

Bupa Care Homes (GL) Limited

# Mount Hall Care Home

## Inspection report

Flash Lane  
Bollington Cross  
Macclesfield  
Cheshire  
SK10 5AQ

Tel: 01625574177

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The inspection was unannounced and took place on 3 and 4 December 2018.

We carried out a responsive inspection on 23 March 2018 in response to concerns that had been raised about standards in clinical care. The inspection found that these were being managed well and we rated the service good. Our previous comprehensive inspection on 9 February 2016 also found the service was rated good.

Mount Hall Care 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.

The home has accommodation for up to 33 people. Accommodation is provided over two floors. There are single bedrooms and all but four of the home's bedrooms have ensuite facilities including wash basin and WC. Two lounges and a dining room are located on the ground floor. The home is set in its own gardens in a semi-rural location near Macclesfield. At the time of our inspection 29 people were living in the home.

At our last inspection we rated the service good. At this inspection we found that there were several areas for improvement and we found that the provider was in breach of Regulation 18 as staff did not have access to regular supervision. The service was rated requires improvement overall. This is the first time, the service has been rated requires improvement.

We found that call bells took a long time to answer, which meant people were not receiving support in a timely manner. Staff told us that they felt there were not sufficient staff to meet the needs of the people in the service. We spoke to the regional management team who were investigating this in more detail to assess whether the current staffing levels were sufficient.

Staff were not receiving regular supervision to support them in their roles. This had been identified as an area for improvement earlier in the year, but little progress had been made to improve this.

Although some of the issues we found on our inspection had been identified by the provider's quality assurance systems, little or no improvements were seen since these had been identified in August.

People and their relatives we spoke with were all positive about the care they received and approach of the staff within the home.

There were systems and processes in place to ensure that people who lived in the home were safeguarded from abuse and staff were aware of how to report any concerns.

Risks to people were effectively recorded and subject to regular reviews and there were clear instructions for

staff to try to minimise risks to people without unnecessary restrictions.

Staff were safely recruited.

Medicines were managed and administered safely.

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. Staff were trained to give them the skills and knowledge to meet the needs of the people.

People had access to other health professionals and staff maintained good relationships with other health professionals.

We observed that staff knew people well and respected their dignity. Staff promoted independence as far as possible and everyone spoke positively about the staff and manager.

People's care plans were person centred and contained details about the person, their history, preferences and how they wanted to be supported. These were regularly reviewed and contained any necessary advice from other professionals. There was a complaints procedure in place and people were clear who to speak to if they wanted to raise any issues.

People, their relatives and staff spoke positively about the management of the home and the approachability and responsiveness of the manager. The home had links with the local community.

You can see what action we took at the end of the report.

## 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 always safe.

Call bells took a long time to answer, which meant that people's need were not always met in a timely manner.

Medication was managed safely.

Risk assessments were in place and there was clear guidance to staff on how to manage risks.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Staff within the service were not receiving regular supervision.

People's nutritional needs were being met and these were monitored regularly.

Staff received adequate training in order to carry out their roles.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

Everyone living in the service was positive about the staff in the home and they felt that they were kind and caring.

People's private and dignity was respected.

Information was kept confidentially and securely.

**Good** ●

### Is the service responsive?

The service was responsive.

Care plans were detailed and these were regularly reviewed.

People had access to a variety of activities and told us that they enjoyed these.

**Good** ●

People were clear how to complain and felt that their concerns were addressed in a timely manner.

### **Is the service well-led?**

The service was not always well led.

Whilst issues had been picked up by the provider's quality assurance systems, they had not been effective at making the necessary improvements.

Regular residents' meetings took place and they had been kept up-to-date with information about the refurbishment.

The home had links with the local community and people visited groups in the local village as well as groups coming into the home.

**Requires Improvement** ●

# Mount Hall Care 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 3 and 4 December 2018 and was unannounced. The inspection was carried out by one adult social care inspector, a Specialist Nurse Advisor and an expert-by-experience on the first day of inspection and one adult social care inspector on the second day of inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked information that we held about the service and the service provider. We viewed the provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We invited the local authority to provide us with any information they held about Mount Hall. We used this information to help us plan our inspection.

During the inspection, we used a number of different methods to help us understand the experiences of people living in the home.

We spoke with a total of 13 people living there, five visiting relatives and friends and 12 members of staff including the registered manager, the regional director, regional support manager, quality support manager, clinical services manager, the chef, one nurse, the activities co-ordinator and four members of care staff. We spoke to two visiting health professionals.

