Sheffield Health and Social Care NHS Foundation Trust

Longley Meadows

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 17 and 20 November 2014 where we identified breaches of legal requirements. This was because people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. There was also a breach because the provider did not have an effective system to regularly assess and monitor the quality of service that people' received. Nor did they have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook a comprehensive inspection on the 16 and 24 February 2016 to check that they had followed their plan and to confirm that they now met all of the legal requirements. 24 hours' notice of the inspection was given because the service is small and we needed to be sure that someone would be in.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Longley Meadows' on our website at www.cqc.org.uk'

Longley Meadows is in the grounds of the Northern General Hospital and provides short stay respite accommodation for adults with learning difficulties. Many of the people accessing the service have profound and multiple learning difficulties, including multiple health needs and physical disabilities. The service can provide care for up to nine people at any one time. 39 people use the service in total.

The service did not have a 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 and associated Regulations about how the service is run. There was an acting manager in post at the time of the inspection however she had only worked at the service for two weeks.

The requirements of the Mental Capacity Act 2005 were in place to protect people who may not have the capacity to make decisions for themselves. However, we found there was not sufficient detail recorded about how consent and best interest decisions were achieved for the use of assistive technology in people's bedrooms.

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

The support plans were centred on people's individual needs and contained information about their preferences, backgrounds and interests. People were treated with dignity and respect throughout our

inspection. Staff were aware of people's differing cultural and religious needs.

There were enough skilled and experienced staff and there was a programme of training, supervision and appraisal to support staff to meet people's needs. Procedures in relation to recruitment and retention of staff were robust and ensured only suitable people were employed in the service.

Our observations, together with our conversations with relatives of people who used the service provided evidence that the service was caring. The staff we spoke with had a clear understanding of the differing needs of people staying at the home and we saw they responded to people in a caring, sensitive, patient and understanding professional manner.

People's physical health needs were monitored and referrals were made when needed to health professionals. People were supported to access existing day time and evening activities during respite stays at Longley Meadows. The service had an open and transparent culture that actively encouraged feedback from people who used the service, their relatives and staff.

We saw there was a complaints procedure that could be accessed by people who used the service and their relatives. Staff told us they would offer assistance if people needed to use it. We saw that the complaints procedure was written in plain English which described how people should raise any concerns they may have. It also explained to people how they could obtain an independent person to assist them if needed.

We found there were systems in place to monitor and improve the quality of the service. However, these were not always effective.

Our inspection identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always safely managed and recorded. The lack of a consistent method of checking medicines received and returned increased the risk of medicines not being administered safely.

People were safeguarded from the risk of abuse; staff knew how to identify and report abuse.

An effective recruitment process was in place. There were enough staff on duty to ensure people were safely supported. Staffing numbers were matched to the number and needs of people receiving respite care at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Most staff had received training on the Mental Capacity Act which helps to protect people if they are unable to make important decisions for themselves. We found evidence that some decisions for people had been made without a formal best interest meeting taking place.

Each member of staff had a programme of training and were trained to care and support people who used the service safely and to a good standard.

People's nutritional needs were met. The food we saw, provided variety and choice and ensured a well-balanced diet for people staying in the home. We observed people being given choices of what to eat and what time to eat.

Support plans contained detailed information about people's healthcare needs. These were reviewed and updated before each respite stay in order to ensure that they were accurate.

Is the service caring?

Good

The service was caring.

Most people had been involved in deciding how they wanted their care to be given and they told us they discussed this before they stayed at the home.

We saw staff had a warm rapport with the people they cared for. Relatives spoke positively about the staff at all levels and were happy with the care.

People were treated well by caring staff who respected their privacy and dignity. Staff were aware of people's differing cultural and religious needs.

Staff interacted well with people and provided them with them support they needed.

Is the service responsive?

Good

The service was responsive.

We found that peoples' needs were thoroughly assessed prior to them staying at the service. A relative told us they had been consulted about the care of their relative before their stay and again after they had returned home.

Relatives told us the staff at all levels were approachable and would respond to any questions they had about their relatives care and treatment.

Communication with relatives was mainly good. The service had a complaints procedure that was accessible to people who used the service and their relatives. People told us they had no reason to complain as the service was very good.

Is the service well-led?

Requires Improvement

The service was not always well led.

People who used the service and their relatives had opportunities to give feedback or raise issues through meetings and one to one discussions with staff.

