Equality Care Limited

# Longbridge Deverill House and Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

At the last inspection in January 2017 the service was rated inadequate. Following this inspection, we asked the provider to complete regular action plans to show what they would do to improve the key questions in Safe, Effective, Responsive and Well Led to at least good. This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

We discussed with the registered manager about ensuring there was continuous improvement in the delivery of care. While there had been improvements some areas needed time to embed into practices and to develop partnership working.

The Longbridge Deverill site provides care to 20 older people at Longbridge Deverill House located at the front of the grounds. Towards the back of the grounds is a 60 bedded nursing home divided into two purpose built units for people with general nursing needs and dementia care needs. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

People were supported to have choice and control of their day to day lives and they were supported by the staff to make some decisions. Documents showed staff lacked an understanding on when they were to assess people's capacity to make complex decisions. For some people the staff reached best interest decisions without consulting families and where lasting power of attorney were in place these individuals were not consulted.

Quality assurance systems were in place and action plans were developed on how shortfalls identified through audits were to be met. However, audits had not identified that frameworks to gain consent from people identified as lacking capacity were not meeting the principles of the Mental Capacity Act 2005.

Safeguarding procedures were in place. People told us they felt safe and staff told us they had attended safeguarding of vulnerable adults from abuse. The staff we spoke with knew the types of abuse and the actions they must take for reporting alleged abuse.

Systems were in place to identify and manage potential harm . Risk assessments to support people to take risks safely were devised and regularly reviewed.

Staffing levels were well maintained. There were sufficient staff to meet people's needs and staff had time to spend with people.

People received their medicines safely. Medicine administration records (MAR) sheets were signed to indicate when medicines were administered. Where people were prescribed medicines with specific instructions for administration we saw these instructions were followed.

People received effective care from staff who had the skills and knowledge to support them and meet their needs. Staff attended training set as mandatory by the provider and attended refresher training when the training had become outdated or expired. Staff had regular meetings with their line manager to discuss their performance, concerns and training needs.

People were supported to access health professionals when needed and staff worked closely with people's GPs to ensure their health and well-being was monitored.

Arrangements were in place to maintain the environment clean and we found the home was free from unpleasant odours. We saw housekeeping staff maintaining the environment.

We saw good interaction between people and staff. The feedback from people and their relatives was complimentary.  Staff knew how to respect the rights of people.

The registered manager monitored the quality of the service and looked for continuous improvement. The registered manager was supported by the provider.

## 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.

Medicine systems were safe

Risks were identified and action plans were developed on minimising the risk. Members of staff were knowledgeable on actions necessary to reduce risks.

There were sufficient staff to support people and we observed that staff were visible and available to people.

People said they felt safe and were able to describe what safe meant to them. Staff knew the types of abuse and the responsibilities placed on them to report abuse.

### Is the service effective?

Requires Improvement

The service was not effective.

Staff enabled people to make choices. People's capacity to make complex decisions were assessed but best interest decisions were taken without consultation from relatives or Lasting Power of Attorney where one was in place.

The staff had the skills and knowledge needed to meet the changing needs of people. New staff received an induction to prepare them for the role.

People's dietary requirements were catered for.

### Is the service caring?

Good

The service was caring

People were treated with kindness and with compassion. We saw positive interactions between staff and people using the service. Staff knew people's needs well and there was a calm and friendly atmosphere.

People's rights were respected and staff explained how these

were observed.

## Is the service responsive?

Good

The service was responsive

Care plans were person centred and people told us the staff knew how to meet their needs in their preferred manner. The care observed was consistent with the care plan guidance.

People had access to group and one to one activities.

The registered manager responded to concerns raised.

## Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were arrangements in place for continuous improvement. The views of people using the service were gathered through residents and relatives meeting. Quality assurance systems were in place and processes for assessing the delivery of care were in place.

Staff were aware of the values of the organisation. They said the team worked well together and the registered manager and nominated individuals were visible around the home.

# Longbridge Deverill House and Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 22 and 23 November 2017 and was unannounced on the first day of the visit. The registered manager was aware of our visit on the second day.

We used information the provider sent us in the Provider Information Return. 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.

Before the inspection, we reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by three inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 27 people about their experiences of care and treatment and to 10 relatives visiting family members at the time of the inspection visits. We spoke with the nominated individual, registered manager, the manager of Longbridge Deverill House, three maintenance staff, three activities coordinators, training manager, two nurses and five caring staff including seniors.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included 13 care and support plans, staff training records, staff duty

rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Good

# Is the service safe?

## Our findings

At the previous inspection we found a breach of Regulation 13 Health and Social Care Act Regulated Activities Regulations 2014. We found that staff carried out acts intended to control and restrain people without the lawful authority to do so. Staff lacked understanding around safeguarding people from abuse. Risk management systems were not effective in protecting people. We wrote to the provider telling them we proposed to impose conditions. The provider wrote to us telling us how the legislation requirements were to be met. We found improvements had taken place.

