SHC Clemsfold Group Limited

Longfield Manor

Inspection report

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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**

Summary of findings

Overall summary

The inspection took place on 23, 24 and 29 July 2018. This was a comprehensive inspection and it was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been made. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and July 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Longfield Manor is a care home that provides nursing and residential care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Longfield Manor is registered to provide nursing and accommodation for up to 60 people. People cared for were older people who needed nursing care, some people had complex health needs and/or some people were living with dementia. At the time of our inspection there were 44 people living at the home. Accommodation is provided across the main building which is split into three areas and Rosewood unit. Rosewood is a unit for people living with dementia. All bedrooms were of single occupancy. People shared communal areas such as lounge's and a large dining room.

A manager was in post who had applied to become the registered manager. 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.

At the last inspection in July 2017 we found the provider was in breach of Regulations associated with safe care and treatment, staffing and governance. The provider told us the action they were taking to meet the legal requirements. At this inspection we identified further improvements were required and the provider remained in breach of Regulations. We found risks were not always managed safely on behalf of people. We also found agency registered nurses were not always adequately trained to assist them in carrying out their role and responsibilities effectively.

Some group activities were offered to people. However, personalised activities and occupation were not consistently provided and information was not always in an accessible format. We observed caring approaches were not consistently applied and we made a recommendation to the provider about this.

Systems were not always effective in measuring and monitoring the quality of the service provided. There were ineffective systems in place to drive continuous improvement.

People's consent to care and treatment was gained in line with the requirements of the Mental Capacity Act 2005. People were supported to have choice and control of their lives and for staff to support them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff received supervisions and appraisals and they found the manager's approach supportive.

People were provided choices daily regarding what food they ate and clothes they wore. Complaints were managed effectively. The provider sought feedback from people and their relatives regarding the care received and they spoke positively about the care provided.

The manager had sought information about the new Key Lines of Enquiry (KLOE) which the Commission introduced from 1 November 2017. They were keen to improve the quality and safety of care provided to people living at the home.

At this inspection we found the service was in breach of four of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Three of these breaches were continuing from the last inspection therefore the service remains rated as Requires Improvement. This is the second consecutive time the service has been rated Requires Improvement.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

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.

Risks to people were not always managed safely.

Medicines were mostly managed safely.

Lessons had not been consistently learnt by the provider.

Staff had attended safeguarding adults training and knew how to protect people from abuse.

There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Training was provided however not all agency registered nurses had attended dementia training.

Pre-admission assessments regarding people's physical, mental health and social needs took place prior to them moving into Longfield Manor.

The provider worked in accordance with MCA legislation.

People were supported to access health care professionals when needed.

People were supported to have sufficient to eat and drink and people's individual physical needs were met by the adaption of the premises.

Is the service caring?

Requires Improvement

The service was not consistently caring.

On two occasions we observed people's dignity and choices

were not respected. We made a recommendation to the provider about this.

We also observed people received care from staff who were kind and caring.

Staff promoted people's rights to be independent.

People were consulted and involved in decisions about their care as much as they were able.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Personalised care was not always delivered to people. Improvements were needed to the activities and stimulation provided to people.

Information including care plans were not consistently in an accessible format to aid people's understanding.

Complaints were responded to and managed effectively.

People received the appropriate care and treatment at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There continued to be a lack of effective and robust auditing systems to identify, measure and improve the quality of the service delivered to people.

The staff complimented the hands-on approach used by the manager and appreciated the support they provided.

People and their relatives were asked their views on the care provided and they spoke positively about the support they received and the service as a whole.

The management team worked effectively alongside the local authority moving and handling assessors.

Longfield Manor

Detailed findings

Background to this inspection

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

This inspection took place on 23, 24 and 29 July 2018. The first day was unannounced and the inspection team consisted of three inspectors, a specialist advisor, a medicines inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise included services for older people and people living with dementia. The second day of inspection consisted of two inspectors and the same specialist advisor. The specialist advisor had specialist clinical experience in supporting older people and/or complex heath needs. The third inspection day, at the weekend, consisted of two inspectors.

Prior to the inspection, we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with eight people who lived at the home to gain their views of the care they received. We also spoke with four people's relatives about their views on the care their family members received. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. To obtain these, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon over the course of the inspection.

During the inspection we spoke with the clinical lead registered nurse, the deputy manager, the manager, two agency registered nurses and one permanent registered nurse. We also spoke with four care staff, the chef and the area manager. We also spoke with a local authority moving and handling assessor who agreed for us to use their comments in this inspection report.

