Cream I Limited

Longrun House

Inspection report

Longrun House
Bishops Hull
Taunton
Somerset
TA1 5AY

Tel: 01823272633
Website: www.creamcare.co.uk

Date of inspection visit:
28 January 2019
29 January 2019

Date of publication:
01 March 2019

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 28 and 29 January 2019 and was unannounced. This is the first inspection of this service since it re-registered from Cream Residential Care to Longrun House in 2018.

Longrun House is a residential home that consists of two units. The main house accommodates ten people and The Lodge accommodates seven people. The home specialises in providing care to younger adults who have a learning disability, physical disability and/or sensory impairments. The home is staffed 24 hours a day. The home has a range of aids and adaptations in place to assist people who have mobility difficulties and all bedrooms are for single occupancy. Longrun House has links into the local community, and access to a range of facilities such as a full-sized Hydrotherapy pool and interactive sensory room that are situated within the grounds of the home.

At the time of the inspection there were 16 people living at Longrun House. The people we met had very complex physical and learning disabilities and not all were able to communicate with us verbally. We therefore used our observations of care and our discussions with staff, relatives and professionals to help form our judgements.

The home has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in post. 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.

People living at Longrun House told us they felt safe. Staff understood how to recognise and report signs of abuse or mistreatment. Safeguarding and whistleblowing policies and procedures were available for staff to access.

Detailed risk assessments were carried out to ensure people could make choices and keep their independence. This also included environmental risk assessments such as fire maintenance and safe use of water outlets.

Recruitment processes minimised the risk of employing unsuitable staff. There were sufficient numbers of staff available to keep people safe and support people when they displayed behaviours that challenged.

People's medicines support needs were clearly identified and staff delivered medicines in a personalised way. Staff were trained and competent to administer medicines.

Staff had received training on infection control, although we did find some concerns regarding the cleanliness of the home which the provider responded to immediately. Staff knew the reporting process for any accidents or incidents. Lessons learned were shared with staff through their electronic system and regular discussions.

People received effective care and support from competent and well-trained staff. Formal supervision and appraisals were not carried out regularly but staff felt supported by the management team in their roles and said they could ask questions when they needed to.

We observed meal times and the food looked nutritious and was cooked using fresh ingredients. Although the menus only gave one choice, people did confirm they could have an alternative if they didn't like what was on the menu. Where needed, other professionals were contacted for specialist guidance and support to meet people's needs. Care records showed staff shared information effectively with professionals and involved them appropriately.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA). Although we did observe one staff member restricting one person's movement when we arrived at the home and had to discuss this with the registered manager.

Staff treated people with kindness, respect and compassion and care plans gave guidance on how to communicate appropriately with people. The home did not display information for people and visitors to the service on how to officially make a complaint but people told us if they had concerns they could talk to staff and they felt confident that any concerns would be taken seriously.

Records showed people had their needs assessed before they moved in to the home. People and their family members were invited to formal reviews of people's care and staff encouraged people to access their community when they wanted to.

The leadership was visible and accessible. There was a management structure in place, which gave clear lines of responsibility and accountability. People spoke highly of the staff and management team. The providers approach to quality assurance included the completion of an annual survey. There were quality assurance arrangements in place to raise standards and drive improvements within the home although some of these checks needed more management oversight to ensure they were fully effective.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

There were procedures in place to keep people safe, which staff understood.

Safe recruitment procedures were in place. There was enough staff to support people safely.

People's risks were assessed and risk management guidance was completed.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective

People's relatives felt they received care from competent staff.

The service was meeting the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received relevant training and support.

People had access to healthcare professionals.

Is the service caring?

Good

The service was caring

People were observed as relaxed and happy in the service

People's relatives spoke positively of the staff at the service.

Staff respected people's choices and decision-making.

People and their relatives were involved in their care and support planning.

Is the service responsive?

Good

The service was responsive

People's care records were detailed and easy to read.

People's relatives felt staff were responsive.

People knew how to raise a concern and felt confident these were acted upon.

Staff supported people to undertake activities of their choice.

There were links with the local community.

Is the service well-led?

