HICA

Longhill House - Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Longhill House is situated in a residential area. It is registered to provide personal care for up to 41 people who may be living with dementia. Bedrooms and bathrooms are located over two floors which are accessed by a passenger lift. All bedrooms are for single occupancy and most have an en suite toilet. There are two sitting rooms and a large dining room on the ground floor, which has access to an enclosed garden. There is a reminiscence room on the first floor.

The service had a registered manager in post as required by a condition of registration. 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.

We undertook this unannounced inspection on the 17 and 18 November 2016. At the time of the inspection there were 38 people living in Longhill House.

At the last inspection on 14 September 2015, we had concerns about infection prevention and control and how the quality of the service provided to people was monitored. The registered provider sent us an action plan which stated the measures they were to take to improve and when they would be compliant in these areas. We found there have been improvements in both these areas at this inspection. For example, we found the service was clean, tidy and smelled fresh. Some minor issues were attended to on the day of inspection. Staff had appropriate personal and protective equipment to use when required and there were sufficient supplies of cleaning products.

The registered manager was carrying out more audits and checks on the quality of the service and asking people their views in surveys and meetings. We saw some areas required review to continue the improvement achieved so far, especially in relation to records. We have made a recommendation about this in the well-led section.

During this inspection, we found people had not always received their medicines as prescribed. You can see what action we have asked the registered provider to take at the back of the full version of this report.

Staff knew how to keep people safe from the risk of harm and abuse; they had received relevant safeguarding training and knew how to report issues of concern. Staff completed risk assessments for people who used the service to help them minimise risk and keep people safe. The registered manager had looked at accidents and incidents so staffing levels could be adjusted at specific times of the day in order to reduce the number of incidents.

We found people's health care needs were met. Staff had developed good relationships with health care professionals and they made referrals to them when required.

People's nutritional needs were met. There were choices available for them on the menus and alternatives if they didn't like what was on offer. Nutritional risk was assessed and people were weighed in accordance with risk and their diet adjusted when required.

People's needs were assessed prior to admission and this was kept under review and updated when there was any significant change. People had care plans which provided staff with guidance in how to look after them. Some care plans were very detailed but others lacked some information which could be relevant to their care. However, in discussions it was clear that staff were very knowledgeable about people's individual needs and how each person preferred to be cared for. The registered manager confirmed the minor issues with care plans were to be addressed straight away.

We found the staff approach was kind, patient and caring; there were positive comments about staff approach from people who used the service, relatives and visiting professionals. Staff respected people's dignity and privacy and we saw them encourage people to be as independent as possible and to make their own decisions when they were able to. When people were assessed as lacking capacity, staff acted within the principles of the Mental Capacity Act 2005 and ensured important decisions were made within best interest meetings with relevant people attending.

We saw confidentiality was maintained and personal data protected and stored securely.

Staff had access to training which helped them to feel skilled and confident when supporting people who used the service. The training was monitored and refresher courses made available; there was an expectation that staff completed training in a timely way. There was an induction which covered training considered as essential and which gave new staff basic skills on which to build on. Staff received supervision, appraisal and support.

We found the registered manager was approachable and people who used the service and their relatives were listened to. There was a complaints procedure on display and people felt able to complain.

At the last inspection in September 2015, staff had been recruited safely and all employment checks had been carried out before they started work in the service. The recruitment process had not changed in the interim so we did not feel it necessary to check this again. Recruitment processes will be checked at the next inspection to ensure the robust processes continue to be maintained.

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 consistently safe.

People had not always received their medicines as prescribed and staff lacked guidance when people were prescribed medicines 'when required' or when there was a variable dose.

There had been improvements in the cleanliness of the service and systems designed to help infection prevention and control.

There were sufficient staff to meet people's needs although this was under review as some people's needs had changed.

Staff knew how to keep people safe from the risk of harm and abuse and knew how to raise concerns.

Is the service effective?

Good

The service was effective.

People's health care needs including their nutritional needs were met. There was a range of health care professionals who provided treatment and advice when required. People liked the meals provided to them and they had sufficient to eat and drink.

