Larchwood Care Homes (North) Limited

Belmont

Inspection report

Inglewhite Road
Longridge
Preston
Lancashire
PR3 2DB

Tel: 01772782031

Date of inspection visit:
21 July 2017
25 July 2017

Date of publication:
16 August 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 21 and 25 July 2017.
Belmont is situated in a rural location on the outskirts of Longridge. The service is registered to provide personal care and accommodation for a maximum of 49 people. Accommodation is provided in 46 bedrooms with en suite facilities. The home is a single storey building divided into four units, each with its own lounge, dining room and kitchen. There are two other large communal rooms mainly used for activities and social functions, and outdoor areas people can use. At the time of the inspection 41 people lived at the service.

At the last inspection on 17 April 2015, the service was rated 'Good'. At this inspection we found the service remained Good.

People had received their medicines as prescribed and staff had been trained in the safe management of medicines. We found areas that required improvement in the medication storage. The registered manager took immediate action to make the required improvements during the inspection. Medicines were stored securely to ensure they were safe. There were risk assessments which identified risks to people and management plans had been put in place to ensure people's health and well-being were maintained.

The registered manager understood the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People's consent to various aspects of their care was considered and where required DoLS authorisations had been sought from the local authority. However, improvements were required in relation to staff knowledge and understanding of mental capacity.
Staff had received regular training and supervision to ensure they were supported in their role.

The registered manager had systems in place to record safeguarding concerns, accidents and incidents and take appropriate action when required. Recruitment checks were carried out to ensure suitable people were employed to work at the home. Our observations and discussions with staff and people who lived at the home confirmed sufficient staff were on duty. Risk assessments had been developed to minimise the potential risk of harm to people who lived at the home. These had been kept under review and were relevant to the care and support people required.

Care plans were in place detailing how people wished to be supported. However people who received support, or where appropriate their relatives, were not adequately involved in reviewing their care records. The registered manager had identified this before our inspection through their audits. People's independence was promoted.

We observed regular snacks and drinks were provided between meals to ensure people received adequate nutrition and hydration. Comments from people who lived at the home were all positive about the quality of meals provided. One person said, "The food is very good, I get a choice and I get enough." We found people had access to healthcare professionals and their healthcare needs were met.

People who lived at the home told us they were encouraged to participate in activities of their choice and a range of activities that had been organised. We observed the activities coordinator engaging people and offering a range of activities. People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

The registered manager used a variety of methods to assess and monitor the quality of care at Belmont. These included, regular internal audits of the service, surveys for residents, staff and resident meetings to seek the views of people about the quality of care being provided. We found improvements were required to ensure that issues and concerns identified in audits were overseen by the registered manager and action plans were signed to demonstrate that the remedial work had been undertaken and completed by those responsible.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Belmont

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 21 and 25 July 2017 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection visit we reviewed the information we held on Belmont. This included notifications we had received from the registered provider, about incidents that affect the health, safety and welfare of people who lived at the home. A notification is information about important events which the service is required to send us by law. We also reviewed the Provider Information Return (PIR) we received prior to our inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service.

We spoke with a range of people about the home including eight people who lived at the home, six visitors and six care staff, catering staff and the maintenance staff. In addition, we also spoke with the deputy manager and the registered manager.

We carried out observations of the environment and interactions between care staff and people. We looked at the care records of five people who lived at the home, training and four recruitment records of staff members and one volunteer. We also reviewed records relating to the management of the service. We also contacted the commissioning department at the local authority. This helped us to gain a balanced overview of what people experienced living at Belmont.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe living at Belmont and with the way staff supported them. Comments from individuals who lived at the home included, "Yes I feel safe about everything here", "I am safe because I don't think anyone's going to come in", and, "If you want anything there's always someone here to give it to you." Feedback from relatives was also positive. Comments included; "I think he's as safe here as he could be anywhere", "I feel like we've come home. I'm so pleased with everything here; I can't fault it at all."

The registered manager had procedures in place to minimise the potential risk of abuse or unsafe care. These had been reviewed regularly and training continued to be updated for staff. In addition, staff and volunteers had been recruited safely, appropriately trained and supported by the management team.

Care plans seen had risk assessments completed to identify the potential risk of accidents and harm to people and the people in their care. The risk assessments we saw provided instructions for staff members when delivering support to people. Where potential risks had been identified the action taken by the service had been recorded. For example, we saw evidence of actions following incidents such as moving and handling incidents or medicine errors. The staff members involved were provided with supervision and guidance on how to use carryout these tasks safely and effectively. During the inspection we noted slings had not been individually labelled to ensure staff use the correct slings for each individual. We discussed the importance of ensuring that care staff use the correct slings for each individual and to keep the slings separately. The registered manager took action to correct this.