Medicines were generally managed safely. Medicines were stored securely, including those with additional security requirements. Medicine storage room temperatures were monitored; however, the room temperatures on Marques and Wylie had been recorded as running higher than the recommended maximum temperature on some occasions. For example, on Marquess on the second day of our inspection the temperature at 09.50 hours was 24.6 degrees centigrade and two days earlier it was recorded as 25.3 degrees centigrade. On some occasions staff had documented the action they had taken, such as "fan on", but this was not seen consistently. Additionally, when high temperatures had been recorded, staff had not always rechecked the temperature later in the day. The provider's medication policy stated "the temperature should be between 16-25 degrees centigrade". We discussed this with the Registered Manager, the Deputy Manager and the provider during the inspection and they said that were aware of this issue and were in the process of addressing it by installing ventilation.

Medicines in trolleys and fridges had all been labelled with the date of opening which meant staff were aware of expiry dates. Regular stock checks of medicines were undertaken to ensure people had sufficient medicines to take them as prescribed and had not passed expiry dates.
We observed part of two medicine rounds. On both occasions staff knew people well and knew the medicines they were prescribed and the reasons why. They informed people they had their medicines for them and asked if they were happy to take them. People were provided with drinks and the staff checked people had swallowed their medicines prior to signing the medicine administration record (MAR). We looked at all of the MAR charts and all had been completed in full.

When people were prescribed additional medicines on an 'as required' (PRN) basis there were protocols in place to guide staff about when people might require them. However, these were not always person centred and did not always provide staff with enough information. For example, some people had been prescribed anti-anxiety medicines, but the protocols in place did not describe the signs that people might present with, or the steps staff should take to try and relieve the anxiety before resorting to the use of medication. We discussed this with staff during our inspection and on the second day we were provided with an example of an updated protocol that was person centred and detailed.

Although MAR charts had photographs of people in place to help staff to recognise people, some of these had not been dated and others had been in place for up to two years. It was unclear if they were still a true likeness of people because they had not been updated.

The people we spoke with told us they felt safe living at the service. Comments made by people included, "feel quite safe, people around [staff and residents] makes you secure," "it does make me feel safe living here. Four walls and someone to help me. Very happy here," "safe because all my things are kept safe" and "yes I feel safe and well cared for, it's nice having people to look after you and ensure you are safe."

The Abuse and Neglect of Adults at risk procedure detailed the types of abuse and the expectation that staff respond to allegations of abuse. A flow chart accompanied the procedure and included the actions staff needed to take for reporting abuse along with contact details for the local authority safeguarding team. Also detailed was the follow up action staff needed to take such as informing commissioners.

Staff said they had received training on how to protect people from avoidable harm and abuse. The staff we spoke to knew the types of abuse and the expected actions to take for alleged abuse. Records showed that when staff had concerns about conflict or risk of harm between people using the service these concerns were reported. In one person's plan it had been documented that they expressed distress by being aggressive towards another person. The plan documented potential causes of distress for this person and de-escalation techniques.

Risks to people were assessed and managed to support people to stay safe. The staff we spoke with knew the actions needed to support people assessed at risk of harm. A member of staff said there were people at risk of falls, choking and with complex behaviours. They said people were supported with their mobility needs and where people were at risk of choking thickeners were used in fluids. Another member of staff said risks were assessed and for some identified risks referrals for specialist healthcare support were made. For example, Speech and Language Therapists (SaLT) gave staff guidance on textured diets for people who required them

The manager for Longbridge Deverill House told us risks to the person were identified during the pre-admission process and risk assessments were developed on how risks were to be managed safely. They said some people were at risk of "malnutrition and dehydration" and the actions included having snacks available between meals and monitoring food and fluid intake. Where people had a history of falls risk assessments were completed to assess the cause of the falls and to prevent reoccurrences. For example, referrals were made for physiotherapy input and pressure alarm mats were used in bedrooms. There were people who at times used aggressive and complex behaviours to show distress. Staff received training to support complex behaviours, used a calm approach and gave people time and space.

