MPS (Investments) Limited

Longton Nursing and Residential Home

Inspection report

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Longton
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Ratings

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

Overall summary

This was an unannounced inspection which meant the provider did not know we were coming. It was conducted on the 6 May 2015.

Longton Nursing and Residential Home provides accommodation for up to 58 people who need help with personal or nursing care needs. Respite care can also be arranged. The home has four lounges and a spacious dining area. Large landscaped gardens are accessible for those wishing to utilise them. Private accommodation is on two floors and a passenger lift allows easy access to both levels. Twin rooms are also available for those wishing to share facilities. The home is situated in Longton, which is a pleasant suburb of the City of Preston. The home has good access to local amenities and transport links to the surrounding areas. Ample car parking space is available at the home.

We last inspected this location on 2 March 2015 in response to concerns raised. At that time we found the home was not compliant in the areas of respecting and involving people who use services, staffing and assessing

Summary of findings

and monitoring the quality of service provision. We asked the provider to submit an action plan telling us how and when they would make improvements. This was received. During this inspection we found these concerns had been addressed. However, further improvements were still needed.

At the time of our inspection to this location the registered manager was on duty. She had been in post for several years. 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 registered manager and her staff team were very co-operative during our inspection. We were provided with the records we requested in a timely manner.

During the course of our inspection we toured the premises and found the standard of cleanliness to be satisfactory. Clinical waste was being disposed of in accordance with current legislation and good practice guidelines. However, most areas of the home were in need of upgrading and modernising. We established that 25% of people who lived at Longton Nursing and Residential home were living with dementia. However, the environment was not dementia friendly and did not promote best practice for those clients.

Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use. However, some areas of risk had not always been managed appropriately. Legal requirements had been followed in relation to Deprivation of Liberty Safeguards (DoLS).

We looked at medication procedures within the home and found failings, which meant that people were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed.

Recruitment practices adopted by the home were robust. This meant that new employees were deemed fit to work with this vulnerable client group before they commenced employment. Induction programmes for new employees were formally recorded. Regular supervision and annual appraisal meetings for staff were arranged and training documents were up to date. This meant that the staff team were supported to gain confidence and to deliver the care people needed.

People were supported to access advocacy services, should they wish to do so, or if a relative was not involved and they were unable to make some decisions for themselves. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

We found people's privacy and dignity was not consistently protected and the planning of people's care varied. Some records were person centred and well written, providing staff with clear guidance about people's needs and how these were to be best met. Others contained basic information only and did not cover all assessed needs or how people wished their care and support to be delivered.

The provision of activities could have been better. On the day of our inspection people were not engaged in meaningful activities throughout the day. The activities co-ordinator told us she had been asked to work in the kitchen to cover staff shortages. This did not allow for activities to be consistent or provided in accordance with the planned programme of activities.

Systems for assessing and monitoring the quality of service provided were not always effective and confidential records were not retained securely.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for person-centred care, dignity and respect, need for consent, safe care and treatment, premises and equipment and good governance.

You can see what action we told 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

This service was not safe.

Medicines were not always managed consistently because they were sometimes left unattended and those who needed assistance, received their medicines in an unhygienic manner.

People who lived at Longton Nursing and Residential Home told us they felt safe living there and were happy with the cleanliness of the environment, which we found to be of a good standard.

The staff team had been trained in safeguarding adults and whistle-blowing procedures. The recruitment practices adopted by the home were robust. This helped to ensure people were protected from harm.

Risks to people's health, welfare and safety had not always been managed well.

Is the service effective?

Requires improvement

This service was not effective.

Formal consent had not been obtained in relation to various areas of care and treatment. However, freedom of movement within the home was evident and we did not observe this being restricted. People's rights were protected, in accordance with the Mental Capacity Act 2005.

Staff employed at the home were knowledgeable and experienced. They had the right skills and attitudes to provide the appropriate care and support.

The induction of new staff was thorough, which helped them to meet people's needs and to be aware of their responsibilities. Regular supervision and annual appraisals were conducted, which linked in to the comprehensive training programme.

Some areas of the environment were in need of updating and modernising. Improvements were needed to make it a dementia friendly environment.

Is the service caring?

Requires improvement

This service was not consistently caring.

People's privacy and dignity was not always promoted in day-to-day practice. However, plans of care we saw incorporated the importance of respecting people.

Everyone we spoke with felt that staff were kind, caring and respectful and that they were very patient and took their time when helping people.

Summary of findings

People were supported to access advocacy services, should they wish to do so, or if a relative was not involved and they were unable to make some decisions for themselves.

Is the service responsive?

Requires improvement

This service was not responsive.

An assessment of people's needs was conducted before a placement was arranged. This helped to ensure the staff team were confident they could provide the care and treatment needed by each individual.