Measures had been undertaken to reduce risks associated with fire. Staff had received fire safety awareness training. There was an updated fire risk assessment and fire prevention equipment had been serviced in line with related regulations.

The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. During our inspection visit staffing levels were observed to be sufficient to meet the needs of people who lived at the home. Comments from staff included, "Staffing levels are fine we have a great team and have enough of us around to give the residents the care they need." The majority of people we spoke with felt that there were adequate numbers of staff to provide them with care in a timely manner. However two people and one relative who lived at the home felt that there were times when the service appeared short staffed and staff struggled to attend to people timely especially night time. We discussed this with the registered manager who informed us that there were times when staff had been busy however they monitor call bell response times and would review staffing levels to reflect people's needs. We looked at how medicines were recorded and administered.

We observed the staff on duty administering medicines during the two days of inspection. We saw the medicines trolley was locked securely whilst attending each person. People were sensitively assisted as required and medicines were signed for after they had been administered. The eight people we spoke with told us they were happy with the support they received with their medicines. Medicines had been checked

on receipt into the home, given as prescribed and stored and disposed of correctly. We looked at the storage of topical medicines such as creams and found improvements were required to ensure that these medicines were stored securely in people's rooms to avoid risks of misuse. The deputy manager took immediate action to address this.

We checked individual medication packs which confirmed all administered medicines could be accounted for. This meant people had received their medicines as prescribed and at the right time. The registered manager had internal and external audits in place to monitor medicines procedures. The service worked closely with the local practice nurse and the local pharmacists to ensure effective management of medicines in the home. We found people who had 'as required' medicines also known as PRN had documentation to guide care staff what this medicines was for and when to give it to people. We also noted that efforts had been made by the service to ensure that they reduced medicines waste.

The building was clean and free from offensive odours with hand sanitising gel and hand washing facilities available around the premises. We observed staff making appropriate use of personal protective equipment such as disposable gloves and aprons. We found equipment had been serviced and maintained as required. For example records confirmed gas appliances and electrical equipment complied with statutory requirements and had been checked to ensure they were safe for use.

Good

Is the service effective?

Our findings

People received effective care because they were supported by a staff team that were trained and had a good understanding of people's needs and wishes. All the people we spoke with told us that staff were competent and they had confidence in their skills and knowledge. For example, the majority of the care staff we spoke with told us they knew the residents so well because they had worked at the care home for a few years. One staff member said, "I have been here for more than two years and my induction was comprehensive." A person who lived at the home said, "It is a special place and we all get on very well and help each other" and, "I get to see the doctor quickly."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible; the policies and systems in the service supported this practice. When we undertook our inspection visit 14 people who lived at the home had been assessed as lacking capacity to consent to their care and DoLS authorisation requests had been made to the local authority.

Discussions with the registered manager confirmed they understood when an application should be made and how to submit one. We did not observe people being restricted or deprived of their liberty during our inspection. Staff sought consent and considered people's mental capacity in line with MCA 2005 principles while providing care support. Consent to photographs and medicines management had been completed however this was no consistent in all records we reviewed. We spoke to the registered manager and regarding this and they immediately took action. Staff knowledge and understanding of the principles of mental capacity and how it's applied to their roles needed improvement. We discussed this with the registered manager who informed us that they would seek support to improve staff's knowledge through further training and supervision.

We observed staff supported people to eat their meals. Staff offered people a choice of drinks. They encouraged individuals with their meals and checked they had enough to eat. We observed staff gave people an alternative choice if they didn't like the meals on offer. Comments about the food were good, they included, "The food is very good, I enjoy it although I'm on a soft diet", "The food is alright, its home cooked most of the time, but the menus displayed erratically." Another person gave mixed feedback, they felt food had been served cold. We observed menus had been displayed however they had the print was too small and the height was not suitable for people to be able to read them. We discussed people's comments and the menus with the registered manager took immediate action to order new menus. They also informed us they were aware of the comments regarding food being cold had addressed this with people concerned.

Staff recorded in care records each person's food and fluid likes and dislikes. This was good practice to provide preferred meals in order to increase their nutritional intake. People were weighed regularly and more frequently if loss or increase was noted. We found staff assessed people against the risks of

malnutrition and made referrals to dieticians where appropriate. We spoke to the chef who showed awareness of people's dietary needs and had developed action plans for all individuals who were at risk of weight loss. The system for monitoring weight loss was effective and an example of best practice. This was supported by comments from one healthcare professional we spoke to who said, "The weight loss management systems at this service is the best."