During the inspection, we observed medicines being administered to people. We reviewed a range of records about people's care which included seven care plans. We also looked at three care staff records which included information about their training, support and recruitment record. We read audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports, Medication Administration Records (MAR) and other documents relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2017 the provider was in breach of a Regulation about safe care and treatment as medicines were not being managed safely. We identified stocks of medicines were not being routinely checked by staff to ensure people were receiving their medicines as prescribed. We also found records relating to some people's medicines were not completed sufficiently and this posed potential risks to the people receiving them. After the inspection the provider told us the actions they were taking to improve how medicines were managed on behalf of people.

Since the last inspection, the provider had met with the local authority safeguarding team routinely to discuss, amongst other items, how medicines were being managed to ensure risks had been mitigated. At this inspection we found the provider, including the new manager had taken some action and regular medicine systems checks carried out were supporting safe practices for nearly all the people living in the home. Medication Administration Records (MAR) checked demonstrated people received their medicines as prescribed. However, we also found records relating to one person posed a potential risk they would be administered a medicine they were no longer prescribed. The person was a diabetic and prescribed insulin. Their care plan referred to one type of insulin they were no longer prescribed for. The care plan had been reviewed monthly between January and June 2018 stating no changes to types of insulin. The discontinued insulin also remained in the medicine fridge as had not been returned to the pharmacy. Whilst the discontinued insulin had been removed from the person's Medication Administration Record (MAR) the care plan had not been updated to reflect this change. This meant the error in the person's care plan posed a potential risk to the person the discontinued insulin would be administered to them. The risk was increased as the home used agency registered nurses who may have referred to the care plan as guidance if they did not know the person well. We informed the management team of this error. They told us the medicine would be returned and the care plan updated to reflect the change.

Another person was at risk of constipation. They were prescribed a 'when required' medicine for this. The associated guidance informed staff this was to be administered if there had been no bowel movement for three days. Staff completed a bowel chart on behalf of this person. In May 2018, records showed that the person went eight days before they opened their bowels. We checked the associated MAR and their prescribed 'when required' medicine was not administered until day five. This meant the person may not have been administered their medicine as prescribed as stated in their guidance. People who suffer with constipation can experience discomfort and in some cases further medical intervention and treatment might be needed. Therefore, it is essential this aspect of care is monitored and not overlooked. We highlighted this to the clinical lead and the home's manager who agreed this had been overlooked at the time. This was of particular concern as we have highlighted the associated risks when supporting people with constipation at other inspections which have taken place at other locations owned by this provider.

We also identified other inconsistencies regarding how risks were being managed on behalf of people. For example, some people living at the home were at high risk of pressure damage to their skin as they had 'fragile skin' and required support to mitigate this risk. Pressure damage or ulcers can develop for people with health conditions who find it difficult to move regularly. Risks are increased for people who received

their care in bed or spend long periods of time sitting in the same position. Some people used specialist equipment such as air flow mattresses to relieve the pressure on their skin. Settings on mattresses should be adjusted in accordance to a person's weight. We read one person's daily chart for their mattress settings. Staff had recorded a correct setting in accordance with the person's weight. We checked the setting on the actual mattress and found it was on a higher setting than it should have been. This meant it would have been too hard for the person. The mattress may have been uncomfortable for the person and this would have increased the risk of them developing pressure damage to their skin. We alerted the manager to this and we were told this would be checked and altered. On the second day of the inspection we found the setting remained at the same setting which was too high. We spoke with the manager about this who instructed staff to revisit all air flow mattress settings to ensure they were correct.

The same person had turning charts in place. Their care plan guidance stated staff to reposition them every four hours throughout the night and every two hours throughout the day time. However, on two occasions records failed to demonstrate they had been supported to move within their comfy chair and wheelchair in the daytime. This meant that staff could not be sure that the person had been moved at the required intervals. At the time of this inspection, the person was not suffering any pressure damage to their skin. However, they were described as having 'fragile skin' and being monitored due to skin tear wounds, therefore improvements were required to ensure they were being supported to move frequently in the daytime to avoid any damage to their skin.

Some people were at risk of falls. We observed staff supporting people to move safely with the use of walking aids and wheelchairs. Most people also had sensor mats positioned in their bedrooms. When people stood on the sensor mats an alarm would be activated which alerted staff the person was moving. Staff could then go and check they had the correct support in place from staff at the time. Since this inspection, the manager informed us the local authority commissioning team had visited the home in August 2018 to review care provided to people. On 22 August 2018 they had highlighted one person's sensor mat had not been working correctly for 12 days. This meant if the person had fallen in this period or was at risk of falling, staff may not have been alerted. The manager informed us they had investigated and established a request to replace the mat had not been fulfilled. The manager also confirmed there were other control measures in place to mitigate risk at the time, such as support from staff and bedrails on the person's bed. They also shared the person had not experienced a fall in this time. However, the lack of timely action to mitigate the risk on behalf of this person was of concern considering the support the provider had been receiving in the past year about risk management from partner agencies. This included the local authorities moving and handling assessor who, since July 2017, had visited the home and supported the staff team almost monthly.

