National Care Consortium Ltd

Longhill House Care Home

Inspection report

Coldstream Close
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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 comprehensive rated inspection took place on 17 and 18 October 2018 and was unannounced. It was the first rated inspection of the service under the provider National Care Consortium Ltd, which registered Longhill House Care Home as a new location in November 2017.

Longhill House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Longhill House Care Home accommodates 41 people on two floors in one adapted building. It provides a service to older people and those who may be living with dementia. At the time of this inspection there were 39 people using the service.

The provider is required to have a registered manager in post. At this inspection there was a manager that had been registered and in post for the past year. A registered manager is a person who has registered with the CQC 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 were protected from the risk of harm because the provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in these matters. Risks were also managed and reduced so that people avoided injury or harm.

The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Staffing numbers were sufficient to meet people's needs and we saw that rosters accurately reflected the staff that were on duty. Recruitment policies, procedures and practices were carefully followed to ensure staff were suitable to care for and support vulnerable people. We found that the management of medication and risk of infection were safely carried out. The staff learned from accidents and incidents to avoid these being repeated.

People were cared for and supported by qualified staff that were regularly supervised and appraised regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected. Employees of the service had knowledge and understanding of their roles and responsibilities in respect of the Mental Capacity Act (MCA) 2005 and they understood the importance of people being supported to make decisions for themselves. The registered manager explained how the service worked with other health and social care professionals and family members to ensure decisions were made in people's best interests where they lacked capacity. People received adequate nutrition and hydration to maintain their health and wellbeing. The premises were suitable for providing care to older people and those living with dementia.

We found that people received compassionate care from kind staff and that staff knew about people's needs and preferences. People were supplied with the information they needed at the right time, were involved in all aspects of their care and were always asked for their consent before staff undertook care and support tasks. People's wellbeing, privacy, dignity and independence were monitored and respected.

People were supported according to person-centred care plans, which reflected their needs well. These were regularly reviewed. People had the opportunity to engage in pastimes and activities if they wished to in order maintain mobility and conversation skills. Activities stimulated the brain and kept people's skills going. People had very good family connections and support networks. An effective complaint procedure was in place and people's complaints were investigated without bias. People that used the service, relatives and their friends were encouraged to maintain relationships with one another through frequent visits, telephone calls and sharing news.

We saw that the service was well-led. People benefited from a culture and management style of the service that were positive. There was an effective system in place for checking the quality of the service using audits, satisfaction surveys, meetings and effective communication.

People had opportunities to make their views known through direct discussion with the provider's nominated individual or the staff and management team. People were assured that recording systems used in the service protected their privacy and confidentiality of information, as records were well maintained and held securely in the premises.

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.

People were protected from the risk of harm because systems were in place to detect, monitor and report potential or actual safeguarding concerns. Risks were also managed so that people's risk of injury was reduced.

The premises were safely maintained, staffing numbers were sufficient to meet people's need and recruitment practices were safely followed. People's medication was safely managed, as were infection control and prevention measures.

Is the service effective?

Good

The service was effective.

People were supported by qualified staff that were regularly supervised and received appraisal of their personal performance. Communication was effective. People's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their levels of health and wellbeing. The premises were suitable for providing care to older people and those living with dementia.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff. They were provided with the information they needed and were involved in all aspects of their care.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff maintained these when and wherever possible.

Is the service responsive?

Good

The service was responsive.

People were supported according to person-centred care plans, which were regularly reviewed. They had the opportunity to engage in some pastimes and activities to stay in control of their lives.

People complaints were investigated without bias and they were encouraged to maintain family and friend relationships.

Is the service well-led?

Good

The service was well-led.

People had the benefit of a culture and management style that were positive. The checking of the quality of the service was effective.

People had opportunities to make their views known and were assured that recording systems in use protected their privacy and confidentiality. Records were well maintained and held securely in the premises.