People's consent was sought prior to care interventions. When people were assessed as lacking capacity to make their own decisions or when their liberty was restricted, the registered provider acted within the law.

Staff had access to training, support, supervision and appraisal to help them feel confident in supporting people.

Is the service caring?

Good

The service was caring.

Staff supported people to make their own decisions and provided information to them to help this process.

Staff approach was kind, patient and caring. Staff supported people to maintain their privacy and treated them with dignity

and respect.

Staff maintained confidentiality and personal information was held securely.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and information was included in plans of care. Staff had a good understanding of people's needs and delivered individualised care.

There were activities for people to participate in, which provided them with opportunities to socialise with others and helped to stimulate their interests.

The service had a complaints procedure that was on display. People felt able to make complaints and they were clear about who they would report concerns to.

Is the service well-led?

Requires Improvement

Although there had been improvements in this area, the service was not consistently well-led.

There was a quality monitoring system in place but some parts required more robust attention, especially records, to ensure these were up to date. We have made a recommendation about this.

The culture of the organisation and of the registered manager was one of providing individualised care, involving people, listening to their views and learning from mistakes.

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

This inspection took place on 17 and 18 November 2016 and was unannounced. The inspection team consisted of one adult social care inspector over the two days.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority contracts and commissioning teams and safeguarding team about their views of the service.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with two people who used the service and five people who were visiting their relatives. We spoke with the registered manager, two senior care workers, seven care workers and the cook. We also spoke with a health care professional and a chiropodist.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as all their medication administration records (MARs) and monitoring charts for food and fluid intake, weights and pressure relief. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These

included training records, the staff rota, minutes of meetings with staff and people who used the service or their relatives, quality assurance audits, complaints management and maintenance of equipment records.

We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in September 2015, we had concerns about how effective the infection prevention and control systems were in the service. We found during this inspection, that the service was clean and tidy and areas of concern with laundry systems had been resolved. There were some minor issues noted during the environmental check such as one wheelchair that needed cleaning, a bedrail protector that needed replacement and a clinical waste bin that needed to be a foot-operated one to avoid cross contamination. These were addressed on the day by the registered manager. Staff had access to personal, protective equipment such as gloves, hand wash, gel sanitiser, paper towels, and appropriate bags and covered linen skips for soiled laundry. There were sufficient supplies of cleaning products. The laundry facility included a dirty to clean flow, commercial sluice washing machines and driers, and information for staff on the correct temperatures to wash linen and clothes. Staff had completed training in infection prevention and control and there were procedures to guide staff in how to manage outbreaks of infection. These measures helped to prevent the spread of infection in the service.

We had concerns about the management of medicines which had meant a small number of people had not received them as prescribed. In one instance, a person had not received a specific medicine three days in a row which amounted to nine doses. Staff said they had difficulty with the pharmacy and had tried to obtain the medicine on time. One person was prescribed a pain relief patch to be applied every 72hours. On various occasions staff had not kept to this timescale and had been under or over the 72 hours by margins that were not acceptable. On one occasion there were five days between applications. One person was prescribed eye drops to be instilled every two hours for the first two days and then four times a day. There was no recording the eye drops were instilled, or offered and declined, every two hours as prescribed. The person's medication administration record (MAR) indicated the eye drops were offered four times a day but were consistently declined; however, there was no evidence staff had informed the person's GP about this. One person did not receive a specific medicine three times a day on one occasion as staff had recorded the person awoke late and had their first dose at lunchtime. The person had two doses instead of three that day when there was no reason why the medicine could have been spaced more effectively for them to have the full three doses. Some people were recorded as asleep during the day and missed their doses of medicine; there was no reason why staff could not have given the medicine when people woke up.

There were some recording issues which were mentioned to the registered manager to address. These included a lack of protocols giving clear guidance to staff when people were prescribed 'when required' or a variable dose medicines, and a judgement was needed as to how much to give. There were some gaps observed with no code to define the omissions, however, when checked this was a recording error and the medicine had actually been given to the person.

