SHC Clemsfold Group Limited

Longfield Manor

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place on 10 and 11 October 2016 and was unannounced.

Longfield Manor provides nursing care and can accommodate up to 60 older people with a variety of physical and mental health needs. Fourteen of the beds are within the Rosewood unit, which cares for people living with dementia. There were 54 people in residence at the time of our visit, including 14 in Rosewood.

The service did not have a registered manager. The registered manager had left in September 2016 and was in the process of deregistering. 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. In the absence of a registered manager, the deputy manager was overseeing the service with support from a representative of the provider.

Medicines may not have been consistently administered. We have made a recommendation about reviewing written guidance relating to medicines. This was because information on how specific medicines should be administered was missing or lacked detail. This could have an impact on the consistency of support that people received, especially when temporary staff were involved in administering medicines.

People, relatives and staff spoke of improvements in the service and a reduction in the number of agency staff used. We found, however, that the changes in the staff team and the relatively high use of temporary staff was still impacting on people's experience. The provider was actively recruiting to the vacant positions and tried wherever possible to use the same members of agency staff to promote continuity.

People told us they felt safe at the service and that staff treated them respectfully. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned someone was at risk of abuse. Risks to people's safety were assessed and reviewed.

People had developed good relationships with staff and had confidence in their skills and abilities. Staff had received training and were supported by the management through supervision and appraisal. Staff were able to pursue additional training which helped them to improve the care they provided to people.

Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The home included a dementia community known as 'Rosewood'. A team leader had been appointed to run this part of the service. They had made improvements to the care and the home environment which was having a positive effect on people's wellbeing.

People told us the meals at the service were improving and that the new Chef was listening to their feedback and suggestions. Staff monitored people's weight to ensure they were receiving enough to eat. Where concerns were identified, action had been taken to ensure people had adequate food and fluids.

Staff responded quickly to changes in people's needs and adapted care and support to suit them. Where appropriate, referrals were made to healthcare professionals, such as the GP or dietician, and advice followed.

People were involved in planning their care but on-going involvement had not always been recorded. The deputy manager was planning to introduce six monthly reviews to ensure that staff actively sought input from people and, where appropriate, their families.

There was an established system in place to monitor and review the quality of care delivered and to make improvements. People, their relatives and staff felt confident to raise issues or concerns. Where improvements had been identified action had been taken or was underway.

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

Improvements were required to ensure the safety and consistency of care in some areas.

Further guidance on the use of certain medicines was needed to ensure they were administered consistently.

There were enough staff to keep people safe but the level of agency usage impacted on people's experience.

Risk assessments were in place to help protect people from harm.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People spoke positively about the changes in the menu since a new Chef had started in post.

People had access to healthcare professionals to maintain good health.

The provider had improved the premises, including the gardens which people enjoyed.

Is the service caring?

Good

The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care and a system of regular reviews was due to be introduced

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People' received personalised care that met their needs.

People enjoyed a variety of activities.

People were able to share their experiences and felt confident to raise any concerns.

Is the service well-led?

Good

The service was well-led.

People and staff felt able to share ideas or concerns with the management.

The registered manager had recently left the service. The deputy manager was taking charge of the home until a new manager was appointed.

There was a system in place to monitor the delivery of care that people received and to make improvements.

Longfield Manor

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 October 2016 and was unannounced.

One inspector, an inspection manager and a specialist advisor in nursing and dementia care undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for 13 people, medication administration records (MAR) for 39 people, monitoring records, accident and activity records. We also looked at two staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 15 people using the service, six relatives, the deputy manager, one registered nurse, one agency nurse, one team leader, three care assistants, one agency care assistant, the activities coordinator, the chef, a representative of the provider and the GP who was visiting. Following the inspection, we contacted an Admission Avoidance Matron, a Speech and Language Therapist (SALT), Chiropodist and Dietician to seek their views and experiences. They consented to share their views in this report. We also received feedback from two additional relatives.

This was the first inspection of Longfield Manor since a change in the provider's registration in October 2014.

