Longacre Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 29 October 2018 and was unannounced.

Longacre Care Home Limited is a 'care home.' 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. The home is registered to provide accommodation and nursing or personal care for up to 30 older people living with dementia, physical disabilities, and mental health needs. At the time of the inspection there were 20 people living at the home.

Longacre Care Home Limited is a detached property in a suburban area of Worthing. It has been adapted from a domestic house and has been extended. There were two passenger lifts so people can access the first floor and corridors had sloping floors rather than steps for those with mobility needs. All bedrooms were single apart from one which could be used as a double. Twenty bedrooms had an en suite toilet. People were observed using communal areas, which included two conservatories which people used for activities plus a lounge – dining room. There was a garden which people said they enjoyed using.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

We made a recommendation following our last inspection on 29 January and 5 February 2016 for action to be taken to ensure people had access to a range of personalised activities and to address social isolation for those who remained in their rooms. The provider had taken action to address this and we found the provision of activities for people had improved.

People and their relatives said they were satisfied with the standard of care provided. For example, one relative said, "the care is good. The staff are fantastic. Nothing is too much trouble." Another relative said, "It's a lovely home. No faults at all."

The provider ensured safe care was provided to people. Risks to people were assessed and measures taken to mitigate these. The premises and equipment were safely maintained. Action was being taken to address fire safety matters as required by the fire and rescue service. Sufficient numbers of care and nursing staff were deployed to meet people's needs. Checks were made to ensure staff were suitable to work in a care setting. Medicines were safely managed. The home was clean and hygienic. Incidents or accidents were reviewed and action taken to reduce the likelihood of any reoccurrence.

The provider and management team ensured current guidance and legislation was followed regarding people's care and treatment. Staff were well trained and supervised. The staff felt supported and valued.

People's nutritional needs were assessed and people were supported to eat and drink. There was a choice of food. Health care needs were monitored and referrals made to other services to ensure there was a coordinated approach to people's care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were treated with kindness, respect and compassion. Care was individualised and reflected people's preferences. People's privacy and dignity were promoted.

People received personalised care which was responsive to their needs. Assessments, care plans and records showed attention to detail in monitoring and responding to people's needs. The provider identified and met people's communication needs. The provider had an effective complaints procedure and people and their relatives confirmed there was a good dialogue with the staff and management team so any issues were resolved. Whilst there were no people in receipt of end of life care at the time of the inspection the provider had policies and procedures for this. Staff were trained in end of life care.

The service was well led and provided person centred care. The provider's values of compassion, care, commitment, competence and communication were prominently displayed and were reflected in the service provision. People and their relatives had opportunities to express their views about the service and were consulted about their care. There were comprehensive audits and checks on the quality and safety of the service with corresponding plans to make changes where this was identified. The registered manager and provider were committed to continuous improvement of the service.

Further information is in the detailed findings below.

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 has improved to Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Longacre Care Home Limited

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 was 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 29 October 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. 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.

During the inspection we spoke with three people who lived at the home and three relatives. We spoke with three care staff and the registered manager.

We received feedback from a local authority commissioning team regarding their ongoing monitoring of the service. We spoke to a Community Psychiatric Nurse (CPN) from a local community mental health team.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for four people. We reviewed other records, including

the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, records of medicines administered to people and complaints. We looked at staff training records and staff supervision records.

Good

Is the service safe?

Our findings

There were systems in place to safeguard people from possible abuse. Staff were trained in safeguarding procedures and knew about the need to protect people who were in their care. Where safeguarding concerns had been raised in the past these were looked into by the provider.

Risks to people were assessed and recorded. People and their relatives said the staff provided safe care. These included care needs such as the risk of falls, the risk of pressure areas developing on people's skin, risks of malnutrition, moving and handling assessments and the use of equipment such as bed rails. Care plans included measures to control and reduce identified risks. Staff were observed to support people to move safely and used hoists and aids to do so. We observed a belt was used by staff to prevent someone sliding from a chair whilst they ate their lunch. The risks of this had not been formally assessed and recorded. This was discussed with the registered manager who committed to the completion of this, which was confirmed after the inspection.

