Sheffield Health and Social Care NHS Foundation Trust

Longley Meadows

Inspection report

Northern General Hospital
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

An unannounced inspection visit to Longley Meadows took place on 17 November 2014.

Longley Meadows is in the grounds of the Northern General Hospital and provides short stay respite accommodation for adults with learning difficulties. Many of the people accessing the service have profound and multiple learning difficulties, including multiple health needs and physical disabilities. The service is has nine registered beds.

The service was last inspected by the Care Quality Commission (CQC) in November 2013 and was found to be meeting regulations relating to respecting and involving people who use services, care and welfare of people who use services, safeguarding, staffing and assessing and monitoring the quality of service provision.

During our inspection we spoke with people and undertook a number of informal observations in order to see how staff interacted with people and see how care was provided. This was because some people accessing

Summary of findings

the service had communication difficulties and were not always able to verbally communicate their experience of the service to us. We also telephoned the relatives of three people on 20 November 2014 in order to gain their views about the service.

During our inspection visit we spoke with the registered manager, deputy manager and two support workers. 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.

Our check of medication records identified that medicines were not always safely managed and recorded. This meant that people accessing the service may not be protected against the risks associated with the unsafe management of medication.

Our review care plans highlighted some gaps and inconsistencies about records at Longley Meadows. Our findings made it difficult to establish whether some plans were current and accurately reflected people's needs. Whilst there was no evidence to suggest that these shortfalls had negatively impacted upon people, the lack of information, review and recording within some key documents meant that people may not be protected against the risks of receiving inappropriate care and treatment.

Whilst detailed checks took place in relation to health and safety and the premises, we identified that audits relating to key areas of practice did not take place. For example, the shortfalls identified during our inspection in relation to medicines, equipment and records had not been identified or highlighted by an internal auditing system.

Observations throughout our inspection demonstrated that people were supported safely by staff who knew their individual needs and preferences. Conversations with staff and our observations showed us that staff offered and involved people in a range of day to day decisions. People were treated with dignity and respect throughout our inspection. Staff were aware of people's differing cultural and religious needs.

Relatives contacted following our inspection were confident that their family members were safe when staying at Longley Meadows. Our conversations with staff and our review of records demonstrated that staff identified safeguarding issues and followed local procedures in order to safeguard people. .

Staff were appropriately vetted to ensure they were suitable people to work with vulnerable adults before starting work. There were enough staff to safely meet people's needs in a timely manner. Staff had appropriate qualifications, knowledge and skills to perform their roles and there were systems and opportunities for staff to develop their skills and discuss good practice.

People were appropriately supported to make decisions in accordance with the Mental Capacity Act, 2005 (MCA). Staff demonstrated a good understanding of these pieces of legislation and how they applied in practice.

Our observations of a meal time and our review of records evidenced that people's nutritional needs were met. People's physical health needs were monitored and referrals were made when needed to health professionals.

People were supported to access existing day time and evening activities during respite stays at Longley Meadows. The service had an open and transparent culture that actively encouraged feedback from people who used the service, their relatives and staff.

Our inspection identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have asked the provider to take at the back of the full version of this report.

Summary of findings

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 consistently safe. People's medicines were not always safely managed and recorded. The lack of a consistent method of checking medicines in received and returned increased the risk of medicines not being administered safely. Some pieces of equipment were found to be out of date and may not be safe to use.

People were safeguarded from the risk of abuse; staff knew how to identify and report abuse. An effective recruitment process was in place.

There were enough staff on duty to ensure people were safely supported. Staffing numbers were matched to the number and needs of people receiving respite care at the service. Support was available for staff outside of office hours.

Is the service effective?

Good

The service was effective.

Longley Meadows were meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training and demonstrated a good understanding of the DoLS and the Mental Capacity Act and how these applied in practice.

People received care that met their individual needs. Staff were qualified, skilled and knowledgeable about their roles and received appropriate support through the provision of training, supervision and appraisal of their work.

People's nutritional needs were met and their physical health needs were monitored.

Is the service caring?

Good

The service was caring.

Relatives told us the staff were kind and caring and that they were happy with the way in which Longley Meadows cared for and met the needs of their family members.

Observations and conversations with staff demonstrated that they had a good understanding of people's individual needs and preferences.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

We found that the care plans did not always reflect people's needs and contain accurate and up to date information. This, together with lack of review and recording within some records meant that people may not be protected against the risks of receiving inappropriate care and treatment.

