Mrs Maralyn Hussein and Michael Moreland

Littlebourne House Residential Care Home

Inspection report

Littlebourne House Residential Care Home
2 High Street Littlebourne
Canterbury
Kent
CT3 1UN

Tel: 01227721527
Website: www.littlebournecarehome.co.uk

Date of inspection visit:
09 August 2016

Date of publication:
29 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 09 August 2016 and was unannounced.

Littlebourne House Residential Home provides personal care to up to 64 adults. Accommodation is flexible with a detached house with a new extension for 42 people, a separate detached house – King William for 18 and four self-contained one bedroom flats. At the time of our visit, there were 63 people who lived in the home. People had a variety of complex needs including onset of dementia, physical health needs and mobility difficulties.

There was a registered manager at the home. 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.

The home had risk assessments in place to identify risks that may be involved when meeting people's needs. However, the risk assessments did not show ways that these risks could be reduced. Risk assessments were not individualised to meet people's needs safely.

There were sufficient numbers of staff. However, staff had not been adequately deployed to meet people's needs. We have made a recommendation about this.

The provider had not operated safe recruitment procedures. While some files had at least two references, others do not have. There were no job descriptions and staff interview records on file.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. There were procedures in place and guidance was clear in relation to Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. However, not all staff had received training in the Mental Capacity Act 2005. Staff had limited awareness of Deprivation of Liberty Safeguards. Hence, appropriate DoLS applications had not been made when we visited.

Training records showed that not all staff had completed training in a range of areas that reflected their job role, such as essential training they needed to ensure they understood how to provide effective care, and support for people. There were gaps in the training schedule which showed that not all staff had completed safeguarding, Deprivation of Liberty Safeguards (DOLS), Mental Capacity Act (MCA) amongst others.

Staff had not received regular individual one to one supervision meetings and appraisals as specified in the provider's policy.

People's care plans contained information about their personal preferences. People and those closest to them were involved in regular reviews to ensure the support provided continued to meet their needs.

However, care plans were disjointed with information either not recorded in care plan but recorded in another document. We have made a recommendation about this.

Staff encouraged people to undertake activities. However, there was no activities coordinator who could motivate people. Also, some people were observed watching television throughout our visit with little or no engagement from staff. We have made a recommendation about this

Effective systems were not in place to assess and monitor the quality of the home. There were no formal checks in place to ensure that all records were up to date. Care plans and assessments had not been consistently reviewed.

The provider had systems in place to manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. All of the people who were able to converse with us said that they felt safe in the home; and said that if they had any concerns they were confident these would be quickly addressed by the registered manager. Relatives felt their people were safe in the home.

Medicines were stored and administered safely. Clear and accurate medicines records were maintained. Staff knew each person well and had a good knowledge of the needs of people who lived at the home.

The food menus offered variety and choice. They provided people with nutritious and a well-balanced diet. The chef prepared meals to meet people's specialist dietary needs.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People spoke positively about the way the home was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager was very approachable and understanding.

During this inspection, we found breaches of regulations relating to fundamental standards of care. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff told us they were aware of people's risk assessments in place to support people with identified needs that could put them at risk. However, guidance was not always provided in care plans to staff on how to manage identified risks.

There were enough staff employed to ensure people received the care they needed and in a safe way. However, staff were not appropriately deployed to meet people's needs.

Effective recruitment procedures were not always followed.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

Medicines were safely stored and administered to people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received regular supervision from their line manager to ensure they had the support to meet people's needs. Not all staff had been trained in key specialised trainings required to adequately meet people's needs. Yearly appraisals were not always carried out and reviewed.

People's rights were not always protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and relatives were included in making decisions about their care. The staff in the home were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were supported in line with their needs. However, care plans were disjointed with information either not recorded in care plan but recorded in another document. Care plans were not person centred.

New care plans did not detail people's important information such as their life history and personal history.

There were limited activities for people. Activities were occurring at irregular intervals or only in a few places; scattered or isolated at the time we visited.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were no effective systems in place to monitor and improve the quality of the service provided.

Records were not always clear and robust with the newly introduced care plan system. Records relating to people's care were not consistent and could be confusing

The service had an open and approachable management team

There was a robust staffing structure in the home. Both management and staff understood their roles and responsibilities.