Longhill House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We inspected because the service was registered as a new location with National Care Consortium Ltd in November 2017 and had not received a rating under this provider.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

The inspection took place on 17 and 18 October 2018 and was unannounced. One adult social care inspector carried out the inspection and a dental inspector completed the oral health review. Information was gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are documents providers send us containing information about certain changes, events or incidents that occur at the service. We also received feedback from local authorities that contracted services with Longhill House Care Home and reviewed information from people who had contacted CQC, to make their views known about the service. We used information the provider sent to us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people that used the service, three relatives, the registered manager, deputy manager, three care staff, the cook and one visiting health care professional. We looked at care files belonging to three people that used the service and at recruitment files and training records for four staff. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring system, medication management and premises safety certificates. We also looked at equipment maintenance records and complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People told us they felt safe living at Longhill House Care Home. They said, "We are all well looked after and have people around all the time", "There are always staff around when you need them" and "Staff are always there and that makes me feel quite safe." Relatives told us, "I know my family member is safe here, as they are free to move around, but staff are always on hand", "I have no worries about [Name] being here. They are in a safe environment", "The staff answer call bells quickly, are such a friendly bunch and help with whatever you ask of them" and "I am confident my family member is well supported by all the staff."

Systems in place to manage safeguarding incidents were appropriately used. Staff were trained in safeguarding people from abuse and demonstrated knowledge of their safeguarding responsibilities. Records were held in respect of handling incidents and the referrals that had been made to the local authority. All of this ensured that people who used the service were protected from the risk of harm and abuse.

Any risks that people faced were assessed and reduced, for example, with falls, poor positioning, moving around the premises, inadequate nutritional intake, the use of bed safety rails and in their relationships with one another. Risk assessments were reviewed when necessary. Maintenance contracts and safety certificates for utilities and equipment used in the service were kept up-to-date and ensured people were protected from the risk of harm from system failures or incidents. Personal emergency evacuation plans were in place for evacuating people individually from the building in an emergency. This meant that people were kept safe from the risks of harm or injury.

There were accident and incident policies and records in place for in the event of any accident. Records showed these were recorded thoroughly and action was taken to treat injured persons and prevent accidents re-occurring. Staff used equipment to assist people to move around the premises and this was used effectively and safely. People were assessed for its use and there were risk assessments in place to ensure no one used it incorrectly. Bed rail safety equipment was in place on people's beds and these had also been risk assessed for safe use.

Safe systems were in place to ensure staffing levels were appropriate to meet people's needs and recruitment of new staff was robust. We observed that sufficient staff were on duty to attend to people when they needed help: up to seven staff each shift. Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities to meet people's needs. New staff were recruited as vacancies arose and recruitment procedures were safely followed to ensure staff were suitable for the job. Job applications were completed, references requested and Disclosure and Barring Service (DBS) checks were carried out before staff started working. A DBS check is a legal requirement for anyone applying for a job or working voluntarily with children or vulnerable adults. It checks if candidates have a criminal record that would bar them from working with these people, helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. All the appropriate evidence was provided to ensure staffing levels and recruitment procedures were safe.

Medicines were safely managed within the service and a selection of medication administration record (MAR) charts we looked at were accurately completed. Medicines were obtained in a timely way so that people did not run out of them, they were stored safely, and administered on time, recorded correctly and disposed of appropriately. Controlled drugs were also held and managed safely in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001). Anyone needing to take medicines covertly (without them knowing) had this agreed in their best interest by those with responsibility for their care and the decision was backed up with written agreements.

Systems and good hygiene practices ensured that prevention and control of infection was appropriately managed. The premises were clean and easily maintained, staff had completed infection control training, followed guidelines for good practice and had personal protective equipment that they needed to carry out their roles. Cleaning staff were employed and kept the premises clean and free from unpleasant odours. Hoist slings were not individually name labelled but staff knew which sling belonged to people and had sufficient of them to ensure regular laundering. Waste management was appropriate and followed guidelines and contractual arrangements.

The registered manager evidenced that lessons were learned from accidents, incidents and untoward events through the auditing and recording systems they maintained in the service. There was also evidence of staff discussing how to provide an improved service and learn from their mistakes within meeting and supervision records.

Good

Is the service effective?

Our findings

People told us the staff understood them well, had the knowledge to care for them and nurtured some strong relationships. They said, "The staff know what they are doing and how to overcome any difficulties" and "I always get the help I need." Relatives confirmed this and said, "Staff are knowledgeable and have taught me quite a few things about dementia and how to manage situations and emotion", "My relative loves the company here" and "I have every confidence in the staff doing the right thing for my family member." A visiting health care professional said, "Staff are really helpful. They always accompany a patient when I see them and they take on board any instructions for continued treatment. I find the staff are capable workers."