The provider liaised with relevant health services regarding the management of risks to people. This included referrals to a falls prevention team where people were assessed as at risk of falling or to a dietician when people were at risk of losing weight. Records showed any incidents or accidents were monitored, reviewed and changes made regarding the future management of people. A relative said the staff helped ensure people were safely looked after.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical wiring, passenger lifts, hoists, gas heating and electrical appliances. Checks were also made on medical equipment such as scales, blood pressure monitoring devices and nebulisers. Measures were in place regarding the risk of Legionnaire's disease.

Fire alarms and emergency lighting were checked and the fire log book was well maintained. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water. First floor windows had restrictors so people could not fall or jump out. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. The staff were trained in fire safety. There were contingency plans in place in the event of a fire or need to evacuate the premises. The fire and rescue had recently inspected the home and required works to be carried out to improve fire safety in the home. At the time of the inspection this had not yet been completed but the provider had agreed a date for this to be completed. The fire and rescue service were due to return to the home to check on the progress of the works being completed.

The service provided sufficient staff to meet people's needs. People and their relatives said there were enough staff and that staff responded when they asked for help by using the call bells in their rooms. A relative said there was a low turnover of staff which helped ensure people received continuity from staff who knew them well. The registered manager used an assessment tool to indicate the number of staff hours per day each person needed to support them. The staff rota was based on this. From 8am to 2pm there were four care staff and one Registered General Nurse (RGN) on duty and three care staff and one RGN from 2pm

to 8pm. Night time staff consisted of one RGN and two care staff. The provider was recruiting two more RGNs and the registered manager said a decision had been made by the provider to not admit more people to the home until more staff were recruited. Any gaps in the staff duty rota for RGNs or care staff were covered by existing staff, or, the providers who are both RGNs, or, the use of agency staff.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Checks were made that RGNs were registered with the Nursing and Midwifery council (NMC).

Medicines were safely managed. Records and medicines stocks showed medicines were administered to people as prescribed. Medicines were safely stored.

The home was found to be clean and hygienic. Staff were trained in infection control and food hygiene. The service was assessed by the Food Standards Agency as having a five star rating for food hygiene on 12 January 2018.

Good

Is the service effective?

Our findings

People and their relatives said the staff were skilled at meeting people's care needs. For example, a relative said, "The staff are very well trained and knowledgeable."

The RGNs and care staff had good links with organisations who provided advice and updates on the provision of effective care, such as a from the National Institute for Excellence (NICE) and Skills for Care. Care staff were motivated and proud of their work. for example, one staff member told us how they had a lead responsibility for infection control and end of life care in the home.

Staff told us they were supported to attend a range of relevant courses in the provision of care such as the moving and handling of people, medicines management, care planning and dementia. The registered manager monitored staff training and when it needed to be updated. Staff also said they were supported to attend nationally recognised training in care such as the National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels. Eight of the 11 care staff had a NVQ or Diploma in Health and Social Care at levels 2 or 3. This included the five senior care staff who were each trained at level 3. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff were trained in equality and diversity and were aware of people's rights to a good standard of care.

Newly appointed staff were supported with an induction which involved a period of 'shadowing' other staff. This also involved enrolment on the Care Certificate as part of their induction. Newly appointed staff confirmed they received an induction which involved 'shadowing' more experienced staff as well as training. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers.

Staff received regular supervisor and appraisal of their work which included observations by the registered manager of their competencies.

People were supported with food and drink. Nutritional needs were assessed using a recognised format called a malnutrition universal screening tool (MUST). Referrals were made to dietician services where this was needed. Specialist diets were catered for. People's weight was monitored. People said they liked the food and confirmed there was a choice. For example, one person said, "The food is brilliant." Another person said the food was, "Very very good." We observed people were offered a choice of food at lunch time. People were supported by staff to eat.