Care plans contained risk assessments for areas such as moving and handling, falls, skin integrity and malnutrition. Where risks were identified care plans contained clear guidance for staff on how to reduce the risk of harm to people. Where people were at risk of falls an assessment was completed on the areas of risk to identify an overall risk level. We looked at the plan for one person who had been assessed as a high risk of falls due to vision impairment and the symptoms of this were listed. It was also documented that some of the person's medicines might increase their risk of falling. The person could walk unaided, and staff were guided to promote independence whilst maintaining the persons safety. The plan detailed that staff should ensure the person wore well-fitting shoes and that their glasses were always clean. We observed this person during the inspection and saw that their glasses were clean and their slippers fitted well. We also saw that staff offered assistance when needed, but enabled the person to move around on their own.

The moving and handling risk assessments for another person assessed at high risk of falls due to a poor level of awareness and mobility impairments listed the equipment and the number of staff needed for all transfers. The care plan gave staff guidance on how to support the person to stay safe. For example, trained staff to support the person with transfers, alarms to be used when the person was in their bedroom and the

profiling bed was to be at the lowest position to prevent falls.

Some people had been assessed as being at risk of pressure ulceration. The Waterlow assessments for one person had identified them at high risk of pressure ulceration due to continence and mobility needs. The skin integrity plan directed staff to report signs of skin breakdown such as redness. Pressure relieving mattresses were used, staff were to reposition the person four hourly and a well-balanced diet to be served. We saw body maps were used to illustrate the location of skin breakdown on the body. The review of the care plans showed the pressure ulcer had healed. Monitoring charts showed that people had their positions changed in accordance with the care plans. All of the air mattresses we looked at were set correctly.

The mental health care plan for one person stated, "can become distressed and become verbally and physically aggressive towards staff". The Mental health team were involved in supporting the staff to support complex behaviours. The action plans was for staff to enable the person to make day to day decisions. The staff were to be patient and where appropriate use distraction techniques such as talking about interests. Staff to be aware of their proximity to the person and to "walk away" for 15 minutes and try again. The staff knew the actions needed to support people that became distressed and show aggression. They said people were given time to become calm, staff swapped as some people responded to "different [staff] faces". A member of staff said some people responded to "banter". Another member of staff said one person at times showed behaviours that were "unpredictable, "refreshments were offered and by the time it was prepared the person was usually calm.

A member of staff told us incidents were reported and investigated. They said there were discussions about "what can be changed." Records showed that incidents were discussed with staff to prevent the risk of recurrence. Another member of staff said the registered manager analysed accident or incident reports and care plans and risk assessments were reviewed following an incident or accident.

Personal Emergency Evacuation plans (PEEP) were in place, with specific information to support individual needs. PEEP included the person's ability to leave the building safely, the assistance needed from the staff and the number of staff needed. Also detailed was the evacuation meeting point. These plans were reviewed monthly to ensure the action plans were correct and up to date.

People told us there were enough staff on duty and when they were in their bedrooms the call bell system was used to gain staff attention. Comments from people included "use the call bell system- never a long wait. If there is a crisis a longer wait but that is understandable," "Enough staff so there is never a long wait," "Enough people [staff] about to help, usually someone around". This person also said that staff responded when they used call bells to summons support and also stated that at night "they get to me at night quickly."

There was enough staff on duty to meet people's needs. Staff comments included "Agency use had gone down and we are recruiting new staff. We have enough if nobody goes off sick" and "99% of the time we have enough staff". One visitor to the service said, "It always feels like there is enough staff. It's certainly been fine lately." A member of staff on Marques unit told us the staffing ratio was four staff in the morning, three in the afternoon. Another member of staff told us that at night there were two staff on each unit and two registered nurses working across four units.

The manager of Longbridge Deverill House told us staffing levels were based on the needs of the people living at the service. They said at present there were 16 people living at the service and three staff, a senior or manager were on duty in the mornings and two carer and a senior or manager in the afternoon. At night two waking night staff were on duty. Also recruitment had taken place for two vacant posts and in the meantime agency staff were being used.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and conduct. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. Staff we spoke with confirmed these checks had been completed before they were able to start work.

Staff understood their responsibilities in relation to infection control. All said they had completed infection control training. They knew when to use personal protective equipment (PPE) and we saw that staff used gloves and aprons when providing personal care and when assisting people with food. Hand gels were available throughout the building and we saw staff using it.

We found the premises clean, hard to reach areas had received attention and all areas were free from lasting odours. We saw housekeeping staff on duty throughout the day and a member of staff told us that cleaning schedules were in place.

Comments from people included, "Very clean room-cleaned every day. Toilet very clean," "Very clean-everywhere's very clean" and "Cleaners really good, come in, clean and chat." A relative told us "Spotless room-very clean."

We found the floor covering in the office and the staff toilet in Longbridge Deverill House needed repairs or replacements. We spoke with the registered manager about repairs and we were given reassurance the repairs will be taking place.