The service worked closely with the families of people who used the respite service, to ensure they were informed of any changes to their care needs.

The systems and audits to monitor and improve the quality of the service were not always effective. We found in some audits we looked at, areas for improvement had been identified

however these had not been addressed in a timely manner.

Staff told us they felt supported and felt able to have open discussions with the manager and nurses through one-to-one meetings and staff meetings. However uncertainties around the future of the service caused some anxieties for staff.

Longley Meadows

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 24 February 2016 and was announced. 24 hours' notice of the inspection was given because the service is small and we needed to be sure that someone would be in, and the manager would be available. The inspection was undertaken by two adult social care inspectors and a pharmacy inspector. On the first day of the inspection there were three people using the service and on the second day six people were using the service.

We contacted five relatives of people using the respite service by telephone. We spoke with the acting manager, assistant service director, two nurses and four support staff. We also observed how staff interacted and gave support to people throughout this visit.

We did not ask the provider to send us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed all the information we held about the home including notifications that had been sent to us from the home. We also spoke with the Sheffield City council monitoring officer who also undertakes periodic visits to the home. We spoke with local safeguarding staff to assess how the service responded to allegations of abuse.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at three people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found the management of medicines was not safe. This was a breach of Regulation 12(2)(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we checked the medicines and records for four people. We spoke with the assistant service director, the registered manager, a registered nurse, and a student nurse. We found all the records we looked at had any allergies recorded on each person's medicines record. We found there were no photographs of each person with their medicines record to help the person administrating medicines to identify people. Having photographs reduces the risk of medicines being given to the wrong person as per current guidance.

Medicines were not always given as prescribed by the doctor. One person's prescription chart had been written incorrectly; this meant staff may have administered medication which was no as intended by the prescriber. This had not been noticed by the staff at the home. The same person was prescribed an eye drop on the day we visited. The strength that had been prescribed by the doctor on the prescription chart was different to the strength of eye drop supplied by the pharmacy. An emergency verbal order was written by a nurse, however this was different to the directions on the pharmacy label and the verbal conversation with the doctor had not been recorded in the person's care notes so that staff could be assured this person was receiving the correct dose as prescribed.

A second person who was prescribed a patch to reduce nausea and sickness did not have it applied during their stay as the medicine had not been written on the prescription chart. The same person was given a prescribed medicine before they went to a day centre for the day. When we contacted the day centre, the person had also received the same medicine at the day centre as there was no process to communicate which medicine had been given on the unit. A third and fourth person were prescribed a fluid thickener to help with swallowing difficulties; the consistency of the fluids given was different to what had been written in both care plans and the fluid thickener had not been prescribed on the prescription chart.

The home did not reconcile (check) people's medicines when they were admitted to the unit, and therefore it was unclear of what medicines a person should be taking. The home did ask family members what medicines their relatives were taking, but there was no formal record to check this against.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were being stored in accordance with legislation, but stock balances were not always being checked weekly as the policy stated. For example we saw they were checked on 20 January 2016 then not checked again until 3 February 2016. The current fridge temperatures were being recorded each day, however national guidance recommends minimum and maximum temperatures should be recorded.

This was a breach of Regulation 12(2)(f) and (g) the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We were unable to speak with people who were using the service at the time of our inspection because people accessing the service had communication difficulties and were not always able to verbally communicate their experience of the service to us. We spoke to four relatives of people who used the service and they told us they thought the care and treatment their family member received was safe. One relative said, "I have no worries when my [family member] stays at Longley Meadows the staff are well trained and know how to meet [family members] needs." Another relative said, "We have used the service for six years and we have never had any problems. Staff ring us if they are worried about my [family member] and they get medical advice from our doctor."

We spoke with staff about their understanding of protecting adults from abuse. They told us they had undertaken safeguarding training and would know what to do if they witnessed bad practice or other incidents that they felt should be reported. They said they would report anything straight away to the nurse or manager. We saw staff had received training in this subject; however we saw they were due for refresher training to update staff.

Before this inspection took place we reviewed information shared with us regarding allegations of abuse. We looked at safeguarding referrals that were on-going and the outcomes of those that had been investigated. From our discussions with the assistant service director, acting manager and staff, we found the service was open and transparent about what they needed to do to protect people who used the service. They were clear about reporting allegations to the appropriate authority including the Care Quality Commission (CQC), Police and the Sheffield City Councils safeguarding authority.