Throughout the inspection, we observed how staff supported people with their care during the day.

We used the Short Observational Framework for Inspection (SOFI) and undertook a SOFI during the course of the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked around the service as well as checking records. We looked at a total of five care plans. We looked at other documents including policies and procedures; staffing rotas; risk assessments; complaints; staff files covering recruitment; training; maintenance records; health and safety checks; minutes of meetings and medication records.

# Is the service safe?

## Our findings

Staff told us they felt there were not enough staff in place to meet the needs of the people living in the home. Comments included, "If two of us are helping in a room and come out, we can't tell on the call bell system who rang first, so people can wait longer", "We haven't got time to chat. Some people would like to get up earlier, but we haven't got time to get them up earlier" and "We need more staff, we don't have enough. It's safe, but we have to rush".

We noticed that call bells were taking a while to answer and we asked to view a sample of call bell response times. We saw in the week prior to our inspection, there were 27 occasions when people have waited fifteen minutes or longer for their call bells to be answered. We spoke to the registered manager as well as the regional management team about this. The provider had identified this as an issue prior to our inspection and the regional management team were offering support and completing further investigations into why this was happening.

People we spoke with all spoke of their call bells being answered and all but one relative felt that there were enough staff to assist people within the home. The dependency of people within the home was monitored regularly and adjustments were made to staffing levels to ensure there were enough staff to meet people's needs. We looked at the rotas and saw that the staffing levels were consistent with the amounts which had been calculated by the dependency tool.

We were given reassurances by the regional management team that this was being investigated as a matter of priority and pagers had been ordered for staff to enable them to see which people had been waiting longer for assistance. This is an area for improvement. Following our inspection, we have received feedback from the regional management team that this is being continually monitored and recommendations have been provided for how this can be improved.

Risks were managed safely. We found risks were assessed for people in relation to falls, nutrition and pressure care. There were clear plans in place when risks had been identified on what action staff needed to take to minimise the risk to people. These were reviewed on a regular basis.

We saw that handovers took place at every shift change; these highlighted which people needed additional monitoring or which professionals were visiting the home that day. Meetings also took place each day called '10 at 10' which again reviewed any people or issues in the home that needed specific attention that day.

We looked at the accident and incident records in the home. We could see incidents forms were completed when anything happened in the home. These were monitored by the manager and it was clearly documented what action had been taken when any patterns were identified.

People living in the home told us that they felt safe. Comments included, "I feel safe here. They come quickly if I ring for them", "I have no worries about my safety here, they know what they are doing and do it well" and "If I didn't feel safe, I wouldn't stay here". Relatives provided comments, which included, "Nothing seems too

much trouble for them, they look after [relative] well and I think they have a much better understanding than me how to care for them" and "Safety is the most important thing for me, I know they will get everything they need, when they need it and will be looked after here".

We observed medicines being dispensed and saw that practices for administering medicines were safe. We checked Medicine Administration Records (MARs), which showed people were getting their medicines when they needed them and at the times they were prescribed. We saw records were kept of all medicines received into the home and if necessary their disposal. There was guidance in place for medication 'given when necessary' (PRN medication) to inform staff when people may need this medication. We saw both the medicines trolley and the treatment room was securely locked and daily temperature checks were made. Regular medication audits were carried out and any actions were followed up promptly.

We saw that the provider had a safeguarding policy in place. This was designed to ensure that any safeguarding concerns that arose were dealt with openly and people were protected from possible harm. The manager told us that they were aware of the relevant process to follow and the requirement to report any concerns to the local authority and to the Care Quality Commission (CQC).

Staff members confirmed that they had received training in protecting vulnerable adults and when we checked the records we could see that this had been completed recently. Staff members told us that they understood the process to follow if a safeguarding incident occurred and they were aware of their responsibilities for caring for vulnerable adults. Staff were aware of the need to report safeguarding incidents both within and outside of their organisation. Lessons were learnt and we saw some root cause analysis had been carried out following a couple of incidents, practice amended and recommendations shared with staff.

The provider had a whistleblowing policy in place. Staff were familiar with the term whistleblowing and each said they would report any concerns regarding poor practice they had to senior staff or external agencies. We saw that safeguarding incidents were clearly documented, had been appropriately referred to the local authority and in general notified to CQC.

We found that appropriate recruitment checks had been made to ensure new staff were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each file held suitable proof of identity, the application form with full employment history, a medical check and references. We did note some files where people had been employed over 20 years did not contain all these documents. We raised this with the registered manager to address.

