to date and regularly reviewed.

There were systems in place to respond to complaints.

End of life care was responsive to people's needs and wishes.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff told us they felt supported and listened to.

The provider had systems and processes in place to make sure they assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users. However, these had not always identified issues.

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 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.

This inspection took place on 6 August 2018 and was unannounced. The inspection team consisted of one adult social care inspector, an assistant inspector, a bank inspector and a specialist advisor who was an occupational therapist.

We reviewed information we held about the service, such as notifications and information from Healthwatch. Healthwatch is an independent consumer champion which gathers information about people's experiences of using health and social care in England. We contacted commissioners, the local authority safeguarding team, the clinical commissioning group and the Fire Service prior to inspection.

The registered provider had been asked to complete a Provider Information Return (PIR) and they returned this to us prior to the inspection. 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.

During the inspection we spoke with five people who used the service, two relatives, four members of care staff, the cook, the care manager and the registered manager.

We looked at a variety of documentation including; care documentation for six people, two staff recruitment files, three staff supervision files, meeting minutes, documents relating to the management of medicines and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with were happy living at Lee Mount. One person said, "'I like living here." Another person told us, "It's lovely, everybody is so happy and friendly." People commented that the staff were kind and friendly. Comments included, "Oh yes, [the staff are] very nice. They are kind." "It's very lovely [here]." And "They're [staff] all so smiley."

Staff explained the signs of abuse and what they would do to make sure people were safeguarded. Staff knew who to report any concerns to both within the organisation and to external agencies, such as the CQC. The local authority confirmed the provider was appropriately reporting safeguarding information to them.

We saw risk assessments were kept up to date and covered areas such as falls, medicines, mobility, pressure care and nutrition. We saw people were supported appropriately with their moving and handling needs. For example, one person was transferred into a chair using appropriate equipment and staff ensured there was a cushion on the chair for the person. There was good communication between the care staff and the person throughout the transfer. Personal Emergency Evacuation Plans (PEEPs) were in place and regularly reviewed.

Although people had all relevant information within their care plans, there was no readily accessible 'essential' information held. For example there was no information in people's rooms, regarding their mobility, particular medical or dietary needs. This would provide staff with important information about the person to ensure the care they were delivering was appropriate. We recommend an accessible overview of people's current needs would be beneficial for staff.

The provider carried out appropriate checks on the premises and equipment to ensure its safety. They had an overview spreadsheet of when some of the equipment and safety checks were due. However, due to a date being incorrectly recorded on this overview the gas safety certificate was overdue by three weeks. The provider immediately arranged for the gas safety check to be completed the day after inspection and forwarded the certificate to the lead inspector.

There was a large downstairs bathroom with a fixed hoist to transfer people in and out of the bath safely. However, there was limited showering and bathing facilities upstairs. For example, the shower chair did not have castors. Castors enable a person to be transferred in the most appropriate safe place. Once the person has been safely transferred / hoisted onto the shower chair they can then be safely wheeled under the shower. Although equipment was checked we recommend the provider has a clear inventory of all equipment including, cushions, wheelchairs and shower chairs. This is to ensure there is a clear system in place to prevent equipment servicing and checks being overlooked.

Staff recruitment records demonstrated the service was ensuring staff were subject to the appropriate scrutiny. References were obtained and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

The registered manager used a dependency tool as a guide to ensure there were enough staff to meet people's needs. This was regularly reviewed. We observed and staff told us there were enough staff to meet people's needs.

Medicines were managed safely within the home. There were appropriate systems in place to order, receive, store, record, administer and dispose of medicines. When medicines had been prescribed 'as required' or PRN, the care staff asked people if they wanted the medicine before preparing them. We saw there were protocols in place for each PRN medicine which included information about when the person might require it, what it was for and how the person communicated.