Care plans were found to have been completed, but the standard of these varied. Some were well written, person centred documents, but others lacked important information and did not provide staff with clear guidance about people's needs, or how these were to be best met. Information about how people wished to be supported and what they liked or disliked was not always recorded.

Complaints were being well managed and people we spoke with were confident about raising their concerns, should the need arise.

Some activities were provided, but these were not consistent and could be more person centred.

Is the service well-led?

Requires improvement

This service was not consistently well-led.

Confidential records were not retained in a secure manner and systems for assessing and monitoring the quality of service provided were not always effective. This was because the auditing system had not identified the shortfalls we found at the time of our inspection.

Annual surveys were conducted. This enabled the registered person to gather the views from a wide range of people with an interest in the home about the quality of service provided.

A variety of meetings were held for those who lived at the home, family members and the staff team, so that relevant information could be passed on and so that people had the opportunity to raise any concerns or areas of good practice during an open forum.

Longton Nursing and Residential 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 6 May 2015 by two Adult Social Care inspectors from the Care Quality Commission, who were accompanied by an Expert by Experience. An Expert by Experience is a person who has experience of the type of service being inspected. Their role is to find out what it is like to use the service. This was achieved through discussions with those who lived at Longton Nursing and Residential Home, their relatives and staff members, as well as observation of the day-to-day activity.

At the time of our inspection of this location there were 58 people who lived at Longton Nursing and Residential Home. We were able to speak with 14 of them and seven family members. We also spoke with eight staff members and the registered manager of the home.

We toured the premises, viewing a selection of private accommodation and all communal areas. We observed people dining and we also looked at a wide range of records, including the care files of seven people who used the service and the personnel records of three staff members. We 'pathway tracked' the care of five people who lived at the home. 'Pathway tracking' enables us to determine if people receive the care and support they need and if any risks to people's health and wellbeing are being appropriately managed.

We also conducted a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk with us. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We also requested feedback from nine community professionals, such as medical practitioners, district nurses and specialist nursing services. We received one response, which provided us with positive feedback about Longton Nursing and Residential Home.

Requires improvement

Is the service safe?

Our findings

People who lived at Longton Nursing and Residential Home and their visitors all felt the home was a safe environment. We asked if people felt able to talk with someone if they were worried or upset. One person said, "I feel I am able to talk to someone if I am anxious" and another told us, "If I am worried, the deputy matron is very good."

Other comments we received from those who lived at the home included: "I have been here a long time and I am more than happy. The staff work so hard and make sure we are kept safe"; "Carers are around if we need them. If we need anything they are straight over" and "It is very safe. It is brilliant." One person told us that she required help being transferred to and from a chair. She added, "This is always carried out by two staff members, even though they may be short staffed." However, one visitor told us, "I have some concerns due to my relative's poor vision and she is not good on her feet." This visitor was unaware of any particular measures in place to reduce the risk of falls, of which she had experienced 'one or two'. Another visitor felt the home was safe, but that her relative was upset by others when they shouted out aggressively. She told us that sometimes people who lived at the home did get angry with each other, but that there were always two members of staff in the lounge, who responded 'nicely' to any confrontations.

We asked people who lived at the home if they felt call bells were answered quickly. One person said, "It depends. I just wait. They (the staff) don't forget to come" and another told us, "I use my buzzer and they come quickly." Comments from relatives included: "Call bells do seem to be ringing for a long time"; "There have been times when I have been here when people have asked for assistance, but they are always changed when necessary"; "Each time I come in there are plenty of staff around. I have never seen any problems. The carers are really supportive" and "I have never seen anything that's has me worried. I feel people here are well looked after and cared for."

One risk assessment showed the individual could be confused at times and was at high risk of falls. Therefore, bed rails with bumpers were used. However, the plan of care for this person showed that the bed rails had been removed. This again provided contradictory information for staff. The risk assessment for one person showed they were at high risk of developing pressure sores and were in need of two hourly positional changes. However, a specific plan of care for this area of need had not been generated. Therefore, staff were not provided with clear guidance about how to manage pressure care for this individual, although it was evident that specialised pressure relieving equipment had been provided. A further risk assessment showed the person to be at low risk of malnutrition. However, evidence was available to demonstrate this person currently had a very poor dietary and fluid intake, which did not correspond with the information provided within the relevant risk assessment.

We found the registered person had not always assessed risks to the health and safety of people who received care or treatment. This was in breach of regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We assessed the management of medicines and found the storage of all medicines to be secure. The Medication Administration Records (MARs) we looked at had been completed appropriately and Controlled Drugs (CDs) had been checked and signed for by two senior members of staff. The CD register corresponded with the stock available within the home.

