Shaw Healthcare (Group) Limited

Longlands Specialist Care Centre

Inspection report

London Road
Daventry
Northamptonshire
NN11 4DY

Tel: 01327316820
Website: www.shaw.co.uk

Date of inspection visit:
15 August 2016
16 August 2016

Date of publication:
29 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 15 and 16 August 2016 and was unannounced.

Longlands provides accommodation for older people requiring support with their personal care and nursing needs. The service can accommodate up to 51 people. At the time of our inspection there were 36 people using the service. The home is divided into three distinct areas which are situated over the two floors of the home. On the first floor there was Pippin area which provided care for older people with complex nursing needs, Minstrel which provided residential care for older people and Jay which provided respite care for older people. On the ground floor Primrose and Kingfisher areas provided residential care for people living with dementia and in Siskin and Harlequin areas respite care was available for people living with dementia. People live in the area that is best suited to their assessed needs.

The service had a registered manager. 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.

There were not always sufficient staff to meet the needs of people in a timely way and in some areas of the home staff did not have the time to interact with people outside of meeting people's basic care needs. People's experience of care differed depending on where they lived within the home.

There were a variety of audits in place that monitored the quality and safety of the service; however these did not identify that on some occasions care staff were task focussed and lacked interaction with people who used the service.

People's nutritional needs were being met but people did not always feel the standard of the food was consistent and there was sufficient choice.

People received care from staff that were friendly, kind and thoughtful and their right to privacy and dignity respected. Care staff knew how to protect people from harm and people's health care was carefully considered and relevant health care professionals were appropriately involved in people's care.

Relatives spoke positively about the care their relative received and felt that they could approach management and staff to discuss any issues or concerns they had. People had care plans which detailed their needs, preferences, likes and dislikes.

Staff were supported through regular supervisions and undertook training which helped them to understand the needs of the people they were supporting. People were involved in decisions about the way in which their care and support was provided. Staff understood the need to undertake specific assessments

where people lacked capacity to consent to their care and / or their day to day routines.

There were opportunities for people and their families to share their experience of the home. Management was visible and open to feedback, actively looking at ways to improve the service.

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 always safe.

There was not always sufficient staff to meet people's needs in a safe and timely way.

The system in place for the administration of medicines was not always effective.

Risk assessments were in place to ensure people's safety and mitigate any risks.

There were appropriate recruitment practices in place which ensured people were safeguarded against the risk of being cared for by unsuitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People's dining experience varied dependent on where they lived within the home. The standard of the food varied and the choice of food limited.

People received support from staff that had the skills and experience to meet their needs and who received regular supervision and support.

People were involved in decisions about the way their support was delivered; staff understood their roles and responsibilities in relation to assessing people's capacity to make decisions about their care.

Is the service caring?

Requires Improvement

The service was not always caring.

People received care form staff that were kind and thoughtful but in some areas of the home their interaction with staff was task focussed.

People's right to privacy and dignity was respected.

People were encouraged to express their views and to make choices.

Family and friends were welcome at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were encouraged to follow their interests and join in any activities being offered, however people's experiences differed from where they lived within the home.

People's needs were assessed before they came to live at the home to ensure that all their individual needs could be met.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led

The provider had failed to recognise the impact the staffing levels had on people receiving care in a timely manner and how different people's experience of the home was.

People and their families were encouraged to share their experience of the home to help drive improvements.

Quality assurance audits were regularly undertaken to ensure that standards were maintained and action taken to address any shortfalls.

Longlands Specialist Care Centre

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 unannounced inspection took place on 15 and 16 August 2016 and was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance our expert-by-experience had cared for a relative and supported them to find an appropriate care setting to live.

Before the inspection, the provider completed 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. The provider returned the PIR and we took this into account when we inspected the service and made judgements in this report. We reviewed the completed PIR and previous inspection report before the inspection. We checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.

We contacted the health and social care commissioners who help place and monitor the care of people living in the home and other authorities who may have information about the quality of the service.

During our inspection we spoke with16 people who used the service, 15 members of staff which included seven care staff, two nurses, two team leaders, one housekeeper, two kitchen staff and an activities co-ordinator, plus the deputy manager and the registered manager. We were also able to speak to the provider and seven relatives who were visiting at the time. We undertook general observations in communal areas

and during mealtimes.

We looked at six records and charts relating to people staying at the home and four staff recruitment records. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

Before the inspection we had received information which suggested that on the first floor (Minstrel and Pippin) particularly, there was not always sufficient staff to meet people's needs safely and that people were left to wait for their needs to be met; care plans were not being followed in relation to providing the care at agreed intervals which meant that those people who had been identified as being at risk of developing pressure ulcers were being put at unnecessary risk.