Good

The service was well led

The provider had a clear vision to deliver care and support that promoted a positive culture.

The provider had identified developments required to improve the service

The registered manager was visible and accessible.

Longrun 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 comprehensive inspection started on 28 January 2019 and ended on 29 January 2019. Day one was unannounced and day two was announced.

On day one of the inspection one adult social care inspector, one medicines inspector and one expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two of the inspection was carried out by one adult social care inspector.

Before the inspection, we did not request a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report. However, we did look at other information we held about the service including safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection, we spoke with six people who lived at Longrun House and could communicate with us either verbally or by using their preferred communication method. Some people were not able to communicate with us at all, so we observed how those people interacted with staff throughout the inspection process. We also spoke with two family members who were closely involved in people's care and support and four health and social care professionals who regularly visited people living at Longrun House. We met with the registered manager, the deputy manager, and nine care and support workers. We also met with the providers quality lead and their care support manager.

During the inspection we looked at six peoples care and support plans and other records associated with people's care and support such as daily care notes, risk management plans and medicine records. We also

reviewed records relevant to the management of the service, this included staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and quality assurance audits.

Good

Is the service safe?

Our findings

People received safe care.

People living at Longrun House told us they felt safe. Some people indicated they felt safe by holding up their hands, for example, if they held up their left hand that meant yes and their right hand meant no. One person smiled when we asked if they felt safe at Longrun House. Another person we spoke with told us, "Yes I am safe." A relative told us, "(Relatives name) is very safe, the staff are super here". Another relative said, "I'm very lucky I know (person's name) is safe here". Adding, "The staff are lovely".

The service had effective safeguarding systems in place, and managed safeguarding concerns promptly. Staff understood abuse and knew what to do to make sure that people were protected. Staff received training on how to recognise the various forms of abuse, which was regularly updated. The risk of financial abuse to people was minimised. The provider had safe systems in place to ensure staff recorded and checked people's money regularly. Staff supported people to access their money safely. When people wanted money for activities two staff signed the money in and out

The registered manager understood their responsibilities to raise concerns and report these internally and externally. All staff we spoke with agreed the registered manager would act if they reported any suspicions of abuse. Staff we spoke with knew which external bodies to contact if no action was taken by the management to keep people safe. One member of staff said, "I would tell the seniors, and if they did nothing I would go to the manager". Another staff member said, "We inform the local authority as well. "Safeguarding and whistleblowing policies and procedures were available for staff to access.

The provider had a proactive approach to anticipating and managing risks to people's health and safety. Staff identified risks to people and put guidance in place to mitigate them. This helped keep people safe. Risk assessments were carried out to ensure people could make choices and keep their independence. Staff told us, "We encourage people to take positive risks". They added, "One person had a seizure last year but they liked to have a bath on their own". Staff continued, "We worked closely with the GP after three months this person was having a bath on their own again". Staff added, "We are always in the area but at least they can have that independence". One care plan we looked at showed one person liked to make their own hot drinks and a risk assessment had been carried out to enable them to do this safely.

People were supported safely to transfer between two places. There was a mobile hoist available and lifting equipment had been tested in 2018 to ensure its safety. Staff had received training in how to safely move people using the equipment available. People we observed looked comfortable once transferred into their wheelchairs and staff checked how comfortable people were throughout the day. We observed one staff member adding additional cushions for one person and asking if they felt more comfortable now.

The provider employed a team of maintenance workers. They completed environmental risk assessments such as fire maintenance and safe use of water outlets. We reviewed the homes business contingency plan that ensured the service would continue if an emergency happened. Care plans included a personal

emergency evacuation plan (PEEP) for each person. A PEEP sets out the specific physical and communication requirements that each person had to ensure that they could be safely evacuated in the event of an emergency. The provider had contractors that serviced their equipment to ensure it was safe to use and staff had access to an on-call service for out of hours concerns.