We have inspected nearly all other locations owned by the same provider in the past twelve months. We have found concerns relating to the way risks have been managed on behalf of people. We found lessons had not consistently been learnt and applied across the organisation. We have discussed concerns surrounding gaps in records relating to health monitoring further in other parts of this inspection report.

The above evidence demonstrates that not all was reasonably done to mitigate risks to service users. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager wrote to us after the inspection and informed us about the actions and checks they had taken. This included implementing a new system to check mattress settings were correct and in line with each person's body weight. They also told us they had reviewed care planning documentation.

We also found other aspects of prescribed medicines were managed safely. We observed registered nurses administer medicines to people with confidence. Registered nurses were knowledgeable as to the reasons why people had medicines prescribed to them, any known side effects and what to do in the event of any concerns. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Tablets were dispensed from blister packs and medicines administered from bottles or boxes were stored and labelled correctly. We observed that the Medication Administration Record (MAR) was completed on behalf of each person by the registered nurse on duty, when they took their medicines. Oral medicines were administered by registered nurses only.

Prescribed topical creams such as skin barrier creams to prevent pressure wounds, were prescribed and applied when a person received their personal care. Support was provided from registered nurses to new care staff with the administration of topical creams. Body maps and associated guidance highlighted for care staff when, where and how much cream to apply to a person. Records were completed to demonstrate they had been applied as prescribed. Care staff were able to tell us how they applied topical creams safely and effectively and if they had any concerns they would highlight them to one of the registered nurses.

We checked records relating to other equipment used to support people and found risks had been managed appropriately; these were monitored and checked to promote safety. Equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electrical safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Records confirmed that maintenance staff attended when contacted by staff to repair damage, which ensured people were protected from environmental risks. Other service checks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. Fire equipment such as emergency lighting, extinguishers and alarms were tested by the provider's maintenance engineer. One person told us, "It is well maintained, there's a chap who does the maintenance. Very good. I'd say it's as near perfect as it can be". Another person said, "Oh it's safe as houses here. It's secure, no-one can just walk in".

At the last inspection the provider was in breach of Regulations associated with how staff were being deployed across the service. After the inspection, the provider informed us the action they were taking to meet the legal requirement. At this inspection, we observed there were enough staff working across each of the units to ensure people's needs and requests were responded to. Although under the same roof, the home was referred to as four units or areas. The manager told us they used a dependency tool to establish safe staffing levels. We were told and records confirmed, there were three registered nurses and 11 care staff across each area throughout the day. We saw that staff responded within a reasonable time to those who required assistance, this included for people who received care in their bedrooms. In addition to care staff the provider employed maintenance, domestic and kitchen staff. This meant care staff could focus on providing care to people. One person said, "Plenty of staff around". Another person said, "Oh yes, I think there's plenty. Always someone on hand. If I press the bell it's not very long at all before someone comes. It's very much the same at weekends as every other day and night".

Prior to this inspection, the manager had only been full time based at the home for a few months. The manager recognised the home had been through a period of instability and was committed to improving how the home was viewed by the local community. Agency staff were used to fill in any gaps and provided with an induction. The manager told us where possible the same agency staff were used who knew the people they were supporting. The manager said, "We do try and keep people (staff) who are suited". This inspection was carried out over three days. This included inspecting the home on a Sunday. On the Sunday a member of staff was unable to work and had informed the staff team that morning. By the time we arrived the lead registered nurse had resolved the issue and an agency member of staff had been deployed to

support the existing staff team.

People and their representatives, such as their relatives told us they were happy with the care provided and that safe practices were applied by the staff team. One person told us, "I can tell you I feel safe that's because everyone is so kind and caring and I'm looked after well". They added, "There's always someone around". Another person said, "It's the organisation of everything here that makes me feel safe. They're well organised. If they say something is going to happen, it will when they say it will. That makes me feel confident". A third person said, "I feel safe from harm, I can talk quite freely to everyone here and feel happy about it. I know I can go out and know my purse will be intact when I get back".

At this inspection we read the accident and incident file. Accidents and incidents had been recorded and reported by staff to the manager who then shared the information with external agencies such as the local authority safeguarding team. When an incident did occur, it was also sent to the quality team for their review. We were told this was to ensure shared learning could be taken from how a situation was managed by staff. Prior to the inspection the manager notified the Commission of any accidents and incidents and provided assurances actions had been taken to mitigate further risks to people. Staff we spoke with demonstrated they understood the importance of protecting the people they supported and were knowledgeable about different types of abuse. One staff member said if they were concerned about a person, "I would tell the nurse in charge they speak with the manager, we inform families and the manager informs the council".

