Mrs Patricia Beaumont

High Lee Care Home

Inspection report

High Lee Barn
Sowerby Lane
Luddendenfoot
Halifax
HX2 6LB
Tel: 01422 882437
Website:

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected High Lee Care Home on 1 October 2014; the visit was unannounced. Our last inspection took place on 5 October 2013 and, at that time, we found the regulations we looked at were met.

High Lee Care Home is a 17-bed service and is registered to provide accommodation and personal care for older people. Nursing care is not provided. The accommodation is arranged over two floors linked by a stair lift. All of the bedrooms are singles and there are communal lounges and a dining room for people to use. The home is located in Luddedenfoot, Halifax.

The service has a registered manager who had worked at the home for four years. 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.

Summary of findings

People living at the service, staff, relatives and the two health care professionals we spoke with all told us the registered manager and deputy manager had not been present in the home with any regularity, due to helping at one of the provider's other homes and illness since July 2014. People reported the service was lacking in leadership, communication could be problematic and there were issues arising that were not being dealt with.

We found there was a lack of management oversight and very few checks were being made on the overall operation and quality of the service. This meant there was no ongoing improvement plan to develop the service.

People who lived at the service and relatives told us they liked the small, friendly size of the home, their bedrooms and the rural location. They told us they found the staff helpful and caring and they liked the, "home cooking." People also told us there was a lack of activities and, "Nothing going on" to keep them stimulated.

We found people's safety was being compromised in some areas. The medication system was not well managed and people were not always receiving their medication as prescribed. The procedures for recruiting staff were not robust and the suitability of prospective employees was not fully explored before they started working in the service.

We found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate 

The service was not safe. Some medication was not being stored safely and other medicines were not being given as prescribed.

The recruitment procedure was not robust and staff had been employed without their suitability being fully explored.

Staff we spoke with knew how to recognise and respond to abuse correctly.

Is the service effective?

Requires Improvement 

The service was not always effective. Staff training was not up to date and staff were not receiving regular supervision or annual appraisals. This meant there was no formal support system to look at individual practice and professional development.

People were generally positive about the food and described it as 'home cooking.'

There were a range of health care professionals visiting the home to make sure people's health care needs were being met.

Is the service caring?

Good 

The service was caring. People who lived at the home and relatives told us the staff were friendly and kind.

We found information about people's life histories and personal preferences in their care plans. When we spoke with staff they knew about people's likes and dislikes.

Is the service responsive?

Requires Improvement 

The service was not always responsive, to people's needs. Care plans did not always identify people's specific needs or detail what support staff needed to offer.

There were no activities on offer to keep people stimulated.

People told us if they had any concerns they would tell the staff and said they thought they would be sorted out.

Is the service well-led?

Inadequate 

The service was not well-led. People we spoke with told us the manager and deputy manager had not been at the home on a regular basis and there was a general lack of leadership and management oversight.

Audits to check and monitor the quality of the service were not being completed and people were not being involved in the development of the home.

High Lee 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 October 2014 and was unannounced. The inspection was completed by one inspector. At the time of our visit there were 11 people living at the service.

Before the inspection we reviewed the information we held about the home. This included notifications from the provider, and speaking with the local authority safeguarding and contracting teams.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

On the day of our inspection we spoke with six people who lived at High Lee Care Home, one relative who was visiting the service, five members of staff and one visiting health care assistant. Following the visit we spoke with another relative to get their views.

We spent time observing practices in the home and looking at records. The records we looked at included four people's care records, two staff recruitment records and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

We looked at the recruitment records for two staff members. We found that recruitment practices were not safe.

We saw both staff members had completed an application form and staff had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

We spoke with one member of staff who told us they had completed an application form and attended an interview before being appointed.

However, at interview the gaps in their employment had not been discussed. We also saw the dates of employment one person had given on their application form differed from those given on the employers reference. The deputy manager told us they had not picked this up when the reference was returned.

In the other recruitment file we saw the application form was dated 23 April 2014. We saw two references had been provided for this person addressed to 'Whom it may concern'. One of these was undated and the other dated 12 April 2011. The deputy manager told us they thought they had sent for references, but this could not be evidenced. We also found there was no record of the discussions of this person's interview.