When people behaved in a way that challenged others, staff managed the situation in a positive way. There was guidance in people's records on what action staff should take to support them at such times. Staff gave examples that confirmed they knew how to support people safely. One staff member told us, "We avoid triggers and escalation". They added, "we negotiate before it becomes critical and people have behaviour support plans". Another staff member gave an example, they told us, "One person needs their space, if we see they are getting agitated we support them to a quiet area which is often by the office". Another staff member said, "This morning (person's name) displayed new behaviours, we are still getting to know them and will have to talk about how we manage the new behaviours". A third staff member said, "(Persons name) hits them self, hard, so we make sure they have pain relief available so they aren't in pain as this will increase their agitation".

The registered manager produced a staff rota one month in advance, this showed us the service was sufficiently staffed to keep people safe. The provider had 59 staff employed and two vacancies at the time of the inspection. Staff told us, "A few staff have left recently but we all help out and do extra hours". Another staff member said, "We have our own bank staff as well".

The registered manager told us they had recruited four new staff and were in the process of completing their safety checks. When we asked people if they thought there were enough staff to help them one person smiled and another person said "Yes (staff members name) helps me". A relative we spoke with told us "Always so many staff around". Another relative said, "Oh yes plenty of staff". This relative laughed and said, "They look after me too".

Recruitment processes minimised the risk of employing unsuitable staff. Staff records had references, and a Disclosure and Barring Service (DBS) certificate. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups.

Systems were in place so that people received their medicines safely. Suitable arrangements were in place for the ordering, administration and disposal of medicines. Each person had information showing which medicines they were prescribed and how they liked to take their medicines. Staff supported one person to have control in taking their own medicines. We saw staff give four people their lunchtime medicines in a safe and respectful way, following the information provided.

People who had medicines for epilepsy had information about their seizures and the treatment in the case of a seizure. This was available on the providers electronic care records so that staff could easily access it. Protocols agreed with the persons GP were written for the use of some medicines that were given when required

One person was given medicines via a Percutaneous endoscopic gastrostomy (PEG), although they ate normally. Staff said this had been in place for a long time because the person would refuse to take medicines by mouth and with covert administration refused to eat. Staff said they always told (person's name) when they were giving medicine's. Staff also said, "We had training on the care of the PEG and could only administer medicines in this way if we attended this training". This person had a best interest decision in place and their medicines were stored in a locked cupboard in their bedroom. The temperature was checked daily and below 25 degrees C.

One person would only take their medicines covertly. This person was prescribed medicines for epilepsy and their behaviour. There was a Mental Capacity Act assessment, (MCA) relating to medicines and a best interest decision in place. Staff added the medicines to a small bowl of custard before taking the bowl to the person who ate this willingly.

Medicines were stored securely. Staff monitored room temperatures daily, records showed room temperatures to be below 25 degrees C. Medicine refrigerators were monitored twice daily and in safe range although thermometers did not have a minimum and maximum range available for staff to compare. The registered manager told us temperature recording would be moving to an electronic system in the next two weeks where staff would see the minimum and maximum temperatures. The provider did not have any controlled drugs at the time of the inspection but there was secure storage and a recording process if this was to become a need in the future.

A weekly audit allowed staff to check medicines were used as prescribed and recorded. The pharmacy collected waste medicines, we saw three record sheets from December and January, the pharmacy driver had signed two but the third was not signed or dated. We discussed the need to make sure the driver signed and dated the form with a clear name, so they had evidence that returns were safely disposed of.

Staff described processes in place in case of medicine's errors but said none had occurred recently. Staff said once they completed medicines training they shadowed staff and then were shadowed by senior staff at least three times before they were signed off as competent to give medicines. They also had an annual competency check.

The registered manager carried out regular checks to monitor infection control but these had not been consistently effective. On the day of the inspection we observed some areas of the home were not clean. Examples included cobwebs hanging from the roof of the conservatory, sticky and dirty bedside tables and dusty hallways as a result of the ongoing decorating. One person had a used urinary bottle on their table next to their cup of tea. The kitchen had a sealed sewer drain which staff told us was opened at times to clear blockages. This all meant staff did not always follow good infection control practices which could put people at risk.

The registered manager put actions in place to address the infection control issues we identified. Staff told us they were responsible for doing all the cleaning in the home. One staff member said, "We can't keep on top of it, the home is too big". The registered manager told us they would work with the person to ensure that the urinary bottle was managed safely. The support manager immediately arranged for the identified areas to be closed off and deep cleaned. They told us they would arrange for a cleaner to visit the home weekly following the inspection and that they had plans in the future to move the kitchen so that the drain was no longer an issue.