Controlled drugs (CDs) are prescribed medicines that are often used to treat severe pain and they have additional safety precautions and requirements. The home was appropriately storing, recording and administering these medicines. A supply of 'just in case' medication had been prescribed and was available for a person deemed to be reaching end of life care. These had been administered by a district nurse and checked by a senior carer in line with the legislation

We observed morning medication being administered. There was a person centred approach to care. Some people liked their medicines put into their hand and one person was supported to take medicines into their mouth directly from the medicine pot. The member of staff waited until people had taken their medicines, encouraging people as needed and prompting them to drink. Some people preferred to take their medicines in their bedrooms, and were supported to do so. One person told us, "They don't just put pills into your mouth, they tell you the reason for it."

No one was receiving covert medicines at the time of inspection but there were procedures in place to follow if this was required. Staff received medicines training and had their competency checked. Medicines were audited and any issues found were actioned.

Some areas of the home were in need of refurbishment. Redecoration was taking place at the time of inspection. The registered manager had a refurbishment schedule in place.

There were no offensive odours and toilets and bathrooms were equipped with hand wash dispensers, paper towels and foot pedal bins. Notices advised staff to wash their hands using an effective technique. We saw spillages were quickly responded to and cleaned up. 'Wet floor' signs being used when floors had been mopped. This demonstrates good falls prevention practice.

Although we saw cleaning schedules were in place, we found some areas required a deep clean. For example, a freezer required defrosting and cleaning. This had been picked up in an audit but due to the recent absence of the cook no one had taken responsibility for outstanding issues.

A recent independent Food Hygiene Inspection in June 2018 had given the service a rating of four. Whilst we saw all food in the freezers was labelled and in date. We found two items in the domestic fridge which were past their sell by date. We drew these to the attention of the temporary cook who immediately disposed of them.

The registered manager and care manager told us they had identified an infection control lead who would be responsible for infection control auditing which would improve the cleanliness of the home and the accepted standards.

The provider had a system in place for monitoring and reviewing any accidents and incidents. This included

the outcomes and lessons learned from each event. It also had a system of pictorial representation, which included pie and bar charts, to facilitate pattern recognition.

Good

Is the service effective?

Our findings

People's care and support was assessed and reviewed on a regular basis. We saw people had access to healthcare professionals such as; dieticians, district nurses, community psychiatric nurse, memory team and GPs to ensure their needs were met.

Staff received induction training and ongoing training to help them deliver safe care. Staff were supported through regular supervisions. One member of staff said, "They (the management team) showed me around. I met all the residents and did a voluntary day. That was nice. I went to care school in Shipley before I started. I enjoyed it and covered things such as moving and handling."

Staff told us they had received moving and handling training and were supported until they felt competent. One member of staff said, "I felt confident after doing the moving and handling training, but I didn't have to hoist someone on my own until I'd done it with other staff first." Another member of staff told us, "We use the Care School at Shipley, they're very good, they come to us or we go to them, and we get a chance to go in a sling when we were talking about hoisting training."

The provider had a supervision and training matrix to ensure supervision and training was not overlooked. Staff also had an individual training plan in place.

People told us they were happy with the food. Comments included, "It's very good actually. It's wonderful." "The food here is terrific. There's a good cook who works here."

We observed people chose when they had their breakfast and could order what they wanted. Care staff responded promptly to requests for food and drink. We saw people had a choice of food for lunch and were physically shown the food on a plate to help them make a choice, where appropriate. One person did not like their original choice. A member of care staff asked if the person had tried it. The member of care staff then offered an alternative which the person accepted. Although people were given a drink after their meal it would facilitate people's independence if there were jugs of water available on the table so people could help themselves.

People's weight had been recorded each month, or weekly if at risk, and entered into an electronic record which calculated any change from the previous entry. Any necessary action had been entered and then this was signed off when completed. This helped staff ensure effective monitoring of people's weight which in turn reduced the risk of malnutrition. We saw where people had been identified as losing weight or there were any concerns they had been referred to the GP and dietician.