Requires Improvement

Is the service safe?

Our findings

People could not be assured that their medicines would be consistently administered. This was because written guidance regarding how some medicines should be managed and administered to people lacked detail. Some medicines prescribed on a PRN basis did not have a protocol to describe to staff how and when the medicine should be given to the person. Protocols for paracetamol and other analgesics were nearly all in place but those for laxatives were often missing. Furthermore, when protocols were in place for laxatives, there was no link to the care plan to explain when the laxative should be given linked to the person's bowel actions. Protocols for sedation and analgesia were generic, stating, 'For episodes of anxiety and agitation' but without detailed information about what that looked like for the person in question and the actions to take to minimise (or prevent and escalation of this behaviour) before reverting to sedation. Protocols for an inhaler used for respiratory symptoms were insufficiently detailed as to when this might be required and we noted that none had been given to three of the people prescribed this medicine whose records we tracked.

Topical protective creams were administered by care staff and the Medication Administration Record (MAR) completed by nurses. There was no guidance in place for care staff as to where these creams should be applied, for example to the sacrum, legs or arms. For one person, the GP had agreed to covert administration of medicine but there was little detail on the steps staff should take to encourage the person to take their medicine. Conversations with nursing staff indicated that they were generally able to help this person take their medicines without needing to give them covertly.

We recommend that written guidance relating to people's medicines is reviewed to ensure that clear information is available to staff. Written guidance is important in promoting a consistent approach for people as they receive their medicines, especially when temporary staff are involved in administering them.

By the second day of our inspection, the deputy manager was able to show us body maps which had been completed for topical creams to provide guidance to care staff. This would help to ensure that people received appropriate and consistent support. The deputy manager had also addressed a missing care plan for one person who was prescribed warfarin (in relation to bleeding as this medicine thins the blood) and charts to ensure sufficient rotation of transdermal patches prescribed for pain relief.

The home had a detailed medicines policy for administration, ordering and storage. Medicines were administered by registered nurses. We spoke with the two nurses on duty. Both were appropriately trained and knowledgeable about the medicines they are administering. We observed as the nurses administered medicines to people. Each person was supported to take their medicines and staff ensured that they had been taken before signing the MAR. Where people were prescribed medicines on an 'as required' (PRN) basis these were offered.

People shared mixed views on the staffing at the service. They told us that the staff were kind and attentive to their needs but felt that there were too many changes in the team. They explained that the number of temporary staff employed through agencies impacted on their care. This was because agency staff did not know people as well or understand their needs in the same way as the home's regular staff. One person said,

"They come and go all the time, we keep getting different staff". Another told us, "They have got some new staff through recruitment but there are still a lot of agency". A third said, "You spend ages telling the agency staff how to do things. You have to keep explaining stuff to agency staff which can be frustrating and time-consuming". A fourth person said, "I think they are a bit short of staff. Sometimes they come to me a bit late and in a bit of a hurry". A relative told us, "Staffing has improved but we still get weekends with too much agency and that mix isn't there".

The home did not have enough permanent staff to cover all shifts and used agency staff to make up the shortfall. Wherever possible, the same members of agency staff were used to promote continuity. Rotas for the four weeks prior to our inspection demonstrated that staffing numbers, of two nurses with ten care staff during the day and five at night, had been maintained with daily support from agency staff. The one exception to this was in the week of 3 October 2016 when there were nine care staff instead of the planned ten of four days during that week. In addition to the planned nursing and care staff numbers, the deputy manager (also a registered nurse) was available and able to provide support when required. Activity, kitchen, domestic and maintenance staff were also employed.