Staff recruitment checks were thorough. Staff were only able to start employment once the provider had made suitable recruitment checks. This included; two satisfactory reference checks with previous employers and a Disclosure and Barring Service (DBS) check. Staff record checks included validation PIN number for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). This process ensured as far as possible, that staff were of good character and had the skills and experience to meet people's needs.

Longfield Manor had a clean and well-maintained environment. Over the three days of the inspection domestic staff ensured the home remained clean, free from offensive odours and tidy. Equipment was seen to be readily available that promoted effective infection control such as antibacterial hand wash, disposable gloves and clinical waste bins. One person said, "It's lovely, everything is lovely and clean. Everybody looks lovely and clean too". A relative said, "They have amazing cleanliness. There's absolutely no odours. No matter what time I come, there's someone always cleaning".

Requires Improvement

Is the service effective?

Our findings

At the last inspection, the provider was in breach of Regulations associated with a failure to ensure all staff had received appropriate levels of training, supervisions and appraisals. A system of supervision and appraisal is important in monitoring staff skills and knowledge. After the inspection, the provider wrote to us to inform us of the actions they were taking. At this inspection, we spoke with staff and checked staff supervision and appraisal records. We found staff were now receiving this support as required. Staff told us they appreciated the support the new manager was giving to them and complimented their approach. However, we continued to find some gaps in staff skills and competencies.

The provider's website describes Longfield Manor as a home that, 'provides care for older people with nursing support for people with more complex medical needs'. The website also states, 'it has a specialist 14 person unit for people with dementia'. Therefore, at this inspection we checked to see whether all staff supporting people had attended specific training about dementia. We found systems were not always effective in ensuring all staff had completed the necessary training. The provider had its own training academy. The training academy facilitated an extensive rolling training programme throughout each year. Some training sessions were face to face sessions, whilst other courses staff could achieve through an on-line process or with the use of a workbook.

Permanent staff attended dementia training. At the time of this inspection, there were only four permanent registered nurses employed. To compliment the nursing team the provider used agency registered nurses to support people throughout the week. We read 12 training profiles for agency registered nurses. We found agency registered nurses who routinely supported the home had no record they had attended dementia training. The National Institute for Health and Care Excellence (NICE) produced updated guidance in June 2018 for those supporting people living with dementia. The guidance states, 'Care and support providers should provide all staff with training in person-centred and outcome-focused care for people living with dementia.'

We were unable to speak with all agency registered nurses during the inspection to establish their understanding and competencies about the needs of people living with dementia. However, because all people living on Rosewood unit and some people living in other areas of the home were living with a type of dementia, this training should be achieved by all staff routinely used by the provider. This includes agency registered nurses who advise care staff and make decisions throughout the day about the care provided to people living with dementia. Dementia can affect the way a person speaks, thinks, feels and behaves. Therefore, it is essential all staff supporting people living with dementia are provided with training opportunities to increase their own understanding of how having dementia impacts a person and how to deliver care that meets their needs. This was of particular concern as we had discussed the need for all staff to attend specific training, at other inspections, at locations owned by the same provider since July 2017.

The above evidence showed that staff had not always received appropriate training to enable them to carry out their duties as they are employed to perform. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager acted in response to what we had identified. They wrote to us after the inspection to inform us the agency registered nurses working at the time of this inspection had undertaken dementia training. However, no additional training records were received by inspectors and this would not account for all agency registered nurses used since the last inspection. They also told us agency registered nurses would have to provide evidence of training achieved in Dementia prior to working at Longfield Manor in the future.

We found other staff received training in a range of areas, which the provider had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, fire safety, health and safety, infection control, food hygiene and safeguarding. Staff notice boards displayed the subject names and dates of the next courses planned. This included training in end of life care. One staff member told us the new manager had improved training opportunities for them. They said there was, "More training, staff know what they are doing".

New staff were provided with opportunities to shadow experienced staff members until they were competent to work independently. New staff were also required to complete the Care Certificate, covering 15 standards of health and social care topics as part of their induction into working in health and social care. To achieve this, candidates must prove that they have the ability and competence to carry out their job to the required standard. Staff were also encouraged to complete Health and Social Care Diplomas (HSCD). These are work based qualifications that are achieved through assessment and training. This ensured people received care from staff who had been provided the opportunities to gain the knowledge and skills they needed to carry out their roles and responsibilities.

