Leeds City Council

Home Lea House

Inspection report

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Rothwell
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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

The inspection took place on 27 August 2015 and was unannounced. Home Lea House provides accommodation and personal care for up to 29 older people which include two respite places. Bedrooms are single occupancy and the majority have en-suite toilet facilities. Communal lounges, a dining room, a hairdressing salon and a café area are provided. On the day of our visit there were 21 people living at the service.

A registered manager was in place at the service. 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.

Although the provider had systems in place for the handling and administration of medicines we found that records relating to the application of topical medicines were not being kept up to date. Topical medications are those which are applied to skin and include creams, lotions and ointments.

People's care plans contained detailed mental capacity assessments in accordance with the Mental Capacity Act

Summary of findings

(2005). People were not deprived of their liberty unlawfully. The registered manager and provider were aware of their responsibilities regarding the Deprivation of Liberty Safeguards and had ensured the appropriate assessments were completed.

People we spoke with said they liked living at the service and were provided with a good standard of care and had good relationships with staff.

We saw the provider investigated concerns appropriately when these were raised.

There were enough staff to keep people safe and staff training provided staff with the knowledge and skills to support people safely. We found the provider undertook appropriate recruitment checks to ensure people were not at risk from staff who were not suitable to work with vulnerable people.

The service was robust in reporting safeguarding issues and we found staff had an understanding of the forms of abuse and were confident they knew how to act if they believed that anyone were at risk.

People told us they enjoyed the food and we saw the provider consulted people as to what they would like to be on the menu. Mealtimes were sociable occasions and we saw people who needed support to eat their food received personal and dignified assistance.

There was a good programme of activities which people told us they enjoyed. We saw people were asked what they would like to do and that staff encouraged participation.

The registered manager was seen as approachable and responsive by people who lived at the home and by staff. They held regular formal meetings with people living at the home which meant people's feedback and ideas were actively sought. Staff meetings were also held regularly, giving staff an opportunity to discuss any issues.

A number of audits were undertaken by both the provider and registered manager to ensure effective service delivery and improvement.

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?

Requires improvement

The service was not consistently safe.

Although medicines were generally managed safely, the administration of topical medication was not being routinely recorded meaning that the service could not demonstrate that people were receiving these as prescribed.

Individual risk assessments were detailed and provided good guidance for staff.

Staffing levels were maintained and were sufficient to ensure that people's needs could be met.

Is the service effective?

Good

The service was effective.

Staff received regular training, supervision and appraisal to ensure they were supported to deliver care effectively.

People received regular input from health professionals such as doctors, dieticians and speech and language therapists.

People's choices were respected and staff understood the requirements of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

People spoke highly of the staff and told us they were supported with respect and kindness. We observed staff chatting and socialising with people throughout our visit.

Staff understood the importance of respecting people's privacy and dignity.

We saw evidence that people were offered choices and consulted about decisions made in the home.

Is the service responsive?

Good

The service was responsive.

People told us they enjoyed the activities offered in the home and we saw they were consulted about the kinds of things they would like to do.

The service had a robust system in place to record and resolve complaints.

We saw that care records gave staff good guidance of how to provide care that met people's needs.

Summary of findings

Is the service well-led?

Good

The service was well-led.

Staff told us they liked their jobs and we saw many had been employed in the home in excess of ten years.

The registered manager and provider had systems of audits in place to support the running of the home.

We saw the registered manager regularly met with staff and people who lived in the home.

Home Lea House

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 27 August 2015 and was unannounced. Our inspection team consisted of three adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service. We checked the information that we held about the service and the provider. This included the notifications the provider had sent to us about incidents and information we had received from the public.

During the inspection we spoke with eight people who used the service, five members of staff, a visiting health professional and one visitor.

We looked at the care records of three people in detail to ensure these were accurate and up to date. We also looked at records relating to the management of the service. These included medication records, quality checks, staff rotas and recruitment and training records.

Requires improvement

Is the service safe?

Our findings

We saw medicines were administered to people by appropriately trained care staff. We found the service had up-to-date policies and procedures in place for the management of medicines, which were regularly reviewed, to support staff and to ensure that medicines were appropriately managed. The registered manager told us relevant staff had undertaken medicines training to ensure staff managed medicines in a safe way and made sure people who used the service received their medicines as prescribed. Records we looked at showed that training on medicines was up to date.