Risks associated with people's personal care were well managed. For example we saw care records included risk assessments to manage people's risk of choking and also risks associated with the care while in bed. There were emergency plans in place to ensure people's safety in the event of an emergency, for example, a fire. We saw there was an up to date fire risk assessment and people had an emergency evacuation plan in place which was stored with fire records.

We found that the recruitment of staff was robust and thorough. This ensured only suitable people with the right skills were employed by this service. The nurse we spoke with told us that two new qualified staff had been recruited to support the existing nurses.

The assistant service director told us the processes that were followed when recruiting new staff. Application forms were completed, references obtained and formal interviews arranged. They told us that all new staff completed a full induction programme and when completed, was signed off by their line manager. We looked at five staff files, these included two written references, (one being from their previous employer), and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. The assistant service director told us that the Trust were reviewing their policy around DBS checks and that it was anticipated that 3 yearly checks would be undertaken following this as good practice Staff would have a responsibility to inform their manager if anything changed in between the checks.

Through our observations and discussions with relatives and staff members we found there were enough

staff with the right experience to meet the needs of the people currently living in the home. The nurse showed us the rotas which were consistent with the staff on duty. She told us the staffing levels where flexible to support people who used the service. Support staff that we spoke with told us that there was very low morale within the staff team due to the uncertain future of the service and lots of changes in management. They told us that because some staff had recently left the service it had put added pressure on them to work additional hours required covering shifts. One staff member said they felt that staffing levels were often inadequate and that people were leaving the service for other employment opportunities because of the uncertain future of the service. Staff said that staffing levels dictated when they were able to take people who used the service out and participate in activities within the community.

One nurse we spoke with also told us that she felt staffing levels were not always adequate to meet some people's complex needs. She also spoke about the uncertainty of the future of the service and the effect this was having on staff morale. The assistant service director was aware of the anxieties amongst staff but was unable to give any reassurances about the future of the service

We spoke with five relatives of people who used the service and they told us that they thought the care was very good and there always appeared to be sufficient staff to meet people's needs. However one relative told us that the changes in the manager affect the way the service is run. They gave us an example of this. They said, "One manager said it was okay to use taxis when drivers were not available, while another manager told staff they could not use taxis to enable people to access community activities."

Requires Improvement

Is the service effective?

Our findings

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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own. At the time of the inspection the manager told us they had made applications to the local council's supervisory body for some people staying at Longley Meadows. We looked at a one person's DoLS which had been authorised and contained conditions which the service must legally comply with. We found that the provider could not provide evidence of how they were complying with the conditions. One condition said that they should facilitate the person's integration back into the main part of the building which should include the use of the sensory room. This was because they spent time in a separate room staffed on a one to one basis away from other people who used the service. The assistant service director told us the person had not had many stays at the service since the DoLS was authorised. We asked that they produced formal records of any attempts that were made to comply with this condition. We saw other applications which had been submitted were still awaiting decisions.

We saw in the main lounge/dining area of the building assistive technology was being used to monitor people who used the service while they were in their bedrooms at night. Staff we spoke with told us they were used to monitor people who had frequent seizures, so that the night staff could respond quickly to any emergencies. Staff told us they were turned off when staff were present in the room to help to maintain their privacy. The assistant service director told us that camera monitors were used for five people who used the service. We looked at the care records and found one person had asked for the system to be used when they stayed at the service. The record stated they wanted a camera to reduce their anxiety. It was not clear if the person had capacity to make this decision.

We were unable to establish if the other four people had capacity to make the decision to have the assistive technology in use in their bedrooms. There was no evidence to confirm this was the least restrictive way of ensuring their safety or the rational used before the technology was installed. There was no evidence to confirm consent had been gained from all of the people who used the service. There was also no formal evidence of a best interest decision meeting taking place, although the record for one person stated their parent wanted the camera to be used as it was used when the person returned back to the family home. Staff told us the monitors were used whenever bedrooms were occupied.

This was a breach of Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care which was based on best practice, from staff who had the knowledge and skills needed to carry out their roles and responsibilities effectively. Relatives we spoke with told us they thought staff had the right skills and competencies to enable them to care for their family member in the same way as they were cared for at home. Relatives confirmed to us that staff contacted them prior to stays at the service to check if there were any changes to the persons care needs and also to check on medication changes.