People had comprehensive assessments of needs carried out which were used to determine the actions required to meet those needs. People and relatives were involved and included in assessing needs and determining the action they required to ensure needs were met.

The provider had systems in place to ensure staff received the training they required to carry out their roles. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. Induction was provided, regular one-to-one supervision took place and a staff appraisal scheme was operated in conjunction with an 'employee of the month scheme'. Staff confirmed they completed mandatory training (minimum training as required of them by the provider to ensure their skill and knowledge) and had the opportunity to study for qualifications in health care.

The service had set up a volunteer scheme with a local church. On the day of our inspection one multi-faith volunteer visited and spent most of the day talking to people, helping with drinks and snacks and providing that extra contact for people when they were feeling in need of company. The volunteer worked in the communal areas of the service in the main but had been vetted for any one-to-one emotional support. This provided people with comfort and another person to speak with and relate to that was interested in their care needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were assessed as having no capacity to make their own decisions, the registered manager arranged for best interest's decisions to be reached, DoLS applications to be made and reviews to be carried out. This was managed

within the requirements of the MCA legislation.

People consented to care and support from staff by either verbally agreeing or physically going along with staff when they offered support. Staff understood the principles and importance of consent, that people had a right to refuse help and that best interest decisions had to be made where people could not consent, to ensure people's rights were upheld. There were signed documents in people's files that gave permission for photographs to be taken, care plans to be implemented or medication to be handled. We saw first-hand how staff always asked people if they wanted support with every task and that staff told people what they were doing at each stage.

People's nutritional needs were met because staff consulted them about their dietary likes and dislikes, allergies and medical conditions. Staff sought the advice of a Speech and Language Therapist (SALT) when needed. The kitchen staff provided three nutritional meals a day plus snacks and drinks for anyone that requested them, including at supper time. Meals were cooked on the premises. Nutritional risk assessments were in place where people had difficulty swallowing or where they needed support to eat and drink. Menus were on display for people to choose from and people told us they were satisfied with the meals provided.

People's health care needs were met because staff consulted them about medical conditions and liaised with healthcare professionals. Information was collated and reviewed with changes in people's conditions. Staff told us that people could see their doctor on request and the services of the district nurse, chiropodist, dentist and optician were accessed whenever necessary. Health care records held in people's files confirmed when they had seen a professional and the reason why. They contained guidance on how to manage people's health care and recorded the outcome of consultations. Diary notes recorded when people were assisted by staff with the health care that was suggested for them.

For those people that used the service living with dementia, there was signage available to orientate them around the premises and the environment was conducive to meeting their needs. Carpets, furniture fabrics and wallpapers were suitable to enable people to navigate their environment easily.

Good

Is the service caring?

Our findings

People told us they got on very well with staff and each other. They said, "Staff are really caring" and "I find everyone here so nice and thoughtful." Relatives confirmed this and said, "The staff are so good they have given me my mum back", "Staff understand people's needs and emotions" and "I have great faith in the staff and how they approach my family member. They are always relaxed and friendly." People also said, "Staff are discreet" and "I never feel embarrassed because the staff are careful and respect my privacy." Relatives said, "I find staff are respectful of people's privacy and dignity" and "I cannot praise the staff enough. Everyone from the cleaners to the manager always have time for me and my family member."

Staff had a caring, pleasant but professional manner when they approached people. Staff knew people's needs well and were kind when they offered support. The management team led by example and were polite, attentive and informative in their approach to people that used the service and their relatives. We observed some special relationships between people and staff, in which staff fully understood the needs of the people they supported. The service was busy throughout the day with visitors and staff going about their responsibilities. We saw some rewarding interactions taking place and heard some lively conversations.

At the time of our inspection, the service was providing care and support to people who had protected characteristics around age, disability, gender, marital status, race, religion and sexual orientation. Staff completed equality and diversity training, were aware of the differences people might present and were respectful of these. Staff had a thirst for knowledge and were receptive to understanding, for example, people's religious and cultural needs around foods and festivals.