Staff understood their responsibilities to raise concerns and report incidents and accidents. Records showed that the provider had taken appropriate action where necessary, and made changes to reduce the risk of a re-occurrence of the incident. Where incidents had occurred, the provider had used these to make improvements and shared lessons learned with staff. Staff told us a recent incident involved two people becoming aggressive towards each other. Staff said, "We had to review staffing after any activities to ensure both people got the same level of interaction otherwise they would both get agitated". Records showed this incident had been reported and investigated and all staff we spoke with knew the outcome of the investigation.

Good

Is the service effective?

Our findings

People received effective care

The provider had suitable processes to assess people's needs and choices. The provider completed an initial assessment to see if the service could meet their needs. Assessments assisted staff to develop a care plan for the person and deliver care in line with the person's needs and wishes, current legislation, standards, and guidance.

The registered manager told us, "Once a referral is considered suitable for Longrun House I meet with the person and their family and begin a transitional move to Longrun House". They explained, "We spend days with people to help build relationships and assess their routines". Adding, "We don't rush, it can take be weeks or months of transition, it helps get the placement right and means staff can write care plans based on how people want to be cared for". Staff updated care plans regularly to make sure people's current needs were met.

A relative told us, "They know (person's name) well, and know their little nuances." One person said, "(Staff member's name) helps me get ready they ask me what I want to do". Each person had a care and support plan which was personalised to them. These plans set out people's needs and how they would be met. For example, one person liked to use their key board and sing. Staff told us, "The louder they sing the happier that tells us they are".

Nobody we spoke with (for example people who used the service and staff) said they felt they had been subject to any discriminatory practice for example on the grounds of their gender, race, sexuality, disability or age.

People received effective care and support from competent and well-trained staff. New staff received an induction at the start of their employment to ensure they had the basic knowledge and skills necessary to keep people safe. New staff completed a qualification known as the Care Certificate at the start of their employment if they did not already hold a relevant qualification. The Care Certificate covers an identified set of standards which health and social care workers are expected to adhere to. Relatives told us "They know (person's name) well they always know how to look after them". Another relative said, "They do so much training here they know what they are doing". One person told us, "Yes they look after me".

Training records showed that staff had received a wide range of training relevant to the needs of the people. Staff had received training on manual handling, infection control, fire safety, safeguarding, the Mental Capacity Act, first aid and food hygiene. A training record helped the registered manager check the training each member of staff had received and helped them plan the staff team's future training needs. One staff member said, " We get so much training". Another staff member said, "18 work books, we have to complete them all". A third staff member said, we are lucky we have our own training department which is great".

In addition to mandatory training staff received specialist training such as epilepsy, peg feeding, active

support and leadership training. Staff also told us they could also complete national qualifications in health and social care.

Supervision and appraisals were carried out to motivate staff, review their practice or behaviours, and focus on professional development. Staff had not been having formal supervision regularly but staff knew they could speak to management whenever they needed to. One staff member told us, "I go to the seniors, but the registered manager is always there if I need them". All staff we spoke with confirmed they felt supported in their roles but we did discuss the lack of regular formal supervision with the registered manager. They told us they had plans in place to set up more formal supervision so that all staff received a one to one meeting within the provider's guidelines, and appraisals had been planned for 2019.

Staff supported people to eat and drink enough and keep a balanced diet. People's records included information about how their dietary needs had been assessed and how their specific needs were met. If people had problems relating to eating and drinking there were risk assessments in place. This meant staff could monitor people's food and fluid intake and reduce any risks identified, this included people who were at risk of malnutrition.

The provider employed a cook who knew people's nutritional needs extremely well. Menus were available but only one choice was offered each day. We discussed this with the cook who told us, "I did the menu based on what I know people like to eat but if they don't want it they can always ask for something else". People were not involved in making their meals but the quality of the food was good. One person sat at the table waiting for their lunch and got quite excited when it arrived. Another person refused to eat their lunch and staff made them an alternative which they did eat. Staff ate with people to encourage meal times to be a positive social experience but at times we observed staff chatting to each other and not fully engaging with people. We raised this with the registered manager who told us that was not normal practice and that meal times were usually very positive. The registered manager assured us they would raise this with staff.