There was guidance for staff regarding how people expressed pain or discomfort, so they could respond appropriately and seek input from health care professionals, if necessary. The nurse we spoke with described how people were observed and monitored in relation to their general well-being and health. There was emphasis on observations, especially for signs of any pain, as not everyone could effectively communicate their needs verbally. The staff we spoke with were aware of the way each person expressed themselves, and were very tuned in and responsive to people's facial expressions and body language.

People's nutritional needs were assessed during the care and support planning process and again before each visit. We found that people were supported to eat and drink sufficient to maintain a balanced diet. We observed people returning from day activities and were offered drinks while another member of the support team cooked the evening meal. Support staff showed us diaries that go with people to the day services so that food and fluid intake can be assessed. Staff told us one of the day services people accessed provided a hot cooked meal. This meant a lighter meal was provided when they returned.

People's needs in relation to nutrition were seen documented in the plans of care that we looked at. We saw that menus offered variety and provided a well-balanced diet for people. Lighter meals and snacks were also available. We saw that the menus were put together using feedback from relatives about what they liked and didn't like, as well as input from a dietician and a speech and language therapist. Where people did not communicate verbally their plans also included information about what they liked and did not like to eat and drink. This had been built up from what people had indicated they enjoyed and from staffs' observations of people's reactions to different food and drinks, and information from people's families.

The assistant service director told us they had taken on board shortfalls identified from visits by external monitoring organisations. They had recently introduced training in the use of the malnutrition universal screening tool to help assess people that may be at risk from poor nutrition and hydration. They had also taken advice from the speech and language therapist and dietician to assist with assessments of people's nutrition. We were also shown a nutritional action plan which was developed following the visit of the senior dietician which had given clear agenda for the nursing staff and the manager to work towards.

Records we looked at confirmed staff training had improved. Following a safeguarding referral regarding the positioning of people who used the service while remaining in their wheelchair a physiotherapist had delivered posture management training to most of the staff working at the service. Other service specific training had also been delivered to staff for example moving and handling, epilepsy and diabetes. Staff told us that they felt the training provided them with the additional knowledge to meet people's individual needs. They told us this if they identified any areas where they required further training they would let the nurses know and it would be provided. The assistant service director told us that mandatory training was provided by face to face and on-line training. Some refresher training was due at the time of our inspection for a number of staff. New staff attended both an on-site and an external induction programme. They were also expected to work alongside more experienced staff until they were deemed to be competent.

We spoke with staff about supervision and appraisal. Supervisions ensure that staff receive regular support and guidance and appraisals enable staff to discuss any personal and professional development needs. Our review of the provider's supervision records identified that supervision for support workers and clinical supervision for nurses was occurring less frequently than the providers six to eight weekly timescale. NMC guidance for clinical supervision of nursing staff is monthly.
Staff confirmed to us that they received regular supervision on an individual and group basis, which they felt supported them in their roles. Staff told us in the absence of the registered manager support was given by the nurses and they would ask them if they required some advice or needed to discuss something about their roles and responsibilities. Staff were not concerned by these shortfalls. Staff told us they felt supported by the nursing staff and the new manager. We spoke briefly with the assistant clinical director who had been brought into the service to support and develop the qualified staff. She told us that her role was to bring increased support and rigor to drive up quality and develop a culture of safe compassionate care.

The assistant service director took us on a tour of the premises. Each area of the property was clean, tidy and odour free. Adaptations and equipment was in place throughout the premises to meet people's differing needs. For example, there were different types of baths and beds as well as changing beds for people who needed full support to wash and dress. We noted that the equipment in place in some rooms made the environment appear clinical. For example, everything was painted in the same colours and bathrooms were functional but were not homely. We saw rooms were decorated the same throughout and there were not many pictures and other fabrics normally seen in a care setting. This meant the service did not have a homely atmosphere. Whilst there was no evidence of any impact upon people who used the service, we noted that some rooms were quite small. The service had developed a multi-faith room but this was only a very small room and there was also a sensory room but this could only accommodate one or two people at a time.

Good

Is the service caring?

Our findings

We spoke with five relatives about what they thought about the service their family member received from Longley Meadows. All were very complementary about the care provided at the home. One Relative said, "The staff are wonderful, I don't know what we would do without the service. My family member really enjoys going into the home, they never show any signs that they have not received appropriate care and treatment." Another said, "I am very satisfied with the service. My [family member] has been using the service for over 10 years. Staff have a good rapport and know my [family member] very well" Another said, "The staff are marvellous, kind and compassionate, they know my family member very well."

