HICA

Longhill House - Care Home

Inspection report

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Date of inspection visit: 14 and 15 September 2015
Date of publication: 16/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Longhill House is situated in a residential area and close to local amenities and bus routes into the city of Hull. It is registered to provide personal care for up to 41 people, some of whom may be living with dementia. Bedrooms and bathrooms are located over two floors. There are two sitting rooms, a large dining room and a hairdresser's room on the ground floor and another sitting room, currently under reorganisation on the first floor. There is an enclosed garden with patio areas and seating.

The last full comprehensive inspection was completed on 23 and 24 April 2014; the registered provider was non-compliant in two of the six areas assessed which were care and welfare and staffing levels. We completed a follow inspection on 29 September 2014 and found the registered provider was compliant in both these areas.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008

Summary of findings

and associated Regulations about how the service is run. At the time of the inspection, the service had a registered manager who was also responsible for managing another of the registered provider's services.

This current inspection was unannounced and took place on 14 and 15 September 2015. At the time of the inspection, there were 32 people who used the service, although three of them were in hospital at the time of the inspection.

We found staff had not always followed policies and procedures regarding preventing and controlling infection.

We found the quality monitoring system had not been effective in highlighting some areas to improve and action plans had not been consistently produced in order to address shortfalls.

We found there were sufficient staff on duty to meet people's assessed needs. There had been and continued to be a reliance on agency care staff until full recruitment was in place. The recruitment system ensured employment checks were carried out to ensure potential staff were appropriate to work in care settings.

We found staff completed training in how to safeguard people from the risk of abuse. They knew what to do if they witnessed any concerns and who to report them to.

Assessments were completed to help staff minimise the risks people had with their daily living. Care plans were produced from assessments of need and mostly they contained good information about person-centred care. However, we found some care plans had not been updated fully when people's needs changed. The registered manager was to audit care plans to check this out.

We found people health needs were met with input from a range of professionals. Dieticians were involved if staff had concerns about people's nutritional needs. We found menus provided people with a range of balanced meals and there were choices at each meal.

We observed staff spoke to people in a patient and calm way. They provided explanations to them and offered them visual choices at meal times. We saw staff respected people's privacy. However, there were some instances when staff had not taken care of people's clothes and belongings.

We found staff ensured they gained consent from people prior to completing care tasks. In the main, staff worked within mental capacity legislation when people were assessed as not having capacity to make their own decisions. However, we found two instances when best practice had not been followed. Consultation with relatives had occurred but documentation was missing to reflect capacity assessments and decision-making. The registered manager told us they would address this straight away.

We found there were some activities provided to people who used the service but this had reduced recently. It was expected to improve over the next few weeks and return to the normal programme. We will monitor this at our follow up inspection.

Staff had access to induction, training and supervision. We found there were some staff whose training required updating. The registered manager had identified which training courses these were.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff had not always followed good hygiene and infection control policies and procedures. This could place people at risk of developing a health related infection.

There were sufficient staff to support people's needs although until full recruitment had taken place, some of these staff were agency workers. The recruitment process ensured employment checks were carried out prior to new staff working in the service.

Medicines were managed safely and people received their medicines as required.

Is the service effective?

Requires improvement

The service was not consistently effective.

In the main staff ensured people provided consent prior to care being carried out and when they lacked capacity to make their own decisions the principles of the Mental Capacity Act 2005 [MCA] were followed. There were two instances when decisions had been made to put in place restrictions after consultation with relatives. The principles of best practice with MCA of assessing capacity and recording best interest decisions had not been followed in these two instances.

People's health and nutritional needs were met; they had access to a range of community health professionals for treatment and guidance and they were provided with choices at each meal.

Staff received induction and training, although some courses required updating.

Is the service caring?

Requires improvement

The service was not consistently caring.

There were instances when staff had not taken due care of people's clothes and belongings.

Some confidential information relating to personal records had to be made secure on the day of inspection.

Staff were kind and caring when they interacted with people who used the service and their privacy was respected. They supported people to be as independent as possible.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

People's needs were assessed and plans of care produced but at times they lacked important information that would guide staff in how to fully meet their needs.