Consent to care and treatment was sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked that the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People told us they felt free to spend their time how they wanted to without restrictions from the staff team. One person said, "I don't feel restricted. I do make my own choices of how I spend my time. I've not had any falls since I've been here". Care records showed how consent from people had been obtained and or their capacity to make a decision assessed. Where deemed necessary a DoLS application was completed. The manager shared a DoLS authorisation audit they had completed with us. The audit confirmed the management team had only made applications to the DoLS team if a person lacked capacity to make a decision about a specific restriction that was necessary for their safety. The audit also confirmed how conditions on authorisations were being met by the staff team. Other people were assessed as having capacity to make decisions for themselves regarding their own care.

Whilst we found the main principles of MCA and DoLS had been applied appropriately we did discuss how consent for Flu Vaccines were managed with the management team. For example, a consent request for one person who lacked capacity, to have their flu vaccine had been addressed to a person's relative. However, another relative had signed the document. This is not in line with the MCA unless a relative has Lasting Power of Attorney to make health and welfare decisions on behalf of the person. There was also no document to state the relative had this legal authorisation. The manager told us they would ensure this was

in place. Training records confirmed staff had attended training in both MCA and DoLS. Staff could share some knowledge on the topic and provided assurances they were aware of its importance. One staff member told us, "People without capacity can make simple decisions like what they eat or wear, some more complex decisions people are unable to decide which is when best interest decisions are made". We observed staff gain consent from people prior to providing care and support to them.

Where appropriate, 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms had been completed for people, by healthcare professionals, including GPs. DNACPR means that, should a person suffer a sudden cardiac arrest and their heart stops beating, no attempt will be made to resuscitate them. DNACPRs were reviewed by staff at the home to ensure they were still current. The provider used a red and green dot system which was located above their bedroom door. This dot was to assist staff when responding to a person when they suffered a cardiac arrest to ensure the correct action was taken.

The provider carried out assessments regarding people's physical, mental health and social needs prior to them moving into Longfield Manor. However, information was not always utilised in how risks were managed effectively and safely at the time of this inspection. We have discussed this further in the Safe section of this report. The initial assessment processes in place considered certain protected characteristics as defined under the Equality Act. For example, people's religion and disability.

Communication between staff working at the home and across the organisation overall was effective. Daily handover meetings took place at which staff could discuss people's care and support needs. The manager routinely met with other managers who worked for the provider. This was an opportunity to share learning and ideas across the organisation.

People were supported to have enough to eat, drink and maintain a balanced diet considering individual needs. We observed staff provided people with choices and responded to people if they changed their mind about what they wanted to eat. The food looked and smelt appetising. All staff were aware of any specialist diets including any allergies people had and adjusted the menu accordingly. There were allocated kitchen and domestic staff employed to prepare meals for people. The chef demonstrated he knew about people's specialist diets. Meal times were a busy period and we observed staff support people to eat using a sensitive and discrete approach. People and their relatives complimented the food provided by the staff team. One person said, "The food is very good. Plenty of it. I enjoy it all". Another person said, "It's very, very good food. I eat breakfast downstairs in the dining room. We have a cooked breakfast if we want. I prefer to just have cereal and toast. It's just nice to be with people". A relative said, "I think the food is good. I've eaten here". They added, "The lemon drizzle cake is the best there is".

People's healthcare needs were recorded in 'My hospital passport'; this is a document which details what healthcare staff need to know about a person's care and support needs should they be admitted to hospital. Care records documented the input people received from healthcare professionals. People and their relatives confirmed they had access to health and medical professionals when they needed. GP's visited the home and any changes to people's health needs were discussed and any actions to support people carried out. One person said, "If I wanted to see a doctor, they'd discuss it with me and make an appointment. If the doctor didn't want to come here, they'd take me to the surgery. There's a chiropodist who visits. If I needed to see a dentist I'd just ask". A relative said, "I have no doubt, the slightest thing and the doctor would be out and they'd let me know."

The home had been adapted to meet the needs of people with physical disabilities. Some adaptions had been made to create a more 'dementia-friendly' environment. For example, within the Rosewood Unit, there were memory boxes outside people's bedrooms which contained items of importance to them. Bedroom

doors were decorated to look like front doors and brightly coloured which may have assisted people when navigating themselves back to their own room. Brightly coloured beakers were in use in the Rosewood Unit; these enabled people to identify when drinks were placed in front of them and encouraged their independence.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in July 2017 we identified a task driven approach was used which did not promote a caring and personalised service. At this inspection we checked to see if this had improved. We found the new management team were working hard to improve how care was provided to people. However, there was an isolated occasion whereby caring approaches were not applied by staff supporting people. We observed a member of staff discussing people with the registered nurse on duty. They were sat at a table where other people living at the home were also sat. This was insensitive to people in that information about them was not treated discretely or in a confidential way. We recommend the provider reviews how caring approaches are applied when supporting people to ensure people's right to confidentiality is protected. We fed back the examples to the management team for their review. They told us this was not acceptable and not in accordance with the caring culture they were promoting.