When we visited on the second day we saw people arriving back to the home from day services. There was a lively atmosphere with people having drinks and staff chatting to them about what sort of day they had had. We observed staff interacting with people in a positive encouraging way. People were asked what they wanted to do during their spare time and there was lots of encouragement given to people to respond to questions. For example, two people went through into another lounge area to listen to music while another person started to draw and colour pictures. Other people expressed that they were tired and were assisted to their room for a lay down.

Observations throughout our inspection demonstrated that the staff at Longley Meadows had a clear knowledge of the importance of dignity and respect and were able to put this into practice when supporting people. We noted that staff discreetly altered people's clothing to protect their dignity and routinely knocked on bathroom and bedroom doors before entering. Our conversations with staff provided further evidence of how the service respected people's privacy and dignity. For example, when explaining how they supported people with personal care tasks in the morning, one support worker said, "The first thing I do is turn off the monitors which mean other people cannot hear what intervention we are doing in the bedroom. We always make sure doors are closed and curtains are drawn before undertaking personal care."

Our conversations with staff and our review of records demonstrated that Longley Meadows were aware of, and respected the different cultural and religious needs of people who used the service. We noted that staff had recently attended 'respect' training and we saw there was a dignity tree in the main area with examples of how to treat people. We saw that there was a small multi-faith room to meet people's spiritual and religious needs. Staff told us that a Chaplain from the trust visited twice a month to speak with people who used the service. The room included washing facilities, prayer mats, a sign on the wall to inform people of the direction for prayer and differing religious texts.

We found that staff were knowledgeable and respectful of the differing cultural and religious needs of people who used the service. For example, staff told us that they matched the gender of staff on duty to people's preferences and cultural needs. They also informed us that halal foods were obtained from a local butcher and showed us the separate area and utensils used for storing and preparing these foods.

Good

Is the service responsive?

Our findings

We looked at three people's care plans which confirmed that a detailed assessment of their needs had been undertaken by the manager or nursing staff before their admission to the respite service. Relatives confirmed that they had been involved in this initial assessment, and had been able to give their opinion on how their family members care and support was provided. One relative we spoke with confirmed to us that they had recently been involved in a review of their family members care. Relatives confirmed that their family member visited the service several times before they stayed overnight. One relative said they found it very useful as it gave staff time to get to know their relative and get to understand how their family member communicated their needs. Following the initial assessment, care plans were developed detailing the care, treatment and support needed to ensure personalised care was provided to people using the service.

Relatives confirmed to us that one of the nurses telephoned prior to their family members stay at the home to obtain any changes to their family members care and treatment. The assistant service director showed us a new format which was going to be introduced shortly which would give an overview of the person stay at the service. 'My short break' covered all aspects of the persons stay at the home including, how they kept busy during their stay, activities, diet and their general wellbeing.

People could access activities during stays at the service and on our first day of this inspection we saw one person went to Meadowhall shopping centre. The sensory room was also available to people who used the service This contained a range of different coloured lights and objects such as bubble tubes, fibre optic strands of light and vibrating tubes to promote a relaxing and calming environment. Staff we spoke with told us they had the use of a mini-bus to take people out into the community but they told us there was only a small number of staff who could drive the bus. They told us that they used taxis if there was no driver available. Staff told us that most in house and community activities took place at the weekend when people had more leisure time. This was because most people attended day services during week days.

The assistant service director told us that following quality monitoring visit from Sheffield City Council they had developed an action plan to review all of the information they held about the people and review all of the care plans for the 39 people who currently use the service. We were told that this process had begun and was due to be concluded over the next few weeks.

Relative we spoke told us that they were allowed up to 70 nights stay at the service each year. We were told that the maximum number of nights anyone could be allocated was 91. Some relatives take their stays in blocks to enable them to have a holiday. Other relatives told us they had overnight stays and stays at the weekend. One relative said. "The service was very responsive to my situation. I needed to go into hospital at short notice and they made no fuss they agreed to an emergency stay for my relative. I don't know what I would have done if they could not accommodate my family member at very short notice."

Following a Sheffield City Council monitoring visit at the service the provider engaged with Sheffield Mencap to undertake meetings with relatives to gain their view on the quality of the service. We looked at the key points raised from this meeting and found most relatives spoke positively about the care and treatment

provided at Longley Meadows. Comments included "It's a lifeline for my family," and "I trust them to do their best," and "They are like a second family, the service gives me a real break." Relatives gave mixed views on their impression of the facilities at Longley Meadows, describing the service as 'clinical'. Relatives were pleased with the equipment available at the service which gave reassurances that their family member would be safe.