Requires Improvement

# Is the service effective?

## Our findings

At the previous inspection we found a breach of Regulations 11, 15 and 18 of Health and Social Care Act Regulated Activities Regulations 2014. We found the provider was not working within the scope of the Mental Capacity Act 2005. Care plans were not underpinned by the MCA act and authorised restrictions on people. Restrictions were in place where by the lawful authority had not been sought or gained. The environment was not safe as a pathway between the two sites was unsafe. An electrical cupboard was accessible to people and a door way leading down to a cellar was left open and could cause injury from a fall. We wrote to the provider telling them we proposed to impose conditions. The provider wrote to us telling us how the legislation requirements were to be met and the CQC received monthly progress action plans on how the breaches of regulations were to be met. We found some improvements had taken place

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.

Mental Capacity (2005) procedure detailed the principles of the act which specified that where people had a cognitive impairment their capacity to make complex decisions must be assessed to then make best interest decisions in consultation with family and professionals where appropriate.

The registered manager and staff received guidance from the local authority around the completion of Mental Capacity Assessments and Best Interest Decisions.. Mental Capacity Assessments had been completed, but the decisions were not always relevant and there was no overarching assessments regarding consent to care and treatment. However, for some people staff had not fully considered all areas of the complex decision in the capacity assessment. DoLS conditions were recorded in the care plan and the plans evidenced that these were reviewed monthly as required.

Although people were assessed for their ability to consent to certain aspects of their care, when people lacked capacity, best interest decision documentation did not always provide a clear picture of who had been involved in the decision or how the decision had been reached. For example, the clinical intervention capacity assessment for one person living with dementia established they were unable to retain or understand the information. The best interest decision was taken by staff for this person to have medical intervention as appropriate. However, the decision was reached by the staff but families were not consulted. For another person consent for flu vaccination was signed by a relative without lasting power of attorney in health and welfare. The senior told us the incorrect form was used. They said for this person the staff were to request from their relatives their views on their family member having the flu vaccine instead of gaining their consent. This meant staff were not always clear when it was appropriate to consult relatives or when to gain consent because the relative had lasting power of attorney.

People told us the day to day decisions they made. Their comments included "My family make all the

decisions," "My wife makes all the decisions," "I choose all my own clothes and jewellery" and "I make any decisions that need making." The staff we spoke with knew the day to day decisions people made. A member of staff said "people make decisions about their meal. They have choices of meals, clothes to wear and activities."

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 authorisation procedures for this in care homes and hospitals are called the 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. Conditions of the DoLS imposed were being met and reviewed.

Where Do Not Attempt Resuscitation (DNAR) notices were in place the GP completed the mental capacity assessment in consultation with the person and their family where appropriate. The notices detailed the person's capacity to make the decisions, the family members consulted and the rationale for allowing natural death. For example, one person lacked capacity to make the decision about having a DNAR notice and the decision was reached with the person and their family to allow for natural death but can be treated with oral antibiotics.

People's needs were fully assessed prior to moving to the service and the care plans we looked at provided detailed information for staff on how to meet people's needs in a person centred way. A relative told us "the home was recommended" and they were able to look around the home before their family member moved to the home. A member of staff said when people were admitted a short term care plan was devised. They said during the admission process people were given information about living at the home such as using the call bell system and meals. Staff were told about the admission during handovers and instructed to read the short term care plan. A comprehensive care plan and risk assessment then followed. People told us they liked the staff and the staff knew how to "care for them."

The Training Manager explained the different styles of training used that was dependent on the member of staff. For example, "We do one to one and small group sessions, or I give out questionnaires to those who don't like to be in the group training. With the fire training the new starters watch a DVD, complete training." A relative told us there was a consistent approach and there was a "corporate approach to training."

New staff received an induction to prepare them for their role. Staff inductions and shadow shifts were dependent on the training needs of staff. For example, one new starter new to health and social care received a four day induction and had been shadowing for four weeks. The Training Manager explained that with all new starters their training was assessed against the Equality Care Limited standards and refresher training was provided if there were areas which were not at the required standard. They explained that new staff knowledge was tested through questionnaires and observations to ensure their practice were up to date. A new member of staff told us they had vocational qualifications to level two and three and their induction was based on refreshing some training such as the Equalities Diversity and Human Rights (EDHR) because this training was out of date. They said shadow shifts had been organised and was mostly to gain an understanding of people's routines.