The provider and staff worked well with other organisations to provide a coordinated approach to care. Records showed there was joint working with community health services, such as the community nursing teams. We observed care staff and nursing staff worked effectively together: a senior care staff member monitored a person's breathing and pulse and raised concerns to the registered manager. This was followed up immediately with the person's GP and a request made for a GP to assess the person. Health care needs were comprehensively assessed and monitored. A member of the community mental health services said

the staff worked well with them to meet people's needs.

The premises were well maintained and adapted for the people who lived there. There were areas where people could sit together either in the lounge or dining areas. There was also an area where people could take part in games and crafts. There was enough space for people who had physical disabilities to be able to move around. People's bedrooms were personalised with their own belongings. Corridor floors had been adapted so people with mobility needs did not need to negotiate steps.

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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Care records showed people were consulted about their care and had signed their care plans where this was possible. We observed staff sought people's consent before assisting them. A relative said staff explained what they were doing and sought the person's agreement before helping them. Staff were trained in the MCA and the principles of the legislation were included on the back of their name badges.

The provider carried out mental capacity assessments where this was needed. Where people did not have capacity to consent to their care and treatment appropriate action was taken for a DoLS application and a best interests decision for specific care. These were comprehensive and detailed with two exceptions where there was an element of restraint for two people for their own safety. This were for the use of bed rails to stop someone falling out of bed and the use of a belt to stop someone sliding out of a chair which was used to move the person but was also used when it was stationary. These were discussed with the registered manager who acknowledged these two procedures needed to be included in a best interests decision making protocol. The registered manager confirmed this was completed following the inspection.

Good

Is the service caring?

Our findings

People were treated with kindness and respect. We observed staff talked to people with respect. For example, a member of staff was observed to knock on a person's door and ask permission to enter. The staff member then explained politely why they were there and if the person was in agreement to be supported. At lunch we observed staff were friendly and involved people in chatting and jokes. Relatives described the staff as, "Kind and helpful," and, "They treat people with dignity and respect." A relative said staff were successful in improving the mod of people. We observed staff supported people who were distressed and responded to their requests. Staff said they treated people with respect and dignity.

Staff demonstrated they had values of treating people equally, and as if they were a family member. Staff said they tried to make the experience of living at the home as comfortable and homely as they could. It was clear staff valued people and knew how to deal with people's changing moods and behaviour in a way which was respectful and understanding. People knew they mattered to the staff. For example, one person said they knew the staff were concerned about them and another said, "They always check on me."

The care plans were person centred and individualised to show the care each person needed. Details about people's life histories were included in care records so staff knew their background. Care plans included details about people's mental health and behaviour and how staff needed to support people with these. The care plans reflected people's choices about how they wanted to be supported and what they liked to do, under headings such as, 'How I like to be helped.' Care plans showed people were supported to maintain independence where this was appropriate. People confirmed they were able to make choices in the daily routines.

People were consulted about their care and where possible they had signed to acknowledge they agreed with their care plan. People's privacy was promoted. Staff were observed to ensure they respected people's privacy using screens and by knocking on people's doors. People were able to choose if they had a preference to receive care from a male or female member of staff.

Good

Is the service responsive?

Our findings

At the last inspection of 29 January and 5 February 2016 we found people did not have access to a range of meaningful activities including for those who spent time in their rooms. We made a recommendation for this to be improved. At this inspection we found people were provided with a range of activities. The provider employed two staff who provided activities over five days per week. There was an activities programme for the week. Each person was consulted about the activities they would like to do. Activities were provided for those people who spent time in their rooms. People confirmed they were not socially isolated in their rooms and that staff spent time with them. The activities programme included arts and crafts, painting, cooking, quizzes and reminiscence. Equipment was available for people to undertake activities and for interacting with, such as dolls and sensory equipment. The provider had purchased a vehicle to transport people to community events. Links with the community were established and external organisations provided activities for people. People, confirmed they took part in activities. For example, one person said they recently made spaghetti bolognaise with the staff and had attended outings. People had access to a computer for using the internet or communication to friends or relatives. The registered manager had plans and ideas for continuous improvement of the activities for people.