Medicines were securely stored in two locked trolleys, in a locked room. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. The controlled drugs book was in good order and medicines were clearly recorded. There was evidence of regular stock checks and recorded stock balances were correct.

Medicines requiring cool storage were kept in a fridge in a locked room. We saw that temperatures relating to refrigeration had been recorded daily and were overall between 2 and 8 degrees centigrade. We saw temperatures for the medicines rooms were recorded daily and were stored as per manufacturer's instructions.

The senior carer understood how each person preferred to take their medicines. For example, we saw one person preferred to take their medicines from a spoon while other people transferred them from a medicine pot to their mouth themselves. The medication administration record (MAR) was signed only after medicines had been administered. We saw staff who administered the medication spoke with dignity and respect to the people who used the service. A current photograph of each person was attached to their MARs to ensure there were no mistakes of identity when administering medicines.

We looked at Topical Medicine Protocol and Administration Records (TMPAR). Some people were prescribed medications with specific instructions for their use. We saw there were clear protocols in place for administering creams and lotions, however we could not be sure that they had been used as prescribed as actual use was inconsistently recorded. Records showed signatures only once each day on most of the TMPAR's we looked at, or in some cases not at all. We brought this to the attention of the registered manager who told us that they had also identified the issue and we saw that they had started to take action to address it.

All of the people we spoke with told us they felt safe living at the home. We saw from the training records staff received training in safeguarding and updates were planned in advance to ensure this knowledge was refreshed at regular intervals. Staff we spoke with demonstrated an understanding of how to keep people safe and what their responsibilities were if they witnessed something that might not be in a person's best interests. One member of staff told us, "Doing something about it is everybody's job. I would report my concerns to management or raise outside the home if I felt that was necessary." Staff we spoke with were confident that they knew how to report any suspicions of abuse and the different ways in which people might be at risk. The provider had made notifications to the Care Quality Commission and referrals to safeguarding authorities about matters that had occurred in the home. This meant they recognised incidents when people might have been at risk and taken appropriate action to protect them.

We looked at the care records of three people. Care plans demonstrated that individual risk assessments were carried out and identified how risks for individuals could be reduced or managed. For example, we saw in one person's care plan, they had been identified as being at risk of choking. We saw clear guidance for staff as to what to be aware of and what action to take if there was an incident. We saw input from speech and language therapists in identifying risks around eating and drinking and how these should be managed. We saw evidence that risk assessments were reviewed however, we noted the frequency of these reviews was not always consistent. For example, in one person's care plan risk assessments had been reviewed in July 2015, whereas in another person's care plan we saw the moving and handling risk assessment review had taken place in April 2014. This meant that risk assessments may not always take into account changes in a person's needs in a timely way.

We found the atmosphere was relaxed and pleasant throughout the visit. Staff we spoke with could tell us how they would diffuse any agitation between people living at the home and how to report this to ensure that correct records were kept.

Requires improvement

Is the service safe?

We saw accidents and incidents that happened in the home were recorded and we were able to see from these how each occurrence had been investigated. Although the registered manager had a detailed knowledge and understanding of incidents in the home there was no formal mechanism in place to demonstrate how these had been analysed to ensure that full lessons were learnt. We discussed this with the registered manager during the inspection.

We looked at staff rotas for the month before and the month after the inspection and saw staffing was maintained at either four or five care staff during the day and two care staff at night. The fifth member of care staff was added to the rota when the deputy manager was not available to provide cover. There was always a senior member of staff on duty during each shift. The registered manager told us staffing levels were set using a dependency tool and by speaking to staff. We saw there were sufficient staff on duty to meet people's needs and people who lived at the home did not tell us they had any concerns about the number of staff on duty. One member of staff we spoke with told us they did not always feel as though they had enough time to spend with people, however, overall they believed there were sufficient staff. We observed staff interacting with people throughout the day and during lunch we saw there were sufficient staff to provide one to one support for people that needed it.

We looked at the processes in place for staff recruitment. We saw staff members completed an application form and checks had been made with the Disclosure and Barring Service (DBS) by the provider, who alerted the registered manager to any concerns. The DBS is a national agency that holds information about criminal records and persons who are barred from working with vulnerable people. This helped employers make safer recruitment decisions.