Staff felt they were supporting people with religious needs in enabling them to see ministers of different denominations or to attend a church of their choice on Sundays. We were told that food preferences would be catered for in respect of different faiths, but at the time of the inspection there were no people with any specific requirements. Staff were also included in having their protected characteristics respected, for example, with maternity, cultural and religious needs.

People's general well-being was monitored by the staff who knew what incidents or events could upset their physical and mental health. People were supported to engage in old and new pastimes, which meant they could 'keep a hold on' some aspects of the lifestyle they used to lead or they could learn new skills and abilities. Activity and occupation helped people to feel their lives were worthwhile and purposeful, which aided their overall wellbeing. Occupation didn't just involve activities for pleasure it also involved helping staff with light domestic tasks. For example, setting or clearing tables and sometimes dusting or folding laundry.

While everyone living at Longhill House Care Home had relatives or friends to represent them, we were told that advocacy services were available if required. Advocacy services provided impartial and independent support and encouragement to ensure people's best interests in advising or representing them. There was a relative's information board containing details of advocacy and other details and a staffing list with photos

of the staff employed and this showed who was on duty each day.

People's privacy, dignity and independence were respected. Staff ensured personal care was only provided in bedrooms or bathrooms, that doors were closed, information was shared only on a need to know basis and that everyone was given the opportunity to do as much for themselves as they could. These measures ensured people were never seen in an undignified state, they had confidence their personal information was protected and they were enabled to be independent.

Staff expressed the importance of providing people with choice in all things, so they continued to make decisions for themselves and stayed in control of their lives. People had a choice of main menu each day and if they changed their mind the cook provided other alternatives. One visitor told us their relative was unable to make choices about food, for example, and said they had instructed the staff to ensure they received a hot meal option at lunch time. People chose where they sat, who with, when they got up or went to bed, what they wore each day and if they went out or joined in with entertainment and activities. People's needs and choices were therefore respected.

Good

Is the service responsive?

Our findings

People told us their needs were being appropriately met and they knew how to make complaints known. They talked about being supported by staff to go out with family and friends and to achieve all they could. Staff helped with any arrangements that had to be made and liaised with family members. People and relatives said, "I get all the help I need", "Staff know where I need to be and when. They help me to get ready", "My family member need never worry about anything as staff seem to be 'on the ball' with everything" and "Staff are fully aware of what my family member needs help with, how they might react to offers of help and how best to assist them. Staff have helped me learn to roll with my family member's wishes." People and relatives said they were comfortable complaining when necessary. They said, "I am aware of the complaint procedure", "I know who to speak with if I'm unhappy" and "I have no reservations about speaking with the manager."

One person was assisted to prepare to go out with a healthcare professional and was spoken with by the registered manager and staff on their return to find out if they were happy with the arrangements and the outing. Other people were helped to get around the premises: to the dining room or bathroom, and we saw that staff were quick to recognise when people needed support. People's needs were recorded within their care files and care plans. We saw people making requests for support and staff anticipating some people's needs.

People's care files and care plans reflected their assessed needs. Care plans were person-centred and contained information under several areas of support, to show staff how best to meet people's needs. These had been reviewed and changed and while more succinct, had all elements of a care plan written together in one area for each care topic. For example, when mobility was assessed a person's care plan stated their needs, what they were capable of, how they needed help with moving, how that should be achieved and the instructions to do this. Information was clear, but all this information was together in one section. We discussed with the registered manager how splitting up 'the strength', 'the need' and 'the action to take' might enable staff to see their tasks more easily. Care plans were informative and reflected people's needs.

Activities were held in-house and facilitated by an activities coordinator who was sometimes assisted by care staff. People told us they joined in with singing, exercise, quizzes and making all manner of craft items. We saw people engaged in reading, watching television, singing, doing exercises and using doll therapy (holding a doll to simulate caring for a baby, which encourages positive emotions to alleviate anxiety). We saw photographic evidence that people took part in craft activities and celebrating seasonal festivals and events, as well as going out with family members. Some photographs were pinned to the lounge wall in a display. There was a hairdressing room where people could see the hairdresser each week and anyone wishing to assist with an odd domestic chore was encouraged to do so. Visitors to the service were numerous and this gave a real community feel to the service.