Littlebourne House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 09 August 2016 and was unannounced. The inspection was carried out by two inspectors and one expert-by-experience who spoke with people who used the service, families and relatives. Our expert by experience had knowledge, and understanding of residential services and of supporting family and friends with their health care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with six people who used the service. Not everyone was able to verbally share with us their experiences of life at the service. This was because of their complex needs. We therefore spent time observing majority of the people and how care was delivered.

We spoke with four family members, three care workers, chef, administration manager, deputy manager and the registered manager who is also a registered nurse. We also spoke with the provider who supported the inspection process. We also spoke with two visiting healthcare professionals, one visiting community agency worker and requested information via email from healthcare professionals involved in the service. These included professionals from the community mental health team, care managers, continuing healthcare professionals, NHS and the GP.

We looked at the provider's records. These included four people's care records, which included care plans, health records, risk assessments and daily care records. We looked at seven staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures.

At our last inspection on 18 June 2014, we had no concerns and there were no breaches of regulation.

Requires Improvement

Is the service safe?

Our findings

People told us they were safe. Comments included, "I didn't want to live on my own any more. Staff are lovely here, I feel safe here", "Staff have good knowledge; they help to make sure I'm safe when I move about. They handle me pretty well", Pretty well staffed, if I need some help they are here. Very well organised, everything happens on time" and "I have never been treated badly by any of the girls. They are all nice".

Relatives told me that they felt that their family was safe living at the home and that any risks to people living at the home were well managed and staff were able to give their family member the help they needed. One relative said, "There is 24hr staffing here and when my family member has needed help all she has to do is push the button and a staff member comes immediately". Another relative said, "She is as safe as she can be. I have never seen anything untoward when I visit".

A healthcare professional commented, 'We feel it is an excellent Home and provides a safe level of care to their residents'

However, our observation showed that people were not always safe at the home. The home introduced an electronic system called Care Management System (CMS) electronic system for care record documentation in February 2016. The provider told us that the CMS was designed to manage the day-to-day care needs of the people who lived in the home. This includes person centred care plans, risk assessments and care plan reviews. The provider said this was in its infancy and transition and care staff are getting used to this new system. People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. However, the risk assessments in the CMS were not specific to each person as they were system generated. The risks identified generated a standard electronic response through the CMS system, individual concerns were not identified and managed. For example, people who were living with dementia and at risk of absconding at times due to being unsure why they were at the home. Information recorded in the CMS was limited and not individual to the person and the risk assessment gave general guidance rather than detailed guidance for individual people. Another example was where people were at risk of epileptic seizures, we found risk assessment was in place. However, limited information was provided. For instance, 'Observe evidence of seizure. If suspected, put into recovery position and call GP or emergency services if necessary'. It did not give further guidance on how to recognise a seizure or state in what circumstances would you call one of these and in what circumstances you would not need to call for medical help.

Staff told us they were aware of people's risk assessments in place to support people with identified needs that could put them at risk, such as diabetes. Risk assessments were regularly reviewed and updated in line with people's changing circumstances. For example, where people were identified as at risk of fall, specialist equipment such as shower chairs had been obtained. However, other specific guidance were not always provided to staff on how to manage identified risks as stated above.

We spoke with both the registered manager and provider about our findings and how risks to people's safety

and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. Both also understood the shortfall regarding lack of detailed risk assessments in the CMS system, which they said they would look into.

Staff maintained an up to date record of each person's incidents or referrals, so any trends in health and behaviour could be recognised and addressed. Records of each referral to health professionals were maintained, and used to build up a pattern which allowed for earlier intervention by staff. For example, staff sought advice from occupational therapists (OT) about the use of moving and handling equipment to support people. Staff we spoke with told us that they monitored people and checked their care plans regularly, to ensure that the support provided was relevant to the person's needs. However, we found incidents where there were no follow ups or action plans to reduce its occurrence again. For example, incidents of two abscondments recorded within one month (26 June and 23 July) where one person had managed to get out of the premises by climbing the wall at the back of the building. Record stated 'wasn't missed as not gone long. Her clothes were wet through'. We found no action plan or detailed risk assessment to reduce or curtail such incidents. Accident records were kept and audited monthly by the registered manager to look for trends.