On the first day of the inspection we found that there were 16 people staying on the first floor, eight of whom required two care staff to assist them and three people were being nursed in bed. As the inspection started there was a nurse and three care staff deployed. Some of the staff we spoke to said they felt there was not sufficient staff and they had to ask people to wait for assistance. At night, staff felt, if it is all permanent staff or regular relief staff who knew the people then there were enough staff; however, if agency only staff were deployed this made things more difficult as the permanent staff needed to spend time with them to explain what needed to be done. We spoke to the registered manager about this who said that they tried to ensure that if they had to use staff from an agency they also had permanent staff on the same shift and that they used the same agency to try and offer some consistency in the staff deployed. We saw over the two days of the inspection that the same agency staff were being used.

People and relatives of people we spoke to on the first floor all commented that they felt there was not enough staff and that they had to wait for support. One person told us "It varies terribly as to how long it takes for some one to come,sometimes they are there very quickly and sometimes they are a little while,15 minutes or more." Another person told us "It can be 2-3 minutes or 25 -30 minutes before anyone comes if you call them. You see you have to wait, it all depends what else they are doing. I have asked for no male carers for personal care so I have to wait until two female carers are free. They don't put enough staff on, the girls come in to give me a shower, turn off the bell and tell me they will be back and that I have to wait until two girls are free. They do respect my wishes and do not send me a male carer but I do have to wait a long time to get up." A relative told us "[Relative] just walks out of here [bedroom] and goes and gets them but they shouldn't have to."

We observed that people had to wait for support, in one instance a person waited over 30 minutes for their call bell to be answered, one member of staff was helping to feed a person and two staff were helping someone with their personal care, the person wanted to get up but needed assistance.

People's experience on the ground floor (Kingfisher and Primrose) was different. We observed that staff had time to spend with people and no one was left waiting for support. Where people were being cared for in bed checks were carried out at regular intervals and records confirmed that when people needed to be repositioned they had been within the agreed intervals. Staff said at times they could do with more of them but generally felt they were able to meet people's needs. A relative visiting someone on the ground floor commented "At times there does not always seem to be enough staff, the staff can be very busy."

There was an electronic medicine administration system. The system provided staff with information about

a person's medicines, how they worked and what time they needed to be administered. There was also information about medicines people could take on a flexible basis, if they were required and when and how they should be used. However, at times the system was not accessible in parts of the building which meant that staff had to revert to recording the information by hand on the medicine administration record sheets. This had led to confusion at times as to whether someone had received their medicines and had made it difficult to maintain an accurate audit trail of the system. We were aware prior to the inspection that there had been a number of errors made with medicines. The level of training required to use the system effectively was not available to agency staff which meant the permanent staff had to spend time ensuring that the system had correctly recorded the administration of medicines and that audits of the medicines were correct. Staff felt this potentially was a good system but that with the difficulties they were presented with at times made their job more difficult. The provider was trying to rectify the system and had contingency plans in place if the system failed. We saw staff ensured people had taken their medicines.

There were a range of individual risk assessments in place to identify areas where people may need additional support to manage their safety. For example, people identified as being at risk of damage to their skin due to pressure or who were at nutritional risk had been assessed; appropriate controls had been put in place to reduce and manage the risks. However, there was a difference in the level of recording in different areas of the home which meant not all records were accurate and not always being reviewed as regularly as they should have been. We saw that the information recorded for each person was not always kept up to date; this was particularly in the case for the people on the first floor.

People looked happy and relaxed around staff. A number of people commented that they felt safe in the home and would ask staff for help if they needed it. One person said "I do feel safe here; the carers are all very nice to me you see; I get on well with all of them." Relatives told us that they felt their relative was safe and if they had any concerns they would speak to the staff. There were call bells in each room so that people could call for assistance if they needed it, although these were not always answered in a timely way and we observed staff, on the ground floor, regularly checking those people cared for in their bedrooms who were not able to use the call bell.

The staff we spoke with all understood their roles and responsibilities in relation to keeping people safe and all knew how to report any concerns they may have which they had done. We saw from staff training records that all the staff had undertaken training in safeguarding and that this was regularly refreshed. There was an up to date policy and the contact details of the local safeguarding team were all readily available to staff. Staff told us that if they had any concerns they would speak to the registered manager or deputy manager and if they were not satisfied with what happened they would report the incident outside of the home. The provider had submitted safeguarding referrals which demonstrated their knowledge and understanding of the safeguarding process. Where safeguarding referrals had been made we saw that the issues raised had been appropriately investigated and action taken to mitigate any risks.