Summary of findings

People's needs were assessed. A complaints process was in place and people and relatives told us that they felt able to raise any issues or concerns.

The service provided a range of external and internal activities and interactions to meet people's differing needs. For example, people were supported to access the on-site sensory room and, when possible were supported to go for walks and access local shops.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Audits relating to key areas of practice did not take place. For example, the shortfalls identified during our inspection in relation to medicines, equipment and records had not been identified, or highlighted by an internal auditing system.

The registered manager and team leader were visible and provided opportunities for people, relatives and staff to raise concerns and influence the service. Longley Meadows had commissioned a project with an external provider to ensure that they were actively seeking the views and people and their relatives in order to continually improve the service.

Longley Meadows

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.

Our inspection took place on 17 and 20 November 2014 and was unannounced. The inspection team consisted of an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who used this type of care service.

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. Prior to our inspection visit we reviewed the information included in the PIR, together with information we held about the home. We also contacted the person leading a project the provider had commissioned in order to gain and understand the experiences of people who used the service and their relatives.

During our inspection we used different methods to help us understand the experiences of people receiving respite at Longley Meadows. We spoke with two people who used the service and also undertook informal observations in order to see how staff interacted with people and see how care was provided. This was because some of the people who used the service had communication difficulties and were unable to verbally tell us about their experience of the service. We also telephoned the relatives of three people in order to gain their views about the service.

We spoke with the registered manager, deputy manager and with two support workers in order to ask them about their experience of working at Longley Meadows.

The provider's contract GP and a psychiatrist visited Longley Meadows during our inspection. We spoke with both professionals in order to gather their experience of working with Longley Meadows.

We reviewed a range of records during our inspection visit, including six care plans, daily records of people's care and treatment, and policies and procedures related to the running of the home. These included safeguarding records, quality assurance documents and staff training records.

Requires improvement

Is the service safe?

Our findings

One person told us that they received their medicines on time. None of the relatives spoken with following our inspection raised any concerns about medicines. They told us that staff always asked about medicines and any medication changes during a pre-respite telephone call from the service. The registered manager told us that they obtained up to date prescriptions from people's doctors throughout the year, and after being informed of any medication changes. This was to ensure that the medication people brought with them corresponded with their prescription.

We observed the nurse on duty dispending and administering a number of medications to one person. They had a patient and caring approach; they took time to explain the medication and remained with the person until they had taken the medication. The nurse then returned to the medication trolley in order to sign the medication administration records, (MARs) to record that the medication had been taken. We reviewed the MARs for this person and another person. Each medication dose had been initialled to record that the medication had been given. There were no gaps in the two MARs reviewed.

We noted that the MARs did not record the amount of medication checked in and returned following people's stays at the service and spoke with the deputy manager about this. They informed us that nurses used to physically count people's medicines when they arrived at the service and undertake a further check when they left the service. However, they said that nurses no longer had time to do this. The only exception to this was when people were prescribed controlled drugs. These are medicines which are subject to regulation and separate recording. The lack of recording medicines in stock and those administered meant that we were unable to verify that medicines were administered as prescribed.

We found that people's medicines were appropriately stored. Controlled drugs were also stored safely in a separate lockable cupboard within the medication room. We checked the controlled drugs book and found that controlled drugs were recorded correctly and that the medication in stock corresponded with that recorded in the book.

We noted that a number of other medicines, including controlled drugs were stored within the controlled drugs cupboard and asked the registered manager about these. They told us that these were, 'stock' medicines which were supplied by the trusts pharmacy department. We asked the registered manager how these medicines were recorded. They informed us that they were recorded in the front of the controlled drugs book; however, on checking this, we saw these medicines were not recorded. The registered manager immediately recorded these controlled drugs and medicines in the front of the controlled drugs book. Whilst immediate action was taken, we identified that there were no checks to record, check and account for these 'stock' medicines.

Our findings demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the providers training records. Each nurse had received designated medication officer training. The deputy manager told us that this training included a competency assessment and that, in addition to this regular medication competency checks were undertaken to ensure that nurses were safely administering medicines. Our review of records confirmed these checks took place.

We checked a number of pieces of equipment which were stored in the medication room. A label on a mobile suction unit stated that it was due to be serviced in October 2014. Our check of records and our conversation with the registered manager and deputy manager identified that this service had not taken place. Our check of the emergency bag that contained resuscitation equipment identified that the defibrillator pads had expired in October 2014. The three health and safety checks which had been undertaken between October and the date of our inspection had failed to identify these shortfalls.