We walked around the home, looked in all communal areas, bathrooms, toilets and some bedrooms. We saw people lived in an environment that was clean and well cared for. The home was in the process of being redecorated when we visited.

Good

Is the service effective?

Our findings

People we spoke with told us they were cared for by people that they knew and liked and expressed a high level of confidence in the care. People told us, "The staff couldn't be better", "The staff here are very good" and "They've looked after me really well."

People were cared for by trained staff because the provider had systems in place to identify what training should be provided and when this should be completed or refreshed. We looked at staff training records which showed staff had completed a range of training. These included fire training, infection control, food hygiene, dementia awareness and pressure care. Staff we spoke with told us their induction training had been comprehensive.

Staff told us they had regular supervision meetings and an appraisal. We looked at three staff files and saw these meetings were documented and signed by both the staff member and the person providing support and guidance. We saw staff were given opportunity to give feedback to the service and set objectives to enable them to improve their care delivery. There were regular checks on progress towards meeting these objectives.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The registered manager told us there were two people who had a DoLS authorisation in place and we saw these were appropriately completed and in date.

We looked at the records in relation to the assessment of the mental capacity of people who used the service. We saw records of assessment in place together with a statement of capacity which covered specific aspects of a person's life at the home including ability to consent to care and consent to live at the home. Where best interest's decisions were made there was clear and detailed information as to who should make decisions and how this had been determined. We saw evidence of the involvement of people living at the home and their relatives. Staff we spoke with told us they understood how to support people appropriately with making decisions. One person told us, "I know people's capacity from looking at their care plan and from getting to know them. Sometimes people's capacity can change from day to day." We saw the mental capacity assessments had been carried out in relation to people's ability to consent to care, and best interests decisions were made in consultation with a relative.

People's nutritional needs were assessed during the care planning process and we saw evidence these were reviewed either as a part of an overall care plan review or in response to advice given by another health professional such as a dietician or speech and language therapist. During the morning of the visit we observed staff reporting people's food and fluid intake at breakfast to the senior staff member on duty. We saw people's weights were regularly taken and recorded in their care plans, and we saw the frequency of these checks changed according to need, although review of this was not always recorded clearly. Staff we spoke with told us weight management was discussed at handovers. For example, in one person's care plan we saw stated the frequency of weight checks had been changed from monthly to weekly but had reverted to a monthly frequency with no further commentary in the care plan. We brought this to the attention of the registered manager and they told us the person's nutritional needs would be reviewed, with a referral to other health professionals if needed. Where a care plan had been reviewed and dietary advice changed we saw that there was clear guidance for staff to follow. When we asked staff about the support that specific people needed in order to eat and drink safely they were able to tell us in detail about how they supported that person.

We observed the lunch time meal and saw people enjoyed their meal in a relaxed atmosphere. We saw people chatting to staff and amongst themselves. The food was well presented and looked appetising. One person told us, "I like the food. It's much better than I ever cooked for myself." Another person said, "I really like the food." Staff told us people made choices about what they would like eat once they were seated at the table and we observed people being offered choice during lunch. One person asked for something that was not on the menu and we saw they were provided with the food they had asked for..

During the lunch service we observed three people being supported to eat their food. The staff members engaged well with the people they were assisting. One staff member told us, "[name of person] will sometimes like to feed

Good

Is the service effective?

themselves, I would see day to day how they are and support them as I need to." This meant staff understood how to support people to maintain their independence and dignity when eating and drinking.

The registered manager told us people who used the service were consulted on the menus and we saw evidence of this in the minutes of a residents meeting held in July 2015. Drinks and snacks were provided by staff throughout the day and people had access to refreshments to which they could help themselves. We saw a room had been converted into a café area and there were drinks and snacks freely available.

We saw people's individual care plans contained good information as to how their health needs were being met. In one person's care plan we saw they had sustained a head injury when they had fallen out of bed. A risk assessment had been carried out and the least restrictive solution had been identified. We saw evidence an adapted bed and fall monitoring items had been put in place to reduce the risk to the person, and saw in their falls chart they had not fallen since the changes had been madeCare records showed people had regular access other health professionals such as GPs, dieticians, dentists, opticians and chiropodists.

Good

Is the service caring?