Activities were provided for people but these had been reduced recently as the activity co-ordinator had been needed for personal care worker care shifts.

There was a complaints policy and procedure to guide people who wished to raise a concern and staff in how to manage them.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Although there was a quality monitoring system, this had not been wholly effective in highlighting shortfalls and taking action to address them.

Senior managers had visited the service to speak with staff and check progress with refurbishment and redecoration.

Staff told us they felt able to raise concerns. They also said morale had improved and management were supportive.

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 unannounced inspection took place on 14 and 15 September 2015. It was carried out by one adult social care inspector and an expert by experience [ExE]. The ExE who was part of the inspection team had personal experience of caring for someone who uses this type of care service.

Prior to the inspection we contacted the local authority contracts and commissioning team about their views of the service. We also received information from the local clinical commissioning group. They told us there had been no concerns about the service raised with them. We also contacted the local authority safeguarding team; they had recently requested the registered manager to investigate an area of concern and this was still within the timescales required for an outcome.

During the inspection we spoke with three people who used the service and two of their relatives; we also observed how staff interacted with them.

During the inspection, we spoke with the registered manager [who arrived to support staff when they heard the inspection was taking place], a newly appointed personal care manager and two personal care workers, one of which held a senior position. We also spoke with a domestic worker, an activity co-ordinator, an administrator and an agency care worker. We spoke with a visiting health professional, however it was their first visit so they unable to provide any information about the service.

We looked at the care records of four people who used the service including assessments, risk assessments, care plans and daily recording of care.

We looked at other records relating to people who used the service; these included accidents and incidents, weight records for everyone, monitoring charts for six people and medication records for 20 people.

We also looked at a selection of records used in the management of the service. These included recruitment documentation for two staff, shift handovers, memos and notices, staffing rotas, communication methods, training and supervision records, quality assurance audit checks and minutes of meetings with staff and people who used the service.

Requires improvement

Is the service safe?

Our findings

The three people we spoke with who used the service all said they felt safe living in Longhill House. They said they received their medicines on time. One person said they thought there were enough staff most of the time but the period from getting up until about 10.30am was very busy as staff were assisting people with personal care. They said it changed after this time and staff responded quickly to calls for assistance. Comments included, "I'm happy enough here."

The two relatives spoken with were happy with the care their family members were receiving. Comments included, "I think so [whether people were safe], I know they will do another risk assessment when my dad is released from hospital. I feel mum is safe too, I'm very happy" and "He loves it here."

Despite policies and procedures and a good selection of protective equipment, we found some issues that could potentially spread infection; staff had not followed good infection prevention and control practices. We completed a check of the environment and found some hygiene issues that required attention straight away; these were mentioned to domestic staff on duty to address. We found a night catheter bag for one person placed on a stand in the en suite part of their bedroom; there was no cap on the connecting tube which had fallen onto the floor by the toilet. There was also a toilet brush placed in a vase on the floor in this room. In the laundry room, we observed staff had not washed some items of clothes and linen at the correct temperatures in line with good practice and the registered provider's policy and procedure. On people's beds, we found some quilts had splits in them which compromised the ability to keep them clean. In one person's bedroom, we found some cakes and a trifle in their fridge which were past their use by date. In the linen rooms, we saw items thrown onto the floor. In the shower room, we saw the drainage hole was encrusted with debris. In a bathroom we saw part of the floor covering had started to come away in one place. We found some of the first aid boxes had items that were out of date and some bins required lids.

Not ensuring good infection prevention and control practices 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 end of this report.

We found there were sufficient staff on duty to meet people's assessed needs. The staffing rotas highlighted a range of staff at different grades and skills. Staff confirmed there were sufficient staff in place now that a new personal care manager had been appointed. There had also been agency staff in place until recruitment was completed. This was well underway and the registered manager told us they were only awaiting final employment checks before new staff would start. Comments included, "The staffing levels are now better and we are recruiting more staff to have less reliance on agency workers", "We're alright with staffing although mealtimes can sometimes by busy" and "More staff have been recruited now the occupancy levels have gone up."