Care staff knew people well and were aware of people's dietary needs. The registered manager informed us that one cook had recently left and the other cook was currently on sick leave. A bank cook was preparing meals in the interim. We asked whether anyone required special diets. The cook told us they could find out by checking people's care plans. The cook did not know where to find this information in the kitchen. We spoke with the care manager and registered manager who showed us the information about people's

specific dietary needs that was available in the kitchen. They said they would ensure any member staff working in the kitchen would be made aware of this.

The home was in the process of redecoration. The management team were working towards creating a dementia friendly environment with picture signs and colours to help orientate people.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the provider was meeting the requirements of the MCA and DoLS. Care records showed mental capacity assessments were undertaken for specific decisions which were detailed and thorough. For example, decisions included, to have a bed sensor-alarm in place, to consent to photography, to contact a doctor if unwell, to receive medication from staff. Each decision had a separate assessment carried out and a separate best interest meeting recorded.

Staff were clear what to do if a person refused care. For example, they would talk to the person, give them time and explain why it would be a good idea to have care. If people could not be persuaded to receive care their decision would be respected.

Good

Is the service caring?

Our findings

People told us staff were caring. One person said, "If I have left something upstairs, like my cardigan, they will go and get it, no trouble." Another person told us, "It's a nice place. It's lovely out here (in the garden). The staff are very nice, they are very friendly."

We saw positive interactions between staff and people. It was clear staff knew people well when they anticipated needs or preferences or engaged people in conversation. A senior carer administered medicines patiently, allowing people to take their time. People were treated with kindness, respect, and compassion. For example, we saw care staff talking with people throughout transferring from standing to sitting. We saw staff involved one person, who was living with dementia, through communicating with a soft toy which was clearly important to the person. The person was smiling and happy throughout the transfer.

People and relatives were involved in monthly assessments and care plan reviews which included bedroom safety and personal shopping needs. People's views had been sought about satisfaction with current care and support.

People's privacy, dignity and independence was respected and promoted. We observed staff being caring and they spoke about people with compassion and kindness. Staff gave good examples about how they respected people's privacy and dignity. For example, making sure doors are closed, discreetly placing towels, taking time, talking with the person and explaining what was going to happen. Staff gave good examples of how they encouraged people to be independent. For example, encouraging people to walk, encouraging people to use their walking aids and using the toilet. One member of staff said, "We let people do things themselves. It motivates them. We don't want them to loose skills."

Good

Is the service responsive?

Our findings

Preadmission assessments were completed prior to a person moving into the home. This included people's personal care needs, sleeping, mobility, medication and dietary needs. This information allowed the registered manager to ensure the service could meet people's needs before they arrived at the home. The documentation also prompted consideration of people's communication needs, including hearing, vision, language and cognition as well as preferences and characteristics protected under the Equality Act such as gender, religion, sexuality and disability. People's social preferences were also considered, such as listening to music. This information helped staff to plan care and support which was responsive to people's needs.

Care records were person centred with information to show that conversations with the service users had occurred to gain an understanding of their background and their interests. Care records were regularly reviewed and contained up-to-date information about people's needs. Care plans covered mental well-being, nutrition and personal care. The care plans contained details of hoisting requirements such as which coloured loops to use when using a certain sling.

We saw one person had recently developed a behaviour that the service found challenging as it impacted on how the person related to other people living in the home. The registered manager and care manager had quickly sought advice from healthcare professionals and acted on it to help understand the causes, treat medically and prevent triggers that might make the person more anxious.

The provider had a service user guide. However we found the guide was not easy to read or user friendly, particularly for people living with dementia. We recommend the provider ensures information is available to people who use the service in a format that is easy for them to understand.

We saw people enjoyed listening to music and were clapping along to the music. We saw people enjoyed talking to staff and each other and enjoyed dancing. One person said, "You can sit and talk, that's what life is about, getting to know people." Other activities included, active minds class, a walking club, bingo, armchair exercises and play your cards right.