Not ensuring medicines were managed properly and people received them as prescribed was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

We saw medicines were stored appropriately and safely and staff administered them to people in a patient

way. We also noted that people who were prescribed 'when required' medicines to calm them and relieve their anxieties, only had them when necessary.

People told us they felt safe and staff looked after them well. Relatives told us they were happy with the service, it was clean and tidy and there were sufficient staff to support people. Comments included, "Yes, they are safe", "All the staff are amazing and my dad is safe", "Yes, she is safe here", "They are not left in pain", "He has a clean and tidy room, there are no odours; it's nice here", "Sometimes, there is an odour but this is sorted; its clean and tidy", "The home is very clean and their bedroom is very clean" and "Yes, there is enough staff but they are busy." One relative told us they thought there were sufficient numbers of staff but on occasions, agency staff have made up the numbers on duty and they felt they did know people as well as regular staff.

A health professional told us, "Yes it is safe. They have codes for the entrance and exit so no unwanted people can enter and residents can't exit [unescorted]."

There were sufficient staff to meet people's assessed needs. Staff confirmed rotas were correct and the aim was for six care staff during the day and four at night. The registered manager told us absences were managed by existing staff or agency staff when required. They also said they were reviewing the current staffing levels in line with some people's increasing dependency levels. There was a range of ancillary staff on duty each day such as an activity coordinator, and catering, laundry, domestic, administration and maintenance personnel, which helped care staff to be able to focus on care tasks. Staff told us that domestic staff gave people mid-morning and mid-afternoon drinks which helped to free care staff and enable them to provide personal care. Comments from staff included, "Yes, there is enough [staff] but numbers of residents has risen and so has their needs", "Sometimes it's hard but generally it's ok" and "[Registered manager's name] is looking at it [staffing rota]." The registered manager told us they had identified that an additional member of staff would enhance the support to people who used the service in the early evening and recruitment was underway.

There was a safeguarding procedure to guide staff and all had received training in how to safeguard people from the risk of abuse or harm. In discussions, staff demonstrated good knowledge of how to protect people, the signs to look out for that would alert them to concerns and what to do to raise an alert. The registered provider had a whistle blowing procedure and staff were aware of it. Each person who used the service had risk assessments completed which gave staff guidance in how to minimise risk to keep people safe and to prevent injuries or incidents occurring. These included nutritional intake, falls, moving and handling, skin integrity and behaviours which could cause them anxiety or distress. People had personal plans to help guide staff in how to evacuate them in emergency situations. We saw some of these required updated information and was mentioned to the registered manager to address.

We found the environment was safe and equipment used in the service was maintained and checked regularly.

At the last inspection in September 2015, we found the registered provider's recruitment practices were robust and staff only started work when all employment checks had been carried out. The system remained the same, as confirmed in a discussion with a new member of staff during this inspection. As such we did not need to check recruitment records again at this inspection.

Good

Is the service effective?

Our findings

We saw people's health care needs were met and they had access to a range of health care professionals as required. Records showed these included GPs, district nurses, dieticians, physiotherapists, emergency care practitioners, opticians and chiropodists. In discussions with staff, they were able to accurately describe the signs to look out for when someone had a urinary tract infection and how they would prevent pressure areas such as people's hips and elbows from becoming sore. They told us they had regular contact with community nurses and recognised the need to speak to them quickly to pass on important information. Health professionals told us, "It's very effective; if they notice any pressure ulcers on patients, they ring us straight away", "Any concerns I pass on appear to have been acted on appropriately" and "Staff generally ask and explain, and seek consent where appropriate. They are good at coaxing reluctant residents with issues of care."

Visitors told us their relative's health care needs were met and staff were skilled in looking after them. Comments included "Yes, she gets to see the doctor", "They get the doctor when needed" and "The staff are very well-trained; they are good at lifting and handling and dementia care."