We observed the lunch time medication round being conducted by a registered nurse. We found the practice to be inconsistent. People who had the ability to take their own medication had it put down in front of them on the dining table. They were not observed taking their medication and other people were sitting at the same table, who could have easily taken the medication themselves. This created a potential risk for those who lived at the home. Other people were assisted to take their medication. We saw the nurse, who was administering medications take tablets out of the medicine pots with her bare fingers and put them directly into the mouths of people who were prescribed them. This was unhygienic and did not promote good infection control practices.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we toured the home and saw people moving around freely, including those who

Requires improvement

Is the service safe?

used wheelchairs to mobilise. We found the premises to be generally safe with easy access for people with limited mobility. We saw that the home's fire action plan was clearly displayed in the reception area and records showed that weekly fire alarm tests were conducted. This helped to ensure that the fire alarm system was in good working order and free from defects. However, we noted some bedroom doors to be 'propped' open with door stoppers and therefore these would not close on activation of the fire alarm system. We recognise that some people who liked to sit in their bedrooms preferred their bedroom doors to be left open, so they did not feel isolated. In these cases individual risk assessments needed to be implemented and magnetic door closures needed to be installed, which would automatically close on activation of the fire alarm. Propping fire doors open creates a fire hazard and could potentially put people at risk in the event of a fire.

We also observed in one bedroom that a four plug socket extension was being used, which also created a potential fire risk. This created a potential trip hazard for people passing and potentially created a fire risk, should the home need to be evacuated in the case of an emergency. We noted that one of the wall mounted fire extinguishers did not have the standard identifying notice above it.

We saw a number of 'wet floor' signs around the home, which were left for long periods of time after the floors were dry. This created a potential trip hazard for those who lived at the home, visitors and staff members.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment. This was because risks to people's health, welfare and safety had not always been identified and strategies had not been implemented to reduce such risks. This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a general opinion that care was delivered in a safe and kind manner and that staff were knowledgeable about the use of equipment. One visitor told us that her relative required to be transferred by the use of a hoist and this was always carried out by two members of staff. Another visitor felt that staff understood the risks his relatives faced and that the nursing staff communicated these well to the care workers.

People we spoke with felt there were sufficient staff deployed to meet the needs of people who lived at Longton Nursing and Residential Home and from our observations on the day of our inspection we saw a good number of staff were on duty. However, although people we spoke with felt there were enough staff on duty, some felt there could always be more. One person commented, "They are run off their feet and there seems to be less staff around in the early evening." Another remarked, "They are always dashing about, but they are still good!"

We discussed the calculation of staffing hours with the management of the home, who showed us the system used each month to determine the number of staff allocated for duty in accordance with the dependency needs of those who lived at Longton Nursing and Residential Home.

The policies and procedures of the home provided staff with clear guidance about safeguarding adults. Records showed that all staff had completed learning in safeguarding adults and those we spoke with were fully aware of the whistle-blowing policies, which encouraged and supported them to speak up if they had any concerns about the health, safety or wellbeing of those who lived at the home. Staff members told us they would have no hesitation in reporting any potential allegations of abuse to the relevant authorities. One told us, "I know about the whistle-blowing procedure and I would not hesitate to use it. I would talk to the manager right away." Another commented, "I have only been here eight months and my induction was really good. I did safeguarding, infection control and emergency procedures."

During our inspection we looked at the personnel records of five members of staff. We found recruitment practices were sufficient enough to protect those who lived at Longton Nursing and Residential Home.

Prospective employees had produced acceptable identification documents and had completed application forms, which showed the provider was an equal opportunities employer. Registered nurses had been verified as being eligible to practice by their regulating body. Two written references had been obtained before people started to work at the home. DBS (Disclosure and Barring Service) checks had been conducted before people commenced employment, to determine if prospective

Requires improvement

Is the service safe?

employees had any criminal convictions or cautions. This meant that people who lived at Longton Nursing and Residential Home were protected by the recruitment practices adopted by the home.

Policies and procedures were in place in relation to the control of infection and clinical waste was being managed in accordance with legal requirements and good practice guidelines. The home was pleasant smelling, clean and hygienic throughout. This provided a comfortable environment for people to live in. We observed a room being thoroughly cleaned before a new resident was admitted on the day of our inspection. An infection control lead had been selected from the staff team, so that any relevant information, such as changes in legislation or good practice guidelines could be disseminated to the entire workforce, in order to ensure staff were kept up to date with current recommendations. Everyone we spoke with said they were happy with the standard of cleanliness of the environment.

