Quantum Care Limited

Mountbatten Lodge

Inspection report

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Ratings

Overall rating for this service	**Good**
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?	**Good**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced. At our previous inspection on 12 September 2013 we found that the provider was meeting the legal requirements of the Health and Social Care Act 2008.

Mountbatten Lodge is a residential home for up to 60 people who may be elderly, have a physical disability or be living with dementia. It does not provide nursing care. At the time of our inspection there were 60 people who lived at the home. The home has four units. Two units accommodate people who require personal care but who are not living with dementia. The remaining two units accommodate people who are living with dementia of various degrees. People who are living with dementia in the more advanced stages live in one unit whilst people living with dementia in a less advance stage live in the second unit.

Summary of findings

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. At the time of our inspection an application by the manager to become the registered manager of the home was being processed by the CQC.

People who lived at the home told us that they felt safe. People who lived at the home were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Staff members had received training on the Mental Capacity Act 2005 (MCA) and were aware of the Deprivation of Liberty Safeguards (DoLS). They demonstrated an understanding of the requirements of MCA. A number of applications for DoLS had been made to the local authority.

Personalised risks were identified and strategies were in place to reduce the risk as much as possible. People were involved in deciding the level of risk to which they were exposed.

There were enough qualified, skilled and experienced staff to meet people's needs. Use of agency workers was limited as the permanent staff had a better understanding of people's needs. People were cared for by staff who were supported to deliver care safely and to an appropriate standard.

The home was clean, well lit and there was an up to date infection control policy in place to protect people from the risk of acquiring a healthcare associated infection. However, this policy was not always followed, which put people at a greater risk of acquiring an infection. The provider had taken steps to provide care in an environment that was suitably designed and adequately maintained. Two units of the home had been adapted for the needs of people who were living with dementia.

People, or relatives on their behalf, had been involved in determining their care needs. People were supported to be able to eat and drink sufficient amounts to meet their needs and told us the choice of food was good. People were encouraged to be as independent as possible but where additional support was needed this was provided in a caring, respectful manner.

People were supported to maintain their health and well-being. People's needs were assessed and care was planned and delivered in line with their individual needs.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately. Information about complaints and how to make them was included on noticeboards in each of the four units. People who lived at the home and their representatives were asked for their views about their care and they were acted on.

The manager was supported by a deputy manager and also a team leader on each of the four units at the home. Staff members were encouraged to discuss improvements that could be made to the service and raise any concerns that they had at the regular staff meetings. Staff members felt supported, empowered and had a good understanding of their roles and responsibilities.

The provider had an effective system to regularly assess and monitor the quality of service that people received. The manager was supported by a number of specialists in the provider's organisation to ensure that best practice was identified and implemented.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

The provider's infection control policy was not always followed. People were at risk of acquiring a healthcare related infection because of this.

Staff were aware of safeguarding procedures. The requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were applied appropriately.

There were enough skilled, experienced staff to meet the needs of the people who lived at the home

Requires Improvement

Is the service effective?
The service was effective.

People's dietary needs were met. People were encouraged to be as independent as possible but where additional support was needed this was provided in a caring, respectful manner.

People, or relatives on their behalf, had been involved in determining their care needs.

Access to primary care services was encouraged and two units of the home had been adapted for the needs of people who were living with dementia.

Good

Is the service caring?
The service was caring.

Interaction between staff members and people was positive and respectful.

People's dignity was respected.

Good

Is the service responsive?
The service was responsive.

Before people were admitted to the home a full assessment of their needs had been carried out. Care plans were detailed, personalised and reviewed on a monthly basis.

People and their relatives were made aware of the complaints policy and procedure. Complaints were addressed appropriately by the manager.

Good

Is the service well-led?
The service was well-led.

The manager was accessible to people.

Good

Summary of findings

Annual satisfaction surveys were sent to people and their relatives. Action plans were drawn up to address the issues identified.