The failure to adequately complete incident/accident forms with action plan and put robust risk assessment in place to reduce harm to people in line with healthcare professional's guidelines in order to meet people's needs was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were suitable numbers of staff to care for people safely and meet their needs. The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were sufficient staff on shift at all times. We also observed that there were sufficient staff on duty to meet people's needs, for example supporting people attending hospital appointments on an individual basis. The registered manager said that if a member of staff telephones in sick, the staff in charge would contact their bank staff team to find cover. This showed that arrangements were in place to ensure enough staff were made available at short notice. The registered manager told us that the roster was based on the needs of people. The registered manager told us that "Staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly.

However, the provider did not have an effective way of calculating how many staff were required to meet the support needs of people living in the home at any one time. A dependency tool was available on the electronic recording system, completed and reviewed regularly. However, the tool was not effective in supporting the registered manager to work out how many staff were needed across the home. It did not feed in to any other monitoring system as it was stand alone in people's care plan information. For example, if more than one person's needs increased due to deterioration in mobility, thereby requiring two staff to help with all moving and handling. At 8.45am, on our initial tour of the home, as we walked in to King William House we saw one member of staff struggling to support one person into her wheelchair from a lounge chair. The wheelchair was clearly in the wrong position, being straight in front of the lounge chair rather than to the side. This person was in danger of falling as she was unable to move around to the position expected and the member of staff was unable to support her on her own. This person was unsure of what was expected of her so was struggling. Luckily, the registered manager was with us and was able to support this person into her chair safely with the other staff. This person was at real risk of falling. We observed that there were two care staff to 18 people at King William House at this time. One care staff was administering medicines while the other supported people. We spoke with the registered manager about this. They told us that people who lived in this house were fairly independent and staff should have called for assistance from the main house instead of trying to move the person by themselves. Both the provider and registered

manager promised to review staffing at King Williams immediately. The provider sent us a confirmation email on 11 August 2016. It stated 'I can also confirm that an extra member of staff has been deployed to the King William building during the dispensing of morning medication.'

We recommend that the provider seeks further guidance on staff deployment in care homes in order to safely meet people's needs.

Recruitment practices were not always safe. The provider and registered manager told us that robust recruitment procedures were followed to make sure only suitable staff were employed. All staff were vetted before they started work at the service through the Disclosure and Barring Service (DBS) and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We looked at seven staff employment files. Two files had two references taken while another two had only one reference and three had no reference on file. All files showed a full employment history, however some employment and further education listed on application forms did not have end dates, therefore it was not possible to identify if there had been gaps in employment. There were no interview records, which could have showed evidence that this had been investigated by the provider. Following the inspection, the administration manager sent us a confirmation email which showed that they are reviewing their processes. It stated 'We are reviewing personnel files re gaps in employment history and obtaining a second reference where applicable. We have also put into practice an interview questionnaire for the interviewer to make notes for suitability of candidate'. This meant that the provider had not carried out robust recruitment procedure to evidence that staff were suitable to work with people.

The failure to carry out safe recruitment practices was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken reasonable steps to protect people from abuse. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues.

People told us that if they had any safeguarding concerns they would raise issues with the staff member or manager in charge. One person said, "I would discuss it with [Name] my partner and then talk to the manager". Another person said, "I would speak with the manager. I would go into the office and deal with them privately".

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last two years. The staff we spoke with were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. A member of staff said, "Safeguarding is about making sure all residents are safe. Protecting people from abuse. If I am concerned or witnessed any abuse, I will report it to my line manager". Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The home had up to date safeguarding and whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and

processes in place that ensured the protection of people from abuse.

One person told us, "I always get my medicine between 7am and 7.30am with a drink. I suffer a lot back pain and I have been prescribed pain killers. I have another pill time in the evening". Another person said, "I get lots of different medicines and always get it with a drink of water" and "I always have my medicine in the afternoon. I have been taking my medicine for a long time so know what I am taking. I know it for my strokes and my head. I also have a sleeping tablet at night time to help me sleep".