Records showed that systems and equipment within the home had been serviced by outside contractors in accordance with manufacturers' recommendations and that a range of internal checks were also regularly conducted. This helped to ensure people were kept safe and that equipment was fit for use. Accidents and incidents had been appropriately documented and these records were retained in line with data protection guidelines, so that the people's personal details were kept in a confidential manner.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

The learning objectives for person centred care covered the areas of consent, people's rights, choices and values and we observed staff members asking people for their verbal agreement before care and support was provided. However, consent forms for the taking of photographs had been signed by the assistant manager only and no other consent forms were seen for areas, such as medication administration, sharing of information or the use of bedrails.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because written consent had not been obtained. This was in breach of regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that DoLS applications had been made for those who lacked capacity in some areas of decision making and who were being deprived of their liberty for their own safety. However, no authorisations had been received back from the local authority. We recommended that the registered manager follows these up at regular intervals, until they have been reviewed. We have been told by the provider that the registered manager subsequently followed up the DoLS applications with the local authority, as recommended, but was advised not to follow these up at regular intervals.

Records showed that staff had received training in relation to the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Although the registered manager was aware of her legal responsibilities in relation to DoLS, from discussions with staff members there seemed to be some confusion around DoLS applications, with no clear understanding if people were subject to DoLS or not.

An advanced plan of care was in place for one of the people who we 'pathway tracked'. This had been developed with the individual's representative. A 'Do Not Attempt Resuscitation (DNAR) order had been implemented eight weeks previously by the next of kin and the GP, which was a continuous agreement. However, this record stated the person had 'no capacity', but the assessment of activities of daily living and the mental capacity assessment, both last reviewed four months previously showed the person did have capacity. This provided contradictory information for the staff team, which was confusing.

During the course of our inspection we toured the premises viewing all communal areas and a randomly selected number of bedrooms. We noted that some bedrooms were individualised and contained personal items, which helped to promote ownership and furnish people with a sense of belonging?. We found the accommodation to be clean and hygienic and found that, in general the home was well maintained, but basic in relation to the furnishings, fittings and décor. Some areas of the home were in need of upgrading and modernising, in order to provide a homely environment and pleasant surroundings for the people to live in.

The home was not particularly well designed to meet the needs of people who lived with dementia or who were experiencing mental health issues. We did not see evidence of dementia friendly resources or adaptations in the communal areas corridors or bedrooms. People had little chance to explore their surroundings. The lack of dementia friendly amenities resulted in lost opportunities to stimulate exercise and to relieve boredom, as well as enabling people to orientate themselves to their environment. We found colour schemes did not help with orientation and the lack of prominent picture signage did not easily identify areas, such as bathrooms and toilets.

We found that the registered person had not protected people against risks associated with unsuitable premises, because some areas of the home were not of suitable design or layout for all those who lived there. This was in breach of regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Records showed that staff were provided with sufficient information when they began to work at the home. This helped them to do the job expected of them and gave them an insight into the policies, procedures and practices of the home. For example, new staff were provided with codes of practice, duty of care and an employee handbook on commencement of employment, which covered areas, such as terms and conditions of employment, disciplinary and grievance procedures, safeguarding and whistle-blowing and health and safety.

Induction records were seen, which consisted of workbooks completed by new employees, who were supported by named mentors. These demonstrated that competence checks were conducted in important areas, such as personal hygiene, fire awareness, health and safety, dignity and respect, choice and confidentiality. The policies and procedures of the home were also an integral part of the induction programme for all new staff members.

At the end of each person's probationary period, a review was held to ensure their work performance reached the expected standard to continue employment and to determine if the employee wished to remain as part of the workforce. Employees were then issued with formal contracts to ensure legal obligations were met.

Regular supervision and annual appraisals had been conducted, which enabled employees to meet with their line managers on an individual basis, to discuss their work performance, personal and career development, additional training needs and any areas of achievement. Individual supervision sessions were also held to discuss specific areas of need, such as privacy, dignity and respect. This helped staff members to understand the importance of the areas discussed.

We asked if people felt staff were competent to provide the care they needed and if they were knowledgeable and confident. Everyone we spoke with felt they were. One relative said, "Staff appear to be competent and they always chaperone new staff."

Records showed that a wide range of learning modules were provided for staff, including particular mandatory courses and training specific to the needs of those who lived at the home. Staff members we spoke with gave us some good examples of training they had undertaken and these were confirmed by the certificates of training retained on staff personnel records. One of the domestic staff told us she had completed a range of mandatory training relevant to her role. These modules included areas, such as health and safety, fire awareness, moving and handling, control of substances hazardous to health (COSHH) and infection control. She said, "I love working here. It is a nice little job. I have enough equipment and supplies. I never run short of anything." Staff we spoke with were very able to discuss the needs of people with us. They had a good understanding and knowledge of the individual care needs of people who used the service.

Comments received from staff members included, "We have regular meetings and we do get listened to. The staff talk to each other a lot, especially at the end of each shift" and "I have not been here long, but the training and support has been really good. The other carers have helped me so much as well.