We found staff were recruited in a safe way. Employment checks were carried out prior to potential staff starting employment at the service. These included application forms, checks with the disclosure and barring service [which included a police check] and references. There was a selection and interview process.

We found staff completed assessments with people to help minimise risks during their activities of daily living. Care records showed these included falls, moving and handling, nutritional intake, skin integrity and the use of equipment such as bed rails and wheelchairs.

We found people received their medicines as prescribed. These were stored and recorded appropriately. There were some minor issues with medicines which were discussed with staff during the inspection so they could address them. These referred to ensuring GPs were contacted when people refused their medicines on a regular basis and minor recording issues such as clearer guidance for 'when required' medicines.

There were policies and procedures to guide staff in how to safeguard people from the risk of harm and abuse. In discussions, staff confirmed they had completed safeguarding training. They were able to describe the different types of abuse, the signs and symptoms that

Requires improvement

Is the service safe?

would alert them and what to do to raise concerns with their line manager and other agencies. We saw staff had followed policies and procedures and contacted the local authority safeguarding team as required.

Equipment such as the lift, moving and handling items, the nurse call and fire alarm systems had been maintained and serviced. We found call bell leads were missing from most of the bedrooms but these had been ordered and arrived on the day of inspection. Maintenance personnel ensured these were all in place and in working order during the inspection. We also noted a hot water warning sign was required for the sluice; this was mentioned to the registered manager to address.

Requires improvement

Is the service effective?

Our findings

The three people who used the service who were spoken with all said staff were sufficiently skilled and experienced to provide care and support to them. There were variable quotes about the meals provided. For example, one person said the food was 'reasonable' but they thought it was repetitive. Another person said they didn't like the food but said they got plenty to eat and drink throughout the day. A third person said they enjoyed the food and there was choice at each meal.

People told us they had choices about aspects of their lives. For example, one person said, "I decide when to get up and where to have my meals" and another confirmed they were able to walk about the service and choose where to sit during the day. People also told us the staff monitored their health and called their GP when required. They said, "Yes, they call a doctor and I have seen one a couple of times. I see a district nurse who takes my blood and a chiropodist regularly" and "They would get me a doctor."

Relatives told us they were involved in decisions about the care of their family member. One relative said, "Yes, they rely on me to sort out everything and I am currently sorting out Power of Attorney." Another relative said, "I have no issues about how they manage his health. They keep us informed. He never complains about the food and eats well."

We found people's health care needs were met. Documentation indicated people who used the service had visits from a range of health care professionals as required. These included GPs, psychiatrists, psychologists, district nurses, physiotherapists, dieticians, dentists, emergency care practitioners, chiropodists and opticians. People had also attended outpatient appointments, diabetic screening services and been seen by the falls team. The senior staff used a daily diary to record any health concerns which required follow up with professionals. We saw entries were made about contacting a person's GP for stronger painkillers and another entry reminded staff to refer a person to a dietician. Both these tasks had been completed.

We found people's nutritional needs were met. The lunchtime and evening meals were prepared and delivered frozen by an external company. The catering staff heated the meals in a specific oven and served them to people. Special meals, for example textured food or those for specific health or cultural diets were also provided in this prepared format. There was fresh fruit delivered and made available to people. The menus provided a selection of different meals over a four-week period. This ensured there were a variety of meals. We saw people were able to have a cooked breakfast each day. There was a selection of cold juices, hot drinks and snacks served in between meal times and at suppertime. We saw staff had assessed people's nutritional needs on admission and weighed them in accordance with a risk management score. This meant some people were weighed weekly and others monthly. People's weight was recorded in their care files and when any weight loss occurred, this was checked to see if the amount of loss was sufficient to trigger referral to a dietician. There were some anomalies with weight records and the registered manager was to check this out.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people subject to a DoLS at the time of this inspection; the registered manager was aware of the criteria for DoLS.