People were protected from the risks associated with the management of medicines. People were given their medicines in private to ensure confidentiality and appropriate administration. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained this to them. We observed a senior care staff administering people's medicines during the home's lunchtime medicine round. The senior care staff checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were encouraged to be as independent as possible with their medicines. Medicines were given safely.

Medicines were kept safe and secure at all times. Unwanted medicines were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures obtained when they were removed. We saw records of medicines disposed of and this included individual doses wasted, as they were refused by the person they were prescribed for. Fluid thickener, which was used to thicken drinks to help people who have difficulty swallowing, was kept locked away in the cupboard in another locked storage room for safety. This demonstrated that the provider ensured medicines were kept safe.

There was a system of regular audit checks of medication administration records and regular checks of stock. The registered manager and deputy manager conducted a monthly audit of the medicine used. Control drugs were kept in double locked cabinet and double signed by two staff during administration. These were counted and checked every time. This indicated that the provider had an effective governance system in place to ensure medicines were managed and handled safely. A healthcare professional said, 'Prescriptions are ordered in a timely and orderly manner. We communicate changes to medication with the Home by written and signed forms. We are fortunate in the Home is within a few yards of our surgery and staff and patient can make easy contact with our receptionist and staff.'

There was a plan for staff to use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies.

The design of the premises enhanced the levels of care that staff provided because it was specious, well decorated and had been suitably maintained. Corridors were spacious with good lighting and was clean and fresh. The garden was well laid out and well designed to meet the needs of people with dementia.

Requires Improvement

Is the service effective?

Our findings

We asked people if there was enough staff with skills and knowledge working at the home? People said, "I think so; everything runs smoothly and on time. Never have to wait. I don't know about night time. I have my sleeping tablet and that's it until the morning", "I can sit out in the garden and have my meal outside. The meals are alright. I enjoy them" and "Free to walk around using my stick and talk to the staff. I sometimes go into the office and chat with the office staff".

Relatives said that they felt that staff were trained and seemed to understand their family member's needs and wishes. One relative said "Most of them appear well trained. Up to recently the staff have been quite a stable group until several were poached to a new care home. New staff getting to know people quickly". Another relative said that she didn't know what training the staff had but "Staff very kind, good with old people. The company seems to have a knack of employing the right people. They seem to be generally concerned about my relative's wellbeing".

A Healthcare professional commented as follows, 'They are fortunate to be able to employ registered manager who is RGN trained and therefore has a level of medical knowledge of patient's presentations. We feel that patients are referred to us in a timely and appropriate fashion, and that emergency services are also used appropriately. We try to anticipate problems by providing a weekly "ward-round", by setting up Care Plans. The Home engage well with us in this.'

All staff completed training as part of their probationary period. New staff had provider's comprehensive induction records which they worked through during their probationary period. Staff told us that they were mentored by the registered manager to help them to complete their induction. Staff were confident that by the end of their induction period they had attained the skills and knowledge to be able to care for the people living in the home. These skills were built upon with further experience gained from working in the home, and through further training. Staff told us that their training had been planned and that they could request further specialist training if needed.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people living in the home. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene. The registered manager who was a nurse told us they were supported to attend relevant courses to maintain their professional registration.

The registered manager who was also a nurse confirmed that they are given sufficient training to carry out the role and maintain their qualification with the Nursing and Midwifery Council (NMC). We checked the nursing staff registration certificates and found these to be up to date.

However, the staff training plan given to us showed that not all staff had been trained on essential training they needed to ensure they understood how to provide effective care, and support for people. There were gaps in the training schedule which showed that 20 out of 46 staff had not completed safeguarding training. Sixteen out of 46 staff had not completed Mental Capacity Act (MCA) training. The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over. This meant that not all staff had received training to understand the MCA principles and how to apply them in practice and adequately meet people's needs. Further gaps in the training schedule showed that 43 out of 46 staff had not completed epilepsy awareness training needed for the safe and effective support of someone with epilepsy. Staff had not undertaken epilepsy training despite caring for someone who had a diagnosis of epilepsy. Further, only 21 out of 46 staff had completed dementia care training, which would have enabled adequate support of people dementia being supported in the home. No staff had been trained in any behavioural training, which would have enabled adequate support of one person we observed as staff dealt with behaviours that challenge them. This was also evident in the person's records. 29 out of 46 staff had not been trained in diabetes despite the fact that the home had one insulin dependent diabetic person. 10 out of 46 staff had completed 'Falls prevention' training. All these areas were identified as required by the provider in their training plan in other to effectively meet people's needs. This meant that people were at risk because staff may not know how to effectively support their needs.