This breached Regulation 21 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the systems that were in place for the receipt, storage and administration of medicines. We saw that a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We saw medication was being booked in by two members of staff and they were checking the amounts of medication sent by the pharmacy were correct.

We looked at the medication administration record (MAR) for six people. One person had been prescribed an antibiotic to be taken four times a day. Staff had signed the record to indicate this had been given. However, when we counted the remaining tablets with the senior care worker we established that there were two more tablets in stock than there should have been. This meant two tablets had not been given. The instructions for the administration of this medication stated it should be given two hours before or two hours after food. On the MAR staff had recorded it should be given 'morning, lunch, tea time and bedtime.' The senior care worker told us they had given it that morning and then given the person their porridge. This meant the person had not been given their medication in line with their doctor's instructions.

We saw another person had been prescribed Paracetamol with two tablets to be taken four times a day when required. We counted the amount of times staff had signed the MAR indicating the medication had been given. However, when we counted the medication that was left in stock we found there were 24 more tablets than there should have been. This meant the system for managing medication was not effective and the person was not receiving their medication, even though staff had signed the record.

We looked in the drugs fridge and saw it needed to be defrosted. We asked the deputy manager if the temperature of the fridge was checked. They told us they thought it was but no records of any checks could be found. This meant the service could not evidence that staff were checking to make sure people's medication was being stored at the correct temperature.

This breached Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to make suitable arrangements for the management of medication.

People we spoke with told us they felt safe at the home. One person who lived at the home said, "I feel safe here, there's no trouble at all." Another person said, "I feel safe and the staff are helpful." One visitor told us they felt their relative had settled well at the home because they felt it was safe, small and homely.

We looked at the duty rotas and saw there was a senior care assistant and two care staff on duty throughout the day and two waking staff at night. Care staff were responsible for all of the caring duties, the cleaning and preparation of meals. Staff we spoke with told us they felt staffing levels were adequate at the current time as there were only 11 people living at the service.

Inadequate

Is the service safe?

Staff we spoke with told us they had received training in safeguarding adults. They told us this had been completed on the computer and the test at the end consisted of multiple choice questions. Staff told us there had been no follow up discussion to test their overall understanding on a practical level. We found some staff were clear about how to recognise and report any suspicions of abuse; whilst others were less clear about the reporting procedures outside of the service. However, all staff confirmed they would report any concerns about people's treatment in the home to a senior member of staff.

Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the home if they felt they were not being dealt with effectively. This showed us staff were aware of the systems in place to protect people and raise concerns.

Requires Improvement

Is the service effective?

Our findings

We looked at the policy about staff supervision and appraisals. This stated staff would receive supervision every two months and an annual appraisal. Staff we spoke with told us they had not had any one to one supervision or an appraisal over the last 6 months. Some staff told us they did not feel supported in their role.

Staff told us most of their training had been completed on the computer. Some said they would prefer face to face training because it would allow more discussion to help their learning. We asked to see the training matrix but the deputy manager could not find it. They told us they thought most of the training was up to date but they knew people were due practical moving and handling training.

One relative told us staff had a lack of knowledge about memory loss and sensory loss. We found staff had not completed any specific training regarding people living with dementia. This relative also told us they felt staff needed extra training in specific areas such as catheter care and management.

We asked people about the staff. These were some of the things they told us, "I think the staff know what they are doing" and, "Most of the carers are alright. I don't get on with some as well as others."

We spoke with a visiting health care assistant who told us they felt staff would benefit from more training about how to prevent pressure damage to people's skin. The district nurse agreed with this and said, "There are people who need to sit on pressure relieving cushions. These do not always follow them when they move from upstairs to downstairs. Staff need to understand why this is important."

This meant there was a risk that people were not being supported by staff who had the suitable skills and support to deliver effective care. This is because the provider had failed to make suitable arrangements for staff training, supervision and appraisal.