We found that generally the registered provider worked within the good practice guidelines of Mental Capacity Act 2005 [MCA]. For example, mental capacity assessments and best interest meetings had been held to discuss specific issues. We did note that two people preferred to have their door locked at night to prevent other people from entering. One person was able to give permission for this but another person had the door locked at night after staff consultation with relatives. Another person had their medicines administered covertly after a discussion with health professionals. Although both people did lack capacity to make these decisions, the documentation to assess capacity and evidence lack of capacity had not been obtained from health professionals or completed by the registered manager. We discussed this with the registered manager and they told us this would be addressed. Staff had received training in MCA and DoLS.

Staff were clear about how they ensured people who used the service consented to care and treatment. They described how they provided them with choice and

Requires improvement

Is the service effective?

alternatives. They said, “We ask people what they would like to wear and what they would like for breakfast and lunch, also where they would like to sit”, “We always ask them before any tasks and explain what we are going to do”, “We get to know what people want from care programmes, talking to their families and from social services. Some people communicate in a non-verbal way with nods. If people can’t consent there is a process of capacity checks and best interest meetings; some relatives have lasting power of attorney” and “If a resident didn’t want to get up, we would come away but keep checking.”

There was a four-day induction programme for new staff. This included awareness sessions on a range of topics and essential training, for example safeguarding, dementia care, infection control and moving and handling. The training record indicated staff completed training to build on information received during induction. The training documentation provided information on the courses completed and those due for refresher. We found there were several refresher training courses that were overdue; first aid courses were overdue by two years. The registered manager is to complete an analysis of training requirements and ensure this is addressed with the registered provider’s training section. The registered manager described how it had been observed that several staff required more training in how to interact with people living with dementia. This had been organised and staff spoken with said they had found it effective in providing them with approaches to use when assisting people living with dementia. Staff confirmed they completed training and said, for the most part, this was with workbooks for refresher training. We saw staff completed annual medicines competency checks. One member of staff told us workbook training was under review and they were to have more face to face training.

Staff had received formal supervision meetings with their line manager; we saw some staff had received more supervision than others and we were told appraisals were behind schedule this year. Now the service had a new personal care manager, it was envisioned by the registered manager that these shortfalls would be addressed.

We found the building was suitably adapted for people who used the service. Corridors were wide enough for people who used wheelchairs. There were handrails in corridors, toilets and bathrooms and the service had assisted baths and walk-in shower rooms. The dining room was large and spacious enough to accommodate people in wheelchairs. There were two communal sitting rooms on the ground floor and a room on the first floor that was being reorganised into another sitting room for people who wanted a quiet space. There was also a room for people who wished to smoke. We saw there were pictorial signs to assist people to find their way about the service and recognise specific rooms such as toilets, the dining room and sitting rooms.

Requires improvement

Is the service caring?

Our findings

The three people who used the service who were spoken with said staff respected their privacy, helped them as much as possible to be independent and had the right approach. One person who used the service told us a member of staff was 'a bit brusque', although they said they had not been unkind to them. This was mentioned to the registered manager to check out in more detail with the person who used the service. Comments included, "Yes, they knock on the door and I feel comfy with the care." People said staff knew them and understood their needs.

One person told us they had showers but they would prefer to have a bath. However, they said they found the bath uncomfortable. They also said there was a good atmosphere in the service but they didn't always feel involved. These points were mentioned to the registered manager to see if an appropriate cushion could be provided and to see if involvement could be increased for the person.

Relatives spoken with confirmed they had seen staff promote independence and had heard them provide their family member with options. They said staff provided individualised care. Comments included, "Yes, the staff get to know them and yes, they knock on doors", "The staff are lovely; I have overheard them talk to people and it's always ok", "Staff are absolutely lovely", "He looks much smarter and a lot cleaner here, he was letting himself go at home" and "Yes, absolutely 100% [caring] from the cleaners to the carers."

Prior to the inspection, we were told by a relative that staff had informed their family member during their respite stay of a situation they had been explicitly requested not to. They told us this had caused their family member distress. The registered manager told us this was caused due to a lack of communication and they would ensure this was improved to prevent a similar situation from occurring.