People's nutritional and hydration needs were met. The care files had nutritional risk assessments and care plans detailing people's needs and preferences and their weight was monitored in line with the assessment. People at risk of nutritional or fluid intake had monitoring charts in place. We observed the mealtime experience for people; there were four care staff and additional catering staff available in the dining room. Staff offered people choice of food and drinks, and clothes protectors. We saw most people in the dining room were able to eat unassisted but when they required support, this was completed well by staff and at an appropriate pace for them. The dining room was pleasant with tables and chairs to seat four people at each of them. Some people chose to eat alone and some people sat with others; the mealtime was calm and organised. We observed staff take trays, with plated and covered meals, to people who preferred to remain in their bedrooms. A food service assistant told us meals were delivered by an outside agency; the meals were frozen and included specialised diets such as textured meals, sugar-free and fortified with additional calories. The main meal of the day was served in the evening as staff had noted that people required a more substantial meal at this time.

People who used the service told us they liked the meals. Comments included "The food is great" and "Yes, they are alright [meals]." Relatives said the meals provided offered people with choices and alternatives. Comments included, "She has put on weight since she has been here" and "The meals are very good."

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. In discussions, staff demonstrated awareness of the need to gain consent prior to carrying out care tasks. We saw capacity assessments and best interest meetings had been completed for specific issues. These included whether people understood the need for restrictions such as lap straps, electronic keypad

locks, covert medication and 'when required' medication, a protective helmet and entering Longhill House to live.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found the registered manager and registered provider was working within the principles of the MCA. The registered manager was knowledgeable about the criteria for DoLS, staff had received training and appropriate applications had been made for people who used the service.

Records showed staff had access to a range of training to enable them to complete their roles. The training record was monitored and updates arranged at intervals. Staff confirmed they had received training and felt confident supporting people. They said training included 'mandatory courses' such as first aid, safeguarding, fire safety and use of fire-fighting equipment, basic food hygiene, moving and handling, MCA and DoLS, health and safety, infection prevention and control and medicine management. There were other training courses relevant to the care staff role such as dementia care, pressure area care, managing behaviours caused by anxiety and distress, the use of a nutritional screening tool and data protection.

We spoke with a new member of staff who described the induction they had received. They said this had consisted of four days of 'mandatory training', and also included safety and wellbeing, expectations of staff behaviour, respect and dignity, and the values and vision of the organisation. The member of staff told us they shadowed more experienced staff for several shifts and had their practice observed, for example during providing personal care to people who used the service. Staff told us they felt supported and had supervision meetings with their line manager to discuss issues and training needs.

Good

Is the service caring?

Our findings

There were positive comments about the staff and their caring approach from people who used the service, their relatives and health professionals.

One person described how their memory loss affected them and staff supported them. They said, "I have that disease where you can't do anything – it's horrible and I can't concentrate, but I can remember some things; the staff are excellent" and "I get up when I want and go to bed when I want." Another person said, "Yes, the staff are nice."

Relatives said, "The staff are brilliant and they do listen", "Very kind, sensitive and caring staff", "Some carers go above and beyond, I can't praise them enough; I would come here myself", "Yes, they are all those [kind, sensitive, caring and compassionate]", "They are wonderful, all of them including the domestics and laundry staff" and "He is as happy as he can be". When asked if staff promoted people's privacy and dignity, they said, "Yes always in every way" and "Yes, they do." Visitors told us they were made to feel welcome and offered refreshments.

Health professionals told us, "Yes, doors are always closed if they are with a resident", "Always maintain dignity", "They are always there for the residents, to help them and talk to them; the staff are caring", "Very caring staff team; I visit a range of care homes so I can compare" and "Overall, a warm, caring environment and a pleasure to visit."

Staff were clear about how they supported people to maintain independence and how they promoted privacy and dignity. They said, "We would have a quiet place for discussions, keep doors and curtains shut [during personal care] and keep people covered up", "Respect people by asking what their preference is for male or female carer", "Ask people all the time", "Make sure people are covered with a towel during personal care" and "We have to listen to people, encourage them and we know what our residents can do for themselves; we ask them if they want to wash their own hands and face." We observed staff knocked on bedroom doors before entering and respected people's space.