Members of staff felt supported by the registered manager, however one to one formal supervisions had not regularly taken place. Two of the seven staff files we looked at, had no one to one supervision. Members of staff spoken with told us that they do have supervision but cannot remember the date. A member of staff said, "If I have any problem, I will speak with the registered manager. I think my supervision was a while ago". The registered manager confirmed that they had identified gaps in staff supervision and are working on it.

Yearly appraisals were not always carried out and reviewed. Three out of seven staff files looked at had no yearly appraisals carried out. Those that had their appraisals, development & training needs were identified. Tasks to be carried out were also identified with timescales for completion. For example, one member of staff was identified to benefit from additional training. Lack of yearly appraisal would not enable staff to improve on their skills and knowledge which would ensure effective delivery of care to people.

Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS application had been made to the local authority for people who lived in the home. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. However, DoLS applications were not made for all the people with dementia in the home for specific decisions or consent to actions carried out by the home. For example, only nine applications were sent out of 64 people. There were coded key pads on doors in the home. Two people used bed rails, which is a form of restriction. People had not been assessed under the MCA and their consent sought to these

restrictions. Steps taken in the home did not follow the principles of the Mental Capacity Act (MCA) 2005.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before people received any care or treatment they were asked for their consent. Staff interacted well with people, and asked them where they wanted to go and what they wanted to do. They obtained people's verbal consent to assist them with personal care such as helping them with their meals, or taking them to the toilet. Staff were aware of how to treat people with respect and that they allowed people to express their consent to different tasks. There were consent forms in place in each person's care plan. Consent forms had been appropriately completed by people's representatives where this was applicable. The forms showed the representative's relationship to the person concerned, and their authorisation to speak or sign forms on the person's behalf or in their best interests.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians. For example, one person was provided with a soft diet and staff helped them while eating to ensure risks of choking were reduced. Hot and cool beverages and snacks were offered to people by staff twice a day and upon request.

We observed that the chef went around and personally spoke with people the choices on the menu and asked what they would like. The registered manager said this happened each day. They found it worked better as people could remember what they had ordered. After making their choice, their meal was served quickly after that. The kitchen assistants served the food and recorded what people had and how much they had eaten. We observed two gentlemen sitting together had a glass of wine each with their meal upon their request. This showed that the meal time practice was person centred taking into account people's wishes. The chef told us "I always discuss dietary needs with the registered manager at initial stage/meeting. If needs change, they would let the kitchen know or if we spot any change in people, we raise the issue with staff".

People and relatives were very positive about the quality of the food, choice and portions. One relative said, "Food looks quite good, looks nutritious, quite plentiful portions. I am always offered a drink when I come" and another relative said "Food quite varied. She can have a choice from three options. It is quite soft to suit her". We observed lunch in the dining room where all the people were offered a choice. The food looked and smelt appetising and the portions were generous. Staff worked with the cook as team to ensure meals were delivered quickly and hot. There was a pleasant atmosphere in the dining room and it was evident that people enjoyed the food. The chef was aware of the dietary requirements of people and he was very actively involved in the delivery of the food and service. The chef told us that they provided variety of food and special needs/requests such as soft diet like pureed food and diabetic diet for diabetic people are taken care of. This showed that staff ensured people's specific nutritional needs were met.

People or their representatives were involved in discussions about their health care. Two visiting healthcare professional said, 'They do listen to what we advise. They do try to take responsibility'. The doctor visited when requested and people's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the home regularly.

Records confirmed that there were systems in place to monitor people's health care needs, and to make

referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing. Staff described the actions they had taken when they had concerns about people's health. For example, they maintained soft diets for people with swallowing difficulties and repositioned people who were cared for in bed on a regular basis to minimise the risk of pressure ulcers developing.