Our findings

People told us they felt well cared for and happy living at the home. When we asked about the care staff people used positive language such as "Good", "Always helpful," and "Lovely" to describe them. We observed staff interacting with people and found they had a good rapport and engaged in meaningful and respectful conversation. Staff were kind, patient and caring in their approach and tone. They did not rush and we observed staff stopping to socialise with people, showing a genuine interest in what they had to say. One staff member told us, "I want to look after people the way I would want to be looked after." We observed staff helping people move about the home. They were calm and focused on the person, ensuring that equipment such as wheelchairs and walking frames were used correctly.

We found that routines in the home were flexible. We observed people being asked about their medication during lunch. One person was asked if they wanted to have their eye drops applied or if they would rather wait. When the person said that they would prefer to receive them after lunch this was respected. People were free to rise and go to bed as they wished, and we saw the registered manager had responded to some people's preference to rise early by altering the staffing rota to ensure there were sufficient staff to support people at this time of day. People told us they were free to have visitors at any time of the day and we observed relatives and friends being greeted warmly by the management and staff.

People we spoke with did not tell us about any involvement with their care plans, though all felt they received appropriate care and we observed staff regularly asking people if they needed anything and offering choices. We looked at the care records of three people and saw some evidence of people's involvement in review of these. For example, in one person's record we saw the person had been able to provide yes or no answers to questions and we saw a close relative had also been consulted. The registered manager was aware of how to assist people accessing an advocate when needed, meaning that the service was able to support people appropriately when they needed to make decisions.

Staff we spoke with understood the importance of respecting people's dignity and privacy. One member of staff we spoke with told us, "I always make sure I am discreet and offer the person choices about when and where they receive personal care." We observed staff using people's preferred names and knocking on people's doors before entering their bedrooms. Staff were also able to tell us about the importance of maintaining the independence of people who lived at the home. They described the way they did this by listening to people, offering encouragement and being aware of people's needs and preferences.

People told us they were supported in their religious beliefs. One person told us they were able to attend a local church service and another said, "I'm a Catholic, it's very important to me. The Priest comes to visit regularly."

People looked well cared for. They were tidy and clean in their appearance which is achieved through good standards of care. Staff we spoke with were able to tell us about the needs of the people living at the home and said they were fully updated about each person during a handover at the start of their shift to ensure this knowledge was always up to date.

We saw that people had been able to personalise their rooms. The home was undergoing a programme of re-decoration and one person who lived at the home showed us an area that had been finished and said, "What do you think of the decorating? I picked that wallpaper. It's lovely." There were two outdoor areas that people could access freely. One was a garden with bench seating, tables and a pond. The other was a courtyard which the registered manager told us had been improved by a team of volunteers from a local supermarket with whom the home has built a good relationship.

Good

Is the service responsive?

Our findings

People who lived at the home were enthusiastic when we spoke to them about what there was to do. One person told us, "It's pretty good here. There's usually plenty to do. Yesterday was interesting; they brought in some big birds, like eagles and things. I really liked it." We saw that other people in the lounge started discussing this activity amongst themselves and describing the animals they had been able to handle. We saw pictures painted by people displayed in the communal areas of the home.

The registered manager told us there was no dedicated activities co-ordinator but care staff were responsible for initiating activities in discussions with people who lived at the home. The registered manager said, "Everyone takes responsibility for making things happen. We have a bus and we have had some good outings, but people can also go out in the bus individually with a member of staff just for a spin, a change of scenery."

We saw people who lived at the home were consulted as to what kinds of things they would like to do. For example, at a resident's meeting in July 2015 people had suggested film afternoons with ice creams on Sundays, music afternoons, cream teas and day trips. On the morning of our visit there was music playing in one of the lounges and we saw people moved into the room to listen to it. One person enjoyed singing along. In the afternoon the care staff suggested a game of 'Who wants to be a millionaire?' We saw people joining in and enjoying lively exchanges with the staff. Following this people chose a film and enjoyed discussing it with staff as they were watching. The registered manager told us day trips were paid for from the resident's fund. We saw people had easy access to two outside areas of the home and saw people enjoying the sunshine. The registered manager told us the doors to these areas were not locked but had an alarm fitted to alert staff to the fact that someone had gone outside or returned inside. The courtyard area had pot plants and seating..