We checked some of the equipment and safety records and saw that they had been subject to recent safety checks. We conducted a tour of the home and our observations were of a clean, fresh smelling environment which was safe without restricting people's ability to move around freely.

We could see that several maintenance checks being carried out weekly and monthly. These included the fire alarm system, emergency lighting and water temperatures. We saw appropriate safety certificates were in place for gas and electrical installation.

Staff had regular training on fire safety and we saw that fire drills were completed regularly and at different times to ensure all staff had experience of this. We found that the people living in the home had an individual Personal Emergency Evacuation Plan (PEEPS) in place. PEEPS are good practice and would be

used to assist emergency personnel evacuate people from the home in the event of an emergency such as a fire.

## Is the service effective?

### Our findings

Staff told us they had not received regular supervision. We checked records which confirmed that supervision sessions for each member of staff had not been held regularly. Initially it was not clear from the documentation whether any supervision had taken place within the last 12 months and the paperwork was incomplete. On the second day of our inspection, the paperwork had been reviewed and we could see that there had been some group supervisions where areas of practice were highlighted, but staff had not received any individual supervision sessions to discuss their performance and any concerns. Staff felt these would be helpful as they would be able to raise their current concerns for instance in relation to call bells and staffing.

We spoke to the registered manager and regional management team. They told us that this had been highlighted as an area for improvement. We checked documentation and saw that this had been identified in August 2018, but improvements were not seen. Only one group supervision had taken place with three nurses in October and one in November with three care staff. Some care staff had not had one supervision in the past 10 months and four staff members new in post in September had not had any supervision to see how they were progressing in their new roles.

We saw that appraisals had been taking place, however there were still ten members of care staff who had not had an appraisal in the last twelve months and most of the ancillary staff had neither an appraisal or any supervisions in the last year.

This constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not receiving appropriate support and supervision as is necessary to enable them to carry out the duties they are employed to perform.

Following our inspection, we have been informed that supervisions have taken place with staff and a clear schedule is in place to improve this.

All the people and their relatives we spoke with felt that their needs were met. They said staff were caring and knew what they were doing. Comments included, "They know me and know what I need", "It surprises me how well they get to know us all" and "The food is not bad, I get plenty of choice as well". Relatives also commented, "[Relative] can always get a drink or a snack, they only have to ask and I can too as well" and "They always contact the doctor when there is a problem or if they feel something needs to be changed and I am always involved with this".

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the

## Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We saw that the service was working within the principles of the act and conditions were being met. We saw that mental capacity assessments and best interests' decisions had been recorded where necessary. There was a clear tracker of all the applications which had been granted and when these expired.

Staff were clear on the need to gain consent prior to assisting anyone. During our visit we saw that staff took time to ensure that they were fully engaged with each person, for instance by ensuring they were at eye level and they spoke slowly and clearly with people. Staff explained what they needed or intended to do and asked if that was acceptable rather than assuming consent.

We saw that new staff received an induction when starting in post and completed shadowing of existing staff prior to working unsupervised. Any staff new to care the provider's induction booklet which was based on the Care Certificate, which is a nationally recognised and accredited system for inducting new staff. We asked staff members about training and they all confirmed that they had received regular training throughout the year. We subsequently checked the staff training records and saw that staff had undertaken a range of training relevant to their role including moving and handling, safeguarding and health and safety. Dates were booked for any training which was out of date.

We saw that people were weighed regularly and if someone had gained or lost significant amounts of weight, appropriate advice was sought. Visits and advice from other health professionals were recorded on the care files and appropriate action taken. We spoke to one health professional, who commented that they had no concerns about the care or paperwork in the home and there were always staff around to talk to.

Everyone we spoke with in the home and relatives were positive about the food. We saw that people had access to fluids and were offered drinks regularly throughout our inspection. The service employed a chef and there was a four-weekly menu in place. We saw staff asking people for their food choices in the morning prior to their lunchtime meal.

We carried out an observation during meal times and saw people were offered different choices. During lunch time people had the option to eat in their own room, the dining room or other seating areas. Some people chose to eat in the dining room and we saw tables were set for dining. Where people needed support, they were assisted by staff members in a patient and unhurried manner.

Relatives told us they felt involved in their family members' care and kept up-to-date. One relative told us, "Communication between me and the staff is good".