People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place. All staff had been checked for any criminal convictions and satisfactory employment references had been obtained before they started work at the home.

There were regular health and safety audits in place and fire alarm tests were carried out each week. Each person had a personal evacuation plan in place which was kept alongside clinical risk assessments held in a fire evacuation folder; this ensured that in the event of a fire information was readily available to the senior staff that may need to evacuate the building. Equipment used to support people such as hoists were stored safely and regularly maintained.

Any accidents/incidents had been recorded and appropriate notifications had been made. The registered manager collated the information around falls and accidents/incidents on a monthly basis took action as appropriate and shared the information with the provider as part of a monitoring process.

Requires Improvement

Is the service effective?

Our findings

Before the inspection we had received information that suggested that people had little choice in the food being offered, portions at times were not enough and that people could no longer have a cooked breakfast if they wished to each day. We spoke to the registered manager about this and were informed that there had been a change to the breakfast menu and that a full English breakfast was now only available at a weekend. None of the people we spoke to raised any concerns about a cooked breakfast not being available each day. We saw that there was a four week menu in place which offered a choice of meals each day and people could have an alternative if they wished.There was a comments book for staff to record any feedback from people which the kitchen staff reviewed and made any adjustments to the menu needed. However, people's views and experience of the food served varied.

A number of people on the first floor told us that they felt the food had been better and that although there was a choice each day the choice was limited. Comments from people and relatives varied. We observed that on the ground floor where people living with dementia stayed, people appeared to be enjoying the food. People were encouraged to eat and helped if needed.

People's dining experience also varied. On the first floor there was very little interaction from staff with the people who were eating in the dining area. The staff did not talk to people about what they had chosen and just went by a list to serve the meal. When someone did ask what the meal was the response was "It is what you ordered yesterday." The meals were plated up and people were not offered a choice of vegetables. On the ground floor, staff were attentive and explained to people what they were having. Staff were encouraged to sit with people and have their meal with them.

People's nutritional needs and fluid intake was being monitored and we saw from records that were there had been concerns a dietician had been asked for advice.

People were supported and cared for by a staff team which had undertaken a comprehensive programme of training. Some of the staff had worked at the home for a number of years. People told us they felt the regular staff had the skills and knowledge to support them but were unsure about the staff from the agency; however, we spoke to one of the agency staff who told us that they undertook all the basic training such a as manual handling and first aid through the agency and when they came to work at the home they received a basic orientation around the home.

All new staff undertook an induction programme which was specifically tailored to their roles. Newly recruited care staff also undertook the Care Certificate which is based on 15 standards. It aims to give employers and people who receive care the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. In addition to in- house training and on-line based training all new staff shadowed more experienced staff over a period of time until they were assessed to be competent in their role. We spoke to one new member of staff who was shadowing a member of staff, they commented how helpful it was to spend time getting to know people and the training had been good. New staff did not care for people independently until they had undertaken

all mandatory training which included moving and handling, safeguarding and infection control.

We looked at staff files to review the training provision which underpinned staff knowledge and abilities in their role and responsibilities. Training in key areas such as first aid, fire safety, medication, movement and handling and dementia awareness was refreshed regularly to ensure staff kept their skills and understanding up to date. We noted that staff had appropriate qualifications to reinforce their abilities in their work. Staff told us that they were able to discuss and reflect upon their training needs in supervisions with their manager. One member of staff said "The training is on-going, it's all very good." We saw that the provider maintained a training matrix for staff which ensured that staff were booked on to any training they needed.
People were supported by staff that received supervision regularly and had yearly appraisals. We saw that supervisions were scheduled throughout the year for staff. One member of staff told us "You don't need to wait for supervision if you need to talk to your team leader you can at any time."

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 decisions 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 when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and we saw that they were. The registered manager and staff were aware of their responsibilities under the MCA and the DoLS Code of Practice. We saw that DoLS applications had been made for people who had restrictions made on their freedom. The registered manager was aware of those applications which were yet to be authorised and was in contact with the relevant local authority.

People were involved in decisions about the way their support was delivered. Staff sought people's consent before they undertook any care or support. We heard one staff member asking someone "Do you want to go and sit in the lounge?"

There were systems in place to monitor people's health and well-being. People told us that if they needed to see a GP one would be contacted. We saw from people's records that people had accessed a number of different health professionals such as GP, District Nurse, physiotherapist, chiropodist and optician.