Staff felt that the staffing had improved but told us that they felt stretched. One care assistant told us that staff worked "extra hard" to ensure that people's needs were met, often without taking their breaks. Another told us, "We go home on our knees". A third said, "We've got such a good team now. I'm happy with the care. It's so much better and the agency has reduced". The former registered manager told us in the Provider Information Return (PIR) that 14 care staff and two registered nurses had been recruited in the first eight months of 2016. At the time of our inspection, there were vacancies for three registered nurses (including a registered manager), five care staff and an administrator. The provider was actively recruiting to these positions.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

Before a person moved to the service, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, pressure areas or chewing/swallowing, these had been assessed. Risk assessments detailed what reasonable measures and steps should be taken to minimise the risk to the person. For example, people who were at risk of falling had equipment such as walking sticks or frames to help them to move around safely. Staff encouraged people to use their equipment to minimise their risk of falling. The risks assessments were reviewed in order to adapt the support to meet the person's current needs. For one person we read that they had recently required more help to use the toilet safely and the risk assessment and care plan had been updated to reflect this.

Where accidents or incidents occurred, these were logged and reviewed. This helped to identify any patterns or trends and to reduce the risk of future injury. We noted examples of action that staff had taken to respond to changes in risk. This included using a sensor mat for one person who was at risk of falling. The sensor mat would alert staff when the person was up from their chair or the bed so that staff could go directly and offer support. Other people had been referred to the GP, including for a medicines review when there was a concern that particular medicines might be affecting the person's alertness and increasing their risk of falling. Injuries had been reviewed to ensure that they healed. In one monthly audit we read, 'Bruising and wound has now disappeared'. This demonstrated that staff monitored people's changing needs.

People told us they felt safe living at the service. One person said, "The staff are all very kind and helpful. They do things to make you feel satisfied and safe". Another told us, "I sleep well, the nurses attend to me". A third person when asked if they felt safe responded, "Oh yes, completely safe". Relatives had confidence in the support provided. One told us, "Now I can go away comfortable in the fact that she'll be well looked after".

Staff had attended training in safeguarding adults at risk. They had a good understanding of the safeguarding procedures for the home and ways to keep people safe. They were able to describe the action they would take if they observed an incident or activity that constituted abuse. They also knew what action to take if they felt that the matter had not been investigated fully or resolved adequately. Staff told us that they felt able to approach their seniors if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team.

Good

Is the service effective?

Our findings

People spoke positively about the care they received. One person said, "I get very good support. I would recommend it, they're very good". Another said, "The staff are very good". The provider ran a training academy for its staff. New staff attended a programme of induction which included classroom and practical training. Topics included infection control, first aid, safeguarding, The Mental Capacity Act 2005 (MCA), fire prevention, nutrition, safer eating, food hygiene, moving and handling and person centred-care. Once this four-day training was completed, staff shadowed experienced members of the team. One new care assistant told us, "The induction was really useful. You get it all done before you start, then I shadowed for three long days".

On-going and refresher training was provided to staff. The training matrix reflected that training made mandatory by the provider was up to date. Recent courses included moving and handling, and fire safety. The training matrix allowed the deputy manager to see whose training was due. Notices were displayed listing which staff were required to attend forthcoming courses. Staff were positive about the training they received. One care assistant said, "There was good training. You get a mentor and you have shadowing. We had a module on dementia". Another care assistant explained how they hoped to train as a nurse and that the provider was going to support them in this. They said, "They've been so good. All (the training) I've said I wanted to do, I've done".

Staff felt supported and received regular supervision and appraisal. Records confirmed that all permanent staff had attended a minimum two supervision meetings since February 2016. This provided an opportunity to discuss any concerns they had and to speak about development and training wishes. One care assistant said, "I have supervisions. We review the things I wanted to achieve".

The dementia community within the home was known as 'Rosewood'. A team leader had recently been appointed to lead this community and to develop the service. Relatives spoke positively about the changes that had taken place. A relative had written to thank staff saying, 'Just to say how nice the changes in the dementia wing are. The arranging of chairs, the nice table cloths with flower vases, the TV on the wall and the memorabilia dotted around is making it so much nicer for my husband and his fellow companions'. Staff told us how they had noticed a difference in people's demeanour. One care assistant said, "(Team leader) has completely transformed it. It's more homely in here which is what they needed". The team leader told us, "I'm really pleased with how the unit is working out. It makes it better for the residents. They don't seem so frantic around supper time".