The registered manager discussed the Accessible Information Standard (AIS) with us. This is the means of ensuring that those with a disability receive accessible health and social care information by identifying and

managing people's communication need. The provider had already been providing suitable means to meet people and staff needs: use of coloured paper for anyone with dyslexia, large print documents and letters when requested and communication aids like picture cards for those living with dementia. They had determined the full extent of the AIS process by the end of our inspection visit and planned to add this to the admission assessment form.

People's relationships were respected and staff supported people to keep in touch with their family and friends. Staff got to know family members and kept them informed about people's situations if this was what they wanted. Staff encouraged people to receive visitors and spoke with people about them on an appropriate level. There was a great sense of 'community' in the service and relatives we spoke with confirmed this telling us they trusted their family member in the care of the staff and saw them as extended family.

The provider's complaint policy and procedure was accessible to everyone and records showed that complaints and concerns were handled within the timescales outlined in the policy. Compliments were also recorded in the form of emails, letters and cards. An example of the compliments received included one the organiser of a local social club for older people and those living with dementia. They stated that everyone gravitated to Longhill House Care Home staff when they were at the club with people from the service, as they were by far the 'bubbliest' people.

Staff were aware of the complaint procedure and handled issues in a positive way. They understood that complaints helped them to improve the care they provided. We saw that when the registered manager handled complaints, complainants were given written details of explanations and solutions following investigation.

People were appropriately supported with end of life care. Support from the district nurse was accessed. Anticipatory medicines (those that may be needed to enable a pain free death) and equipment was available to ensure people were comfortable in or out of bed. The new NHS Respect Forms had been put in place instead of the 'do not attempt resuscitation' forms. This meant staff and supporting health care professionals addressed people's end of life needs more clearly than before.

Good

Is the service well-led?

Our findings

People and relatives told us the service had a pleasant, family orientated atmosphere and was satisfactorily managed. They said, "We are one family here", "People and staff get on fine together as if we were one happy family" and "I have no concerns about the running of the service, as my family member is well cared for." Staff we spoke with said the culture of the service was, "friendly", "positive" and "encouraging". They said it was a pleasant place to work where everyone got on well together and worked as a team.

There was a registered manager in post, who had been the registered manager for the last year. They were fully aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made) in line with the regulations. Notifications were sent to the Care Quality Commission (CQC) and so the service fulfilled its responsibility in this matter. The management style of the registered manager and deputy manager was open, inclusive and approachable. They led the culture of the service, which was caring and considerate. Staff told us they expressed concerns or ideas freely to the management team and felt these were fairly considered.

People maintained links with the local community where possible, through the church, schools and visiting local services and healthcare services. Relatives played an important role in helping people to keep in touch with the community by supporting people to activities and visits to family and friends.

We looked at documents relating to the system for monitoring and quality assuring the delivery of the service. We saw that there were quality audits completed on a regular basis and that satisfaction surveys were issued to people that used the service, relatives and health care professionals. Audits included checks on care plans, pressure care, risks, medication, infection control, the environment and supervisions.

A questionnaire survey was issued in November 2017 by the new provider, with only two people being able to complete these, but their views were positive. Nine staff had completed surveys and they had also stated positive comments, with minor dissatisfaction with odours in the service, décor, storage and food. There had already been significant changes as a result: flooring changed from carpets to hard surface, some redecoration and new furniture and meals now cooked on the premises. One occupational therapist evaluation form was received, which was complimentary about the staff practice and attitude.

The service had a score of five, which is the highest food hygiene rating from the environmental health department and where one is the lowest score. There were weekly multi-disciplinary team meetings held at the service where each person was discussed in turn and all had now received an annual health check at the request of these meetings.

The registered manager kept records regarding people that used the service, staff and the running of the business. These were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held.

The registered manager, deputy and staff fostered good partnership working with other social and health

care professionals, by sharing information on a need to know basis, assisting visitors for health reasons and seeking advice and support for people when needed. The management team had direct access to those professionals involved in the multi-disciplinary team meetings for advice and to share information. They also worked well with the NHS falls team.