Lester Hall Apartments Limited

Lester Hall Apartments

Inspection report

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Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was unannounced which meant the provider was not aware we were visiting. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Lester Hall Apartments is a care home that provides accommodation for up to 20 people with a range of needs which include old age, physical and mental health and alcohol and drug dependency. Each person has their own apartment. There were 20 people using the service at the time of our inspection.

The service had a registered manager. 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.

People told us they felt safe at the home and that they were well cared for. Staff knew how to recognise and report signs of abuse. Staff understood the risks associated with people's care and protected them from harm. Staffing levels were based on people's and enough staff were on duty to meet the needs of people who used the service. The provider's recruitment procedures ensured as far as possible that only people suited to work at the service were recruited.

Staff had received appropriate and relevant training to be able to meet the needs of people who used the service. Staff had a good understanding of people's needs and they had supported people in line with their care plans. Senior staff understood the relevance of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This is legislation that protects people who lack mental capacity to make decisions and who are or may become deprived of their liberty through the use of restraint, restriction of movement and control. DoLS had been authorised for two people who used the service.

All of the people we spoke with told us that they enjoyed the food at the service. People with special dietary needs had those needs met.

The provider worked closely and effectively with health and social care professionals to ensure that people's health needs were met.

Staff treated people with kindness and consideration. People and their relatives were able to express their views about their care and support to the management team and staff. People had been supported to access advocacy services. People's privacy and dignity had been respected. Staff respected people's cultural backgrounds and supported them appropriately. Staff understood the individual needs of people they supported. People's views, and their relative's views, had been sought and acted upon. That had been through regular surveys, resident's meetings and daily interaction with people.

Summary of findings

The provider promoted a culture that put people's needs at the centre of decision making. Staff knew how they could raise any concerns about the service. The registered manager understood their responsibilities and had ensured that staff understood what the aims of the service were. The provider had effective procedures for monitoring and assessing the quality of service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew how to recognise and respond to abuse appropriately. Enough suitably trained and experienced staff were on duty. The provider's recruitment procedures ensured as far as possible that only staff suited to work at the service were employed. Staff followed risk management policies and procedures to minimise the risks to people.

Good

Is the service effective?
The service was effective.

People were supported by staff who had the necessary skills and knowledge. Staff understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Those safeguards had been the correctly applied at the home. People's needs had been assessed and provided for.

Good

Is the service caring?
The service was caring.

People's privacy, dignity and independence were respected. People were provided with meaningful activities and supported to be as independent as possible. People were supported to access advocacy services.

Good

Is the service responsive?
The service was responsive.

People's care plans were based on people's individual needs. People's and relative's views were regularly sought and acted upon. People knew how to raise concerns.

Good

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

The provider promoted a culture that placed people's individual needs at the forefront of care. The provider had effective systems for monitoring the quality of care.

Good

Lester Hall Apartments

Detailed findings

Background to this inspection

We visited the home on 7 July 2014. This inspection was unannounced. This meant the provider did not know we were visiting. Prior to the inspection we reviewed the home's statement of purpose (SoP) and the notifications we had been sent. A SoP is a document a provider uses to set out the objectives of a service and how they will be met. Notifications are changes, events or incidents that providers must tell us about.

The inspection team consisted of an inspector and an expert by experience who had experience of older people's care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of a service for people with learning disabilities.

During the inspection we spoke with seven people who used the service, two relatives, two care staff, and a director of the service, the registered manager and deputy manager. We spoke to people in their apartments and in communal areas. We observed care and support in communal areas. We looked at four people's care records, four staff recruitment files, a record that summarised what training staff had attended and management records of monitoring that had been carried out.

Before our inspection we reviewed all the information we had about the service. We had not received the provider's information return (PIR) before the inspection. The PIR 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. The provider had not returned the PIR before our inspection, but we received it afterwards. We took this into account when we made the judgements in this report.

Is the service safe?

Our findings

People who used the service told us that they felt safe. A person told us, "I'm definitely safe. The staff are very good. I know I can ask or tell staff if I have any worries."

People were protected from abuse. Staff had been trained to understand what dignity in care meant in practice. Staff had received training about safeguarding people. Staff we spoke with understood and knew how to recognise and report signs of abuse. We saw that staff treated people with dignity and respect which showed that they had put their training into practice.