During an environment check we found some areas that could impact on people's dignity and comfort. For example, some people's clothes in wardrobes had not been put away neatly, the way laundry had been completed left some people's clothes covered in bits of tissue and there was a large bin in the laundry of unclaimed shoes and slippers. In one bedroom we saw the occupant was still in bed by choice but was awake; there was a flat sheet on the mattress that was crumpled and would have been uncomfortable for the person. The registered manager said fitted sheets were usually applied to these specific mattresses to stop this from happening. We saw toothbrushes were not maintained correctly in toothbrush holders and one person did not have their dentures in for breakfast although staff noticed this prior to lunch and fetched them for him. There were jugs of different juices and glasses on the table in both sitting rooms but when we checked later, none of the people who used the service had drinks in front of them. Some bedrooms could be more personalised. The registered manager told us these issues would be addressed with staff.

We saw bedroom, bathroom and toilets had privacy locks and each bedroom had a bedside cabinet with a lockable drawer for people to store items securely. It was unclear if anyone had a key to these drawers to lock up their items.

Staff, in discussions, were clear about how they would promote privacy and dignity. They said, "I always knock on doors before I go in" and "If you need to change people then you would do this in private in their bedroom or the toilet." Staff were observed speaking to people in a friendly and caring way. We observed staff diffuse a situation between two people who used the service; this was completed in a calm way and the people were comforted. We observed personal care workers assisting people into the dining room for lunch; the assistance was at the pace of the person who used the service and staff were seen walking slowly and chatting to people who were linking their arms. We observed the registered manager went to the local shops to obtain cigarettes for one person when they told them they had run out.

Throughout the inspection we observed lots of positive interaction between staff and people who used the service. It was clear all the staff knew people well and were able to talk to them about their relatives; we saw people responded well to the personal care workers. When we arrived at the service, we observed two people were walking about without appropriate footwear and one of them had their pyjamas on. Staff tried to engage the person to return to their bedroom to get dressed but stepped back when it was clear this was not their choice at that moment in time. We later saw the person had been assisted with personal care and looked smart. The other person was successfully encouraged to wear footwear to protect their feet.

Requires improvement

Is the service caring?

During lunch we observed staff were attentive and caring towards people who used the service. They asked people where they wanted to sit, they chatted to them, they provided two options for the main meal and the personal care manager gave people a visual choice of the options which was good practice to aid people living with dementia. We saw there were no clothes protectors offered to people at lunch and staff later told us this was because they had been washed and were not dry yet. Staff offered some people large napkins instead. During lunch, one person asked for a grated cheese sandwich instead of the main meal and this was produced along with a plate of vegetables; staff knew the person's preferences and we saw both plates of food were eaten. Staff checked with people to see if they enjoyed their meals and we heard positive responses such as "beautiful" and "lovely."

There were leaflets about advocacy services but staff told us most people had relatives to assist them to make important decisions and choices.

People's confidential and personal records held in care files were stored securely in the staff office. However, we saw care records due for archive were placed in a room on the first floor but the room had not been made secure. This was mentioned to the registered manager and addressed. Staff files were held securely and computers were password protected. We saw there were offices for staff to use to discuss confidential and personal information with health professionals or relatives.

Requires improvement

Is the service responsive?

Our findings

One person who used the service told us they would not like to make complaints. They said, “No, I wouldn't tell, I keep things secret; I have always been like that.” Another person told us they would tell staff if they had concerns. One of the three people spoken with said they liked to watch television in their bedroom but their TV was not working properly. We mentioned this to the maintenance worker, who was unaware of the problem and they fixed it straight away.

Relatives of people who used the service told us they would have no hesitation in raising concerns. They said, “I would see whoever is in charge; [Name of staff] has taken charge and I would speak to him”, “I feel comfortable telling staff what she likes, for example, she likes three pillows and sometimes she has one when I visit, so I tell them” and “My sister would complain; I don’t think there is anything they could improve.” One relative told us they had seen people playing skittles outdoors in the warmer weather.