Staff were also clear that people were able to make choices about aspects of their lives such as when to get up, when to go to bed, where to sit during the day, what meals they had, the activities they participated in and the freedom to walk around the service. We saw that although most people chose to eat their meals in the dining room, some people chose to eat them in their bedroom and this was respected.

We saw people had their own bedroom, most of which had en suite toilets. This afforded people privacy and space when they wanted to be alone to watch television, sit and read or to see their visitors in private.

We observed people were smartly dressed in clean clothes and were offered clothes protectors at mealtimes.

People were provided with information in order for them to make informed choices and decisions. Menus

were on display and quickly changed when it was noted they had not been changed to the correct day. Prior to lunch, people were informed of the choices of the meal on offer so they could choose. Staff also offered a visual choice to some people. There was a notice board which provided information about the activities to be provided each day and pictures of the staff team.

We overheard staff provide explanations to people in a patient way. For example, one person required reassurance several times about the location of their belongings; staff told the person where they were and offered to show them. People were supported to join in activities and shown what to do and how to participate. We saw staff redirected people to the sitting rooms and the dining room. During lunch, one person walked up to the serving hatch to talk to catering staff and ask about options; staff showed them what was on offer for the meal and checked it was what they wanted.

We saw people who used the service and their relatives had been involved in assessments of their needs; information about likes, dislikes and preferences were included in people's care plans.

The registered manager demonstrated compassion when they described a situation of on-going staff support for the relative of a person who used the service who had recently died. There was also an occasion when the registered manager provided staff support for a person who used the service to attend his daughter's wedding in order for them to be fully involved and to 'give her away'. The registered manager stated the member of staff supported all day to assist the person with the full range of care needs whilst away from Longhill House.

People who used the service had relatives who were able to advocate for them on their behalf. The registered manager was aware of the local advocacy service should any person who used the service require this.

Staff maintained confidentiality. Conversations about personal issues or phone calls made with professionals were carried out in the staff office. Health professionals could see people in their own bedrooms. Staff files were held securely in the administrator's office and care files were in lockable cupboards but were accessible to staff. People's medication administration records were held with the medicines trolleys in the treatment room upstairs. The registered manager confirmed the computers were password protected to aid security. The registered provider was registered with the Information Commissioner's Office, which was a requirement when computerised records were held.

Good

Is the service responsive?

Our findings

Relatives told us staff were responsive to people's needs and they thought there were sufficient activities for them. They said, "She is always smart and tidy", "They have organised specific foods for him", "There are some activities but he prefers to stay in his room. He has talking books, a radio and has a special watch; he prefers his own company and listening to the radio, which is fine", "He doesn't get involved in the activities but he gets the option to go on trips", "Oh yes, they have activities; they put a buffet on for her birthday and I organised a singer" and "He plays curling, card games and board games; there's also quizzes and parties."

Health professionals told us, "If they notice a patient is deteriorating and nurses are required, they call us."

We saw people had assessments of their needs and risk identified prior to admission. Staff built on the assessments and kept them under review. Care plans were formulated from the assessments to provide staff with guidance in how to meet people's needs in the way they preferred. We saw some care plans contained lots of important and relevant information whilst others missed some minor care support issues, for example a person with a catheter had only a brief description of the support they required. However, in discussions with staff, it was clear they were knowledgeable and confident in describing people's needs and how care and support were delivered to people. For example, staff gave an accurate description of how they would support a person with management of their catheter. This included what they looked out for with regards to urine output and fluid intake, how they supported with personal hygiene and positioning of the catheter and drainage tube, the frequency of changes of the catheter bag, what concerns could arise and what action they would take. The registered manager confirmed they would ensure the full support that staff provided to the person was included in their care plan.

We saw staff delivered care to people that was individualised. In discussions with staff, it was clear they knew people's needs well and interactions between staff and people who used the service were very positive. One member of staff said, "One person likes to do her own hair, puts rollers in and takes them out herself. She has soft rollers so she can sleep in them." Staff told us who liked to remain in bed until later in the morning, who was an early riser, what distraction techniques they used when people became anxious and who liked to have a cooked breakfast. We saw staff were responsive to one person who required reassurance several times a day. The person was provided with written information about their personal belongings as this helped to remind them of where they were located.