This breached Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with, a visiting health care assistant and district nurse all said communication had been difficult since the manager and deputy had not been in day to day charge of the service. A member of staff said, "There is a lack of communication about what is going on." The health care assistant told us they had visited to see one individual and the member of staff did not know what room they were in. The district nurse told us communication was a bit, "Hit and Miss" depending upon which staff were on duty. One relative said, "When the deputy manager is here they have their finger on the pulse, but when they are not here things fall down."

We saw staff had received training about the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). We spoke with the deputy manager who was able to tell us the details about an application that had been made to obtain authorisation to deprive someone of their liberty. This had been in relation to them being resistive to interventions to meet their personal care needs. However, when the assessment team visited it was decided a DoLS was not required. This showed staff had an understanding of the legislation and knew when an application to deprive someone of their liberty needed to be made.

We asked people living at the service about the food. These were some of the things people told us, "Food is alright, nothing special but better than a lot of places," and, "The food is homely." Staff told us there was a set menu, but they would find an alternative if someone didn't like the meal. Staff were also aware of people's preferences. For example, there was one person who did not like cheese or pastry so staff made sure if these were on the menu they made them something else.

At lunchtime the meal was homemade lasagne and garlic bread followed by tiramisu. One person we spoke with told us they had never tried lasagne but said they would, "Give it a go." After lunch they told us it was very tasty. The meal time was relaxed some people ate in the dining room whilst others choose to eat in their bedrooms.

We spoke with the deputy manager about meals at the service. They told us people could have what they wanted at breakfast time. However, we found this was not the understanding of people living at the service. One person told us, "There is no choice I never get bacon and egg for breakfast but might get it at tea time sometimes." The deputy manager agreed to make sure people were informed about the choices that were available.

People we spoke with told us if they felt unwell they would tell a member of staff and they would get the doctor or

Requires Improvement

Is the service effective?

community matron to come and see them. One person said, "If I need to see a doctor staff organise it. I am waiting for the dentist at the moment." We spoke with a visiting health care assistant who told us staff followed any instructions they left.

High Lee Care Home was taking part in a new initiative called 'Quest for Quality.' This was a service provided by Calderdale and Kirklees NHS Foundation Trust to provide an increased level of support to people living in care homes. Care workers had been provided with new technology and training so they could, for example, take people's blood pressures. The results were sent automatically to a clinical team and if anything untoward was identified a healthcare professional would be alerted.

Good

Is the service caring?

Our findings

People we spoke with told us they liked the staff that cared for them. One person said, “The staff are wonderful.” Another said, “The staff are kind and I get help with the things I need.” One relative said, “The staff are good, very kind and friendly.” The district nurse said, “People are clean, tidy, well dressed and staff are genuinely caring.”

People we spoke with did not know about their care plans and had not been involved in developing them. There was some evidence of relatives being involved in developing life histories. We heard staff get verbal consent from people before undertaking any personal care tasks.

When we spoke with staff we found they had a good knowledge of people lives, interests and their personal preferences. We heard staff using what they knew about people to engage them in conversation, when they were providing people with support.

We saw people looked well cared for. People were wearing clean clothing and their hair had been brushed or combed. This showed us staff had taken time to support people with their personal appearance. When we looked in people’s bedrooms we saw they had been personalised with pictures, ornaments and furnishings. Rooms were clean and tidy showing staff respected people’s belongings.

We saw one person receiving their visitor in their bedroom. We saw they had their own tea and coffee making facility so they could retain their independence. Their visitor told us they were always made to feel welcome by staff and could visit at any time. We asked the deputy manager about visiting and they told us they asked people to avoid meal times, but otherwise people could visit at any time. They also said if relatives lived away there was a spare room they could make arrangements for them to stay at the home.

Requires Improvement

Is the service responsive?

Our findings

We looked at three care files and found assessments had been completed before people had moved into the service. However, we saw some specific needs had not been planned for. For example, one person had lost 19 kilograms in weight before they moved into the service. There was no care plan in place to address their nutritional needs or guidance for staff about how they should monitor this risk. As this person had only been at the service for a short time they had only been weighed once, three days after admission. This meant we could not establish if they had put on weight, lost weight or if their weight remained stable.