A tour of the premises was undertaken. The home was currently undergoing a scheme of refurbishment and there were decorators present during our inspection. There were clear signs in the reception area about which areas of the home were affected this week and the progress being made. We also saw that this was a regular item on the residents meeting, so people were being kept up to date on the changes. We saw people had access to a communal lounge and dining room. We saw that bedrooms were clean and personalised. There were extensive grounds with several seating areas for people to use.

## Is the service caring?

### Our findings

We asked people who lived in the home and their visitors about the home and the staff who worked there. Everyone we spoke with was positive about staff. People told us, "They are always so kind and caring, they ask me if I'm ok or if I need anything", "We get to do things we like to do, they listen to us and do their best to make us happy" and "They're ever so good here. [Relative] is in another home and they bring them to see me once a week, which is so kind".

Visiting relatives told us, "Staff are absolutely first class, brilliant", "They always make me feel welcome here as well, it's like an extension of my own home" and "I find them very caring here, they always check themselves that we are happy with things".

Throughout the inspection, we observed positive interactions between staff and the people living in the home. We spoke to staff about people's likes and dislikes as well as their history and staff could demonstrate that they knew people well. Staff told us that they enjoyed working at Mount Hall. Comments included, "I love the residents that I work with" and "It's a nice home to work in" and "Lovely home".

We undertook a SOFI on the first day of our inspection. We saw that staff members were speaking to people with respect and were patient and not rushing whilst they were supporting them. They looked interested in what people were saying and took their time to engage with each person, for instance ensuring that they were at eye level with the person in order that they understood what each person wanted. We saw several staff stop and speak to someone who they knew felt the cold. A staff member went to gain another blanket for the person to ensure they were warm.

We saw on both days of our inspection that the people living in the home looked clean and well cared for. For instance, ladies' hair was done and their nails were painted. Those people being cared for in bed also looked clean and comfortable.

People's dignity and privacy were respected; for instance, we saw staff knock on people's doors before entering and always used their preferred name. This was also recorded on the care plan. Care files recorded whether people preferred male or female staff. Privacy signage was used on doors when people were being assisted with personal care, so others did not enter. People were encouraged to be independent, whilst remaining safe. For instance, we saw one plan where the person liked to wander in the garden. This was encouraged, however staff needed to monitor as the person was at risk of falls.

There was a policy for promoting equality and diversity within the service. Protected characteristics (characteristics which are protected from discrimination) were considered at the initial assessment stage and included age, religion, gender and medical conditions/disabilities. They were regularly reviewed. This meant that the registered provider was assessing all areas of care which needed to be supported and established how such areas of care needed to be appropriately managed.

People had access to advocacy services and there was information about this displayed in the foyer of the

home.

People's personal information was kept securely in the nurses' office, so people could be confident that their information was kept confidentially.

## Is the service responsive?

### Our findings

People told us that they had choice in relation to daily living activities. Comments included, "I know my family were involved when I first came in, making sure the staff knew all about me and what I need, it's made me happier and helped me settle in" and "I like that if I am worried about something, they can call the doctor, or you can see the doctor when they come in once a week, it's never too much trouble". Relatives told us, "I come in everyday, so always know what is going on and can talk to people about it, I've never had to complain though, it's always been good" and "I have never had to complain, not formally anyway, where I have a concern or a niggle, I just speak to whoever is best to address it and it gets sorted".

We looked at the care plans and saw that they were detailed, person centred and informative. There was an overview of people's history and people who were important to them. They recorded people's preferences, for instance whether they preferred baths or showers, what time they liked to get up. They were regularly reviewed and we saw where they were significant changes, the care plans had been rewritten. We looked at additional monitoring charts and saw that these were consistently completed to monitor where someone needed pressure care or were at risk of malnutrition or dehydration. One-page profiles were kept in people's room to assist any new staff who were not as familiar with the people living in the home.

From our observations and discussions, we found that staff knew the people they were supporting well. They could tell us about their likes and dislikes as well as some of their history.

The provider had an activities co-ordinator. They kept a detailed record of all the activities they had carried out with each person and how engaged each person had been in the activity. The activities co-ordinator undertook regular trips to the local Parkinson's group held in the local community and a trip was planned to watch the local school nativity. Holy communion took place in the home for people who wished to attend and there were activities ranging from horticultural therapy to pamper and musical entertainers. We saw people enjoying an outside entertainer on the first day of our inspection, one person was swaying and singing along, others were tapping their feet and people were smiling. We also saw the activities co-ordinator sitting with people in their rooms and chatting. The schedule of activities was displayed around the home and the activities co-ordinator varied the programme to ensure that there were different activities available.