In light of the above, we checked a number of other pieces of equipment in order to ensure they were safe and properly maintained. We found that a range of equipment was in place to support the independence and meet people's needs. For example, we saw that ceiling track hoists were in place throughout the building to enable people to safely transfer. We looked at the ceiling track hoists, three beds and two specialist baths. Each item was

Requires improvement

Is the service safe?

clean, was in good condition and fit for purpose. Our review of records provided evidence that checks of these pieces of equipment took place to ensure that they were properly maintained and in safe working order.

We found that staff had received training in how to use equipment safely and correctly. Our observations and conversations with staff provided further evidence of this. One member of staff told us that moving and handling training was provided on-site and was positive about the benefits of this. They told us that the training was, 'hands on,' and said that this had meant that they could discuss the equipment in place and the day to day issues they may encounter when supporting people to move safely. Our review of training records showed us that each member of staff had received moving and handling training within the provider's two yearly timescale.

Relatives contacted following our inspection were confident that their family members were safe when staying at Longley Meadows. One relative stated, "Its 100% safe. My [family member] tells me everything when they get home and I've never heard anything that's worried me."

The providers GP visited during our inspection. They felt that the service was safe and told us that Longley Meadows contacted them promptly in order to look at any bruising or other unexplained injuries they were concerned about. The psychiatrist who visited during our inspection told us that their visits were usually unannounced and said that they had never observed any unsafe or concerning practice. Our conversations with staff and our review of records demonstrated that staff identified safeguarding issues and followed local procedures in order to safeguard vulnerable adults.

There were enough staff on duty to ensure people were safe. Staff spoken with during our inspection told us that staffing numbers were tailored to meet the individual needs and numbers of people receiving respite care. One member of staff who had worked at the service for a number of years commented, "We've got more staff than we've ever had. We rarely run short." When needed, the staffing team were supported by staff from the providers own flexible staffing pool. We were told that these staff had worked at the service for a number of years and were familiar with people's needs. Staff told us on call managers were available for support outside of office hours.

An effective recruitment process was in place. The four staff files reviewed reflected the provider's recruitment policy and corresponded with our conversations with members of staff about their recruitment. Each file contained the required information and checks.

Our conversation with the deputy manager and our review of records demonstrated that there was a system in place to record, analyse and learn from incidents which had resulted in harm or had the potential to result in harm. Support workers were clear about the incident reporting process. The deputy manager told us that they reviewed incident forms and provided examples of the action and learning undertaken to reduce risk and the likelihood of similar incidents.

Good

Is the service effective?

Our findings

One person described the support and care they received at Longley Meadows as, "Fabulous". Each relative we spoke with was positive about the support their family member received. One relative told us, "My [family member] likes going to Longley Meadows and has always been well looked after there."

We reviewed the provider's training records and noted that some training courses which may relate to the needs of people with learning difficulties had not been provided. For example, a number of people who accessed Longley Meadows had epilepsy. Whilst staff said that they knew how to respond to people's seizures due to information within care plans and familiarity with people's seizure patterns, our review of training records identified that 21 of the 23 listed members of staff had not received epilepsy awareness training. Similarly, 13 members of staff had not received 'respect' training. This is a person centred model of preventing and managing behaviours which may challenge. One member of staff said they had requested this training.

Given the needs of people supported by Longley Meadows, there was likelihood that not providing epilepsy and 'respect' training courses may increase the risk of people receiving unsafe care and treatment. We discussed this with the registered manager. They said they had requested places on the 'respect' training course for staff but said that these were often limited. The agreed to make a further request for places and said they would arrange epilepsy training.

Our conversations with staff and review of records showed that a number of courses relevant to supporting people with learning difficulties had been provided. For example, staff had completed courses in effective communication, autism awareness and care and compassion. Relevant mandatory courses, such as basic life support and food hygiene training had also been provided.

Staff welcomed the further training and personal development opportunities they were given. The two support workers we spoke with told us they had completed level one and two National Vocational Qualifications (NVQs) and were currently undertaking level three qualifications in care.