There were systems in place to support the manager and identify best practice.

Mountbatten Lodge

Detailed findings

Background to this inspection

The inspection team was made up of one inspector, a specialist advisor with knowledge of dementia care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of experience was in caring for older people.

Before we undertook the inspection we gathered and reviewed information that had been provided by members of the public and the people who paid for the services of the home, such as the local authority and health commissioning groups (CCG). CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients.

We looked at the report of the previous inspection of Mountbatten Lodge on 12 September 2013. We asked the provider to complete a report telling us about the service and how they met the requirements of a good service (PIR). In addition we looked at the notifications that the home had sent us. A notification is information about important events which the provider is required to send us by law. We spoke with healthcare and other professionals who were involved with the home, including one of their GP's, a community nurse who visited the home every week, an optician and the pharmacist who provided the medication to the home.

During the course of our inspection we spoke with 11 people and two relatives of people who lived at the home. We also spoke with the manager, the chef and four staff members, reviewed records and carried out observations, including observations of lunchtime on three of the four units at the home.

We looked at the care records of six people who lived at the home. We reviewed the complaints records and looked around the home to check that appropriate standards of cleanliness were maintained. We also reviewed records of quality audits that had been completed by the provider and by the manager.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

During our inspection we found that all areas of the home were clean, well lit and free from clutter. We saw that there was an up to date infection control policy and the four staff members we spoke with were aware of content of it. This included the use of protective personal equipment, such as aprons and gloves, disposal of contaminated waste and hand hygiene. However, during the course of our inspection we observed two members of staff who were wearing bands or large watches on their wrists and one member of staff who was wearing a ring with stones in contravention of the provider's hand hygiene policy. These items presented an increased risk of acquiring a healthcare related infection to people who lived at the home.

When we checked the disposal of contaminated waste we found that the large yellow bins in which the waste was stored whilst it awaited collection by the home's contractor were not locked. This meant that the contaminated waste was not stored securely and people were at increased risk of cross infection.

People and the relatives of people who lived at the home that we spoke with told us that they felt that they, or their relative, was safe at the home. One person told us, "I couldn't be looked after any better." We saw that the home had an up to date policy on the safeguarding of vulnerable adults (SoVA) and information on how to report suspected abuse was displayed on notice boards throughout the home. We spoke with four members of staff who told us that they had received training in respect of SoVA. This was confirmed in the records we looked at for all staff groups. They (staff) were able to demonstrate a good understanding of the types of abuse that may occur and the steps that they would take to report any suspicion of abuse.

The training records we looked at showed that all staff members had received training on the requirements of the Mental Capacity Act 2005 (MCA). The staff members we spoke with were able to demonstrate that they were aware of the requirements of the MCA. If people were unable to make decisions for themselves then family members were involved in making decisions in their best interests. The CQC had been notified of two applications by the home to the local authority under the Deprivation of Liberty Safeguards (DoLS). Neither of these been authorised.

The manager told us that they had started a process of carrying out assessments of levels of deprivation of liberty for all people who lived at the home following the recent Supreme Court decision. We saw a log that showed that the manager had made a further seven applications for urgent and standard authorisations which were being considered. This showed that the provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS.

We observed one person as they were assisted to transfer from their bed to a wheelchair with a hoist. This was done safely with due regard to the person's dignity. The care records showed that the staff identified personalised risks that were associated with the care needs of people who lived at the home and used standardised tools for assessing risks connected with tissue viability and malnutrition. The records also documented the triggers that caused people to become agitated or distressed and steps staff members should take to defuse such situations when they arose, to protect the person and other people within the home. However, one record showed that a person was considered to be at risk of choking. Although the care record indicated that a referral to the speech and language therapist (SALT) was appropriate there was no record that the referral had been made. Staff members were unable to tell us whether the referral had been made. The person may not therefore have received care in the safest, most appropriate way.