Care records showed people's needs were comprehensively assessed before they were admitted to the home. The assessments of people's care needs were thorough and showed people and their relatives were consulted. Care plans were individualised and reflected people's preferences and needs. Staff completed monitoring charts where people needed regular assistance; these were recorded well and showed care needs were being met. Any changes were identified and the care plan adjusted accordingly. A Community Psychiatric Nurse said they were impressed with the of care people received at the home and the work staff did with people who were living with dementia.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. People's communication needs were assessed and care plans were of a good standard to give staff guidance on how to communicate. This included details about eye contact and aids which were needed. Large print documentation was used. Several people used a white writing board and felt tip pen to communicate where they had difficulties with hearing or seeing. The inspector was able to use these to speak to two people. Relatives said the staff were skilled at communicating with people.

The provider had an effective complaints procedure which was displayed in the main hall. Relatives said they had good communication with the registered manager and staff and said they were able to raise any issues or concerns which were resolved. The provider informed us eight complaints had been made in the 12 months prior to the inspection. Records showed these were logged, investigated and a response made to the complainant. Where appropriate an apology was made to the complainant, which showed the provider was following the procedures of the Regulation 20 Heath and Social Care Act 2008 Duty of candour.

At the time of the inspection there no people in receipt of end of life care. Staff were trained in procedures

for supporting people at the end of their lives. One staff member had a lead role regarding end of life care for people and said this was an area which they were very motivated in. People had a record of their advance wishes regarding their end of life care. We received feedback from a relative of someone who was supported by the staff at the end of their life; the relative said, "I wanted to report that care was excellent. Staff are very caring and compassionate. Matron runs the place with the very most dedicated care and common sense. End of life care was similarly sensitive and realistic."

Good

Is the service well-led?

Our findings

The service was well led with an open culture which facilitated good communication with staff, people, and their relatives. Staff and people said the registered manager had an 'open door' policy and they felt able to discuss any concerns or issues. Staff said they had opportunities to discuss the home's operation and the care of people at the twice daily team meetings and at staff meetings. For example,' one staff member said, "We can discuss anything we feels needs to be changed. They (provider) likes to get feedback from the staff." Another staff member said, "The manager is wonderful. Very good support to staff. We work well as a team. You can ask for advice."

The provider had a statement on its values of care, compassion, commitment, competence and communication. These values were reflected in how people received a service.

The service had 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 and associated Regulations about how the service is run. There was a system of management structure and delegation of three senior care staff plus the RGN on duty. The registered manager had completed the Diploma in Leadership and Management.

The local authority commissioning team said they had some concerns regarding the quality of the service due to the recent fire safety report, and the need to recruit more RGNs. At this inspection we found these issues were being addressed by the provider.

Surveys were used to gain the views of professionals, people and relatives about the standard of care. The last survey showed people or their relatives were satisfied with the standard of care provided.

Audits and checks were carried out regarding infection control, the safe management of medicines, staff training and supervision, care plans, health and safety, the environment, the mealtime experience and care plans. There were actions plans where it was noted changes or improvements were needed. The provider had a business plan which showed they were committed to the continuous improvement of the service. This included plans to recruit additional staff and to make improvements to the environment.

Records were well maintained and were secure and confidential. The provider was aware of the recent legislation regarding access and retention of personal data on staff and people called General Data Protection Regulation (GDPR), which was effective from 25 May 2018.

The provider and staff worked in partnership with other agencies and safeguarding team to ensure a coordinated approach to care. This included working with dietician services and community nursing teams. The registered manager attended a manager's forum run by the local authority and a dementia working group with local community mental health nurses.