This inspection took place over three days and our other observations of staff's interaction with people were mostly positive and people's dignity was respected. This included providing reassurances to people using a sensitive approach when they became confused or agitated. For example, a person sitting in a communal area expressed they were too hot and decided to remove clothing which compromised their dignity. The person became agitated, a member of staff shielded the person immediately and discretely covered them with a towel. They provided the person with a lighter top and reassured them until they were calm and happy with the outcome.

We also observed the lunchtime period. Staff told people what choices of food and drinks were available using a patient manner. Prior to the meal clothes protectors were offered to people rather than being placed without consulting them. We noted one staff member was particularly attentive and kept checking on each table to ensure people were satisfied or needed more assistance. Staff sat down next to people when they needed to support them with their meal. This meant they were at the same eye level as the person which promoted the person's dignity. Staff routinely knocked on people's bedroom doors before entering. We also observed staff smiling and engaging with people, asking how they were feeling and if they could get them anything, such as a drink or snack. This inspection was carried out during a heatwave. Staff regularly, but gently, reminded people to finish their drinks, since the day was very warm and people were at a higher risk of becoming dehydrated.

People and their relatives told us staff were kind and caring. One person told us, "Yes I think they all do what they can to support us all. [Named staff member] is an absolute angel to me, they're so sweet and friendly though". Another person said, "A relative said, "From time to time they'll sit and go through books with [named family member], or sit and hold her hand".

We were also told staff encouraged people to be involved with their own care, respected choices and prompted them to be independent. Staff explained they supported people to be involved in all aspects of their personal care such as much as they were able. One person said, "I get the care I need, when I need it. I try to do things for myself". Another person said, "I think I am doing pretty well to be fairly independent considering my age". A third person said, "Everything just flows here. Everything is at a nice slow pace.

There's no problem for me to do what I want. "They added, "I have been asked if I mind who gives me personal care, but I really don't mind. It's all very relaxed".

Resident meetings and care plan review meetings provided people and their relative's opportunities to discuss what was important to them. Relatives were also encouraged to discuss care provided informally when they visited their family members and at organised relative meetings. The manager told us they were wanting to increase the opportunities for relative's meetings and there were no restrictions on visiting times. One relative told us, "Communication is very good, they (staff) will contact me about [named person's care plan]". They added, "There is a newsletter and regular meetings about what is going on. We don't always go but they open up the floor for questions and send minutes out".

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found personalised care was being provided to people. At this inspection, we found improvements were needed to ensure people's needs were reflected accurately within care plans, accessible formats were used and appropriate activities offered and opportunities for occupation were consistently meaningful.

Details about each area of people's care and support needs were not always clearly recorded. For example, there was clear information in relation to oral care, sleep patterns and dressing and catheter management. However, a care plan in relation to 'Expressing sexuality', did not capture this topic but described the person's needs in relation to wearing the right clothing. When considering whether this person was able to express their feelings, the care plan described them as being unable to do so, or being confused, due to their cognitive decline. There was some evidence that care plans had been completed in a person-centred way, but we saw at least one example, where the name of the person in the body of the care plan was incorrect. This indicated that information had been copied and pasted from another person's care plan without being checked for accuracy.

Some care plans included information about people's lives before they came to live at Longfield Manor and about their likes, dislikes and preferences. However, the level of detail was variable across the care plans we looked at. For example, there was no information in relation to one person's personal history in their admission documents or care plan. The same person had undergone a pre-admission assessment in July 2017, so had lived at the home for several months. This meant that activities could not always be planned that were tailored to meet people's interests and hobbies.

Five activities staff were employed at the home and they planned and supported people to participate in activities. A structured programme of events was organised across the home and people were encouraged to join in with these if they wished. On the second day of our inspection, a 'knit and natter' group was in progress in the ground floor dining room. This was attended by a few people with the company of two activities staff. The staff were knitting. We observed that some people were engaged in conversation, others were sat quietly and a couple seemed to be asleep. A PAT dog came along with their owner on the first day of our inspection and visited people in the home. PAT dogs are used for therapeutic benefits to give people the opportunity to spend time with and stroke a dog. However, they stayed in Rosewood Unit lounge area for less than five minutes. We were told that work was in progress to identify people's interests and to record what they might like to do, then activities could be organised to meet these. However, only one 'life story' had been completed to date on Rosewood Unit and the information within the document we looked at was not very detailed.