The majority of people we spoke with told us that they were involved in making decisions about taking risks. One person said that they would like to be able to use a walking stick instead of a frame. However, they had discussed the lack of stability that they might have in doing so with the staff members and a relative and had agreed to use the frame as it was a safer option.

People we spoke with told us that their call bells were answered promptly with response times ranging from two to five minutes. One person said that sometimes it took staff longer to respond than at other times. The majority of people said that the staff generally coped very well but they felt that there was a need for additional staff, particularly in the mornings when people were getting up and having

Requires Improvement

Is the service safe?

breakfast and during the evening when people were given their medicines and preparing to go to bed. One person said, “They cope well but I think they could do with a bit more staff to alleviate the stress of others.”

The manager told us that the staffing levels were calculated on the dependency levels of the people who lived at the home and were reviewed when people’s dependency levels changed. We saw that the dependency levels of people on the four units of the home had last been calculated two weeks before our inspection.

Good

Is the service effective?

Our findings

People and the relatives we spoke with told us that they had been involved in the planning of their or their relative's care. The care records that we looked at confirmed that people, or relatives on their behalf, had been involved in determining people's care needs. One relative we spoke with told us that they saw and reviewed their family member's care plan every three months.

The four staff members we spoke with told us that they had regular supervision meetings at which their performance was discussed. They confirmed that they had access to a wide range of training in addition to the provider's core mandatory training. One staff member told us that every time they had a supervision meeting they were asked whether they wanted to undertake professional training or more specialised training. They told us that they were to attend a three day course on dementia to enable them to assist people who were living with dementia more effectively.

The training records that we looked at showed that, as well as the safeguarding of vulnerable adults (SoVA) and infection control, staff members received training in emergency aid, fire safety, food safety and nutrition, health and safety, manual handling and medication. The staff members we spoke with demonstrated that they had the knowledge and skills they needed to carry out their roles effectively. One person who lived at the home told us, "They know what they are doing."

The majority of the people we spoke with said that the food was good. We observed the lunchtime meal on three of the four units at the home. People were offered a choice as to where they sat and what they had to eat. The menu offered a range of choices with both hot and cold options. People were offered a choice of meal, both verbally and visually with meals plated up and people were then offered them to choose which they wanted to eat. Staff members assisted people to eat their food in a caring, respectful manner. People were encouraged to be as independent as possible. We saw a staff member putting food on a spoon and offering the spoon to a person so that they could feed themselves. When people needed more assistance we saw that the staff members went at the person's pace and did not attempt to hurry them. People were able to have second helpings of the meal if they wanted. There was a choice of juices, milkshake, water, tea and coffee for people to have with their meal.

We spoke with the chef who told us that they received a food preference sheet for each person who lived at the home which also indicated any specific dietary requirements for people, such as whether they needed a diabetic diet, pureed or fortified meals. People could be confident that their nutritional needs would be met. In addition to the two choices offered at each meal there were a number of alternative meals that were always available for people. Snacks were offered throughout the morning to people who had declined breakfast or who requested something to eat. There were fruit and biscuits available, along with pate and crackers. All lounge areas had cold drinks in covered jugs available and the café area and kitchenettes had fruit and biscuits available for people to help themselves. This meant that people were supported to have sufficient quantities of food and hydration.

People told us that they were able to see the GP who attended the home twice a week. They were able to make an appointment if they wished to see the GP and people had been supported to see an optician, chiropodist and dentist. A community nurse visited the home on a weekly basis but called to see specific people as and when this was required. People's health care needs were therefore met.

Good

Is the service caring?

Our findings

The 11 people and the two relatives of people who lived at the home we spoke with told us that the staff were kind, compassionate and understood their needs. One person told us, "They are all lovely and caring." Another said, "I couldn't wish for better staff." The majority of people said that the staff spent time talking with them.