Staff had the skills and experience to fulfil their roles. The Training Manager said specific training was sourced and dependent on needs of people receiving care. The Training Manager explained that the nurses will give feedback on training needs and relevant training would be sourced.
A workbook had been sourced for Dysphagia training; and the home also worked with external agencies for additional training support. Nurses said they had access to professional development in order to meet their professional registration requirements. They said they had access to the local hospice for specialist training

and had attended other training sessions specific to their roles. Comments included "We are so lucky to have a full time trainer here. So much training is available" and "I've been on so many courses since I've been here, such as wound care and end of life care". Care staff also said they had access to training and development. Comments included "The trainer always makes sure we're up to date with all of our training".

All of the staff we spoke with said they had regular supervision sessions. Additionally, all said that if they needed support between supervisions they knew who they could speak to. For example, one staff member said "I have supervision every couple of months, but I know I can always speak to the lead nurse on the unit if I need to".

People were supported to have enough to eat and drink. They told us the food was good and their comments included "The food is wonderful in here and the desserts are not too sickly," "I get plenty to eat and drink here," "The food is good and they will always help me if I want help and cut it up for me".

The chef told us menus were devised by the catering staff based on their knowledge of people's likes, dislikes and dietary requirements. There was four week rolling menu and there were choices of meals at all mealtimes. For example, a three course lunch was served and included soups, a choice of main meal and choices of desserts. We saw a large whiteboard in the kitchen that detailed people's name, their photographs, date of birth, known allergies, likes and dislikes as well as specialist diets. The chef told us cakes were baked to celebrate birthdays.

The chef told us 90% of the food was prepared fresh at the home and people's feedback was gathered about the meals. They said a comments book was in each unit for people to record their feedback about the food.

When concerns were identified about weight loss or swallowing difficulties, care plans showed that advice and support had been sought. For example, one person had been reviewed by the speech and language therapist (SALT) during the previous three months. The care plan contained details of the required food texture and the number of scoops of thickener the person needed adding to their drinks. Additional guidance within the plan was detailed, such as the position the person needed to be in when being assisted, and the type of cup to be used. The plan also informed staff to not distract the person when assisting them to eat or drink. This was because it could increase their risk of choking. We observed staff assisting this person with their lunch and saw that the care plan guidance was followed.

When people were having their food or fluid intake monitored the charts that we looked at on Stourhead and Deverill units and Longbridge Deverill House had been completed in full. Daily targets were documented on the charts and in the majority of cases these were met. However, for people in Marques the daily fluid intake chart was not fully completed and showed some people were not reaching the target fluid intake.

We observed lunch on Deverill. Some people ate in the dining room and others chose to stay in their rooms. Staff informed people what the food was as they brought it to them. Although most of the staff asked people if they wanted gravy before pouring it onto the meal, we observed one staff member who didn't ask first. When one person said they didn't want what was on offer, staff immediately arranged for an alternative. Another person asked for some soup and the chef went to get some for them.

People were registered with a GP; they had access to specialists such as Speech and Language Therapists and regular check-ups from dentists and chiropodists. The people we spoke with said they had visits from

their GP and they were able to request visits. Staff documented visits from healthcare professionals. We saw recorded the nature of the GP visit and the advice given.

Nurses said the service had a good working relationship with the GP. One said "I've rung and asked the GP for advice today because someone woke up not feeling so good. They're very accessible". Care plans detailed people's specific health needs. For example, catheter care plans detailed the signs and symptoms of infection and the steps staff should take to prevent these occurring. When people had been reviewed by health professionals the recommended guidance had been clearly written into the care plans. For example, plans for people with diabetes included signs and symptoms of low blood sugar and the blood sugar levels that were normal for that person were highlighted.

We found Dementia friendly features in the premises. Areas were differentiated by the use of pastel colours on the walls. Art work was suitable for people living with Dementia. Room doors were painted different colours and were clearly labelled with peoples' names and for some people their photographs. There was pictorial signage to help people identify toilets and bathrooms. Memory boxes were installed on the bedroom doors with photographs and or art work relating to peoples' interests which helped people identify their bedrooms. They also gave visitors and new members of staff a starting point for conversations. The comments from people included "Like my room, a brilliant place to live in," "room got the best one in the place" and "like my room very much- I have my own phone and own furniture".

People had views across the surrounding countryside and bedrooms had a view of the surrounding area. . The garden area was safe and well maintained. A safe courtyard/garden area was available for people accommodated in the Longbridge Deverill House and people in the nursing home can also use it when the weather is suitable.