The provider supported people to access services from a variety of healthcare professionals including GPs, dentists, and district nurses. One health and social care professional told us, "They always implement the plans we ask them to". Adding, "Staff are very good at being proactive with health care needs". One person had a percutaneous endoscopic gastrostomy (PEG) feeding. PEG feeding is used where patients cannot maintain adequate nutrition with oral intake, although for this person it was fitted specifically to administer medicines, as described in the safe domain of the report. The registered manager arranged for the specialist nurse to deliver training to staff to ensure this equipment was maintained and used correctly.

Staff recorded the outcome of people's contact with health care professionals in their plan of care. Each person had a health action plan and a 'hospital passport'. This is a document which contains important information to help support people when admitted to hospital.

On the first day of the inspection, we spoke to a physiotherapist who was contracted by the provider to work one day a week at Longrun House. The physiotherapist told us, "I support people with their physical needs and equipment". Adding, "I offer some training for staff". They also told us, "The staff always carry out any plans we create for people, they are very proactive". Care records showed staff shared information effectively with professionals and involved them appropriately.

Longrun House provided appropriate accommodation for the people who lived there. Peoples' rooms had lots of personal belongings that made the room special to them and all had their own bathrooms. Staff told us, "(Persons name) dad was in the Air Force and they had an air force theme in their room." We observed there were Airplanes hanging from the ceiling. One relative told us, "(Relatives name) room is decorated with

all things they like." All accommodation including bedrooms, communal areas and the garden could be accessed by people using wheelchairs.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Although when we first arrived at the home we observed one staff member restricting a person from getting up and going to their room. There was no care plan or risk assessment that confirmed this was an appropriate use of restrictive practice and the registered manager confirmed this should not have happened and they immediately spoke with the staff member about the incident.

People's legal rights were protected because staff worked in accordance with the MCA. Staff had undertaken training in the Mental Capacity Act and knew how to support people who were unable to make specific decisions for themselves. Care plans contained information about people's capacity to consent to areas of their care. Best interests' decisions had been made where people lacked the capacity to give consent, but records showed that the provider had not recorded peoples involvement in these decisions. We discussed this with the registered manager who told us, "We always talk to people and their relatives but we know the records do not show that." They added, "We are in the process of transferring the paper records to an electronic system". They also said, "We will look at how people's involvement is being recorded as part of the transfer."

Staff had involved family members where people lacked capacity to make a specific decision. One visiting relative said, "Staff involve me in everything, they never make decisions without my input".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The registered manager had a good knowledge of this legislation and had made 16 applications for people living at the home, six had been authorised and 10 were waiting to be authorised so that people who required this level of protection could be kept safe.

Good

Is the service caring?

Our findings

People received a caring service

People were cared for by kind and caring staff. During the inspection we observed staff interacting with people respectfully. Staff showed kindness and patience when supporting people. We observed one person get up off the sofa and hug a staff member, the staff member hugged them back. Staff said, "(Persons name) prefers to be alone a lot of the time but will seek cuddles from staff when they want them". One relative told us, "I'm lucky to have them they take care of (person's name), they are always happy". Staff told us, "We want people to have a good life." Another relative said, "Staff do so much they are so kind". People interacted with staff in a positive and proactive way. People were happy and laughing and enjoyed being around staff. One person told us, "I like them". Another person said, "Yes "when we asked if staff were kind to them.

Staff knew people very well and could understand their communication even if it was not verbal. Some staff had worked at Longrun House for many years and had built trusting relationships with people who lived there. We observed how one staff member covered a person with a blanket and told them, "There you are, we don't want you getting cold ". One staff member told us, "I'm proud, it's not a care home, it's a home, we try our best to make it a warm environment".