Within the Rosewood Unit, at the time we inspected, there was little in the way of activities that provided stimulation for people. Three people sat in the same armchairs for the majority of the day. There was little for them to engage with, unless staff spent time sitting and talking with people which did not happen often. The television was switched on and some music was played at various times during the day. We looked at records relating to activities or time that was spent individually (one:one) with people. In the records we

saw, people benefited from spending time with activities staff in some parts of the home, however, people living in Rosewood Unit did not receive the same level of attention from activities staff. For example, the activities record for July 2018 for one person in Rosewood stated that on 6 and 7 July, the person was asleep when the activities staff member visited their room. On 21 July, the person's family came to visit. This meant that the person did not receive any one:one time from activities staff although they spent much of their time being cared for in bed. It is important that people living with dementia, have opportunities for activities and mental stimulation and this was explained in a care plan we looked at. This care plan referred to staff providing activities which were mentally stimulating and that staff should ask the person if they wished to participate.

In other areas of the home our experiences and observations were similar. For example, on day one of the inspection, in the East and West wings we observed how people spent their day. People spent long periods of the day in front of the TV. We observed very little offered in the way of activities and occupation and quite often people were asleep. This meant the main activities people were engaged with were personal care and meal times.

We were told that outings into the community occurred every Wednesday or Thursday with visits to places such as garden centres, pubs and the cinema. However, the minibus could only accommodate two people, supported by three staff, at any one time. An activities staff member said, "We try and get different people out every week". This meant that most people, unless taken out by friends or family, did not have the opportunity to go out very much. Staff could take people for a walk locally and records showed these outings tended to be on Thursdays.

We also observed on one occasion a person's choice was not respected. We heard this person explaining to a staff member they were not ready to get up and asked whether they could shower later. The staff member told the person they would not have time later so were coming to support them with a shower now. We checked and the person was supported to have their shower earlier than they had wanted. This meant the staff member had not respected the person's choice to receive personal care support later when they were ready. We fed back what we observed to the management team.

The provider used a written format for care plans which was appropriate for some of the people living at the home but not all. The Accessible Information Standard (AIS) is a requirement of NHS and adult social care services to ensure that people with a disability or sensory loss are given information in a way they can understand. Whilst care plans referred to the AIS, there was a lack of assessment completed to show how information should be recorded or shared with the person in an accessible way that specifically met their communication needs. Reasonable adjustments had not always been made to ensure that people's information needs had been identified or consistently met according to their needs. For example, an activities poster on display in the Rosewood Unit was not presented in an accessible format. People living with dementia may find it difficult to understand information in the written word and pictures or photos could be used to advantage to aid this.

People in Rosewood Unit were asked for their meal choices for lunch and supper the day before. During the afternoon, a staff member was observed asking people what they would like to eat the next day. One person became confused and thought they were being asked what they wanted for lunch that day, but it was teatime and they had already eaten their lunch. People living with dementia often have short-term memories and are unable to remember or recall easily. Asking people what they would like for meals the day before might work in other parts of the home. People in the Rosewood Unit would probably not have remembered what they had chosen to eat the day before. In addition, the staff member asking for people's choices, explained to people there was a choice of spaghetti Bolognese or grilled cod. People's

understanding would have been gained in a more meaningful way if pictures or photos had been used, so people could see what the meal choices looked like.

The above evidence demonstrates that the provider had failed to ensure that people received care or treatment that was personalised specifically for them. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager about some of our findings. They agreed that improvements were needed to activities. They said, "Activities were 50% where we want them to be". They told us that now the home was in a more stable position they would be able to focus on this aspect of care. They wanted to increase what people already told us they enjoyed such as one:one time, poetry sessions, pub sessions and quizzes. They also assessed more reminiscence based projects would be appropriate for people they currently supported. The manager was passionate about creating opportunities to invite in the local community. For example, prior to this inspection the manager had contacted the local Brownies group. They spoke positively about this as they recognised the benefits such work could mean for people living at the home. We were also told they were considering using one room as a 'coffee and cake bar' this would be opened to the public.

Complaints were considered and responded to in a timely manner. There was a complaints policy in place available for both people living at the home and their relatives. There was a clear log of all complaints and the actions taken by the management team. There were no formal complaints open at the time of our inspection. People and their relatives we spoke with, told us, they knew who to go to if they were concerned about a person. A person told us if they had a complaint they would, "Find the manager". Another person said, "I'd make a complaint direct to the management. They're very affable, they'll listen". One relative told us about an issue they had had about not enough blankets in their family members bedroom earlier in the year. They said, "I spoke with [named deputy manager] and she sorted it straight away".

Some people were registered with Echo, an NHS initiative which supports people in the delivery of care as they reached the end of their lives. Procedures were in place with the GP so that the person would receive a comfortable, dignified and pain free death. This included access to pressure relieving equipment and pain relief medicines.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in July 2017 we found there were systems in place to assess, monitor and improve the service but these were not being operated effectively. Shortly after the inspection, the provider informed us the action they were taking to address this.