One member of staff was positive about the way in which the registered manager had supported them to progress from their previous role as a cook/housekeeper to their current role as a support worker. Our conversation with this member of staff and the deputy manager demonstrated that new staff and staff who had changed roles received a comprehensive induction. This enabled them to get to know the tasks and responsibilities of their job role. The induction included mandatory training, as well as a period of time to shadow established members of staff in order to meet and get to know the needs of people using the service.

We spoke with staff about supervision and appraisal. Supervisions ensure that staff receive regular support and guidance and appraisals enable staff to discuss any personal and professional development needs. Our review of the provider's supervision records identified that supervision for support workers and clinical supervision for nurses was occurring less frequently than the providers six to eight weekly timescale. Staff were not concerned by these shortfalls. They said they contact either the registered manager or deputy manager should they need any support or guidance. One member of staff commented, "I can go to the manager or deputy with anything. They're very approachable." We found that each member of staff had received an appraisal within the past 12 months.

The registered manager said that a move to new, purpose built premises had been discussed for several years. They said that people and family carers wished the service to remain at its current location and that a significant amount of money had therefore been spent on improving and developing the premises.

The registered manager took us on a tour of the premises. Each area of the property was clean, tidy and odour free. Adaptations and equipment was in place throughout the premises to meet people's differing needs. For example, there were different types of baths and beds as well as changing beds for people who needed full support to wash and dress. We noted that the equipment in place in some rooms made the environment appear clinical. For example, a number of bedrooms contained dressing trolleys, usually seen within hospital environments. These detracted from the homely feel of the rooms.

Whilst there was no evidence of any impact upon people who used the service, we noted that some rooms were quite small. Staff spoken with during our inspection also

Good

Is the service effective?

commented on this and other elements of the premises. For example, one member of staff said that it was difficult to manoeuvre wheelchairs in the smaller rooms and around corridor areas of the building, whilst another member of staff commented, "The building really lets us down."

The Mental Capacity Act (2005), (MCA), is a legal framework which prompts and safeguards decision-making. It sets out how decisions should be taken where people may lack capacity to make all, or some decisions for themselves. The basic principle of the act is to make sure that, whenever possible, people are assumed to have capacity and are enabled to make decisions. Where this is not possible, an assessment of capacity should be undertaken to ensure that any decisions are made in people's best interests.

The psychiatrist who visited the service during our inspection felt the staff team were knowledgeable about the MCA and said they were always able to answer any questions they may have about people's capacity. Our conversations with staff confirmed this. Each member of staff had a clear understanding of the Act and how it related to their practice.

Staff were also knowledgeable about the Deprivation of Liberty Safeguards (DoLS). The safeguards are part of the MCA and aim to ensure that people are looked after in a way which does not inappropriately restrict their freedom. The registered manager had submitted DoLS applications for a number of people following a Supreme Court ruling earlier in the year. We reviewed the DoLS in place for one person and found that the correct procedure had been followed. The registered manager had also arranged for a DoLS assessor to attend a recent meeting in order to explain and provide information about the safeguards to family carers.

People were supported to eat appropriate food and drink that met their individual needs. Menus took people's nutritional needs, preferences and allergies into account.

Staff told us that they cooked a fresh meal each evening. We observed the evening meal of fish, mashed potatoes and vegetables followed by a yogurt or jelly. One person described their meal as, "Great." We saw that staff provided assistance when needed and noted that appropriate cups, plate guards and large handled cutlery were in place to promote people's independence when eating.

A number of people who received respite at Longley Meadows had swallowing difficulties and/or specific nutritional needs. Staff had received training about nutrition and were able to explain how they prepared softened diets, thickened fluids and how people should be positioned to ensure safe swallowing. We saw records documenting that nurses had been trained and were competent to administer nutritional fluids through a Percutaneous Endoscopic Gastronomy (PEG) tube. This is a tube which is placed directly into the stomach, through which to receive fluids, medication and nutrition. We observed a nurse administering fluid to a person through a PEG tube. They supported the person to move from the dining area to another area of the building in order to preserve their dignity and privacy when administering the fluids. They then ensured that the person was in the correct position and explained each step of the procedure to them.

Our review of records together with conversations with staff and the psychiatrist who visited the service during our inspection showed that Longley Meadows effectively met people's healthcare needs. The psychiatrist told us that the service were responsive to any changes in people's health needs and contacted them to discuss any medical or psychiatric queries they may have. They also told us that the staff were knowledgeable about people and their needs. For example, they said that the purpose of their visit was to get an update about the needs of four people who used the service and commented, "The staff knew each person's needs and didn't need to look at their care plans. I was so impressed."