We found risk assessments in relation to malnutrition to be available on individual care records. This meant that any risks were addressed and staff were provided with guidance on how to support people to maintain adequate nutrition and hydration. The last Environmental Health Officer's food hygiene inspection in 2015 rated the home at level 5, which indicated a 'very good' standard by the local council, the highest level achievable. We saw that opened food was stored appropriately and fridge temperatures had been recorded twice a day. Use by dates on food packages were all within recommended dates for discarding and these were checked regularly.

Records showed that a range of community professionals were involved in the care and treatment provided for those who lived at the home. This helped to ensure people's health care needs were being appropriately met. We observed a GP on site following a request for an emergency visit. This helped to ensure people's health care needs were being appropriately met.

We observed lunch being served. The menu of the day was displayed on a black board in the hall way. A choice of menu was offered to everyone. People were able to dine in the privacy of their bedrooms, if they wished to do so. The cook and registered manager confirmed that if anyone wanted an alternative meal to the menu choices, then it would be provided. Our observations confirmed this as accurate information. We saw that the dining tables were nicely presented and staff wore protective clothing when serving meals. The food served looked appetising. We

Is the service effective?

noted that adequate numbers of staff members were present within communal areas during meal times. On the day of our inspection there was very little food wastage and those we spoke with told us they had enjoyed their lunch.

Comments from those who lived at the home, in relation to food and beverages included; “One of the best things about being here is the food. I have never heard anyone complain. The cook is really good and asks us what we like”; “The food is nice, particularly the meat and mash. I like Sunday lunch. There is a good choice of food and you can have drinks when you ask, as well as when the trolley comes around”; “The food is alright. Sometimes I don’t like it, but I can ask for something else” and “I love the fresh fruit”. One family member told us that her relative liked the food, as it was more varied than it was in hospital. She said her relative was eating well and enjoyed the fresh fruit in the afternoons. Another told us that her relative always had some fruit juice near her. One person, who lived at the home, told us she was had diabetes and enjoyed a ‘jam butty’ for breakfast, with diabetic jam.

We observed staff gently supporting people with their meals in an appropriate and dignified manner. There was on going verbal interaction between staff and those they were assisting, which was pleasing to see. The components of pureed diets were separated, so that people could experience the different tastes and therefore be provided with the same opportunities as those eating a normal diet. We saw that plate guards were used for some people to promote their independence. We saw two family members assisting their relatives with their meals. One of these relatives voluntarily assisted other people, who were sitting at the same dining table. We observed one person, who appeared to be confused and was unable to use appropriate cutlery struggling to co-ordinate eating their meal. A relative, who was visiting another resident was helping them. However, this person perhaps would have benefitted from some staff assistance, but this was not provided.

We saw that beverages and snacks were constantly available throughout the day to ensure people did not go hungry and to make sure they received a well-balanced diet. One member of staff told us, “I go around every day and ask the residents what they would like to eat. They get a good choice of hot and cold food, but if they would like something different, then that’s fine, I would do it.”

Requires improvement

Is the service caring?

Our findings

Everyone we spoke with felt that staff were kind, caring and respectful and that they were very patient and took their time when helping people. We spoke with one person, who was staying at the home for respite care. She told us, "The staff are really very kind." Comments from those who lived at the home included, "The staff always find time for a chat. They are all kind and helpful and always there for you"; "They are not unkind to me" and "The carers are very patient. Some of the new carers are very good with us too. They really are caring and well-mannered."

Comments received from family members we spoke with included: "Staff are kind and always acknowledge my relative and myself"; "Staff are all kind and respectful" and "The staff are very nice. They treat us all with kindness." One of these people told us she felt staff showed respect for her relative, as she was always dressed as she would wish to be, with a necklace on and lipstick.

We asked if staff had time to chat or do something with those who lived at the home. One visitor told us, "They (the staff) have time and patience. They do puzzles with my relative" and another said, "They chat with her now and again." However, one relative commented, "The staff do chat, but only if people are around them when they are working" and another said, "I don't see staff sitting and chatting with the service users." One person who lived at the home said, "A carer takes me out for a walk and a cup of tea" and another told us that she went out to a coffee morning on Tuesdays. She said the Activities Co-ordinator took her and brought her back.

We saw staff members knocking on people's bedroom doors before entering their rooms. However, we noted practice on some occasions throughout our inspection, which did not consistently promote people's privacy and dignity.

We observed one person being administered her insulin injection and two others having blood sugars tested whilst sitting at the dining table with other people. This was not a dignified approach. In discussion the registered manager told us that is the way it had always been monitored and nobody had ever complained. We were told the person who received the injection would not go into the medication room. Therefore, it would be advisable to assist her to her own bedroom in order to provide treatment.