We looked at the building and grounds and found they were appropriate for the care and support provided. There was evidence of work that was being undertaken to ensure the signage in the home could be adapted to meet the needs of people who lived with dementia. We saw people who lived at the home had access to the grounds which were enclosed and safe for people to use. In addition, there were four lounges and other quiet spaces for people to sit. We observed people moved around the building freely.

Care records we looked at contained information about other healthcare services that people who lived at the home had access to. Staff had documented when individuals were supported to attend appointments or received visits from for example, GPs and district nurses. Documentation was updated to reflect the outcomes of professional health visits and appointments.

Good

Is the service caring?

Our findings

During our inspection visit we observed people were relaxed, happy, smiling and comfortable. We confirmed this by talking with people. For example, comments included, "I get on well with them, they're talkative", "Their attitude is fairly good, all the staff day and night, most of them are kind", "I have a shower every Saturday and I'm happy with that." And "The staff are all very nice, very kind and helpful." Comments from relatives included, "Yes, they understand [relative]'s needs and I'm very happy with everything", "I think they're lovely and happy to see my mum." And; "I can just walk in anytime and feel welcomed."

We observed staff engaged with people in a caring and relaxed way. For example, they spoke to people at the same level and used appropriate touch and humour.

Staff had a good understanding of protecting and respecting people's human rights. The majority of the care staff had received training which included guidance in equality and diversity. We discussed this with staff, they described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

We observed people being as independent as possible, in accordance with their needs, abilities and preferences. We observed people being encouraged to do as much as they could for themselves. For example, people were encouraged to eat independently and walk independently with staff providing background support in case people needed assistance. Staff explained how they promoted independence, by enabling people to do things for themselves.

Staff maintained people's privacy and dignity throughout our visit. For example, we saw staff knocked on people's bedroom doors before entering. Staff also addressed people by their preferred names. Care records that we saw had been written in a respectful manner.

Relatives told us the management team encouraged them to visit at any time. They said this gave them the freedom to access the home around their own busy schedules. We observed staff welcomed relatives with care and respect. For example, they had a friendly approach and one relative said, "They always make you feel welcome and offer me a drink."

We spoke with the registered manager about access to advocacy services should people require their guidance and support. The registered provider had information details that could be provided to people and their families if this was required. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed.

Good

Is the service responsive?

Our findings

People who lived at the home and relatives told us they felt the registered manager and staff were responsive and met their needs with an individual approach. Comments from people included, "I spend my time listening to the radio, reading, watching TV and I get books form the library", "I like watching the telly, I join in the activities, I like the singing", "I like watching TV especially, This Morning, Coronation Street and Emmerdale. I like to walk round. I go to the church service; the vicar comes in once a month." And "We go to the residents meeting every month, some things do change, it depends what we say", "I have visitors and the schools come in. The mobile library visits." A relative said, "They always keep us informed of what is going on with [family member]. We get phone calls regularly if there are any concerns." And "Its happy, friendly, welcoming, it made me feel I was making the right decision bringing [relative] here."

We looked at the care records of five people to see if their needs had been assessed and consistently met. The care records had been written in a person centred manner and included people's life histories, and what was important to them. We saw they had been developed where possible with each person and family, identifying what support they required. However in three of the files was little evidence of how people had been involved in their own care plan and reviews. Two relatives we spoke with confirmed they had not been aware of any recent reviews. We spoke to the registered manager who assured us that they would ensure that staff record who they do reviews with. This would ensure they can identify which family member had been involved.. They also informed us they sit down with people when carrying out reviews however staff had not adequately recorded this.

Staff completed a range of assessments to check people's abilities where support was required. For instance, they checked individual's needs in relation to mobility, mental and physical health and medication. We found assessments and all associated documentation was personalised to each individual who lived at Belmont.

Documentation was shared about people's needs should they visit for example, the hospital. These were known in the service as a 'transfer to hospital record.' These are documents which promote communication between health professionals and people who cannot always communicate for themselves. They contain clear direction as to how to support a person and include information about whether a person had a DoLS in place, their mobility, skin integrity, dietary needs and medication. The record also provided information about whether the person had a 'do not attempt cardio pulmonary resuscitation' order (DNACPR) which is a legal form to withhold cardiopulmonary resuscitation (CPR).