Requires Improvement

Is the service caring?

Our findings

There was a warm and friendly atmosphere when you entered the home. People told us that the staff were all very kind and good. One person said "The staff are brilliant; it's lovely here they are all very nice and thoughtful." Another person said "The regular girls all know me well; they are kind and polite, patient, caring and kind."

People's experience of care did however differ as to where they lived within the home. On the first floor staff interactions with people were task focussed and the number of staff available had impacted on the staff's opportunity to spend time with people outside of providing personal care. People told us that the staff spoke to them as they assisted them with their personal care but once they were finished they did not have the time to spend with them. We observed that staff only interacted with people when they were offering to do something for them; for example asking if someone wanted a drink. However, on the ground floor we observed a lot of positive interactions with people. Staff did have the time to spend with people. We saw one person spending time in the garden and staff talking to them about the garden; the person told the staff what they had done. The provider needed to ensure that there was a consistent experience for people across the home.

People's right to privacy and dignity was respected. We observed that when staff were supporting people with their personal care they knocked on the door before entering a person's room and then made sure the door was shut. People told us they felt that all the staff respected their dignity. One person said "They [staff] put the towel over me when they give me a bed bath, or if I have a shower they cover my lap with a towel in the chair; no problems at all."

Staff were knowledgeable about peoples care and support needs. Staff handovers ensured that information was shared with staff as they came on duty, which was particularly important for those staff who were employed from an agency. One person told us "The regular girls know my needs well; I like ice water to make my squash, they know to go and get it for me to make my squash in my Lucozade bottle." We spent time observing how the staff supported people living with dementia, they knew how to engage with people and how to sensitively distract people if they became unsettled or anxious. There was information in people's care plans about their life history and past hobbies and interest which helped the staff to engage with people.

People had been encouraged to personalise their rooms with pictures of their families and small items of furniture. In response to someone who felt they were fenced in, due to the fact that one of the windows in the corridor looked out onto a fence, staff had put murals up; one was a beach scene another a woodland area. The murals enhanced the area and gave people something to talk about and reminisce. People had been involved in choosing the wallpaper in one area of the home.

Visitors were welcomed at any time. People said that their visitors were always made to feel welcome by staff. One relative commented "We can come at any time; we tend not to bother the staff as they are always very busy." We read a number of comments from families 'Thank you for looking after [relative] and making

us feel so welcome.' 'We enjoyed visiting, great fun with the staff'

There was information available about advocacy. The registered manager was aware of the need to involve an Independent Mental Capacity Advocate for people who had no family or representative and lacked the capacity to make certain decisions for them. At the time of the inspection there was no one who needed an advocate.

Requires Improvement

Is the service responsive?

Our findings

Prior to the inspection we had received information that suggested that people may be being put to bed earlier than they wanted to assist the night staff. We spoke to a number of people who all said they got up and went to bed when they liked. One person said "I like a lay in, like a teenager. I ask the staff not to let me stay in bed too long though." The staff we spoke to all said that there was no expectation on when people went to bed; people could choose when they wanted to go to bed but that sometimes they assisted people into their pyjamas earlier in the evening. At 9pm on the first day of the inspection there were a small number of people who had chosen to go to bed and a number of people who had got their pyjamas on but were still up. The care plans detailed the care and support people needed their preferences and likes and dislikes which appeared to be followed.

People were encouraged to follow their interests and join in any activities being offered, however people's experiences differed from where they lived within the home. The home had two activities co-ordinators who between them had put together a programme of group activities for people to join in. On the days of the inspection we observed a game of bingo being played with several people from all areas of the home, a ball game and a sing-a-long which appeared all to be well received and enjoyed. We spoke to one of the co-ordinators who explained that they were also in the process of looking at individual activities with people; for example they had put together a bag with various items about football for one person who had been a football referee, this helped the person to engage in conversation about their life as a referee. We did not see any 1:1 activities being undertaken with anyone on the first floor and one person we spoke to upstairs said that although they could and did join in the activities being offered they did feel there could be more done to help people with their mental stimulation at times.

The people on the first floor, although some of them could access the activities if they wished to, appeared to not have as much offered to them to keep them stimulated. One person told us "I do feel lonely at times and get a bit bored; it would be nice to go out more or have more mental stimulation." The provider needed to ensure that all areas of the home benefitted from the work of the activities co-ordinators and people had the same opportunity to be supported with activities if they wished.

On the ground floor where people lived with dementia there were various areas and items of furniture around to stimulate people. There was a small lounge area which had been furnished with items of furniture and ornaments from times gone by which stimulated people to reminisce about their lives and what they did as a child. Signs and pictures were on doors enabling people to find their way around. People moved freely around and accessed the garden when they wanted to.