We noted one person who was being assisted to the toilet by care staff required a change of clothing. On their return we observed that their clothing had not been changed. The care workers assisted them back to the same lounge chair and sat them down. This was not dignified practice.

We observed on two separate occasions, females being transferred by a hoist, who had their skirts caught in the sling and therefore the tops of their legs were visible. The staff members operating the hoist did not react by straightening their clothing, to ensure dignity was maintained.

We observed one person sitting in the small lounge. She was waiting to go home. However, she was sitting on the edge of an armchair and told us she needed to go to the toilet, because she was on 'water tablets', but the call bell was located at the other side of the lounge and was therefore out of reach. She was unable to walk to get to the toilet herself. We requested staff assistance, so that this person's toileting needs could be met.

We found the registered person had not ensured that the privacy and dignity of people was consistently promoted. This was in breach of regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed several people visiting the home during the course of our inspection. They looked comfortable visiting Longton Nursing and Residential Home and were having easy conversations with staff members. One relative told us there were no restrictions on visiting and she could visit at any time, within reason. People were supported to access advocacy services, should they wish to do so, or if a relative was not involved and they were unable to make some decisions for themselves. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

The atmosphere throughout the home was calm and relaxed. We observed some good interactions between staff members and those who lived at the home, who looked well-presented and comfortable in the presence of staff members. Staff we saw were patient and supportive whilst assisting people.

During the tour of the premises we noted specialised accessories, such as pressure relieving mattresses,

Requires improvement

Is the service caring?

multi-functional beds and moving and handling equipment was provided, as was needed. This helped to promote people's independence and maximise their comfort whilst living at the home.

The plans of care we saw included the importance of promoting privacy and dignity, particularly when assisting people with personal care. The learning objectives for person centred care covered the areas of privacy, dignity in care, independence and compassion. Two staff meetings had been held for the staff team to discuss the topic of 'dignity and respect', to ensure all staff members attended. Those unable to be present met with the manager of the home to ensure they received the relevant information. We saw the minutes of the staff meeting, plus the supervision records of those who did not attend the group session. However our observations demonstrated that staff did not always practice in accordance with these values.

Records showed that a wide range of external professionals were involved with the care and treatment of those who lived at Longton Nursing and Residential Home. This helped to ensure people's health care needs were being fully met. The community professional, who responded to our feedback request wrote, 'I have no cause for concern regarding the home's care for our patients. The staff are proactive in their care and in thinking of ways to help their patients. The staff cooperate with our advice and keep up to date with prescription requests. They seek medical help as appropriate.'

The manager told us that end of life learning had been booked for the staff team, which consisted of six hours training, covering palliative care and syringe driver refresher modules.

One member of staff we spoke with told us, "Obviously we get new residents coming in now and again. There is a new resident coming in today, but we soon get to know about what they like and don't like."

Requires improvement

Is the service responsive?

Our findings

One person, who lived at the home, told us, "I talk to the manager nearly every day. She is always around and has time for everyone" and another stated, "We have a choice of when we get up. Some people are up early, but others might want to have a sleep in."

Comments from visitors we spoke with included: "My husband has not been in here very long but we had a couple of meetings before he came in. It was really thorough"; "I have had a few calls over a period of time. The staff are good at keeping in touch. I do come in a lot and they talk to me when I come in as well"; "I haven't noticed anything I thought wasn't right. The staff are really patient with everyone and are chatting all the time"; "The manager has been here a long time and is easy to talk to. She is always around, so if I wanted to see her about something I would"; I have spoken to the manager and other staff quite a few times and they are all so nice and approachable" and, "They (the staff) are on the ball. The other week my relative wasn't responding and they got it all sorted out."

We reviewed the care records of five people who lived at the home. We found that people's needs had been assessed before they were admitted to the home. This enabled the staff team to be confident they could provide the care and support people needed.

The plans of care varied in quality. Some were very well written, person centred documents and included choices and preferences. Others were less informative with the use of vague statements and did not always reflect people's current status. For example, we established that one person was in a poorly condition and therefore was being nursed in bed. This was confirmed by staff we spoke with and by a relative, who was visiting at the time of our inspection. This person's daily records showed the GP had visited and had said he was 'close to end of life'. However, there was no plan of care in place to outline the individual's specific end of life care needs, although involvement of specialised community professionals was evident. Despite this person requiring to be nursed in bed, one of his care plans, reviewed seven weeks previously stated, '(Name removed) mobilises with a Zimmer frame and one carer. Unsteady at times. Sits with others. Care plan to be reviewed monthly.' This demonstrated that not all plans of care had been reviewed each month and changes in people's needs had not always been clearly reflected, so that the staff team were fully aware of people's up to date requirements. However, one relative told us, "I have been asked to several meetings and reviews. I can't always make it, depending on the time, but I do feel involved in mum's care."