Support staff told us that handover meetings took place at the start of each shift. We reviewed the notes used to inform this meeting and found they contained detailed information about how people had been during the shift and the needs they had been supported with. Some people continued to access their day services and activities with other community providers during their stays at Longley Meadows. Staff told us that communication with these services was good and that key information was shared by meetings, phone calls and communication books. We looked at two communication book and found they contained detailed information about the activities that the person had taken part in. They also contained information about the person's wellbeing and about their diet and fluid intake.

We saw that symbols and pictures were often used to provide information to people in formats that aided their comprehension. The support provided was documented for each person and was appropriate to their age, gender, cultural background and disabilities.

The assistant service director told us there was comprehensive complaints' policy and procedure; this was explained to everyone and their relatives who received a service. It was written in plain English and there was an easy read version which was available to those who needed it in that format. They told us complaints received had been fully investigated and a response sent back to the complainant.

The relatives we spoke with told us they had no concerns but would discuss things with the nurses or the manager if they needed to raise any issues. Three relatives we spoke with told us that in the past they had raised concerns but they were satisfied with how their concern had been addressed. One relative told us about a concern they raised regarding their relatives nutritional intake. They told us they had a meeting where the diabetic nurse and dietician attended and the issue was resolved to their satisfaction.

Staff told us if they received any concerns about the services they would share the information with the manager. They told us they had regular contact with their manager both formally at staff meeting and informally when the manager carried out observations of practice at the home.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found the registered person did not have effective systems in place to monitor the quality of the service delivery. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to send us a report detailing what improvements they would be implementing to address this breach and by when. The provider sent us an action plan stating they would be compliant by July 2015.

At this inspection we found continued breach of this regulation The provider did not have an effective system to regularly assess and monitor the quality of service that people' received. Nor did they have an effective system in place to identify asses and manage risks to the health, safety and welfare of people who used the service and others. For example we checked the systems in place for auditing medication. We looked at the medication audit completed on 12 January which identified that the service was 76% compliant. However the audit completed on 18 February 2016 by assistant service director identified further non-compliance with medication procedures. This meant the service had not learned lessons from errors made previously and improvements were not implemented in a timely manner.

During our inspection we looked at a range of records and spoke with a number of staff in order to review how the quality and safety of the services provided by Longley Meadows was assessed, monitored and where required, improvements made. We looked at the care plan audits completed by the assistant service director on 24 November 2015 and 18 February 2016. The audits identified actions were required in a number of care plans. A care plan audit completed between May and June 2015 also identified shortfalls in the records. We found that although improvements had been identified, action had not been taken in a timely manner to address these areas. This meant people who used the respite service may not receive care that was up to date or met their needs. The assistant service director told us that all care plans were under review and would be completed as soon as practicable. There are currently 39 people who used the service regularly.

In the absence of the registered manager the provider had appointed an acting manager to oversee the day to day management of Longley Meadows. At the start of this inspection the manager had been in post for two weeks. The acting manager was being supported by the assistant service director who was present throughout the inspection. Our conversations with staff raised concerns over the inconsistency of leadership which had impacted on the service provided. For example staff told us the previous manager had restricted the use of taxis when taking people who used the service into the community. Instead staff were told to use public transport. Staff told us this had restricted the community activities available to people who used the service. Staff were also told by one manager they could not eat with people who used the service. Another manager encouraged staff to sit and eat with people who used the service.

Most staff we spoke with at all levels told us that the morale within the staff group was quite low. They told us three staff were leaving which would put pressure on the remaining staff to ensure appropriate levels

were maintained. Uncertainties about the future of the service were given as the main reason for staff leaving. They told us that they did not feel the Trust was being open and transparent about the future plans for the service.

We found the service was not acting in accordance with the requirements of the Mental Capacity Act 2005 and the associated code of practice. Staff put people at risk that their consent may not be considered by not recognising that some people had capacity. Decisions were made without the correct documentary evidence which meant the legal processes had not been followed. Following the inspection the assistant service director had sent us an action plan detailing how they would ensure they acted within the legal requirements of MCA.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Our observations of interactions between the nurses and support workers showed they were inclusive and positive. All staff spoke of a strong commitment to providing a good quality service for people staying in the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with consent of the person, and in accordance with the MCA 2005, where a person lacked capacity. Regulation 11 (1)(3)

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

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