The provider contacted other services that might be able to support them with meeting people's mental health needs. This included the local authority's community mental health team. Details of private OT referral and guidance were in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

A healthcare professional told us, 'Residents are supported to maintain good health by having a regular weekly GP visit, ready access to District Nursing and other Community Nursing services when needed. I understand an independent OT service work with the Home on issues regarding patient mobility and transfers/hoisting. Residents are encouraged to engage in activities such as outings and for entertainment. Pilates is offered in the Home.'

Good

Is the service caring?

Our findings

People told us that the staff treated them with dignity and respect. We observed that staff treated people in a patient caring and respectful manner. We saw people smiling when staff approached them or when they give reassuring touches on their hands or arms. We heard the staff giving lots praise and encouragement such as, "Have you had your hair done today it looks very nice." "Well done"

People commented as follows, "Staff are very polite. They call me by my first name. I can only say positive things about the attitude of staff", "Staff are very caring. They put the shower on for me and check that it the correct temperature. They always ask if I want some help", "All nice people. If I am not well they look after me" and "Staff do care what happens to me. I can tell the way they talk to me".

Relatives told me that they found the staff caring and approachable to their family member. One relative said, "I have found the staff caring and compassionate when I have spoken to them on the phone when I have had a concern". Another relative said, "Yes the staff treat people with kindness and respect and always give the residents lots of encouragement. I find them easy to talk to". Another relative said, "Absolutely approachable, the staff are so good. They are very kind to me as well. The way they approach my relative is marvellous. She can be quite set in her way and sometimes needs cajoling".

We spent time and observed how people and staff interacted. Staff were seen to be kind and caring throughout our visit. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. Staff checked on people's welfare when they preferred to remain in their bedroom or not to take part in the activities. Staff provided reassurance for a person who was anxious during mealtime. The registered manager took her meal to her room and encouraged the person to have their meal in their room, which provided comfort and reassurance. This showed that staff were knowledgeable about how to care for this person.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

People were presented with options, such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their previous care plans. The provider had not yet fully completed the electronic care plans, so people's individual and personal information was limited. However,

staff had worked on a folder called 'This is me' which had important facts about people, recorded by staff who had spent time with people gathering the information. For example, likes, dislikes, important people in their lives and what is important to me. Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. For example, we saw people sitting in the garden as the weather was lovely. This showed that people's choices were respected by staff.

Staff addressed people by their preferred names and displayed a polite and respectful attitude. They knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. People were assisted with their personal care needs in a way that respected their dignity. Staff covered people with blankets when necessary to preserve their dignity.

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People's care plans were reviewed monthly by senior staff or whenever needs changed.

The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the home and who support people to make and communicate their wishes. People told us they were aware of how to access advocacy support. Advocacy information was on the notice board for people in the home.

Requires Improvement

Is the service responsive?

Our findings

People told us that they felt staff listened to what they said and respected their views and that the care was focussed on what they wanted.

One person said, "On the whole the care is focused on what I want help with. The carer helps me wash and dress me and help me get to the toilet. I try to be independent. I had my hair done this morning by the visiting hairdresser". Another person said, "I don't like showers, staff always take me to have a bath never a problem". Another person said, "Staff very good. I like to do most things myself. If I need help I just have to ask".

Relatives told us that they had been involved or one of their family members had been involved in the care planning and the care was focussed on their individual needs. One relative said, "It is focused on her needs. It is personalised tasks". Another relative said, "She (their relative) has had an inspection every so often. The staff are very good at making sure they help her as she wishes".

Each person's physical, medical and social needs had been assessed before they moved into the home and communicated to staff. Pre-admission assessment of needs included information about people's life history, likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about people's individual needs from the onset.

As stated above, the provider had recently introduced an electronic care plan system called CMS. This is still in transition according to the provider. Hence, people's care plans including risk assessments on the CMS did not have clear recommendations to staff about how to reduce the risk that was identified. For example, a person who experienced falls was assessed by the privately engaged occupational therapist and provided with wheelchair for use whenever necessary and appropriate risk assessments. However, the detailed risk assessment could not be found on CMS. People were placed under observation following a fall and their progress was recorded.