Staff had received training in how to support people living with dementia. As the service developed, the aim was that staff would be dedicated to working in Rosewood and would undertake further training, namely the level two diploma in dementia care. Adaptations to the environment, including door stickers to make bedroom doors look like individual front doors and a pictorial menu, had helped some people to become more involved in choices and to move freely around the home. One person had a doll which they cared for as a child. Staff supported this person and treated the doll with care. One staff member told us, "The doll helps keep (name of person) calm". Staff provided individual support and reassurance to people throughout

the day. Staff promoted a non-pharmacological approach to managing distressed behaviours using meaningful activity and occupation to support the people living within the dementia community. People appeared very calm and staff were attentive to the different needs of people.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, 36 applications had been made to deprive people of their liberty and four had been approved.

We checked whether the service was working within the principles of the MCA. We observed that staff asked people's permission before delivering care and involved them in decisions on how and where they wished to spend their time. Some people had consented directly to their care and accommodation at the home, including for specific decisions such as the use of bed rails to prevent them falling from bed. Others had been assessed as lacking capacity to make these decisions and their placement had been made involving healthcare professionals and family members. One person had expressed a wish to return home and staff were supporting them in making arrangements, including with other professionals, to see if this wish could be realised.

Staff understood the requirements MCA and put this into practice. One staff member said, "I discuss with them and try to help them make the right decision for them. I try to encourage them". Another told us, "You don't have the right to impose your views on people". A third said, "If they don't want to do something, they don't have to". We noted examples of decisions that had been made in the best interest of people who lacked capacity to decide for themselves. For example, administering medicines covertly when people were assessed as lacking capacity to understand the risks of refusing. We noted two examples where best interest meetings had been convened to decide how best to support the person. These meetings involved the GP, staff and family members.

Although staff demonstrated a clear understanding of how to apply the legislation, we found that records relating to capacity assessments and involvement were not always clear. For example, the records did not always show how people were supported during the capacity assessments or if anyone else was involved in the decision making process. In some cases, the person had been assessed as having capacity to make a decision but the consent had been signed by a family member who did not have legal authority to take decisions on the person's behalf. We discussed with the deputy manager, how recording could be improved so as to demonstrate the people's rights were consistently respected.

People shared mixed views on the quality and choice of meals available. Some people felt the food was "Marvellous" and "Tasty", whilst others said meals were "Tasteless" and "Monotonous". There had been several changes of Chef during 2016. We met the new Chef who had started in post during August 2016. The home was in a period of transition as regards to the menu. We noted that people were not presented with a choice of meals, although alternatives were offered if people did not like what was served. By the second day of our inspection, people had been asked to choose their meal. The choice sheet demonstrated a variety of options and people told us they were glad to be asked what they would prefer to eat. A new menu was due to be rolled out from the following week. This included a choice of lunch and supper. One person told us, "There is a new chef who is introducing new things so there is hope on the horizon". Another said,

"He (the Chef) is so keen and interested".

The Chef had information about people's dietary needs, such as if they were diabetic or required a soft or pureed diet. There was also information on allergies and preferences. The chef was keen to develop the menu in line with people's wishes. People were asked for their feedback on the meals and the comments shared with the chef. He described how he had already met with some people who had expressed dissatisfaction. He said, "I got to know what (name of person) likes. She wanted seasoning" and told us that curry had been added to the menu. In relation to the new menu he told us, "If they don't like it, I'll take it off the menu". Staff told us that they had noticed an improvement in the meals. One care assistant said, "The chef has made great changes. The food is so much better and people are eating better".

Staff monitored people's weight and regularly reviewed their risk of malnutrition. Where concerns were identified, action had been taken. For some people this included referrals to the dietician and high-calorie nutritional supplements being prescribed. Where people required specific support, staff followed guidelines. One person needed to be positioned in a particular way to reduce the risk of choking or aspiration. This was detailed using photographs in the care plan and staff followed the guidance. A second person was unable to eat orally and received nutrition via a tube directly into their stomach (PEG). The dietician told us, '(Name of person) is well cared for and they follow our advice clearly regarding her feed regimen'.