People and their relatives were very complimentary about the activities in the home. Comments included, "The new activities co-ordinator is wonderful, so bubbly and enthusiastic and there is so much to do", "Being able to just go outside and enjoy ourselves is nice, but not so much in this weather" and "I love the entertainers coming in, I have a bit of a sing and sometimes a boogie". Relatives told us, "Sometimes I wonder if [relative] wants me to come in so much now as they are always busy with something" and "There's always something happening and lots more different things now, something to please everyone".

We found that appropriate 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were in place on some of the care files that we reviewed. We saw that the person, their relative or health professional had been involved in the decision making. Records were dated and signed by a GP and were reviewed

appropriately. A DNACPR form is used if cardiac or respiratory arrest is an expected part of the dying process and where CPR would not be successful. Making and recording an advance decision not to attempt CPR will help to ensure that the person's advance decisions about their end of life care are respected.

We saw that information was recorded about people's end of life wishes so staff were aware of how people would like to spend the end stages of their life.

The service had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. People living in the home and their relatives told us that they could raise any concerns and were confident that they were listened to and complaints would be dealt with. We saw the complaints received had been recorded and responded to within the provider's guidelines.

The provider had considered the Accessible Information Standard and recorded in care files people's individual communication needs and how staff could meet these needs. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for providers of NHS and publicly-funded care to ensure people with a disability or sensory loss can access and understand information they are given. These were detailed and would help any member of staff to understand how they could support someone with communication needs. They had also produced some documentation in pictorial format to help people's reading and understanding.

## Is the service well-led?

### Our findings

As we have explained earlier in this report, we found the home was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not providing regular supervision and support to staff to assist them to carry out their roles. Whilst the registered provider had identified these issues, little progress had been made in terms of improvement. This meant the provider did not have effective systems in place to recognise and make improvements in relation to this breach of the regulations.

We saw that regular audits were taking place in respect of care plans, medication and the environment. The home received regular visits from the provider's quality assurance team. We saw where areas of improvement had been identified by the quality monitoring team, action had not always been taken to address this. Weekly clinical risk meetings took place reviewing care plans, additional monitoring forms as well as anyone identified as being at risk for instance of pressure sores, malnutrition or falls. Monthly clinical reviews were also completed to ensure that care plans, safeguarding referrals, medication audits and complaints had all been dealt with. We saw that these had been completed monthly by the registered manager, however they had not identified the issues we found on inspection.

There was a registered manager in place at the time of our inspection who had been registered since February 2017. We spoke to people, their relatives and staff about how the home was run. Everyone we spoke with was positive about the registered manager. Comments included, "Any minor issues have been dealt with instantly", "I really like [the manager], when you raise something, they deal with it" and "The manager is lovely, they are always around, making sure we are okay and having a chat with us".

Regular spot checks were completed at different times by the manager to ensure that there were no issues. The registered manager also completed regular 'walk arounds' the home to check that standards of care were maintained.

We saw that residents' and relatives' meetings were taking place regularly and people had chance to voice their concerns about any issues. Each month, they completed a 'you said, we did' exercise and the results were displayed within the foyer of the home. An annual survey was completed and we saw the last survey completed in December 2017 showed that 100% of people living in the home were happy with the care they received.

We saw that staff meetings were held regularly and staff could raise any concerns. Issues such as recruitment, training, safeguarding and staffing had been discussed. We did note that there had not been a staff meeting since July 2018 as the last one had been cancelled.

The home had links to the local community. The activities co-ordinator supported people to attend the local Parkinson's group in the local village. The local 'knit and natter' now used the home as their meeting place and would sit amongst people living there and chat with them. They had links with the local school and were due to attend the nativity the week of our inspection. The home had also been involved in an initiative

'Hard to hear', which tests people who are having hearing difficulties. Whilst the project had finished, they had been able to retain the equipment to continue testing people and for people who do not like using hearing aids, they had phones to assist them to hear more clearly.

Providers are required to notify the CQC of events or changes that affect a service or the people using it, for instance serious injuries or where the provider has made an application to deprive someone of their liberty. We saw the provider was in general appropriately notifying CQC of incidents within the home.

From April 2015, providers must clearly display their CQC ratings. This is to make sure the public see the ratings, and they are accessible to all the people who use their services. We saw this was appropriately displayed within the home and on the provider's website.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care  Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing  Staff did not receive appropriate support and supervision to enable them to carry out their duties.