We found that the care plans were disjointed with information either not recorded in CMS care plan but recorded in another old/previous document. For example, people who were at risk of finding many situations challenging and therefore responding with frustration and behaviour that challenged staff. Although, risks were identified in the care plan (Not risk assessment), guidance for staff in how to support people appropriately using techniques individual to the person had not been recorded. We saw no behavioural guidelines in place for staff, which would enable adequate behavioural support. At the same time, we saw in one person's care plan (CMS), who had no support needs around behaviour but had the same standard generic guidance listed as a person who was deemed to have behaviour that challenges staff. Therefore guidance in the care plan was limited and not individual to the person. This demonstrated that the CMS care plan was generic, task oriented and not person centred.

We recommend that the provider seeks further guidance on the use of the electronic system regards person centred care plans in order to meet people's needs in a person centred way.

Staff ensured that people's social isolation was reduced. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "We are encouraged to keep in contact by phone, visits, meals and birthday celebrations.

We found that staff worked in a variety of ways to ensure people received support they needed. Equality and diversity was covered in people's care plans and it details people's preferences and individuality. We observed that staff called them these preferred names. Religious and cultural needs are also taken into consideration. People attended church services of their faith when they wished. The home holds a communion service for those who wish to attend. This showed that people were given the opportunity to express their faith. This showed that staff supported people based on the person's choice and preference.

People were able to express their individuality. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice.

The home currently did not have a full time activities coordinator. The administration manager explained and said, "The activities coordinator left two months ago and we have been trying to recruit without success since. Presently, we are using an experienced staff, an activities assistant to carry out the role of an activities coordinator. Activities were occurring at irregular intervals or only in a few places; scattered or isolated at the time we visited. We saw a planned activity for 15 August 2016 for a professional vocalist and entertainer to visit the home. Also, on 03 August 2016, they had a Church service. We saw no up to date activities time table for people.

People told us that there were a few activities they were involved in. In the afternoon of our visit, several people were taken out on the minibus for a trip by the driver and the OT team came and had a movement session with four people in the garden. We observed that most people in the smaller unit sat around the TV either watching it or asleep. A couple of resident sat outside in the sunshine. In the main house, people were encouraged to go into the garden. One staff member told us that the activity person had just left and they were struggling to find a replacement to stay.

Relatives told us that they thought that sometimes there were not enough activities to keep their family member stimulated. One relative said, "I haven't seen that much. There is bingo one day a week. We asked if my relative could come over to the main lounge during the day so she can look out into the garden and see more people to chat to". Another relative said, "I don't know what goes on, never seen anything in the communal area only a church service".

People seemed pleased with the weekly hairdresser. People said "I get my hair done once a week". The provider told us that they plan to introduce a game table called 'Tovertafel'. A magic table game for people with dementia. The Tovertafel by Active Cues was designed to encourage elderly people with Alzheimer's disease to be more active in an independent way during the day.

We recommend that the staff seek and follow suitable guidelines to support them in providing an increased range of activities for people living with dementia.

The complaints process was displayed in one of the communal areas so all people were aware of how to

complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). One complaint was received in the last 12 months before this inspection. This was satisfactorily resolved by the registered manager within stipulated time period.

Staff told us that they would try to resolve any complaints or comments locally, but were happy to forward any unresolved issues to the registered manager. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction. One person said, "We have no complaints, I would speak with the girls or the manager". A relative told us, "I am sure if I had a complaint I am sure I could find all the details in the 'Book of Words (service information booklet)". We saw complimentary messages sent to the registered manager and staff. One of these comments was, 'Thank you so much for the love, patience and kindness shown to dad and me'.

Requires Improvement

Is the service well-led?

Our findings

People told us they were satisfied with the service they received and that the residents meeting were held monthly and said that they were able to talk freely at residents meetings.

Relatives told us that the registered manager was very approachable and responsive. Relatives told us that they could talk with any of the staff and the door to the office was always open and the manager always encouraged them to speak with her. One relative said, "I have always been able to speak with the manager when I have been here". Another relative said, "I can come at any time, they are always very welcoming. They are naturally very busy but take the time to listen and welcome you" and "Staff always bring us a cup of tea and cake on a tray for us to share when I visit".