We observed that interaction between staff members and the people who lived at the home was positive and respectful. Staff members demonstrated that they had a good understanding of people's needs. Although most of the interactions we observed were directly related to the provision of care we did observe staff members having conversations with people and, when invited, a staff member accompanied one person to look at something in their room.

The four staff members we spoke with told us that they knew the people they cared for. They understood their likes and dislikes, the triggers that caused people to become agitated or distressed and steps to take to defuse situations when they arose. The staff members told us that they used people's care plans and also talked to other staff members that cared for people to get to understand their needs.

People told us that they had received a schedule of meetings that had been arranged by the manager to discuss their opinions and views on the services they received. We reviewed the minutes of the last meeting. These showed that people had discussed the menus, their hobbies and interests, special events and any complaints or grumbles that they had with the manager. In addition, the manager had advised people about staff changes that had or were about to occur, fire safety, health and safety, infection control and people's care plans.

People told us that staff respected their dignity. There was information about a dignity campaign on the notice board in each unit. The manager had appointed a 'Dignity Champion'. A 'Dignity Champion' is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. The 'Dignity Champion told us that they had identified key areas of focus, which included ensuring privacy, such as drawing curtains when providing personal care, ensuring consent was obtained before care was given and offering choices. One person told us of

positive support they had been given to maintain their dignity after an incident that had occurred in the communal lounge. When people required assistance to maintain their hygiene, such as wiping their hands before and after meals, this was done respectfully with due regard to their dignity.

Staff members had recognised the importance of how people looked to enhance their sense of well-being. We saw that people were well dressed and wearing matching outfits. Some women were wearing freshly applied make up, nail varnish and jewellery that co-ordinated with their outfits. Some men had chosen to wear a shirt and tie whilst others were more casually dressed. The staff members told us that they encouraged people to choose the clothes they wore for themselves.

Good

Is the service responsive?

Our findings

The relatives we spoke with told us that they were always made to feel welcome at the home and felt that they could visit at any time. People told us that they felt that staff listened to them and acted on what they said. They confirmed that staff asked their permission before providing any support to them.

We looked at the care records of six people who lived at the home. We saw that before people were admitted to the home a full assessment of their needs had been carried out. This was reviewed on their admission and a care profile was established. The care profiles were reviewed after six weeks and thereafter on a monthly basis to ensure that they continued to reflect people's needs. Most care records included a family history form that had been completed to give staff a background to the person and enable relevant activities and conversation prompts to be provided for them.

People's needs were assessed and care and treatment was planned in line with their individual care plans. We found that these were personalised, detailed and had been reviewed on a monthly basis.

There were care plans for all aspects of a person's life. These included cultural, spiritual and religious lifestyle and a statement of wishes for their end of life care. One relative said that they were pleased that a religious official had been welcomed in the home and that their relative's care plan included the contact details should they request pastoral care. This showed that the provider had addressed the person's spiritual needs.

We also saw that there were specific care plans for people who received end of life care. These detailed the preferences of the person and their relatives as to the way in which their care was provided. We looked at one plan which specified that the person was to be cared for in their bed and music was to be played quietly in their room. Their request for minimal interventions to take place, such as not being weighed, had been recorded and actioned, whilst appropriate records were in place to prevent unnecessary admission to hospital. The home had introduced a communication book in the person's room for them to leave messages about anything they wanted to share with the staff. This demonstrated that the home had responded to their wishes.

People told us that staff had respected their request for changes but also noticed when changes were needed. For example, one person told us that they had been asked if they wanted a different bed as they had appeared to have difficulty getting in and out of the one that was in their room. The manager had also noticed that the branches of a tree outside their room blocked the light and had arranged for the branches to be pruned to improve the light quality for them.

We saw that two units at the home had been adapted to respond to the needs of people who were living with dementia. People had been asked what their favourite colour was and the door to their room had been painted in this colour. This enabled them to more easily identify which was their room. There were many small areas set up around the units with seats, activity and memory boxes, touch cushions with ribbons and bows and other memorabilia. People were encouraged to touch and use these for mental stimulation which research had shown can impair the progress of dementia.