Good

# Is the service caring?

## Our findings

People were treated with kindness, respect and compassion but the staff's delivery was not always considered in one unit when they were supporting people living with dementia and a visual impairment. During our observations there were very positive examples of staff supporting people who displayed behaviours that may challenge the service. These staff demonstrated their knowledge and understanding of the person. However, there were also examples where one person was observed to be withdrawn and staff were not always aware of the needs of individuals who were not communicating verbally. The daily recording notes identified that at times one person was "self-isolating", but staff did not use the information to provide one-to-one time instead of group activities. We observed there were few attempts by staff to engage with this person and when the person made attempts to communicate the staff missed the signs. We saw this person enjoying one to one interactions with the staff but these were not explored further. The manager explained the staff were getting to know this person, but acknowledged that more time should be invested in this. The feedback was also taken on board regarding recording the interactions that aren't part of the main group activity as a way of evidencing a person centred approach.

We also observed in other units many positive interactions between staff and people using the service. For example, we heard staff compliment people on their hair after visiting the hairdresser, we saw that staff crouched down to people's level when speaking with them and we saw and heard staff speaking to people in a friendly and open way. People appeared relaxed around the staff; they were smiling and talking to staff. The atmosphere was calm and friendly.

Members of staff knew the importance of developing relationships with people. A member of staff said "everybody is different. Some people you can have a banter with and others like to hold your hand." They said trust was developed overtime by "talking to people at eye level." Another member of staff said, "I introduce myself, I ask for consent, I explain the task and I offer assistance. I respect people's choices." The registered manager told us "the philosophy is resident first which includes dignity, respect, choice and listening to people. We are a community we spend a lot of time together. I am out observing care, if I see practice I don't like I address it there and then".

Comments made from people included "Very caring. I wanted a bag for my walking frame. Carers showed me some on her phone, picked the one I wanted and she ordered it for me. A little thing but makes an awful lot of difference," "Caring and kind. Very good. Staff have a sense of humour-good laugh with them, "Whenever I wake up in the night always so cheerful and helpful" and "Staff wonderful. Help me get dressed. They are extremely helpful, come and fetch me to things, drop in to see me. Make me birthday cakes."

Comments made by the relatives included "Care for him, care for us," "Staff on this unit [Wylye] are fantastic – never witnessed any bad practice-no concerns," "Can't fault the care" "A debt of gratitude to the whole team. Made life bearable," and "Carers communicate with him. Responds well to staff and the manager-comes in to see him often."

Overall staff had information on how to develop person centred care plans. My life story detailed family

network, education and past employment, hobbies and pastimes.  For one person we saw recorded in the "Getting to know me" section of the care plan their preferred first name, interests, work history, likes and dislikes. In all other units staff demonstrated a full understanding of people's needs and preferences. They fully understood people's preferred routines and personalities. Staff said they had been involved in writing the care plans and had read them. It was clear from observing staff that they knew people's needs because they were providing care as documented within the plans we had read.

People's rights were respected by the staff. Staff knew how to maintain people's dignity. Comments included "I always knock on people's bedroom doors, ensure the door and curtains are shut during personal care, and give people choice about what to wear and where to go. We treat the residents as if they were our parents" and "The care is really good here. People get offered a bath or shower every day, we make sure every person is treated well. For example, everyone here will have clean finger nails, it's important"

Good

# Is the service responsive?

## Our findings

At the previous inspection we found a breach of Regulations 9 of Health and Social Care Act Regulated Activities Regulations 2014. We found people did not receive appropriate care and support which met their individual needs during meal times and were not supported to make choices about the meal preferences. There was a lack of social interaction and meaningful occupation for people. Care records were not person centred and reflect the person's preferences. We wrote to the provider telling them we proposed to impose conditions. The provider wrote to us telling us how the legislation requirements were to be met. We found improvements had taken place.

Most the people we asked said they were not aware of having a care plan. One person said "I do have a care plan and I don't disagree with it at all." Another person said, "Staff chat to me about my care from time to time." A relative said, "the care plan is discussed with me and we go through it, they let me know of any medicine changes or a hearing issue."". People told us staff knew about their preferences. For example, "I can stay in bed if I want to but I like to get up if I can or I can sit in my chair or stay on my bed," and "it's up to me really." The care plans we looked at were person centred and we saw there was a clear emphasis on people's preferences in relation to how they received their care. Staff understood what "person centred" meant and were able to explain in detail the ways in which people preferred to receive support.

Care plans were reflective of people's needs and interactions observed corresponded to information that had been recorded. Staff said care plans were devised by the seniors and registered nurses. A member of staff said "Its very person centred here. We're resident focussed rather than being commercial". Another member of staff said "we go through the [care plans]. I notify XX if they need to change the care plans". Another member of staff said care plans were more person centred and the information on how to care for people had improved.