The provider had not carried out an annual questionnaire to gain feedback on the quality of the service. These should have been sent to people living in the home, staff, health and social care professionals and relatives. The administration manager told us in an email that 'I can confirm that we are in the process of sending out a questionnaire to our residents (where appropriate), next of kin or POA. This will enable them to comment on the service we are providing'. This meant that the provider had no system in place to ensure that they continually routinely listen and learn from people's experiences, concerns, complaints and maintain standard of care from people who used the service, relatives and healthcare professional's views.

Records were not always clear and robust with the newly introduced CMS. Records relating to people's care and the management of the service were not consistent and could be confusing. It was not always clear from the records if and when a healthcare professional's guidance or recommendations had been implemented. For example, we found no guidance relating to one person with epilepsy in care records. Risk assessments were in place, however, limited information was provided. We found no records of behavioural guidelines and no appropriate risk assessments. There was no guidance for staff around signs to look out for if the person may be deteriorating in their health. We saw no ABC charts or recordings of this in any format in the care plans. ABC means (Antecedent, Behaviour and Consequences), this should be completed every time the person displayed behaviour which was considered challenging. "A" refers to the antecedent, or the event or activity that immediately precedes problem behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence, or the event that immediately follows a response. Guidance in the care plan was limited and not individual to the person. Another example was limited standard guidance in care plan but no risk assessment regards moving and handling for the person we observed transferring from lounge chair to a wheelchair when we arrived. The person's care plan stated, 'To transfer safely – transfer with one carer, explain procedure to 'X'. It did not state what the procedure was. 'All staff adhere to moving and handling assessment'. There was no moving and handling assessment in the CMS care plan.

Audit systems were not in place to monitor the quality of care and support. There were no documentary evidence of audits of care plans carried out to ensure that people were getting the care and support they were assessed for. Staff files, infection control, health and safety, recruitment files and risk assessments were not being audited. The audit system would have identified the areas we had identified above. There were systems in place to manage and audit accidents and incidents. The only area that was being audited

monthly was the medicines. We spoke with the registered manager and provider about this and they told us that this would be implemented immediately.

The provider has failed to operate an effective quality assurance system to ensure they assess, monitor and failed to maintain accurate records to improve the quality and safety of the services provided. This was a breach of Regulation 17 (1) (2) (a) (b) (c) (e) (f) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager and provider had an open door policy. Staff said, "We talk every time. Management have an open door policy, which is good".

The provider had clear values. These stated 'As a family run home, we offer a friendly and comfortable place of residence and provide compassionate care you would expect from a family member. A relaxed, friendly atmosphere is the first thing you will notice when you visit Littlebourne House'. Our observations showed us that these values had been successfully cascaded to the staff who worked in the home. Staff demonstrated these values by meeting people's needs in a relaxed atmosphere.

The management team at Littlebourne House Residential Home included the registered manager and the deputy manager. Support was provided to the registered manager by the provider who has an office on the premises, in order to support the home and the staff. The registered manager oversaw the day to day management of the home. Both the registered manager and deputy manager knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the provider who provided all necessary resources necessary to ensure the effective operation of the service. The registered manager is also a trained registered nurse. This was an added advantage for people who lived in the home because the home is not a nursing home. With a registered nurse as registered manager, people's healthcare needs could be met as swiftly as possible. We observed the presence of the provider in the home and found people chatting with them. A member of staff said, "The home is well led. We know who to report to and the head of care can be approached". This showed that the registered manager and staff were well supported by the provider.

Staff understood their roles and responsibilities and told us they worked well as a team. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Communication within the home was facilitated through monthly management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the home. Staff told us there was good communication between staff and the management team.

The home worked well with other agencies and services to make sure people received their care in a cohesive way. Healthcare professionals we contacted told us that the home always liaised with them. A healthcare professional told us that staff at Littlebourne worked well with them at all times. They said, "We agree that communication with the Home is good". This showed that the management worked in a joined up way with external agencies in order to ensure that people's needs were met.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People had not been assessed under the MCA and their consent sought regarding restrictions in the home. This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to adequately complete incident/accident forms with action plan and put robust risk assessment in place to reduce harm to people in line with healthcare professional's guidelines in order to meet people's needs. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to operate an effective quality assurance system to ensure they assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 (1) (2) (a) (b)

(e) (f) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failure to carry out safe recruitment practices. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.