People's care plans contained risk assessments of activities associated with people's personal care routines and behaviours. Those risk assessments were understood by staff who therefore knew how to support people safely.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA and DoLS is legislation that protects people may lack mental capacity to make decisions and who may become deprived of their liberty through the use of restraint, restriction of movement and control. Senior staff understood the relevance of the MCA and DoLS. DoLS had been authorised for two people who used the service. Those safeguards had been applied only after a proper process of authorisation had been followed. In both cases, authorisations had been made in people's best interests and for their safety. Both people had access to advocacy support and a right to challenge the DoLS authorisations. People who lacked capacity to make decisions were supported by staff to understand their needs.

Some of the people who used the service had at times displayed behaviour that challenged. Staff had received training on how to support these people. Staff we spoke with staff have a good understanding of how to support people on an individual basis in relation to their behaviours. Staff knew which people could be left alone and which required discrete observation. The provider's policy and practice was that only non-physical intervention techniques could be used and knew that no forms of physical restraint were allowed. Those people's care plans included clear guidance about how they should be supported with their care and behavioural needs.

People were supported to go outside the home either with a care worker or alone. The provider had effective arrangements for ensuring as far as possible that people were safe went they were out. Staff ensured that people carried contact details of the home when they went out.

We saw from four staff recruitment files that staff who worked at the home had undergone pre-employment checks that included checks as to whether they had a criminal record or were unsuited to work with the people who used the service. The provider had reviewed information about staff every three years to ensure their suitability to work with vulnerable people had not been brought into question.

Staffing levels were decided at weekly management team meetings. The management team decided how many staff should be in duty by taking into account the dependency levels of people who used the service. This ensured that there was a safe ratio of trained and experienced staff to care for people. Staff we spoke with confidently expressed that enough staff were always on duty. We observed that staff responded quickly when people summoned help by using call alarms in their flats. That contributed to people feeling safe because they had not been kept waiting or feeling vulnerable after summoning help.

Is the service effective?

Our findings

People told us that they were able to live their lives as they chose. A person told us, "They let me do what I want. There is no interference." That person's relative told us, "[My relative] has got a lot better. She mixes more. The service has done really well for my [relative]. They have worked hard to get her back on track. I can't thank them enough." When we looked at that person's care plan we saw that they required support to become more independent and to become more confident with other people. What the relative told us and what we saw in the care plan showed that the service had helped that person achieve an important goal. A relative of another person was complimentary about how their mother had been cared for. They told us, "My [relative's] done really well here."

Staff had received appropriate training and development that enabled them to understand and meet the needs of people they supported. The management team and staff were very knowledgeable about the people who used the service. The management team had supported staff through supervision, appraisal and training and development opportunities. People who used the service told us that they felt staff understood their needs .A person told us, "Staff are very helpful. They definitely understand my needs." Staff we spoke with told us about the training they had and we were able to confirm what they told us by looking at training records. A care worker told us, "The training has been good. We are definitely well supported."

We found evidence that people's well-being had improved as a result of the care and support they had received. One relative had left a comment on a survey to the effect that their parent's wellbeing had much improved because of the care and support from staff. Two people who had been assessed as requiring end of life care had been supported to improve their health and wellbeing. Their levels of dependency had reduced and they were able to do more for themselves. A relative of another person told us, "My [relative] has got better. The service has worked hard to get her back on track."

Some people who used the service spent much of their time in their bed. They had been identified as at risk of developing pressure ulcers because of that. The provider had acted on advise from doctors about how to provide care for those people and help them be comfortable. We were informed that no person had developed a pressure ulcer in the last 12 months. This showed that people who had been identified as at risk of developing pressure ulcers had been effectively cared for.

People were supported to have sufficient to drink and eat. People's cultural dietary needs had been respected. People told us they enjoyed their meals at the home. A person told us, "The food is good." Another person told us, "They make me drinks. I've never been thirsty." A relative told us, "There is a variety of food. There is a nice choice. I can have lunch with my [person who used the service] if I want." Some people at the home made their own meals in their flats whilst others had meals they chose in a communal dining room. Some people at the home required their food to be prepared in a particular way and staff had done that after consulting and involving a NHS dietician service. It was a very warm day on the day of our inspection. Staff offered people plenty of drinks throughout the day. The provider had effective procedures for monitoring people food and fluid intake.