We observed the lunchtime experience in the main dining room and in Rosewood. Staff were attentive to people's needs. Thy asked for permission before assisting people and engaged in conversation and laughter. Those who required support to eat were assisted, and at a pace that appeared comfortable to them. Staff explained to one person who had reduced vision where each component of the meal was located on their plate. A choice of dessert was served, with staff showing people the different options to encourage them to make a choice.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. A GP visited the service weekly and referrals had been made to other professionals including the Dietician and Speech and Language Therapist (SALT). Recommendations from professionals had been incorporated into people's care plans. For example wound care advice from the Tissue Viability Nurse (TVN) formed part of people's wound care plans. Professionals told us that staff contacted them for advice. The Admissions Avoidance Matron said, "(Deputy manager) will phone me if she needs me". The Chiropodist said, 'If I have found any problems with the residents' feet that I feel needs the doctor to look at they will let the doctor know for me and get them seen'.

The premises had been improved. The flooring in Rosewood had been replaced and murals decorated the walls. This made the environment more vibrant and helped staff to keep the flooring clean. The garden had been transformed, much to the praise of people and their relatives. There were different areas, including a beach with a sandpit and an area for growing vegetables and herbs. One relative told us that visiting children had enjoyed the sandpit during the summer and people had enjoyed watching them play. One relative said, "(Activity coordinator) has done a good job there. It's changing again, it's a seasonal thing. It's going to be a winter wonderland". People told us that they had enjoyed using the garden, which had been entered by the provider into the National Dementia Care Awards.

Good

Is the service caring?

Our findings

People enjoyed the company of staff. One person told us, "They (the staff) are lovely. I love them all". Another said, "They're all very kind". Some people mentioned that they preferred being supported by the staff they knew well. One person said, "All the regular staff know me. The vast majority of staff are very good and very friendly". Relatives had written to the home to express their thanks. We read, 'We as a family feel your staff do a fantastic job. They are unfailingly polite and welcoming' and, 'Thank you so much for your care and support in looking after Mum. This has benefited her. You all do such an amazing job with a smile'. During our visit we observed that staff were kind and attentive to people.

People were involved in planning their care when they first moved to the home. Care plans included information on people's preferred daily routines, their food likes and dislikes and on how they enjoyed spending their time. People had also been involved in arranging their bedrooms. One person told us, "They don't mind how you do it (the décor)". A second person said that they had their own furniture and that shelves had been put up to accommodate their ornaments. People told us that staff understood their needs and that there was flexibility within the daily routine. One person said, "We can have as many (showers) as we want". The activity coordinator told us that she met with people individually to discuss their experiences but the records of these conversations were not available for us to view. This included people's satisfaction with the food, laundry, activities and cleanliness of the home. She shared example of changes that had been made in response to feedback, such as not playing music in the dining room at lunchtime and the addition of curry to the menu. The activity coordinator told us that individual meetings had been more effective than group resident's meetings. However, one person suggested to us that there could be a 'residents' committee'. We shared this feedback with the deputy manager and provider.

We discussed with the deputy manager how there was little evidence of people being involved in ongoing reviews of their care. The deputy manager explained that formal reviews took place on request or if there was a significant change. She told us that they were planning to introduce a more regular pattern of reviews which would include people and, with their agreement, family members. Nevertheless, we noted examples of input from individuals regarding their care. For example, one person had requested not to be checked during the night. In the staff meeting minutes it was recorded that staff were to, 'Honour this wish'. Another person told us they usually gave feedback through chatting with staff. They said, "I know them quite well, I don't have to wait to be asked." In Rosewood, the care plans completed by the new team leader were very person-centred. The team leader explained that she had devised them based on her knowledge of caring for each person but with time she planned to involve people more directly in the process.