People who used the service had their needs assessed and risk was taken into account when planning care. We saw the care plans contained information about people’s histories in a ‘map of life’. This detailed important relationships, family and friends, previous hobbies and interests and their work life. There was also information on people’s preferred routines, how independent they were with daily activities of living and what likes and dislikes they had. For example, one person’s routine page stated they liked to get up at 9am and enjoyed cereals or a bacon sandwich for breakfast. There was written information about people’s preferences for the gender of personal care worker. We saw one care plan included information and guidance from health professionals; this was very detailed with suggestions in how to manage the person’s behaviour which could be challenging to others. Staff had responded to some people’s needs by providing equipment such as sensor mats, special mattresses and pressure relieving cushions. We saw the registered manager was liaising with health professionals regarding specific seating requirements for one person.

We saw there were documentation sheets about people who used the service which were used to provide medical and nursing staff with important person-centred information during any hospital admission. The one we looked at stated, “Please use butterfly scheme” [a support system for people living with dementia] and “I have my tablets crushed or in liquid form.”

However, there were instances when important information had not been updated in plans of care when people’s needs changed. For example, one person had recently experienced episodes of anxiety and had received treatment for this from their GP. Their care plan did not fully reflect their needs in this area and the support staff should provide. In another care plan, the person had their medicines hidden in their food. Correct procedures had been followed regarding this decision but the care plan did not provide guidance about which foods would be appropriate and safe to administer the medicines in. In a third person’s care plan they had been seen by a dietician and specific nutritional measures suggested but these had not been added to the care plan. The dietician had suggested a selection of high calorie biscuits be placed in a waist bag for the person to have access to all the time but this was not seen on the day of inspection. We also observed during lunch that some people who used the service would benefit from easier to grip cutlery and rimmed plates. These points were mentioned to the registered manager to address straight away.

The activity co-ordinator told us they worked 23 and a half hours at present but funding had been agreed to increase this to 30 hours a week. They said they were in discussion about when this would start. The activities provided to people had reduced lately as the activity coordinator completed care tasks until new permanent staff were recruited. There were some activities still completed such as exercises to music, which we saw took place on the day of inspection. There was an activities board but staff said it was difficult to keep to the schedule. The activity co-ordinator described the activities that had taken place recently. They said people who used the service always loved sing-a-longs, they had curling tournaments, games, reminiscence work, outings, and arts and crafts. There were ‘Oomph’ sessions facilitated by an external company which consisted of chair exercise sessions and five people attended a local community centre on Tuesdays. The activity co-ordinator told us one person preferred to stay in their bedroom so they provided activities there such as singing hymns with them and supporting them with prayers.

Requires improvement

Is the service responsive?

We saw staff had responded to people's needs in relation to memory impairment. There were pictures on the walls with film stars and television personalities from the 40s and 50s which staff told us were used to stimulate conversation and the memories of people living with dementia. We saw bedroom doors were painted in different colours and all had photographs of the occupant to help them recognise their own room.

There was a complaints policy and procedure with timescales for acknowledgement. The procedure stated the length of time for investigation would be decided during discussion with the complainant. Staff were aware of how to deal with complaints. There was evidence the registered manager had met with a relative to address some complaints.

Requires improvement

Is the service well-led?

Our findings

People we spoke with were unsure who was managing the service as there had been some changes. One person said, "I think so [when asked if the service was managed well], I don't know who the manager is." They also told us they had not completed any surveys. We observed the registered manager walking about the home and chatting to people who used the service in one of the sitting rooms and the dining room.

Relatives told us there was a positive culture in the service and they felt able to approach staff or the registered manager if they wanted to make suggestions of raise concerns. Comments included, "I know there are meetings but I have never been to one" and "When they changed the food suppliers, I was invited to come in and taste the food; I am always welcome to stay for meals."