People who lived at the home were given appropriate information and support regarding their care. We saw that information was displayed on notice boards in each unit of the home. This included a guide for people who lived at the home and details of the compliments and complaints procedures. People and relatives we spoke with said that their requests were responded to and they would not hesitate to raise any issues with the manager or the staff at the reception desk. One relative told us that they had raised the issue of decoration in the corridors and communal areas and we saw that some areas had been recently redecorated. One person said, "Staff come in every day and ask what I need." Another person told us, "Carers know my needs without asking." One staff member told us that they regularly saw the manager talking with individual people about what they wanted.

The minutes of a meeting held with relatives of people who lived at the home showed that they had discussed the Deprivation of Liberty Safeguards (DoLS), becoming dementia friends and the role of the Care Quality Commission (CQC). This meant that relatives were aware that the provider might apply for authorisation to restrict their family member's liberty if they deemed it necessary for their protection.

We looked at the records of two complaints that had been received by the home in 2014. We saw that these had been

Good

Is the service responsive?

acknowledged by the manager and fully investigated. A response had been sent to the complainant within two weeks of the complaint having been received. The response explained the findings of the investigation and the actions that had been taken to prevent a similar incident from occurring. This was to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

Mountbatten Lodge is one of twenty eight homes owned or managed by Quantum Care Limited. The current manager of the home moved from another home within the group two months prior to our inspection. Their application to become the registered manager at Mountbatten Lodge was being processed at the time of our inspection.

The majority of people we spoke with told us that they knew who the manager was and spoke with them daily. They said they felt able to talk to them about the service. The relatives we spoke with told us that they felt confident in the management of the home. One relative told us that they attended meetings every few months where they had met regional managers and had been able to discuss service improvements.

The manager was supported by a deputy manager and also a team leader on each of the four units at the home. Regular staff meetings are held on each of the units and in addition a general staff meeting was held for staff from all units. We saw from the minutes of the general staff meeting held on 28 May 2014 that staff discussed health and safety issues, medication, confidentiality, complaints, legislation and safeguarding. The minutes showed that infection control, special events and human resources issues were also discussed. The senior staff also held a separate meeting at issues were discussed in depth. This enabled staff to be made aware of best practice and involved in discussions as to how it should be implemented.

Staff members we spoke with told us that they were encouraged in their one to one supervision meetings to discuss the needs of the people they cared for and improvements that could be made to the service. They told us they felt supported by their team leaders and the manager and had a good understanding of their roles and responsibilities. They said that they understood the management structure and knew how to raise concerns, and to whom, should they need to do so. This showed that people were cared for by staff that were supported and empowered in their role.

We looked at the action plan that had been produced following a registered provider's audit completed in May 2014. This included the outstanding actions that had arisen from the previous month's audit and those from the audit itself. We noted that the action plan required the manager to investigate 'near miss' incidents to reduce the risk of harm to people who lived at the home.

We saw that a number of quality audits had been completed. These included checks of food and hydration charts, infection control, hand hygiene and standardisation training. We saw records that confirmed that the deputy manager had completed a walk round of the home every two hours to check on people's hydration and that their charts had been correctly completed. Information and identified trends from these audits were analysed by the manager and used to improve service and reduce risk to the people who lived at the home.

The manager was supported by specialist departments within the provider's organisation, such as the quality assurance department, health and safety manager and the dementia manager to ensure that the service identified and implemented best practice.

We looked at the results of the most recent annual questionnaire in February 2014. Although the results had mostly been positive there were comments made about the laundry service provided, access to healthcare professionals, refreshments for visitors and the cleanliness of commodes. We saw that an action plan had been devised to address the issues raised and actions had been completed. For example, the laundry service had been improved and that, where needed, clothing was now ironed before it was returned to people's rooms.