In the 2018 satisfaction surveys there was a high level of positive comments from both professionals and family members. Comments from relatives included, "I can't tell you as a parent what a difference it means having so many lovely people who genuinely care for (relatives name)". And, "There is no doubt that Cream Care(provider??) is the best possible place for (person's name), they thrive". Professionals said, "I can rely on staff to put plans in to action". And, "Amazing, true professionalism and honest compassion from every member of staff".

The provider operated a key worker system. This was where the staff took responsibility for providing care to certain people who lived there. One staff member told us, "The key worker system means we can offer consistency". Adding, "It helps us really get to know people's likes and dislikes".

People felt involved in decisions about their care and told us they could express their views about how their care was delivered. Three people we spoke with said they had been included in their care but they did not recall seeing any care plans. We discussed this with the registered manager and checked the care records. People had not signed care plans to say they were involved in the care planning process, and staff had not offered them a copy of their care plan or explained to people where it was kept. This meant people could not review their goals, request changes to be made or monitor their progress if they had the capacity to do so. The registered manager said they always involved people and their families in their care but needed to evidence it in their records better.

Staff respected people's privacy and dignity. All staff we spoke with could tell us how to protect people's dignity when supporting people with personal care. One staff member said, "I make sure the bedroom door

is closed and curtains are closed." All staff we spoke with knew to knock on people's doors when they entered the room. During the inspection we observed staff supporting people with personal care, this was carried out discreetly and with kindness. One person told us, "They don't make me do things I don't want to". A relative said, "They make (person's name) comfortable they always look nice."

People were supported to maintain their independence including their relationships with family and friends. The registered manager told us relatives visited when they wanted to. One member of staff told us, "We help (person's name) to face time their relatives when they want to speak with them." A relative told us, "They send a taxi for me every week to bring me to see (Persons name), they are like my carers too". Another relative said, "I am very heavily involved." One person told us, "I see my mum often".

We did notice people were not given information about other organisations. People didn't know about other support or advocacy that may be able to help with their care and support needs. There were no leaflets available and staff did not know what advocacy services were available for people if they needed one. We discussed this with the registered manager and they told us they were updating the current welcome pack for people and they would add that information in. They also said they would ensure information for people and their relative was available when they entered the building.

Staff were not always aware of confidentiality and how they should not speak about people in front of other people. When they discussed people with us they were respectful and knowledgeable. We observed some staff discussing peoples care and support in front of other people during lunch. The registered manager assured us staff would be reminded of the importance of maintaining confidentiality. Relatives we spoke with confirmed that staff did not speak about people in front of them and care records were stored securely.

Staff respected people's religious and cultural differences. The registered manager told us, "We speak to people and relatives during the assessment period to find out what their religious preferences may be". Adding, "No one goes to church now but we would support anyone to go if they wanted to".

Good

Is the service responsive?

Our findings

People received a responsive service

The provider was responsive to people's needs. The support plans were detailed and easy to read. They provided a range of information about the person that included details about their family history. Staff also recorded preferred daily routines, likes, and dislikes and details of people and things that were important to them as well as risks and how these should be managed. This was important for staff to understand because some people receiving support had limited or no verbal communication. The staff we spoke with at the time of the inspection demonstrated a very good knowledge of the people they cared for.

Staff reviewed care plans regularly to ensure they were up to date with people's needs, although there was some confusion as to how staff involved people in care planning as described in the care domain of this report. When we asked people if they had a care plan they told us, "I don't know". Another person said, "No I don't think so". Relatives we spoke with said, "The care is great and staff keep us informed about changes". Adding, "I don't know what specifics are in (relative's name) care plan but I am involved". This meant people and their families were not fully involved in their care planning. We discussed this with the registered manager who told us they created the plans with people but they did not offer copies of the plans once written. The registered manager told us they would ensure people and their relatives, where appropriate, received a copy of their care plan in the future.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Staff sought ways to communicate with people and to reduce barriers when their protected characteristics made this necessary. For example, care records had communication profiles that showed how staff should support people to communicate. Most people living at Longrun House could not communicate well with staff, but staff told us they would assess anyone who couldn't communicate and identify the best way for them such as using signing or assistive technology to help anyone that did have communication difficulties make a choice. When we spoke to the Quality lead within the organisation they showed an information pack they were developing for people. This included information on how they stored people's records.