People's needs were assessed by the registered manager and deputy manager before they came to live at Longlands or stay for respite. People's individual needs and expectations were discussed which enabled a decision to be made as to whether Longlands could offer a place to the person. A number of people who attended a day centre which was based within the building had decided to use the respite facility and the longer term beds. One relative told us "[Relative] use to come to the Day Centre so when they needed residential care we felt this was the best place because [relative] knew people and it was familiar to them.

The staff are always approachable and always try to be helpful."

The information shared from the initial assessment was used to develop an individual care plan for each person. The care plan contained a 'Life Map' which informed the staff about a person's life, hobbies, interests and relationships prior to coming to the home. This was particularly important to effectively support people living with dementia. Staff demonstrated their knowledge of people as they engaged in supporting them; for example we saw staff taking people out into the garden and talking with them about their own gardens and about a recent trip they had had to a local garden centre. The person told us how much they enjoyed the garden and being able to spend time out in it.

We saw that where people needed specific equipment to support them this was in place. For example where it had been identified a person with limited mobility required a hoist to help them to transfer from their bed to a wheelchair that this was in place. Pressure relief equipment was in place for people who may be at risk of pressure ulcers and we checked that airflow mattresses were set at the right level according to the care plan.

People chose how and where to spend their time. Meals were served in either people's own rooms or in the lounge and dining area. Some people liked to spend time in their bedrooms; others spent time in the lounge areas or outside in the garden. People were able to move freely around the building. The people living on the first floor could access the ground floor and garden via a lift and we saw people spending time downstairs.

People were aware that they could raise a concern about their care. Although there was written information available on how to make a complaint many of the people and their relatives we spoke to did not remember seeing it. People did know who the registered manager and deputy were and said they would speak to them if they needed to. We saw that when complaints had been made these had been investigated and responded to in a timely way and in accordance with the procedure in place. One family we spoke to said that when they had raised complaints that they had been responded to and action taken to resolve things for them.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not ensured that people's care and support needs were safely met through out the home. There was a noticeable difference between the quality of care and support that people received on the top floor of the home in comparison to the bottom floor. On the top floor of the home there were times when people were left waiting for care and support for unacceptable periods of time. Risk assessments were not always reflective of peoples current needs and were not updated regularly. We observed that on some occasions care staff were task focussed and offered limited interaction with people.

People and their relatives felt they could approach the registered manager with any concerns and those we spoke with said their concerns were rectified in a timely manner, however; the staff felt frustrated that the registered manager had not been able to address some of their concerns, specifically about staffing levels.

Although a range of quality assurance audits had been undertaken they failed to recognise that people had to wait for unacceptable periods of time for care to be delivered and that not all documentation was up to date and reflected peoples current assessed needs.

There were yearly satisfaction questionnaires sent out to people and their families to ascertain their views of the service. Overall people were satisfied with the service, we read one comment 'Very good, well looked after, no problems' In answer to the question about any improvements 'Choice of food.'

The registered manager had sought further opportunities to gather feedback from people and keep people informed about the home. They had a schedule of meetings in place for people using the service and their relatives with the aim of getting feedback from people and sharing with them about any service development. However, despite arranging the meetings at different times the up take had been limited. The relatives we spoke to said they had seen the dates for the meetings but had been unable to attend. People said they had never seen any minutes from the meetings so were unsure as to what they were about. Following the inspection the provider provided information which detailed that the minutes were available on a noticeboard for relatives and a box of copies of the minutes were left by the 'signing in book' for people to take.

There were regular staff meetings which gave the staff the opportunity share best practice and raise any concerns. We read in the minutes of the most recent meeting that staff had asked for more guidance in relation to daily record keeping which the registered manager had agreed to provide. We also saw that the registered manager had reminded staff about the completion of food and fluid charts.

The service had policies and procedures in place which covered all aspects relevant to operating a care home including the employment of staff. The policies and procedures were comprehensive and had been updated when legislation changed. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their induction and when any had been updated.

Records relating to the day-to-day management of the home were up-to-date and accurate. Care records,

however, did not always accurately reflect the level of care received by people. The registered manager was aware of this and was taking steps to address this. All senior staff had been tasked with following up audit actions. Records relating to staff recruitment and training were fit for purpose. Training records showed that new staff had completed their induction and staff that had been employed for twelve months or more were scheduled to attend 'refresher' training. Staff were encouraged to gain further qualifications and specialised training was provided.