Good

Is the service caring?

Our findings

Relatives spoken with following our inspection were positive about the care their family members received at Longley Meadows. One relative told us that the service was, "So thoughtful and caring." A second relative stated, "Longley Meadows are genuinely caring and concerned."

Staff spoke in a fond and caring way about people and told us that they enjoyed working at Longley Meadows. One member of staff told us, "I love coming to work; it's more like spending time with good friends and family because so many service users and staff have been here so long." Another member of staff stated, "It's the best place I've ever worked. We have a fantastic rapport with clients and their parents."

Our observations confirmed that staff had a positive rapport with people and that people were treated kindly and with respect. A number of people receiving respite care at the time of our inspection had communication difficulties. Throughout our inspection we saw that staff spent time talking with each person, regardless of their communication difficulties. For example, on entering areas of the home, members of staff greeted each person in the room by saying, "Hello" and "How are you?" When speaking with people who had communication difficulties this greeting was supported by shaking people's hands or by gently touching peoples arms. Throughout our inspection we saw that staff consulted and explained any care or support they provided. They then observed and gave each person time to respond to the information and/or any choices presented to them. People responded positively to the person centred approach of staff and demonstrated this by eye-contact, positive body language, smiles and laughter.

Our observations showed us that members of staff encouraged people to make decisions and promoted people's independence wherever possible. For example, we saw one member of staff encouraging and supporting one person to hold a cup independently and saw that another member of staff encouraged a person to choose and independently reach for their choice of pudding. Some people's care plans also contained information about how to promote their independence. For example, one person's care plan had a section titled, 'how I help with my personal care' and stated that the person's independence should be promoted by encouraging them to, 'Push their arms into sleeves and their legs into trousers.'

Observations throughout our inspection demonstrated that the staff at Longley Meadows had a clear knowledge of the importance of dignity and respect and were able to put this into practice when supporting people. We noted that staff discreetly altered people's clothing to protect their dignity and routinely knocked on bathroom and bedroom doors before entering.

Our conversations with staff provided further evidence of how the service respected people's privacy and dignity. For example, when explaining how they supported people with personal care tasks in the morning, one support worker told us, "I knock on the door and then tell people my name, why I'm there and what I'm going to be helping them with. I explain every step before I do it so people know what I'm doing next." Another member of staff told us that they maintained people's confidentiality by, "Not discussing information about people openly and in front of other people. We always make sure that handover and team meetings take place in private areas of the building."

Our conversations with staff and our review of records demonstrated that Longley Meadows were aware of, and respected the different cultural and religious needs of people who used the service. For example, we saw that the recent upgrade of the premises included the creation of a small multi-faith room to meet people's spiritual and religious needs. A ceiling track hoist ran into the room in order to ensure it was accessible to each person who may wish to use it. The room included washing facilities, prayer mats, a sign on the wall to inform people of the direction for prayer and differing religious texts.

We found that staff were knowledgeable and respectful of the differing cultural and religious needs of people who used the service. For example, staff told us that they matched the gender of staff on duty to people's preferences and cultural needs. They also informed us that halal foods were obtained from a local butcher and showed us the separate area and utensils used for storing and preparing these foods. We noted that people's care plans contained information about their spiritual and religious needs. Our review of training records showed us that most staff had received equality and diversity training.

Requires improvement

Is the service responsive?

Our findings

Our review of six people's care plans highlighted some gaps and inconsistencies. Observations throughout our inspection demonstrated that people were supported safely by staff who knew their needs and preferences. Whilst there was no evidence to suggest that the shortfalls identified in people's records had negatively impacted upon them, the lack of information, review and recording within some key documents meant that people may not be protected against the risks of receiving inappropriate care and treatment.

Whilst some care plans were detailed and contained comprehensive information detailing people's needs and the support they required, other care plans lacked detail and contained duplicate records about the same area of need with differing information. For example, one person's care plan contained two differing care plans about their nutritional needs. One of these care plans noted some specific dietary needs; the other care plan did not mention these needs. The care plans for two people contained two different profile documents which again provided some differing and contradictory information. The profile document within the care plan folder of another person had not been completed.