Records showed the staff contacted relatives to keep them informed about important events such as GP visits. Care plan review meetings showed people attended care plan reviews and their relatives were invited to review meetings. The minutes of the care plan review for one person detailed the areas of need discussed. Also recorded were areas of concern raised by the relatives, their suggestions and the actions to be taken to improve the delivery of care.

Admission profiles included personal details, next of kin, medical history, reason for admission and legal power of attorney where there was one. Where DNAR notices were in place this information was also recorded on the admission profile.

Care plans in relation to people's personal care needs were detailed. For example, people's preferred clothing choices were listed, whether they preferred male or female staff to assist them, and whether they preferred a bath or shower. Additional details such as one person who preferred staff to blow dry her hair and male preferences for wet or dry shaves were also documented. The personal care for another person defined their daily routines. For example to have their breakfast in bed before staff support them with personal care and "likes to wear her hair short".

Some people using the service occasionally displayed behaviours that staff and other people using the service might find distressing. The personal care plan for one person stated they required the assistance from staff but at times offers of support was resisted. A member of staff said this person was able to manage their personal care but needed reassurance from having a member of staff present. The action plan detailed this person required prompting from one member of staff. Actions plans gave staff guidance on the actions staff must take if the person refused their assistance. For example, the staff were to be patient and give the person time. Where the person consistently refused the staff were to seek guidance from the registered manager of senior on duty.

Mental Health care plans for one person detailed the medical condition and gave staff guidance to encourage the person to take their medicines. Staff were to reassure the person if they became disoriented and to avoid contradicting them. However, more detail was needed on the signs of deteriorating mental health.

People's accessible information needs were assessed. Their information and communication needs were identified and action plans were in place on how to meet their accessible needs. The communication care plan for one person detailed their ability to communicate verbally. For example, "responds to questions using simple yes and no responses". The action plan was for one staff to introduce themselves and if the person did not respond, to give them time. Instructions were also included for staff to engage in conversation by talking about favourite interests such as gardening and family.

The communication care plan for another stated "it is important for staff to communicate in writing with short concise sentences" due to hearing impairment staff were to give the person time to understand and react to what was being discussed. Staff were instructed to write in black ink on a white board as the person had visual impairments.

People's life story and background history were gathered and for some people included their education, employment history, important dates and anniversaries. For some people their interests, likes and dislikes were detailed with their personality and how others describe them. For example, sociable, excellent wife and mother, caring and good sense of humour.

The activities coordinator had organised a diary for each person which assisted with communication. In the diaries there were signing in sheets for staff and visitors, monthly review pages with evaluation and outcomes, The programme of activities included music, yoga, Holy service, photography and sewing. One to one activities were also arranged and these took place in bedrooms. We observed one person was sewing with a card as this was an interest they pursued. On fireworks evening the activities coordinator had organised an indoor fireworks display using a projector to music, people were given homemade sparklers. Children from local schools came in to sing regularly.

Some people said they did not participate in activities while others made the following comments "every month we get a schedule of what is on. Been to an exhibition in the village hall, no trips other than that [I] would like to get out more." "Carer comes up to play scrabble with me." There are "team activities, crosswords, people sing like to join in with things." "Yes I try to take part in some of the activities if I can, I have no idea what my favourite is but we do get a lot of different choices in here" and "I also do creative writing on a one to one basis which I really enjoy."

Most people said they had not made a complaint or had cause to make a complaint. Comments made by people living in Longbridge Deverill House said "If thing go wrong I talk to the people here first-sure it would be put right" and "if I had a complaint [I] would talk to the manager here. She is very good." One visitor to the

service said "I haven't needed to complain for a long time. If I'm not happy, I will go and see the manager or the owner". Copies of Longbridge Deverill's complaints procedure were clearly displayed. This contained information on how to complain and the external agencies to be contacted for unresolved complaints. The registered manager received eight complaints in 2017 and each complaint was investigated and responded to appropriately.

People and their family were involved in planning and making decisions about their end of life care. End of Life plans had been written and people's preferences and choices had been taken into consideration. For example, the end of life plan for one person included their wishes for staff to liaise with relatives about their end of life care. Where do no attempt resuscitation (DNAR) notices were in place this information was recorded. Staff were proactive in recognising when people were approaching the end of their lives. For example, medicines that might be needed had been prescribed to ensure that people were kept comfortable and pain free.