Health professionals who visited the home had responded to a recent survey that asked them questions of their view of the home. Their views were positive and referred to the service as providing high standards of care and support. We found from looking at records that people had been supported to attend appointments with healthcare professionals. Most appointments had been routine appointments, for example annual health checks, or appointments with a dentist or optician. Other appointments were with specialists. These had been arranged by staff after they had noted changes in people's behaviour or were appointments arranged by those specialists. Staff had also arranged for people to see their social workers and advocates when they wanted. This meant that people who used the service had been supported to access health and social care services when they needed to.

The service worked with health professionals that included mental health specialists, nurses, physiotherapists and others to help people achieve their aims. When care plans had been reviewed all relevant professionals and the people who used the service, and where appropriate a representative or relative, had been involved.

Is the service caring?

Our findings

People who used the service told us that staff were approachable and very helpful. A person told us, "I know I can ask or tell staff if I have any worries." A relative told us, "staff are very helpful." We saw positive feedback healthcare professionals had given the provider through correspondence and surveys. Our observations confirmed what people told us about their experience of the service. Care was planned to meet individual people's needs. People had been involved in decisions about their care; and staff understood people's individual preferences and desired outcomes and supported people in ways they wanted to be supported. This meant that staff and people they supported had developed positive relationships.

An important part of every person's care plan was that they were helped to be as independent as possible. The provider told us that the service's ethos was `Let residents do, not do for residents' by which the provider meant that people were supported to do as much for themselves as possible. People lived in their own self- contained apartments where they had privacy and independence. They also used communal areas where they mixed with other people who used the service. The provider had promoted a sense of community within the home and people celebrated birthdays and other occasions together. People told us that they enjoyed the social activity within the service. We saw people in communal areas talking with each other and laughing.

Staff helped people to maintain contact with their families. Their relatives were able to visit them when they wanted. People had been supported to go out and visit places that were of interest to them and to mix with other people who used the service. A relative told us, "[person] mixes more; the service has done really well for [person]."

We saw from care records that people had been involved in the development and reviews of their care plans. People told us they understood about the care and support provided. A person told us, "I understand what they are doing to help me." A relative told us, "I've been involved. The service has always kept me well informed." This showed that the provider cared about relative's input and feedback.

The registered manager and their deputy had supported people to access advocacy services, for example if they wanted to challenge a Deprivation of Liberty Safeguards (DoLS) authorisation. On the day of our inspection an advocate visited the service to discuss a DoLS authorisation with a person who had one in place. The service supported people to maintain contact with family and friends if they wanted to. People had also been supported to receive visits from representatives of their faith so that they could worship and practice their faith. People received visitors in the privacy of their apartments, but some faith services took place in communal areas.

We saw from records of staff meetings that dignity in care had regularly been promoted. We observed that staff displayed compassion and spoke to people in a respectful way. Staff took time to hold meaningful conversations with people. Our observations confirmed what people had told us about how staff treated them. One person told us, "The staff are very helpful. I understand what they are doing to help me." Another said, "The staff are very good. I know I can ask the staff if I have any worries."

People's care plans showed that they and their relatives were supported to make decisions about their preferences for end of life care and funeral arrangements.

Is the service responsive?

Our findings

People who used the service told us that they received the care and support they wanted. One person told us, "I understand what staff are doing to help me; they encourage me to do more for myself." Another person told us, "The staff let me do what I want. There is no interference." They added, "The staff are very good. I'm definitely very well looked after." Relatives of people who used the service told us that they had been involved in ensuring that care reflected how their relatives wanted to be supported.

Care plans that we looked at contained clear aims and objectives of what people wanted to achieve. These were broadly to improve their health, be more independent and reduce dependency on alcohol and substances. This meant that care had been planned to meet people's individual needs in a way that they wanted.

People's needs had been assessed by the registered manager and deputy manager and health professionals; all people who had the competencies to do so. It was evident from all care plans we looked at that the service worked with health professionals that included mental health specialists, nurses, physiotherapists and others to help people achieve their aims. When care plans had been reviewed all relevant professionals and the people who used the service, and where appropriate a representative or relative, had been involved. This meant that people's care and support reflected people's latest circumstances and wishes.