The service had a system in place for the recording and management of complaints and we saw a copy of the complaints procedure on display in the home. We looked at the complaints log and found detailed notes were kept as to the nature of the complaint and the process followed to resolve it.

We asked people what they would do if they had any complaints and most told us they would raise the matter with 'the staff' or 'the manager.' One person told us they would talk first to their key worker and another told us they would speak to one of the care staff because, "I can confide in them."

We looked at the records of compliments received from relatives and saw positive feedback about the care provided. One person said, "Everything was done to make [name of person]'s care as stress free as possible. Nothing was too much trouble for any member of staff." Another referred to 'care and consideration' shown to a relative who lived at the home. We saw people's personal information was treated confidentially and their personal records were stored securely.

We saw that people's care plans these were detailed and gave a good account of the person as an individual. For example, we saw detail about people's drinking preferences recorded, and when we spoke to staff about these they were able to tell us what drinks people preferred and whether they liked milk and sugar with tea or coffee. Care plans were kept under review and we saw evidence these were updated as needed. Daily records were detailed and contained information about people's daily routines as well as health, eating and drinking. People told us their call bells were answered straight away. We saw that call bells and requests for assistance were answered promptly.

We saw people's individuality and life history had been recorded in their care plan in a document entitled 'My life story'. This contained detail about the person's life in a number of sections including 'significant relationships', 'my life now – things I like, things I don't like' and 'people important to me now. 'One care plan included photographs from the person's past life to support what had been written, however, others care plans we saw contained less detail. We saw people's preferences were documented and we concluded that staff had a good knowledge of these through observing their practice and talking to them about people they supported.

Good

Is the service well-led?

Our findings

The registered manager demonstrated they understood the responsibilities of their registration with us. They reported significant events to the Care Quality Commission in accordance with this.

The registered manager had identified a number of areas for improvement and had planned the way these would be achieved. Funds had been successfully secured from the provider for new dining chairs and for a full redecoration of the home.

Staff we spoke with were happy working at the home and many had been employed there for ten years or more. One staff member told us, "I love my job." We saw staff worked as a team in delivering care. Staff told us the registered manager was approachable and they felt able to raise things with them. One staff member said, "I've been here a long time but I think the manager is OK, I can talk to them." We observed the registered manager engage in friendly conversation with people and their visitors throughout the day. People who lived at the home told us that they knew who the registered manager was and regularly saw them in the communal areas of the home.

The registered manager undertook direct observation of out of hours practice by making unannounced spot checks. At a recent spot check staff were found to be correctly deployed in areas of the home where they were able to quickly respond to people's needs.

We saw the registered manager conducted a rolling programme of audits. Audits carried out included medicines, care plans and the internal environment and fabric of the building. The outcomes of these audits were translated into action plans to ensure problems were addressed speedily. For example, we saw any maintenance issues within the home were identified quickly and recorded in the maintenance register for action by a suitable contractor. In addition to audits carried out in the home we saw the provider made regular visits to support the registered manager and a detailed quality assurance report was sent to give formal feedback. We saw these audits covered staffing, premises and environment, care planning, stakeholder perspectives, performance and quality and the day to day life in the home. These reports contained action plans with clear guidance as to when action should be taken and by whom. We saw a report from the provider visit in August 2015 where the registered manager had been asked to give a presentation to staff clarifying their responsibilities under the duty of candour policy.

We saw staff meetings were held to ensure all staff were kept up to date with any changes in policies and procedures, which might affect the management of the service or the care and treatment people received.

People who lived at the home told us they attended regular meetings with the registered manager. One person said, "They usually happen after a meal when we're all in the dining room. They ask us what we like and how we want things, the menus, outings and things to do." We looked at records of the most recent meeting and saw this was well attended by people who lived at the home. People had been asked for feedback on the food they were served and had said they were happy and did not want any changes. New teapots were to be provided to replace ones which the residents told the registered provider were too heavy to lift.

We looked at a number of recently completed questionnaires by people and their relatives and found most of the comments received were positive and people were pleased with the standard of care and facilities provided. Comments included, "Completely satisfied with the care and condition of the home, and general helpfulness of friendly staff" and "Excellent general and personal care, very pleased." The results were displayed in the entrance to the home.