Since the last inspection, the provider had developed a new senior management team. The manager and area manager shared with us a new direction the senior management team were taking regarding how checks on care delivery were made. This included quality auditors carrying out audits on the service which were complete with areas which needed improvements. We were told this provided senior managers with themes and trends of what and when was happening in a particular service. However, some of the systems in place to check the quality and safety of care provided to people remained ineffective. They failed to highlight all the areas we identified on this inspection. Further work was required to ensure risks to the quality of care provided to people were mitigated.

Some areas such as improvements to the activities offered to people had been recognised by the manager and there was an action plan in place to state how this was going to beimplemented. Yet other gaps and inconsistencies we highlighted such as incorrect mattress settings and gaps in dementia training for agency nurses had not been identified through the providers own quality assurance systems. We also spoke with the management team about what we had found in care records which required their attention.

For example, the provider had introduced the National Early Warning Score (NEWS) at Longfield Manor. This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. The NEWS will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions nurses should take if physiological checks they take are outside of the baseline and a person's health deteriorates further. NEWS for people's care we checked at this inspection, had no baseline observations recorded. This meant there was no reference point for a registered nurse to make comparisons with when assessing a person's health. During the inspection, registered nurses told us if a person's health deteriorated they would consult with their GP or if needed emergency services would be contacted. However, this was a missed opportunity to fully utilise the NEWS system. The risk was increased further due to the regular use of agency nursing staff who may not have known people and their health needs as well as permanent staff.

Some people were at risk of malnutrition. This had been identified by the provider prior to this inspection. Care plans provided details about the support that should be provided to people with this known risk and the control measures in place. This included a regular review of the person's weight. If a person had lost weight then staff calculated what the percentage weight-loss was. We identified that the percentage of weight loss was not always calculated correctly on behalf of people. For example, one person's percentage weight loss during 2018 was much more than what had been recorded in their health monitoring records. We checked with staff to see whether they were meeting this person's needs. We found actions had been taken to support the person with their meals and nutritional supplements had been introduced. However, inaccurate information relating to the person's weight may have been shared with the person, visiting health

and social care professionals and/or relatives. It is important records relating to people's health are checked by providers. This ensures professional and expert advice is sought when a person needs it, so that the appropriate changes to care provided can be made. This had not been identified by the provider in their monitoring of the service prior to this inspection.

The above evidence shows that the provider was unable to demonstrate that systems or processes in place operated effectively to ensure compliance with requirements. There was a failure to assess, monitor and mitigate the risks relating to health, safety and welfare of people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, people and their relatives were positive about the culture of the home and the support they received from the staff team, including the manager. One person told us, "You won't get anywhere better". A relative said, "The new manager made a point of coming in to meet me. I think she seems very capable". Another relative said, "I met the new manager at a relatives meeting. I had a long chat with her. I've emailed her and I think she's very capable and glad she has, [named deputy]".

We checked how the provider gained people's and relative's views of the quality of care provided. Relatives could speak with staff when they visited, attend group meetings and surveys were sent out monthly from the provider's head office. Survey responses we read were all positive and demonstrated the staff team adopted an open-door policy which helped promote an inclusive atmosphere.

On the 1 November 2017 amendments to the Key Lines of Enquiry (KLOE) came into effect, with five new KLOE and amendments to others that all regulated services are inspected against. The manager was aware of the changes and shared with us communications by the provider about how the amended KLOE would impact on location inspections.

The manager was committed to improving the service offered to people and the support provided to the staff team. They told us they were most proud of improving, "the general morale (staff team) and the feel of the place" They felt they had empowered staff to have, "confidence to ask", if they had a question. Staff complimented the approach used by the manager and appreciated she got involved and used a 'hands-on' approach. One staff member said, "Management are always around".

The deputy manager and manager told us they worked alongside other health and social care professionals and partner agencies. They told us they were keen for this to continue to benefit the people living at the home. A local authority moving and handling assessor had been supporting the staff team since May 2017. They told us, "Longfield have been very proactive and acted upon my recommendations quickly and effectively".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Personalised care was not consistently provided to service users

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 Safe care and treatment was not consistently provided as risks were not always mitigated on behalf of service users

The enforcement action we took:

Imposed provider level conditions see overall summary

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 Systems to check the quality of care were not effective in assessing, monitoring and improving the care provided to service users.

The enforcement action we took:

Imposed provider level conditions see overall summary

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had been provided training opportunities specific to the needs of service users.

The enforcement action we took:

Imposed provider level conditions see overall summary