One visitor told us when their relative first moved into the service staff had told them they didn't have time to assist them to shower. An agreement had subsequently been made that the person would be supported to shower twice a week. However, their relative said this did not always happen. We raised this with the deputy manager and they told us the individual would sometimes refuse a shower.

We asked people how they spent their time at the service. One person who was sitting in the lounge said, "It's boring, nobody talks, this is what it's like everyday." Another person said, "I like to read or listen to music. I can't read because the light in here is not good enough, I have trouble with my eyes." Another person said, "My relative brings me the newspaper to read and takes me out regularly." We saw a list of weekly activities was on display on the lounge door. We asked the same two people if these happened and they said they did not. We spoke with a relative who told us there were no activities on offer. They also added the only time staff spent time with people was when they were delivering personal care or support.

Staff told us they found it difficult to find time to provide activities because they were busy attending to people's personal care needs. One member of staff told us the registered manager did take people out but this had not happened recently with any frequency. Another member of staff said, "There isn't as much going on as there used to be." This meant there was a lack of stimulation and occupation for people who lived at the service.

This breached Regulation 9 (Care and welfare) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people who lived at the service if they were unhappy about anything or needed to make a complaint who would they talk to. One person told us they would tell a member of staff and all of the others told us they would tell a relative so they could sort it out. We saw a complaints procedure was in place and a copy was in the front entrance hall. We asked the deputy manager how complaints and concerns were managed. They told us minor concerns were not documented but would be dealt with. For example, one person did not like the bread so they were getting bread for them that they liked. This showed staff were responding to concerns, however, in the absence of a log of concerns or complaints it was not possible for the provider to spot any particular themes or trends.

Inadequate

Is the service well-led?

Our findings

Staff told us the registered manager had not been at the service regularly over recent months. This was because they had been helping out at another service owned by the provider. They also said the deputy manager had been unwell and although they had spent some time at the service they had not been there as much as in the past. This was confirmed by the deputy manager. Some staff said they did not think the home had been well-led over recent months. One member of staff said, "There is a lack of leadership, staff do what needs to be done from experience. There needs to be more of a routine with all staff working to the same standards." Another member of staff said, "The manager hasn't been around it needs someone to take charge." The district nurse and health care assistant also said they felt some of the issues that had arisen more recently were because of a lack of leadership in the home.

We asked people living at the service who the manager was. No one identified the registered manager or the deputy. One person gave us the name of one of the senior care assistants as the person they thought was in charge.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

People told us they hadn't been involved in any meetings to share their opinions about the way the home was managed. We asked staff if residents meetings were held and they told us they were not. We asked the deputy manager how they got people's views about the service. They told us this was done by speaking with people individually. However, there was no evidence of these discussions or of any changes that had been made to the service in response to people's comments.

We asked for the analysis of accidents and incidents. The deputy manager told us there was no analysis being completed. This meant no one was looking at the overview of accidents and incidents to identify any themes or trends and then identifying any actions that needed to be taken.

We asked to see audits that were completed in the home. We were shown a reasonably recent audit of the environment, but all of the other audits dated back to January 2014. This meant audits were not up to date and were not identifying current issues. For example, there were no recent medication audits in place which could have identified some of the risks associated with the management of medicines we found during this inspection.

This breached Regulation 10, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This meant there were no robust systems in place to assess and monitor the quality of the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People who use services and others were not protected against the risks of being cared for by unsuitable staff because had failed to fully explore the suitability of staff before employing them. Regulation 21 (a) (i) and (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. The registered person did not ensure there were suitable arrangements for the safekeeping and administration of medication. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers. The registered provider did not ensure staff received appropriate supervision and appraisal. Regulation 23 (1) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare The registered provider did not always ensure care was always planned to meet individual needs. Regulation 9 (1) (a) (b) (i) and (ii)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. The registered person did not have effective systems in place to monitor the quality of service delivery. Regulation 10 (1)(a) and 2(c)

The enforcement action we took:
Warning notice to be met by 31 January 2015