One plan of care, reviewed seven weeks before our inspection stated, '(Name removed) can become increasingly confused and restless and attempt to mobilise on his own.' However, there was no guidance for staff about how this was to be managed.

Another plan of care stated, 'Is able to ask staff for help with controlling body temperature by asking for windows to be opened or closed and asking for extra clothing. No support plan needed at present.' However, this person's mental capacity assessment stated, 'Unable to communicate decisions and does not have capacity', but this did not identify in which area decision making was difficult. Therefore, staff were provided with contradictory information, which was confusing and could have resulted in unsafe or inappropriate care and treatment being provided.

These observations showed the registered person had not ensured people's care and treatment was appropriately planned to meet their needs and to reflect their preferences. This was in breach of regulation 9(1)(3)(b)(d)(f)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The plan of care for one person in relation to pressure care was well written and person centred. It identified the level of assessed risk, how pressure relief was to be managed and the type of pressure relieving equipment in use, which was clear and informative. One individual's leisure interests, likes and dislikes were detailed, which helped staff to respond to his social care needs. Sky TV had been installed in this person's bedroom, as he was an avid football fan and a keen follower of Manchester United. Evidence was available to show those who lived at the home or their relative had been consulted about the initial development of their care plan, which demonstrated that their wishes had been taken in to consideration. However, there was no evidence available to show that people had been involved in the care plan reviews.

Requires improvement

Is the service responsive?

Daily records were well maintained, providing staff with information about events that had occurred on each shift, so that they could keep up to date with any changes in circumstances. We observed staff attending to people in a well-mannered and patient way.

A 'hospital passport' was available in only one of the care files we saw. Hospital passports are used to summarise all the important information about people's health and other areas of assessed need, which would be useful for medical professionals to know, should the person be taken to hospital. We recommend that these be rolled out for all those who live at the home.

We were shown the learning objectives, which had been introduced since our last visit to the home, in relation to person centred care. This area had been developed by a member of the staff team, which showed commitment and demonstrated enthusiasm to support staff training. A range of dates had been arranged to encompass all members of the staff team.

A Service Users' Guide and Statement of Purpose was in place at Longton Nursing and Residential home, which was readily available for any interested parties to read. The information contained in these documents provided both prospective residents and those who lived at the home with background information about the organisation, as well as details about the facilities and services available. This helped people to make choices about staying at the home and what they preferred to do whilst living at Longton Nursing and Residential home.

A complaints policy was clearly displayed at the home and a system was available for recording and monitoring complaints received, although none had been documented since our last inspection of this location. People who lived at the home and their relatives told us they would not hesitate to report any concerns they might have and they felt any issues would be dealt with appropriately. One relative we spoke with told us, "I am very happy with my husband's care. The staff are so friendly. I have made a complaint in the past, which was dealt with well. I have no concerns at all."

We were told that two activity co-ordinators were employed and a general activity plan was displayed within the home. On the day of our inspection one of them was on duty. However, we did not observe any activities being provided. The activity co-ordinator told us that she also did caring duties and worked in the kitchen. On the day of our visit she had been asked to work in the kitchen because the kitchen assistant was on leave. Therefore, activities were not being provided, although she felt that later in the day she would have some time to spend with people. This showed that the provision of activities was inconsistent. We recommend that this area be reviewed, so that activities are provided in accordance with the planned programme and that the activity co-ordinators are solely responsible for the provision of activities during their 'activity' shift.

One person commented, "We do have some entertainment once a month, but we could do with something more to do during the day, especially at the weekend, not much goes on." Another told us she had been at the home a long time and had taken part in quizzes, played dominoes, watched television and sometimes played with a soft ball. A visitor told us that she has seen some of the ladies playing card games. Some people told us that they preferred to stay in their rooms and one person said they didn't know if any outside entertainers visited the home. However, we established that external entertainers did visit the home once every month. There was also an annual barge trip arranged and the activity co-ordinator played classical music for those who enjoyed it.

The activity co-ordinator outlined the activities usually provided, such as reading articles from magazines and newspapers, reminiscence and board games, dominoes and bingo. She told us that craft sessions were offered in the form of collages, painting and pottery, the end products of which were on display. We were told that people were encouraged to be involved in gardening and some were currently having a competition to see whose sunflower would grow the tallest.

Requires improvement

Is the service well-led?