Some people preferred to smoke and staff had responded by providing a designated room with appropriate ventilation to facilitate this.

There was a designated activity co-ordinator employed who provided a range of activities; these were highlighted in a notice board near the entrance. The activities included curling, board games, musical bingo, bean bag and hoop target practice, sing a longs, hand massages, arts and crafts, one to one chats and sessions with people and reminiscing about past events. There were also 'Oomph' sessions three times a week which were movement, music and fun interactions. Some people were able to take advantage of trips to local venues such as garden centres, cafes and a community club. There were seasonal activities,

celebrations of people's birthdays and lots of Christmas fun arranged such as a party, a trip to a local village to see the lights, attending a local school for the nativity play, visiting a local church and café for lunch, and an outing to the Christmas shop at a garden centre in Hornsea. The registered manager told us some people enjoyed going to the local social club as they could catch up with friends, play bingo, have lunch and time away from the home.

The registered manager also told us they were looking into obtaining MP3 players (for listening to music) and headphones so people who used the service could have their own playlist of music to help with reminiscence. They said, "Research has shown that this is very beneficial for the type of clientele we support and the next fundraising effort will be focused on obtaining more equipment for this."

We saw thought had been given to the environment to assist people living with dementia and respond to their needs. This included having wide corridors for people who used wheelchairs and hand rails to assist balance when walking. Toilet doors were painted yellow and toilet seats were blue in most of the toilets to help people's visual and perceptual needs. The registered manager told us all toilets would have blue seats eventually but purchase had been put on hold until a new supplier was sourced. There were pictorial signs reminding people of where toilets and bathrooms were. The clocks were set at the correct time and there were notice boards with pictures of staff and the activities to be provided. Fire extinguishers were held in tamper-proof containers.

There was a complaints procedure on display and this was provided to people in a 'service user guide'. The policy and procedure described timescales for acknowledgement, investigation and resolution. It also provided information of where people could escalate complaints if they were unhappy with the outcome of an investigation. Staff knew how to manage complaints. Relatives knew they could raise concerns or complaints with staff or the registered manager and gave specific names of the staff they would go to. They said, "I have raised concerns and they were always listened to and managed", "I'd feel happy raising concerns", "I'd raise issues with [Registered manager's name]" and "I raised a complaint and they sorted it."

The provider information return included information on complaints and stated, "All complaints are taken seriously and the ensuing investigation leads to fact findings which are then recorded and acted upon in the appropriate manner." We saw this happened in practice; there was a log of complaints which showed us these had been addressed by acknowledging the complaint, meeting with people or having phone calls to resolve issues and recording the outcome.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in September 2015, we saw that oversight of the service and monitoring of the quality of the service provided to people required improvement. Since the inspection, management arrangements have been reorganised and a new manager has been registered with the Care Quality Commission (CQC). There was a quality monitoring system in place in the service. This consisted of audits, surveys and meetings to seek people's views. Whilst improvements in quality monitoring were observed, there remained some shortfalls in the monitoring of records. For example, when checking the consistency of recording on fluid intake charts, the difficult to follow staffing rotas and minor shortfalls in care plans to make sure all needs are highlighted. The registered manager told us these areas would be addressed straight away.

Medication was checked regularly and audited monthly; we saw improvements had been made between the October and November 2016 audits. We saw the audits identified shortfalls that were then addressed with staff or the pharmacy. Although the medication audit checked security, stock levels of controlled drugs and the requirement for two signatures on administration to people, it did not check the recording of pain relief patch applications. The shortfalls found in medicines management during the inspection evidenced a need to audit this more closely.

We recommend the audit system, including medicines, is developed further to include robust monitoring of records and follow up when shortfalls identified.