Requires Improvement

# Is the service well-led?

## Our findings

At the previous inspection we found a breach of Regulations 17 of Health and Social Care Act Regulated Activities Regulations 2014. Although the provider had systems in place to audit the quality of the service received however concerns which had been identified were not followed up to ensure action had been taken. Not all of the concerns we found had been identified. There was a lack of direction and leadership in the nursing home. Communication between staff was not always respectful. We wrote to the provider telling them we proposed to impose conditions. The provider kept us informed on the improvements made and where shortfalls were identified the action plan listed the date for completion. We found improvements had taken place

Systems were in place to assess and monitor the delivery of care. There was an overarching improvement plan that related to care planning, nutritional assessments, infection control, Health and Safety. The timescales for meeting the improvements were listed with the staff responsible for achieving the plan.

A local authority commissioner visit took place in July 2017 and the report included the recommendations made. The records reviewed showed advise in relation to mental capacity assessments were not followed or the procedure in place. Audits had not identified that the principles of the Mental Capacity Act 2005 were not being followed for people lacking capacity. The registered manager told us the aim was to get staff "thinking about assessing people's capacity" and other commissioners preferred for the staff to have mental capacity assessments for each specific decision instead of having overarching assessments for care and treatment.

We saw a matrix of the audits completed which included care planning, nutrition, staff training, accidents and incidents. Quarterly care plan audits reflected that the content of the care file was assessed however, there was no assessment on the quality of the information and if it was person centred.

Medication audits were undertaken regularly. We looked at the latest Pharmacist Advice reports, where no major issues were noted. Infection control audits were undertaken regularly. When actions were identified, all had been completed.

A registered manager was in post. The registered manager and nominated individual were present in different units of the home during the inspection, interacting with people and speaking with staff. Staff spoke highly of the registered manager and of the morale at the service. Staff said the registered manager was "very open, very hands on", "knows all of the residents" and "she is very person centred". One member of staff said "It felt very institutionalised before the [registered] manager came here". Other comments about the team working included "We've all worked so hard for this inspection. We've really pulled together", "Staff enjoy working here" and "I'm really proud to work here".

The staff had a good understanding of the organisations vision and values. The manager of Longbridge Deverill House told us the emphasis was a person centred approach. They said the aim was "getting staff away from being task orientated." Staff said the management team were approachable and available; as

well as knowledgeable about those living at the service. The staff were also positive about team working. Their comments included "I like the team even the housekeeping staff. We all bring different "traits to the table," "at night there is good support [between staff]. A member of staff told us that Longbridge Deverill House had a "homely environment, staff stay. It's a family."

People told us "A very happy place, a good place. Staff were ok everybody happy altogether and Friendly atmosphere. Good will and you can feel it." A relative said "Definitely a friendly atmosphere". People told us feedback about the delivery of care was not gained through surveys. Some people told us they had a "chat" at residents meetings. The registered manager said there were "meetings with relative and staff. We have been open and transparent with anyone that enters [about the rating of the home]."

There was open and transparent communications with staff and people as well as those that mattered to them. One person said they attended "residents" meetings. The minutes of the carer's meetings detailed areas discussed which included the previous inspection report and activities. Staff meetings were taking place and at the meeting in July 2017 the inspection process was discussed.

Clinical meetings took place regularly. The minutes of these showed that individual people's needs were discussed, monitoring of people at risk and best practice was shared. Clinical investigations were shared with the clinical team in order to learn from incidents or errors. We heard care staff discussing with the deputy manager about a topical cream and lotion audit. The staff were working together to review how creams were recorded along with the use of instructions and body maps.

Managers meetings and Operations meetings took place regularly. Staffing levels, complaints and compliments were all regularly reviewed. The registered manager told us "the owners visit weekly and are contactable. [There was] trust from the owners to move the home forward. I use my skills and they let me run the home".

The registered manager told us about the challenges which included the recruitment of good staff instead of "making up staffing numbers". They said there were good working relationships with external social and healthcare professionals.

The registered manager had recognised the importance of continuous learning and ensuring sustainability of the service. They said at clinical meetings there was reflective practice which motivates staff and get the message where I want it to go. Learning is shared to the nursing staff. Staff feel motivated because they see the [registered] manager and the deputy, they feel safe with us. Staff have to see changes for them to change their attitudes." The registered manager also told us they "challenged attitudes" of the staff as previously staff had a "to do attitude" towards people and the aim was to breakdown barriers. It's about not giving in and going forwards."

There were links with external agencies and the local community. The registered manager said there were good working partnerships with GP and Care home liaison team. This registered manager also told us there were visits from the local school, volunteers were used in the home and visits to pubs were arranged. We spoke with a Speech and Language Therapist (SaLT) who told us the staff made referral for support in a timely manner and their guidance was followed. A volunteer told us they had experience of the home and "wanted to give back for the care their family member received from the staff."