The registered manager told us the quality monitoring system consisted of monthly audits. The quality monitoring information was recorded on a specific tool for this purpose. This covered a range of topics and was scored. We found some areas of this system had not been effective in highlighting areas for improvement. For example, there had been insufficient call bell leads for a number of months but this had not been picked up during monthly checks of the system. Staff had recorded they had checked the nurse call system but failed to notice call bell leads were missing or failed to take action. This had resulted in people not being able to summon assistance. This situation had not been factored into the frequency of checks on people when they were in their bedrooms. This situation was resolved on the day of the inspection as call bell leads had recently been ordered and arrived and were fitted to bedrooms whilst we were there. Following another check, call bell leads were ordered for the remaining three bedrooms, which were vacant on the day of the inspection. Environmental audits had not picked up areas for tidying or cleaning. There had been limited checks on laundry systems. Care plan and medicines audits lacked action plans when shortfalls were identified.

We saw the monthly audits had been completed between March and July 2015 but they lacked information about actions which had been taken to address issues. We saw one action plan which had been produced following an audit in July 2015. This had the 'achieved date' as 'ongoing' for some areas, for example, training plans and the development of senior personal care workers; this did not provide a clear timescale to audit progress. A senior manager told us that the quality assurance system was under review at present and tools are being produced that would be linked to the Care Quality Commission's [CQC] Key Lines of Enquiry [KLOE]. The KLOEs are what CQC inspectors use to guide them when they look for evidence that the service is compliant and meeting regulations.

We could not locate any records of surveys completed to seek the views of people who used the service, their relatives, staff and visiting professionals.

Not ensuring the service had a robust quality monitoring system was a breach of Regulation 17 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 end of this report.

We saw the induction programme for new staff included awareness sessions on values and attitudes and also on codes of practice. The registered manager described the culture of the organisation and said that since a reorganisation of senior managers had taken place it had improved. They said, "Service users come first but we try to care for staff as well", "They listen to us more and ask us our views" and "Senior managers visit every two months; they were here last week." The registered manager told us they felt supported by senior managers.

We saw there was oversight by senior managers when they visited and the service had been redecorated and refurbished in certain areas. Senior managers had also completed a spot check visit at night in May 2015. Some issues had been identified such as the need for more dementia care training around staff interaction with people who used the service and this had been organised. A senior manager told us the registered provider was currently working with an external consultant to review the organisation's dementia strategy and dementia pathway training for staff. Policies and procedures were being updated and made reference to national good practice guidance. We saw the new Chief Executive of HICA [registered provider] had also completed a visit to the service in September 2015.

The registered manager had been in post since January 2015 but as they were also the registered manager for another service, they were only able to spend two days a week at Longhill House. Initially a deputy manager was

Requires improvement

Is the service well-led?

available to offer support but this ceased in May 2015. The inconsistency regarding management support and the uncertain future of the service had led to a period when staff morale had fallen. However, the occupancy levels have risen and staff told us morale had increased. Comments included, "Morale was really low a year ago and staff left but it's now getting better; occupancy is up and more staff have been recruited", "We seem to have had lots of management changes and last year morale was low but it's picking up now. Hopefully having the new PCM [personal care manager] will give seniors a chance to catch up with admin work", "I can see a difference in morale; it's getting better. It was at a low ebb when we were not full and the closure issue was on everyone's mind" and "We know everything is not right here yet but we are determined to get it back on track."

Staff spoken with told us the registered manager provided support. Comments included, "Management is good; you can speak to them if there is a problem" and "The manager is fantastic, very focussed on service users." We asked staff about communication systems and how these were managed so they were kept informed about important issues. Comments included, "It [communication] is not always great; sometimes we don't get to know things like changes in people's needs when we've been off." We checked handover sheets and found these were not always fully completed. This was mentioned to the registered manager; they were aware of some communication difficulties and had changed the handover recording system. It was hoped the new staffing arrangements and handover information would improve communication. The registered manager told us they would keep this under review.

We saw several meetings had taken place with staff and there was also one in May 2015 about activities held with people who used the service. The meetings provided people with opportunities to express their views.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 How the regulation was not being met: The registered provider did not have effective systems to prevent, detect and control the spread of infection. Regulation 12 [1] [2] [h]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered provider did not have effective systems and processes to ensure the service provided was safe, effective, caring, responsive or well-led. Regulation 17 [1] [2] [a] [e]