We saw copies of referrals made to the 'Alternative to Restraints team,' part of the local Community Learning Disability Team within people's records. These referrals were made to ensure that the least restrictive alternatives were considered prior to restraints such as lap-belts being put in place to safeguard people. One person's plan contained a partially completed restraints form about the use of lap straps and harnesses. A restraint detailed in one person's care plan had not been reviewed since September 2011 to see if it was still required. The registered manager agreed with our findings and informed us of their intention to undertake a review of restraints.

We found that people's care plans contained detailed information about their preferences, likes and dislikes. We saw that staff knew people's likes, dislikes and the people and things which were important to them. For example, one support worker told us, "I know all the little things that make a difference such as who has sugar in their tea, who doesn't like noise, who likes action movies and who likes musicals." We heard staff using this information to prompt their interactions and conversations with people. For example, one member of staff spoke of one person's love of motor racing and imitated fast car noises. This prompted laughter and smiles from the person concerned.

We spoke with the registered manager and deputy manager about how people's needs were assessed, planned and reviewed. On receiving a referral, the deputy manager told us that information was gathered by arranging a home visit to meet the person and their family. The deputy manager also told us that they requested information and /or visited other services accessed by the person in order to gather further information. The information gathered from these visits and assessments was then incorporated into the services assessment document. The registered manager told us that the assessment was, "Built around the needs of the person and their family."

The completed assessment was shared with the person and their relatives to ensure its accuracy. Following this, 'tea visits' were arranged for the person and/or their relatives to visit Longley Meadows. The number of visits was based around the needs of the person. When appropriate, an overnight stay was then arranged. As with tea visits, the registered manager told us that some people required a number of overnight stays to get used to the service before then receiving respite for a longer period of time. The deputy manager told us they visited people and their relative's to review the progress of these visits prior to longer respite stays being arranged. Our conversations with relatives confirmed that this review, as well as reviews for people who had accessed the service for a number of years took place.

Staff told us that they were encouraged to report any changed needs to nurses so that people's care plans could be updated. They also told us that the deputy manager listed any care plans for people new to the service, or changes to the care plans of people who already accessed the service, on a board within the office area. Staff then read these plans in order to ensure their knowledge was up to date.

Members of care staff told us that handover meetings took place at the start of each shift. We reviewed the notes used to inform this meeting and found they contained detailed information about how people had been during the shift and the needs they had been supported with. Some people continued to access their day services and activities with

Requires improvement

Is the service responsive?

other community providers during their stays at Longley Meadows. Staff told us that communication with these services was good and that key information was shared by meetings, phone calls and communication books.

We found that Longley Meadows provided a range of internal and external activities and interactions to meet the differing needs of people who used the service. For example, during our inspection we saw that one person was supported to use the on-site sensory room. This contained a range of different coloured lights and objects such as bubble tunes, fibre optic strands of light and vibrating tubes to promote a relaxing and calming environment. The ceiling track hoist which could be used to access this room was described by the registered manager as, 'the star ship enterprise' as it also contained different coloured lights.

We found that objects and activities liked by people who accessed the service were placed around the building. A corridor area housed an electronic organ favoured by one person and the registered manger showed us that a board with objects to grasp and 'post' had been positioned at wheelchair height specifically for one person who used the service.

The psychiatrist who visited the service during our inspection told us that they often saw staff providing activities and appropriate interactions with people. For example, they told us that they had seen staff massaging people's hands, engaging people in games of catch using soft balls and encouraging people to dance. Staff told us that they tried to go out for walks and visit local shops with people at weekends.

Relatives spoken with following our inspection visit told us they had no complaints with the service. One relative said they were confident that the staff and Longley Meadows would listen and do their best to address any concerns they may have. The registered manager confirmed that there were no current complaints at the service. They told us that they encouraged feedback from people and their relatives in order to review and improve the care and support provided. The registered manager informed us that the results of the last relative's survey had identified that some relatives did not know how to make a compliant. In order to address this, complaints leaflets had been sent out and information about how to make a complaint had also been included in the newsletter sent to people and their relative's. This demonstrated that Longley Meadows actively encouraged complaints and feedback about the service.

Requires improvement

Is the service well-led?

Our findings

Members of staff spoken with during our inspection were positive about the registered manager and the deputy manager. One member of staff described the registered manager and team leader as, “Approachable” and said, “They look after us.” Another member of staff told us that the registered manager, “Does his upmost to support us.”