The deputy manager had completed training in end of life care with a local hospice and was the home's lead nurse in palliative care. Some people had end of life care plans in place. These described the support people would wish to receive at the end of their lives, who they would like to be with them and where they would prefer to be cared for. There was also detail on any advance decisions, such as to refuse treatment. The deputy manager told us that these conversations usually took place once a person's health had started to decline. We discussed how a more proactive approach and earlier intervention could promote involvement, as people may be more able to contribute to discussion about their wishes.

Relatives told us that staff kept them updated. One relative said, "The nurses always keep me informed of any changes when the doctor visits". A second relative who contacted us said that communication had improved and that they received a weekly email providing updates.

People were supported to be as independent as they were able. One person told us, "They let me do as I like. If I can do things I will do it". Care plans directed staff as to which tasks people could manage independently and where they required support. The aim in one person's care plan was,
'To participate as much as possible in dressing/undressing'. We observed that staff encouraged people to do things for themselves, but were quick to offer support if they were not able.

People told us that staff treated them respectfully and were mindful of their privacy. One person said, "The staff are wonderful. They treat me with affection and respect. They are jolly nice people". We observed that staff were discreet when people needed support, such as to change wet clothing. On the noticeboard we saw the 'Alzheimer's Bill or Rights'. This included statements such that people will be treated as adults and be cared for by staff who are well trained in dementia care. Staff were aware of this. They spoke of their approach and their understanding of dignity. The activity coordinator told us, "It's treating them as individuals. I always make a point to include everyone".

Good

Is the service responsive?

Our findings

Before a person moved the home, nursing staff completed a pre-admission assessment. This detailed the person's medical history, key details regarding their care and information about their preferences. Nursing staff used this and other information, such as a discharge summary if the person was coming from hospital, to plan the person's care and support. Each person had a care plan describing how staff should meet their needs in areas such as communication, mobility, nutrition, sleeping and mental health. This described how the person wished to be supported, how many staff and which equipment was needed. One relative told us, "We went through the whole background, the lot, and we get updates". Another said, that staff were, "Fantastic" and knew their relative's background.

We observed that staff responded promptly to people when they needed assistance or reassurance. People were able to spend their time as they wished. We observed one person who had chosen to eat alone sitting in a sunny spot then wishing to join others at a nearby table. Staff quickly picked up on this and helped the person to move across.

Staff were kept up to date on changes in people's needs through a system of handover. This took place between each shift and written records were maintained. The records showed people's fluid intake and recorded bowel movements. There were also specific notes such as that one person had a cough, that another was appearing disorientated and that a third had been referred to the SALT by the GP. One care assistant told us, "We're all (staff) comfortable and we know what we're doing. I can always speak to somebody. There is always someone to help".

People were able to participate in a variety of activities. One person told us, "They often have shows and things". Another said, "I go down to the lounge and we have a sing-song or reading or someone performs for us". A third said the best thing about the service was, "They do leave us to do what we want. They provide us with lots of activities. There are nice gardens at the back we can go out and sit in". A monthly activity schedule was displayed and individual copies were given to people. This included an exercise and music class, external entertainers, Holy Communion and bingo. A volunteer visited and ran a 'book club' which gave people who liked to read the opportunity to buy and swap books. There were also visits from a 'Pets as Therapy' (PAT) dog. The home had its own minibus and outings were arranged at weekends.

People's individual interests were recorded when they moved to the home. We read that some people liked listening to music and reading books, others enjoyed watching particular sports on television. The activity coordinator told us that they tried to adapt the activity schedule to people's likes and preferences. They also liked to try new initiatives. The week prior to our visit the home had hosted a charity coffee morning. This had been very successful and weekly coffee mornings were now planned. There was also a 'guess the weight of the pumpkin' competition for Halloween and to win a Halloween hamper. People who preferred to stay in their rooms received one to one time with activity staff. One person told us, "Someone comes and reads to me".

