Equality Care Limited

Longbridge Deverill House and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service well-led?	**Good**

Summary of findings

Overall summary

About the service
Longbridge Deverill House and Nursing Home is made up of two buildings on the same site. The house is a residential care home for up to 20 people and is located at the front of the grounds. The nursing home is situated towards the back of the grounds and up to 60 people can live there for residential, dementia, and nursing care.

People's experience of using this service and what we found
This inspection took place at 5.30am due to concerns about people having to get up early. We found most people were in bed in their nightclothes. Some people were in the communal lounges, but this was their choice. Whilst staff explained people were encouraged to get up when they wanted to, there were some comments about specific staff assisting people from 4am onwards. The manager said they were aware of this and had spoken to staff. However, checks to ensure this practice was not taking place, had not been undertaken.

Staff told us they generally started assisting people with their personal care at around 6am. They described this as, "starting their rounds" or "pad changes". This terminology and practice were not person centred and did not promote a 24-hour approach to care. The manager said they would address this within staff meetings.

Audits to check the safety and quality of the service had been undertaken. However, whilst the audits had identified some shortfalls, action plans had not been documented. This increased the risk of shortfalls not being appropriately addressed.

Not all risks to people's safety had been identified. This included one person who had their legs over their bed rails and another who had their table too high to eat safely. There was a hot water urn in a nurse's station, and staff took drinking water from a hand wash basin, next to a toilet in an en-suite. The manager told us they would consider and address these areas without delay.

Food and drink within the kitchenettes were not stored safely. Dates of opening and expiry dates were not recorded, which did not ensure the items were safe to use. People had snacks, such as biscuits and crisps, available to them during the night but there was no access to the main kitchen. The manager told us they had identified the range of food available at night, was limited. They said a review of all food and snacks was being undertaken.

People were encouraged to give their views about the service. Records of 'resident' and relative meetings showed the points raised, but action plans were not in place. This did not show people were being listened to, and their views were being addressed.

Whilst staff said they had a good team, they felt there needed to be an increased management presence

within the home. They said the manager's leadership did not fully inform them of the ethos or direction of the service. Staff told us the manager was often office based and did not know people or staff well. The manager was aware of this and said they would be addressing the amount of contact they had with people and staff.

The manager was aware of their responsibility regarding the duty of candour. Since their appointment, they had spent time considering what worked well and what needed improvement. They were committed to improving the service and had recruited additional staff to minimise the use of agency staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 07 February 2019).

Why we inspected
The inspection was prompted due to concerns received about some staff assisting people to get up as early as 4am. There were also concerns about the lack of food available to people during the night, and staff not being able to access continence supplies.

Following the receipt of the concerns, a decision was made for us to inspect and examine the risks. We undertook a targeted inspection to review the key question of well-led only.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We have found evidence that the provider needs to make improvements. Please see the well-led section of this full report.

After the inspection, the manager sent us an improvement plan. This showed actions that were being undertaken to monitor and develop the service.

You can see what action we have asked the provider to take at the end of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Longbridge Deverill House and Nursing Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check a specific concern we had about people being assisted to get up as early as 4am. There were also concerns about the lack of food available to people during the night, and staff not being able to access continence supplies.

Inspection team
This inspection was carried out by three inspectors.

Service and service type
Longbridge Deverill House and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who started employment at the service in November 2019. They had not yet registered with the Care Quality Commission to become the registered manager. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included notifications the provider is required to send us by law and any feedback, such as positive comments or concerns.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people and nine members of staff including the manager, registered nurses and care staff. We looked at four people's care plans.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check a specific concern we had about two members of staff, assisting people to get up and dressed from as early as 4am. There were also concerns about the lack of food available to people during the night, and staff not being able to access continence supplies.