We spoke with the activities coordinator who had linked up with a local school to talk to people about healthy eating. The children spoke about fruit and vegetables and helped people plant strawberries and herbs in the garden. The children also helped decorate plant pots, create mood boards about healthy food and got to know people who lived at Lee Mount. The school invited people who lived at Lee Mount for afternoon tea so they could be introduced to the new children who were coming to the home in September. The activities coordinator told us, "It makes such a massive difference for the residents. Just watching the children is enough for some. [One person's] eyes light up and sparkle."

Links had also been developed with a local college where older children would come to Lee Mount to carry out activities to offer one to one time and group activities.

People's care plans reflected the activities they were enjoying. However, one person's care documentation

recorded the person had enjoyed attending church but we did not see any evidence to show this had continued after they moved to the home. We raised these issues with the registered manager and care manager who told us they were working towards improving activities for everyone and tailoring them to individual needs.

The provider had an up to date complaints policy displayed within the home. We saw complaints were logged, investigated and responded to appropriately.

End of life preferences had also been discussed during preadmission assessments, including resuscitation status, attending hospital if unwell and funeral directors if known. A person was receiving end of life care and they were being supported to have comfortable dignified pain free care.

Requires Improvement

Is the service well-led?

Our findings

At the time of inspection there was a registered manager in post. A registered manager is a person who has registered with the 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.

At the previous inspection we found the provider had not submitted all relevant notifications to the CQC. We found this was a breach of the CQC (Registration) Regulations 2009 Notification of other incidents. At this inspection we looked at accidents and incidents and saw the provider was now submitting notifications to the CQC and was no longer in breach of this regulation.

The provider had continued to sustain improvements since the last inspection, however we identified a number of areas which required improvement. For example, the bank cook not being aware of the information kept in the kitchen regarding people's dietary needs. The equipment and premises check overview spreadsheet had incorrectly recorded when the gas safety certificate was due for renewal. Cleanliness standards in the home had begun to slip. No one had taken responsibility for outstanding issues of ensuring issues highlighted in the kitchen cleaning schedule had been addressed in the cook's absence. The registered manager and care manager acknowledged this had been due to staff leaving and were in the process of recruiting new staff.

People were complimentary about the running of the home. One person commented, "They've got such patience with everybody." Another person said, "If you have a problem she [care manager] will talk to you. She's nice."

The provider had systems in place to assess and monitor the quality of the service. There were audits in place for areas such as medication, infection control, complaints, training and supervision. Each individual audit was linked to one action plan that detailed the action required and the date of completion. This plan also identified staff training and supervision issues. The care manager and registered manager said they tried to look at outstanding issues on the action plan once a week but recognised a more formal approach was required to ensure issues raised had been addressed in a timely manner.

Staff and the management team had access to a comprehensive range of online policies that included, risk assessment, risk taking, falls management and use of bed rails. Each policy was also linked to other external resources such as Royal College of Nursing guidelines and the Health and Safety Executive. This enabled staff to obtain the most up-to-date guidance.

A consultant carried out quality assurance visits to provide independent oversight. We found there reports required more detail and guidance around issues they found and how the service could improve.

Staff felt listened to and supported by the management team. One member of staff told us, "I think it's really nice, everyone is lovely, the management are really nice. Everyone gets along and knows everybody's

needs." Another member of staff said, "We're all a team. If there are any problems you can go to a manager. They listen." Staff we spoke with told us they would be happy for their family member to live at Lee Mount. Comments included, "All the staff know the residents. It's a nice little home. It's quite calm. It suits the needs." "I think the care is really good and management has picked up over the years I have been here."

Views on the quality of the service were obtained and acted on through service user and staff surveys. The registered manager told us they were planning to conduct surveys of professionals and relatives. Resident meetings discussed areas such as; decoration, catering, activities and housekeeping. Staff meetings discussed areas including; completion of food and fluid charts, warmer weather to encourage fluid intake and infection control.

Links had been developed between the home and the local community. For example, pupils from a local school were working with people who lived at the home around healthy eating.