People felt able to raise concerns and they knew how to make a complaint if needed. One person told us, "If

I'm displeased with anything, I would say". Two other people told us that they had not needed to complain but would feel comfortable to do so if needed. In staff meetings, the former registered manager had encouraged staff to be open to feedback. We read, 'If the relatives have concerns we should accept this and not see it as a complaint. Our response should always be to assist'. Relatives' meetings had taken place in March and July 2016. The minutes included discussions on staffing, outings and activities. There was also an open time for questions and suggestions. The provider sent out surveys to relatives to ask for feedback. We looked at a selection of responses and saw that action had been taken. For example, a quote had been obtained to replace a bedroom carpet and new staff name badges had been purchased, including temporary badges and visitor badges.

We looked at the record of formal complaints. These had been responded to in line with the provider's policy. In June 2016, one relative had written, 'Thank you for listening to my points and replying in such a positive and helpful way'. The registered manager had maintained a quarterly record of complaints which helped to identify any trends. In the PIR she had noted that the sense of most complaints was that the number of agency staff was too high and that some personal belongings had gone missing. In response, recruitment was on-going and individual staff had been given responsibility for checking people's belongings.

Good

Is the service well-led?

Our findings

People and relatives spoke well of the home. One person told us, "It's a good place to stay". One relative described how they had visited several care homes before deciding on Longfield Manor. They told us, "It feels homely, everyone is kind and caring and I am welcomed here". Another relative had written to thank staff for the use of a room to celebrate their relative's 90th birthday. Staff spoke of how they felt they had a strong team. One care assistant said, "I like this place, it's like a family". Staff told us that they felt able to share any concerns openly.

The home did not have a registered manager at the time of our inspection. The registered manager had left in the middle of September 2016 and was in the process of deregistering with the Commission. People, staff and relatives spoke highly of the former registered manager and the improvements she had overseen at the home. Some relatives shared concerns about the turnover of registered managers. One told us, "We've had six managers in five and half years". Another said, "The problem is constant uncertainty". A third shared that when concerns were raised with the registered managers things changed but sometimes only short-term because the managers had then left.

Recruitment was underway to appoint a new registered manager. In the absence of a registered manager, the deputy manager was leading the service, with support from a representative of the provider. The deputy manager had been given protected time for management responsibilities and was only working limited hours as a registered nurse. Staff spoke positively about the deputy manager. One care assistant said, "(Deputy manager) is supportive". One person told us, "(Deputy manager) is very good". There were regular staff meetings, including all staff, registered nurse, domestic and heads of department meetings. We saw from the minutes that these meetings offered an opportunity to staff to share their views and to be updated by the management. Some meetings included updates on specific training areas such as the MCA or safeguarding and staff had been reminded about forthcoming training dates.

There were systems in place to monitor the quality of the service and to make improvements. We received positive feedback about recent changes in the service. One person told us, "I've been here a year. It has improved in some respects. They do try". A relative said, "The home has got a lot better. The home and staff have improved". An agency staff member said, "They've made improvements here; before I was not happy to come".

Checks had been carried out by the registered manager and were being continued by the deputy manager. There were spot checks which included weight charts, care plans, daily notes and night time observations. Any issues identified during these checks had been addressed with individual staff and reminders were placed in the communication book. Other actions had been completed, for example we read, 'New body maps in place' and, 'All the care notes were tidied up and old sheets replaced'. Call bell response times were checked at least weekly by the deputy manager. This was done by ringing a bell chosen at random and recording the response time. The response times for October 2016 had all been within two to four minutes.

Staff carried out audits on infection control, medicines and hoist slings. The deputy manager completed a

monthly audit of accidents and incidents, hospital admissions and ambulance call-outs. The information was analysed to identify any patterns so that action could be taken to prevent reoccurrence wherever possible. A representative of the provider carried out monthly audits of the service and a provider internal audit had been completed in July 2015. The provider also commissioned external audits of the service. These included a review of medicines by the pharmacy, a quality audit of the service by an external professional and a health and safety audit. Following each audit an action plan was in place. The former registered manager had updated the action plans which showed where actions had been completed or were underway. Improvements included individually named hoist slings, staff receiving the planned number of supervision meetings and an update to the training matrix. In the health and safety audit, the home had improved their score to 92 percent in June 2016, up from 89.5 percent six months earlier.