People were fully encouraged to access their community when they wanted to. Staff supported people in a way that promoted their independence and well-being. One person told us, "I am going to college tomorrow, and soon it's Forest School". they said, "I am excited about Forest School because there is going to be cooking in the forest and I am preparing the onions, it's brilliant fun". On the day of the inspection, there were some organised activities and entertainment for people to take part in if they wished to. We observed arts and crafts taking place in the morning and animals were bought in later in the day. People who wanted to took part in these activities, other people had family visiting and some people sat quietly reading books and chatting with staff. A relative told us, "The staff have social events and always invite us". They gave an example of summer parties they had been invited to. One relative told us, "They take me out

for dinner with (Persons Name)". They added, "I always get invited when they do anything with (person's name)".

People we spoke with knew if they were concerned about anything they could speak to the registered manager or a staff member and everyone we spoke with felt confident that any concerns would be taken seriously, although there was no information available that explained what people should do if they did want to complain officially. We mentioned this to the registered manager who immediately had some information put up in the front entrance of the home. We also saw information about complaints in the providers statement of purpose but people were not given this information. Staff told us, "We use to have a residents meeting where we talked about things like complaints and concerns but that stopped". The registered manager told us they would begin these again. This meant people could raise issues and have a say in how the home was run.

People could be confident that at the end of their lives they would be treated with compassion and any discomfort would be effectively managed. At the time of the inspection no one was receiving end of life care, but staff told us, "We have received end of life training".

Good

Is the service well-led?

Our findings

People received a well led service.

The provider had a clear vision to deliver care and support that promoted a positive culture. Their mission statement said, "Cream Care's purpose is to provide a home where people are empowered to live in a kind, supportive and caring environment. Processes in place supported this mission statement. Staff appreciated the values of the provider and the way it was run. A member of staff told us, "We all support each other here."

There was a registered manager in post. 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.

The leadership was visible and accessible. We saw open, honest, skilled leadership throughout Longrun House. People said the registered manager was very approachable. A deputy manager supported the registered manager. They both showed an excellent knowledge of people and their care needs. During the inspection we observed people approach the registered manager regularly, people pulled the registered manager away to get their attention. We also observed people hugging the registered manager, they were very comfortable in their presence.

There was a management structure in place, which gave clear lines of responsibility and accountability. There was a positive culture of support and cohesiveness amongst managers and staff. There were manager's meetings, staff meetings and regular email alerts through the electronic system which meant staff were kept up to date with developments about the service., staff told us, "We can talk anytime to the manager". One staff member said, "We are kept up to date we talk to each other all the time".

People spoke highly of the staff and management team. One relative told us, "(Registered Managers name) does so much, not just for (relatives name) for me as well". Another relative said, "Staff are just lovely they really care here". The registered manager understood the importance and responsibility of their role. They told us they felt supported by the organisation.

The providers approach to quality assurance included the completion of annual surveys. We reviewed the most recent ones sent out to family and professionals in November 2018. The results were mostly positive but the provider had not created action plans or been able to demonstrate what changes might be implemented because of the surveys. We discussed this with the registered manager who told us they had not completed that work yet as the surveys were only carried out in Nov 2018 and the information was still being collated.

There were quality assurance arrangements in place to raise standards and drive improvements. This included a system of audits to ensure quality in all areas of the service was checked, maintained, and where

necessary improved. Audits that were regularly completed included medicine records, care plans, health and safety audits and infection control. Although the infection control audits were not always effective because we found some areas of the home remained unclean, as discussed in the safe domain of this report.

The provider was transparent, collaborative, and open with all relevant external stakeholders and agencies. Staff worked in partnership with key organisations to support care provision, service development, and joined-up care. For example, community nurses visited the home to see people who had physical healthcare needs and required additional support. This helped to make sure people received care and support in accordance with best practice guidance. We spoke with one professional who told us, "Staff are on the ball I don't have to worry about anyone here".

The provider had followed all relevant legal requirements, including registration and safety obligations, and the submission of notifications. They also displayed the previous Good rating issued by CQC in the front reception area for the public to see.