Care staff were positive about the way nurses and the registered and deputy manager led the service. They said they felt valued and said the registered manager acknowledged and praised good practice and also provided feedback about any practice they felt could be improved. The registered manager was visible throughout our inspection; they had a positive rapport with people and spent time interacting with people.

The deputy manager was appreciative of the way the registered manager had supported them to develop their leadership skills. They told us that the registered manager had encouraged them to undertake a leadership programme in Leeds. Whilst challenging at times, the deputy manager said that overall, this course had been a positive experience and had enabled them to develop their confidence and leadership style.

During our inspection we looked at a range of records and spoke with a number of staff in order to review how the quality of care provided by Longley Meadows was monitored and safely maintained.

Our conversations with staff and our review of records provided evidence that a number of weekly checks in relation to the health and safety and the premises took place. For example, we saw a comprehensive weekly health and safety inspection took place which incorporated areas such as fire safety, food hygiene and safety and electrical equipment. We also saw a copy of a recent infection control audit and noted that the service had carried out the actions needed to address the shortfalls identified in an initial audit and had achieved a score of 99% when re-audited.

Whilst the registered manager told us that the quality of the service was reviewed within regular governance meetings, we found that audits relating to key areas of practice did not take place. For example, the shortfalls identified during our inspection in relation to medicines and records had not been identified by an effective internal auditing system.

The deputy manager told us that they checked the care plan documents completed by nurses and feedback any shortfalls within supervision sessions. When asked, they said that they did not use an audit document to benchmark standards, ensure consistency and enable them to identify any recurring patterns or trends .Similarly, the registered manager told us that they undertook a ‘walk round’ each morning and asked staff to address any shortfalls they identified during this, but did not record this.

Where audits were in place, we found that these were not always effective in practice. For example, the three health and safety checks which had been undertaken between October and the date of our inspection had failed to identify that some pieces of equipment were out of date and therefore potentially not safe. Our findings provided evidence that Longley Meadows did not have an effective comprehensive system in place to continually assess, monitor and improve all aspects of the service.

Our findings demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff spoken with during our inspection told us that staff meetings took place and our check of records verified this. We noted that the meetings included discussions about the service in general as well as a ‘clinical’ section to discuss any specific needs or observations about people who had received, or were due to receive respite. Staff told us that they were able to raise issues within these meetings and felt that their views and contributions were listened to. They also told us that they valued the way in which these meetings provided them with the opportunity to discuss people’s needs and share best practice.

We looked at how Longley Meadows gathered the views of people and their relatives in order to improve the service. Relatives told us that their views were obtained at coffee mornings and by a relative’s questionnaire. We reviewed a copy of the relative’s questionnaire and found that the results of this were positive. The questionnaire asked if relatives had any suggestions about how the service could be improved. Suggestions made by respondents were listed as actions within the survey. This showed us that Longley Meadows had listened to relatives comments.

Requires improvement

Is the service well-led?

We found that a meeting had recently taken place with a sister service and had been attended by people and their relative's. We reviewed the minutes of this meeting and found that the meeting provided a range of information about key areas of the service. A visiting speaker had also attended in order to speak about and provide written information about the Mental Capacity Act and Deprivation of Liberty Safeguards.

We found that people and their relatives were invited to view the changes made to the premises earlier in the year. The registered manager showed us a letter sent by relatives following this visit. This thanked the provider for the thought and consideration given to the changes made to the premises.

In order to further gain and understand the experiences of people who used the service and their relatives, the provider had commissioned a project from Sheffield Mencap Sharing Caring Project, an external, impartial organisation. Longley Meadows mentioned this project within their provider information.

We contacted the person leading this project prior to our inspection. They told us that they were in the process of scoping the project and developing a steering group involving people who used the service and their relatives. From previous engagement with the service, they told us that Longley Meadows, "Routinely engages well with family carers." They were positive about the forthcoming project and the services wish to work in partnership with them in order to understand people's experiences of the care provided, and look at any areas of improvement. They also told us that there was a commitment from the provider's senior leadership team to make sure that, "Outcomes are embedded in practice."

The registered manager told us that a staff questionnaire had taken place earlier in the year and said that a 'micro-systems' approach involving staff had recently begun in direct response to this. The registered manager told us that this was a partnership approach with staff in order to look at how the service could change workplace practices and systems in order to continuously improve quality and make, "Good things happen."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people' received. Nor did they have an effective system place to identify, asses and manage risks to the health, safety and welfare of people who used the service and others.