Our findings

People who lived at the home and their relatives, in general spoke positively about the registered manager, describing her as 'approachable' and 'easy to talk to'. One person who lived at the home told us, "Every time I see the manager she asks if everything is OK and do I need anything. She is always around" and another said, "I have been talking with the manager this morning. I have been in to talk to her many times and there's never a problem – you just go and knock (on the office door)." However, other comments we received when asked if people felt comfortable to approach the manager were: "No, not really, but I can approach the deputy"; "I don't know the manager" and "The deputy is very good." One visitor told us, "She (the manager) says hello, but she doesn't come and chat." Another two visitors said the manager did not go to speak with them when they were in the home.

Comments received from relatives included, "Every time I come in the manager and staff talk to me. They are always around somewhere and can't do enough for you" and "I feel I could talk to any of the staff anytime. They are really approachable – all the staff are, so if I needed to talk to them about anything I would be fine with that."

Records showed that monthly internal audits were conducted, which included topics, such as care planning, medications, infection control, falls and complaints. Any shortfalls identified were produced in an action plan, which outlined how improvements were to be made. We saw that a senior member of staff periodically worked at night in order to observe and monitor the effectiveness of the night shift. This was considered to be good practice. However, the audits we viewed were not always effective, as they had not identified the shortfalls we found during our inspection, particularly in relation to care planning, risk assessing, medication management and consent to care and treatment.

We noted that confidential records containing sensitive information about those who lived at the home were stored on shelving units in the ground floor office, which was not locked when vacant. A room on the first floor also contained confidential records and again this room was not locked when vacant. Therefore, these records were easily accessible for anyone to read or to remove them. This was not in accordance with data protection guidelines and therefore did not protect confidential information.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective and confidential records were not securely maintained. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that a variety of surveys had been completed within the last year, which enabled the provider to gather feedback from a range of people interested in the home, such as those who lived there, their relatives, staff members and visiting community professionals. This helped the provider to identify any shortfalls in the service provision and to take on board any suggestions for improvement. We saw that a wide range of correspondence was compiled in albums, which expressed people's gratitude to staff members and the management team.

Evidence was available to demonstrate that meetings for those who lived at the home, their relatives and the staff team were held at intervals throughout the year. The staff meetings incorporated important areas of need, such as privacy and dignity, communication and self-awareness.

Comments from people who worked at the home included, "We have regular meetings. We have just had one not so long back. We have them quite often and yes, we do get listened to"; "If we want to make a suggestion or have a problem we can just go and see (name removed)" and "We have completed surveys for residents, staff and the different professionals that come to the home, like doctors and nurses."

The registered manager told us that regular visits to the home were conducted by representatives of the organisation and reports seen confirmed this information to be accurate. We noted the home had been accredited by an external professional organisation, which showed that periodic audits were conducted by an independent assessor.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up-to-date good practice guidelines. These had been reviewed and updated this year and covered areas, such as The Mental Capacity Act, Deprivation of Liberty Safeguards, fire awareness, privacy and dignity, safeguarding adults and whistle-blowing procedures, infection control and health and safety.

Requires improvement

Is the service well-led?

The registered manager was fully aware of notifications, which needed to be submitted to the CQC in relations to deaths, DoLS authorisations, serious injuries or events that prevent the service from operating properly.

A business continuity plan had been developed, which provided staff with clear guidance about the action they needed to take in the event of an environmental emergency, where evacuation may or may not be necessary. This document included situations, such as power failure, heat-wave, gas leak, flood and winter constraints.

Staff members we spoke with told us they felt well supported by the management team and records showed they were formally supervised on a regular basis, to identify their strengths and to identify any areas in need of improvement. One member of staff told us she had worked at the home for eight months and had already had three supervision sessions with her line manager. Records seen confirmed this information as accurate. Another care worker commented, “We get plenty of training. I have just started an NVQ and really enjoy it. I was asked did I want to do it, which I thought was good.”

Staff members we spoke with had a good understanding of their roles and responsibilities towards those who lived at the home. Records showed that there was a good retention of staff, several who had worked at the home for many years. This demonstrated a committed staff team and good continuity of care for those who lived at Longton Nursing and Residential Home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed.** **Regulation 12(1)(2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found the registered person had not always assessed risks to the health and safety of people who received care or treatment.** **Regulation 12(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment. This was because risks to people's health, welfare and safety had not always been identified and strategies had not been implemented to reduce such risks.** **Regulation 17(1)(2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

Diagnostic and screening procedures Treatment of disease, disorder or injury	We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because written consent had not been obtained. Regulation 11(1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered person had not protected people against risks associated with unsuitable premises, because some areas of the home were not of suitable design or layout for all those who lived there. Regulation 15(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found the registered person had not ensured that the privacy and dignity of people was consistently promoted. This was in breach of regulation 10(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured people's care and treatment was appropriately planned to meet their needs and to reflect their preferences. Regulation 9(1)(3)(b)(d)(f)(h)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective and confidential records were not securely maintained. Regulation 17(1)(2)(a)(b)(c)