Care plans were maintained to reflect people's needs, choices and preferences and how they wanted to be supported. Staff told us they referred to peoples care plans in order to understand people's needs. We saw evidence that care plans had been read by staff. Staff we spoke with demonstrated that they understood people's care plans. Staff made daily records about how they had supported people. Those records were used to record that people had been supported with personal care routines such as bathing or showering, cleaning teeth and more intimate care. People told us that they had been well looked after. We saw that staff supported people in line with their care plan; for example when staff supported people with their chosen aim to reduce their intake of alcohol and cigarettes.

People had been supported to maintain and develop personal interests and hobbies. The home had supported people to do this through a range of activities. People were able to cook for themselves, visit garden centres and cultivate parts of the home's garden, make models and visit sporting venues. These were things people told us they liked doing and they were recorded in people's care plans. Staff supported people who wanted to participate in social activities that were meaningful and stimulating, for example birthday parties and religious festivals. Other activities included meal times that included meals that reflected the diverse ethnic background of people who used the service. Some people who used the service had specific faith needs that staff supported them with. Staff had arranged visits from representatives of different faiths to visit the service to provide for people's faith needs.

People had been encouraged to express their views about their care and support and their experience of the service. The provider carried out two surveys a year that asked people and their relatives for their views. The surveys were comprehensive because they included questions about the whole range of the delivery of care People had provided positive feedback and had made suggestions that had been acted upon. People's views had been sought at reviews of their care plans. Other opportunities occurred through daily dialogue with staff, residents meetings, reviews of care plans and surveys.

The service had a complaints procedure. People told us that they knew how to make a complaint or raise a concern. None of the people we spoke with had concerns. The registered manager told us that no complaints had been made since our last inspection in July 2013.

Is the service well-led?

Our findings

The management team and staff had a very good understanding of the needs of the people who used the service. What they told us was confirmed by what we saw in people's care plans.

People who used the service, relatives and staff were involved in developing the service because the provider had sought their views. Relatives had been able to give their views when they visited the service and through regular surveys. People who used the service and relatives told us that staff were "approachable" and that they had felt involved in decisions about their family member's care. A relative told us, "I've been involved" and "The staff definitely understand [person's] needs." Staff told us they felt able to make suggestions and propose ideas about the service at staff meetings and in one-to-one meetings with their manager.

The provider promoted a culture that placed people's individual needs at the forefront of care. They did this through policies and procedures about people's safety, choice, privacy, independence, people's rights and dignity. Staff had easy access to those policies. Staff meetings and individual supervision were used to by the management to feedback information and reinforce good practice. A communication book was also used to pass information between staff who worked on different shifts. Staff were aware of the provider's whistle blowing policy and knew how they could raise any concerns they had about the service with the local authority safeguarding team, the police and Care Quality Commission.

We saw that staff had put the provider's policies into practice. Staff showed kindness and compassion when they interacted with people. Staff referred to people by their preferred name. The atmosphere at the service was friendly and relaxed. Staff engaged in conversation with people and encouraged them to describe how they felt and ask for anything they needed.

Management and leadership of the service were evident because either the registered manager or deputy manager were always on duty. A director visited the home daily to support the registered manager and staff. They were on-call during the night. The director, registered manager and deputy manager made up a management team. The registered manager had kept up to date with research and guidance in adult social care. They had, for example, used guidance about activities for people with dementia and they were aware of a recent Supreme Court ruling about how the Deprivation of Liberty safeguards applied to people in care homes. The provider had an organisation chart which allowed staff to understand lines of accountability and all care staff had job descriptions.

The registered manager understood their legal responsibilities for notifying the Care Quality Commission of deaths, incidents and injuries that occurred at the home or affected people who used the service.

Staff we spoke with told us that they understood the aims of the service which one described as "making a difference to people's lives and helping people be as independent as possible." When we spoke with the provider they told us that the aim of the service was to that people were supported to do as much for themselves as possible. This showed that the provider and staff had a shared understanding of the aims of the service.

The provider had a system for assessing and monitoring the quality of service. This included surveys and a series of routine and scheduled checks. The quality assurance system was based on seven internal standards the provider had implemented. Those standards covered the delivery of care and included checks of the physical environment of the home.