We observed the activities coordinator supporting people with activities. Activities were delivered at a steady pace to ensure that everyone was taking part. They also offered a variety of activities to suit people with different cognitive capabilities. There were activity plans displayed in the service. Some of these activities, and others, were clearly marked with pictures and words on a large noticeboard for everyone to see.

People were supported to maintain local connections and important relationships. People were actively

encouraged and supported to maintain local community links. For example, people had been supported to maintain contact with their family relations and were encouraged to continue attending church if they wished to. The service also had a volunteer who provided a befriending service. A befriender is a volunteer who is trained to provide support and companionship to people who are at risk of becoming isolated because of ill health, disability or social disadvantage. The use of this befriender allowed people to make friends and reduce isolation.

We saw compliments that had been received from people who were satisfied with the service and people who had visited the home. One person had left a comment on a website which collates comments about care services; "Belmont is a very friendly care home, my mum has been there for three years. It is very quiet and calm. The staff are always kind and have built up a very caring relationship with my mum. My mum lives with dementia and can be very challenging at times but they deal with it very professionally and calmly."

The service had a complaints procedure which was made available to people on their admission to the home. Copies were on view in the home. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations.

We spoke with people who lived at the home and with relatives. They told us they knew how to make a complaint if they were unhappy. They told us they would speak with the manager who they knew would listen to them. One person who lived at the home said, "It depends on what it is, but I think I would complain". A relative said "I'd feel comfortable going to the manager." We saw examples of a complaint that had been received in the last 12 months. This had been dealt with in line with the organisation's own polices and people were happy with the outcome. No complaints had been received at the time of our inspection.

Good

Is the service well-led?

Our findings

There was a registered manager employed at Belmont. 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.

Staff we spoke with told us they felt the registered manager worked with them and supported them to provide quality care. For example, we only received positive comments from staff and relatives and they included, "[registered manager] is great, they listen to you and will support with work and family issues. They listen and take action." Also, "The place is well organised and managed very well." A relative said, "It's peaceful and they seem to have an open culture. Another relative said; "We don't attend the meetings but we get the newsletter and I'm more than happy with it."

Staff we talked with demonstrated they had a good understanding of their roles and responsibilities. We found the service had clear lines of responsibility and accountability with a structured management team in place. The registered manager and the deputy manager were experienced and had an extensive health and social care background. They were experienced, knowledgeable and familiar with the needs of the people they supported. Care staff had delegated roles including medicines ordering and being key workers for all residents. Each person took responsibility of their role and had been provided oversight by the registered manager who was in turn accountable to the regional manager and the registered provider.

In their PIR the registered manager informed us, 'I am the registered manager with a supporting team in place at the home and the wider company, dedicated HR advisor, compliance officer, operations manager, regional manager and a training executive. I operate an open and transparent culture and I am responsible and accountable for running the home. I am supported by my regional manager through regular visits to work with me and my team, support the home in the implementation of new legislation.'

Staff and resident meetings were held on a regular basis. We confirmed this by looking at minutes taken of meetings. In addition, resident/family surveys were carried out annually. The management would analyse any comments and act upon them. We saw people and staff were consulted on the daily running of the service and any future plans. For example people told us during the inspection there was a meeting to discuss painting and decorations choice for the refurbishment programme that was underway. However we noted surveys had not been carried out for care staff. The registered manager informed us there had been an error at their head office which led to the questionnaires not being sent to staff. Staff surveys would ensure that the registered provider was actively seeking feedback from their own staff.

The registered manager and registered provider had auditing systems to assess quality assurance and the maintenance of people's wellbeing. We found regular audits had been completed by the registered manager and provider. These included medication, the environment, care records, accidents and incidents and infection control. The majority of the issues found on audits were quickly acted upon and lessons learnt to improve the care the service provided. However, we found actions plans had not always been signed off to

demonstrate that all actions had been completed. This related to care file audits and health and safety audits. We were assured this would be implemented immediately.

Regular checks were also made to ensure fire safety equipment was functioning and in line with health and safety guidelines. This helped to ensure people were living in a safe environment.

We saw evidence to demonstrate that the management and leadership at the home were willing to learn and develop the service based on best practice. For example we noted the registered manager had written on their PIR; 'the service measures performance against recognised quality assurance scheme - Investors in People (IIP). I attend monthly managers' meetings where we discuss and share company and individual home best practices.' IIP is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management.

The service worked in partnership with other organisations to make sure they were following current practice, providing a quality service and the people in their care were safe. These included social services, healthcare professionals including General Practitioners, practice nurses, psychiatrist's and district nurses.