Other audits had been useful in identifying areas to improve. For example, one audit included assessing and reporting on outbreaks of infections and who had pressure ulcers each month and how they were improving with district nurse input. There was an environment check to look at infection prevention and control, general cleanliness and the need to replace items. There was a monthly early warning tool completed by the registered manager which covered a range of areas such as health and safety, infection control, staff training and supervision, complaints, staffing levels, recruitment and retention, medication, a selection of care files and nutrition. We saw senior managers had completed numerous monitoring visits and reported on their findings. They had completed observations of staff practice, monitored mealtime experience for people who used the service, checked cleanliness, held drop-in sessions for families and spoke to staff. There had also been a monitoring visit from a lay Board member in November 2016; they had commented on the cleanliness of the environment and how staff worked with other agencies.

The registered manager logged accidents and incidents and recorded where these took place, the time they occurred, who was involved, any injuries and what action was taken. This helped to highlight any specific issues. The accidents and incidents that had occurred were minor but frequent and the registered manager told us an analysis was underway to look at how they could be reduced. The registered manager was to send CQC the results of the analysis when completed. Following the inspection, the registered manager told us the initial results of the accident and incident analysis had identified a specific time of day when more of them occurred. The review of staffing levels completed, alongside the accident analysis, meant an increase in staff at this time of day has been agreed and recruitment is underway.

Relatives told us they could not think of any improvements that could be made in the service. They knew the names of the registered manager and senior care staff. This told us the management team made themselves known to people and were available to talk to visitors. Meetings for relatives took place. One relative told us they had attended a cheese and wine evening organised so people could meet the registered manager and discuss any concerns. Comments included, "[Registered manager's name] has said their door is always open; I think there have been improvements", "The new manager has raised staff morale" and "Yes, the manager is available; there is an open-door policy." The registered manager said, "Drop in surgeries have been instigated to encourage relatives and significant others to meet with the home's manager."

We spoke with the registered manager about the culture of the organisation and their own management style. We found the registered manager was open in their approach and willing to learn from previous issues so improvements could be made. They wanted to ensure people who used the service were able to make their views known. The registered provider had developed a new survey which had been sent out to relatives to complete with their family member; these were due back in December 2016 for analysis. The registered manager described senior managers in terms of 'encouraging staff development', being 'very supportive' and 'actively listening'. We saw the telephone numbers of senior managers were readily available for staff to use when required.

The organisation had 'SHINE' philosophy" [expectations of staff behaviour that underpins HICA's values and vision]. There were SHINE awards that staff could achieve through nominations from colleagues or relatives of people who used the service. The Chief Executive Officer (CEO) and senior management had visited the service and made themselves available to staff should they wish to raise concerns. The registered manager told us the SHINE philosophy embodied staff delivering personalised care, tailored to meet people's individual needs. We saw this philosophy was translated into practice when staff supported people to meet their needs.

The provider Information Return stated, "At Longhill House we strongly believe that although mistakes can be made, the need to learn from any mistakes can only improve our work practices as we strive to improve in all areas of our respective roles. Support from the QA [quality assurance] team either by site visits, in conjunction with supportive visits from an experienced line manager, also offer advice and guidance as and when required. These visits are accompanied by further unannounced visits from the organisations CEO, fellow directors and lay persons. Actions plans are drawn up from these visits. The action plans are realistic and achievable which gives me confidence in the organisation and a true feeling of ownership of the home."

There were communication systems to ensure staff received information. At the service level, these included staff meetings, shift handovers, a diary to record appointments and concerns to follow up and supervision sessions. There were also meetings specifically for managers and bulletins and memos from senior management.

The registered manager worked well with other agencies and staff who supported people who used the service. The registered manager described a situation in which they had liaised with a social worker when a relative was struggling with paperwork and required assistance. They said support has now been put in place for the person. The registered manager liaised with health professionals when required in a timely way. Health professionals commented, "The manager and seniors are personable and professional. I believe Longhill House is managed well" and "Management is very helpful; always there to help if we have any questions."

The registered manager was aware of their responsibilities in notifying the CQC of incidents which affected the safety, health and welfare of people who used the service.

We saw the score awarded from a food safety inspection was displayed for people to see; this was '5', which was the highest rating possible ['0' being the worst and '5' being the best].

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured the proper and safe management of medicines. Some people had not received their medicines as prescribed. Regulation 12 (2) (g)