We will assess all of the key question at the next comprehensive inspection of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- On visiting the nursing home at 5.30am, most people were in bed, in their nightclothes and generally asleep. There were a couple of people in the communal lounges, but this was their choice. Whilst this did not give evidence to substantiate the concerns we had received, two staff told us they were aware some people were assisted very early in the morning. We were told there was also an expectation from some day staff that several people should be 'up, washed and dressed' before they started their shift. This did not take account of people's individual preferences and did not demonstrate person-centred care.
- Other staff told us they encouraged people to wake and get up, in their own time. They said they generally started "their rounds" or "pad changes" at 6am. This terminology and practice were task orientated and did not promote a 24-hour approach to care.
- There was a strong feeling from staff that the new manager's leadership did not ensure they were clearly informed of the service's ethos or direction. They said the manager did not have enough presence within the home, and there was limited management at weekends. They told us the manager was often office based, which made them unapproachable and limited their ability to know people, their relatives or staff well. The manager told us they were aware of this and would be increasing their time within the units.
- Some staff raised concern that they could not freely access continence aids for people, as cupboards where they were stored were locked. The manager explained the rationale for this but said nurses and senior care staff, had access to all supplies. This conflicted with staff told us. The manager said people were allocated continence aids, in response to their need but would get people reassessed where needed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The manager told us they were aware of some staff assisting people to get up very early in the morning. They said they had discussed this with staff individually, and within a staff meeting. However, checks to ensure the practice was not taking place, had not been undertaken. In addition, records of a staff meeting showed one staff had asked why the night staff were not washing and dressing more people. They were told to assist more than one person due to time restraints. This instruction reinforced the practice of assisting

people too early and did not promote person-centred care.
● Audits to monitor and assess the quality and safety of the service had been undertaken, but not all had been recorded. Those records in place, were not always fully completed, dated or signed. Where shortfalls in service provision had been identified, action plans were limited and did not show how improvements would be made. This included an infection control audit which identified odour to pillows, stained bed rail bumpers and mattress covers that needed to be changed.
● There were shortfalls with the safe storage of food and drink. Small plates of sandwiches in the refrigerators in kitchenettes were not dated, so it was not clear when they needed to be eaten by. One showed a date, but this had expired. Cold drinks had been decanted into jugs without dates of when this took place. One chocolate milk drink had separated and congealed, with no safe date of use. These shortfalls had not been identified or addressed.
● Not all risks to people's safety had been identified. One person had their legs over their bed rails with an electric cable, which operated their bed, wrapped round them. Staff responded promptly when we brought this to their attention. However, the person's bed rail assessment had not identified this risk. Another person had been given their breakfast, but the table was too high for them to reach it. Their hot drink was filled to the brim, which meant there was a risk of it being spilt, causing injury. Within one unit, staff were taking water for people to drink, from a hand wash basin, next to a toilet in an en-suite. Whilst the water was drinking water, it was not hygienic to do this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems, including 'resident' and relative meetings, took place to enable people to give their views about the service. Records showed the discussions undertaken, but action points were not documented. This did not ensure any requests or shortfalls identified, were properly addressed. Within a recent meeting, such improvements included better safety in the garden and improved cleaning of the chairs. The manager told us these areas had been addressed although recognised this was not evidenced within documentation.

We recommend the provider undertakes further assessment and monitoring of people's care, including risks to their safety.

Continuous learning and improving care
● The manager told us they were committed to ensuring people received a good standard of care. They said they had taken time since their appointment, to identify what worked well and what needed further attention.
● Additional staff had been recruited to minimise the use of agency staff. The manager said they were building on the existing team, to ensure consistency and on-going development.
● Staff told us they enjoyed working at the home and there was a good team. There were some concerns however, that the good standards of care which had been achieved, would deteriorate. The manager was concerned at this feedback and said they were determined this would not happen.
● There were some sandwiches, biscuits and crisps available to people during the night if they were hungry. Staff did not have access to the main kitchen when the chef was not on duty. The manager told us they had identified the snacks available to people, lacked variety. They said time had been allocated to review and develop all menus and snacks available.
● During the inspection, we identified people did not have drinks or jugs of fluid in their room. The manager addressed this immediately by ordering a range of jugs and glasses for people's use. There was also a hot water urn in one of the nurse's stations, which was accessible to those people who were mobile. The manager told us this had been risk assessed but they would revisit it to promote safety.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager was aware of their responsibility to appropriately report any incidents such as serious injury or allegations of abuse. They said they would apologise if anything went wrong and would ensure systems were put in place to minimise any reoccurrences.