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

About the service:
• Longfield Manor is a care home that provides nursing and residential care. 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 48 people living at the service.
• 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 lounges and a large dining room.
• Longfield Manor is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is ongoing, and no conclusions have yet been reached.
• At the previous inspection in July 2018 we found four breaches of regulation in relation to safe care and treatment, staffing, person-centred care and governance. At this inspection we found that the provider continued to be in breach of these four regulations and was in breach of one new regulation in relation to dignity and respect.

People's experience of using this service:

● The service met the characteristics of 'requires improvement' in each domain inspected. This meant that the provider needed to make some improvements to people's support. These are detailed below.

● Some aspects of the service did not ensure that people remained safe from harm. There were elements of moving and handling practices that did not always ensure the safety of people at the service. The provider had not always fully assessed, and mitigated the risks, associated with repositioning people and the periods that people spent in their wheelchairs.

● The provider did not always ensure that staff had the training and skills to meet some of the needs of people who lived at the service.

● People's dignity was not always promoted by staff.

● People did not always receive personalised support because peoples likes, dislikes and preferences had not always been identified and used in the care planning process. However, the provider had made improvements in the provision of activities and social engagement for people.

● Systems of governance and quality assurance were not always effective in highlighting shortfalls in the service.

● People's health needs were met with the support of staff. Staff worked in partnership with other organisations to ensure people's needs were met.

● People medicines were administered and managed safely and effectively.

● People were supported to eat enough food and drink. People who required additional help to safely manage their nutritional needs were supported effectively by staff.

● Staff had made appropriate checks and carried out maintenance to ensure the service and equipment was safe for the people living at Longfield Manor.

● People received compassionate and caring end of life support. People's complaints were addressed and dealt with appropriately.

● Recruitment processes were robust and ensured staff were safe to work with people before they started working at the service.

● People, relatives and staff spoke positively about the registered manager and felt able to raise concerns and were confident that these would be addressed.

● People, their family members and staff told us that the management were responsive and had taken steps towards implementing improvements at the service.

More information is in the detailed findings below.

Rating at last inspection:
• At our last inspection in July 2018, the service was rated "requires improvement". Our last report was published in February 2019. This is the third time the service has been rated as requires improvement overall.

Why we inspected:
• All services with rated as requires improvement with breaches are re-inspected within twelve months of our prior inspection. However, this inspection was brought forward in response to incidents that had occurred in the service and concerns that had been raised about the safety and management of the service.

Enforcement: Please see the 'Action we told provider to take' section towards the end of the report. 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.

Follow up: We have asked the provider to send us an action plan telling us what steps they are to take to make the improvements needed. We will continue to monitor information and intelligence we receive about the service to ensure good quality is provided to people. We will return to re-inspect in line with our inspection timescales for Requires Improvement services.

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

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Longfield Manor

Detailed findings

Background to this inspection

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

Inspection team:
Our inspection team consisted of three inspectors, a specialist advisor and 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. The expert by experience's area of expertise was in supporting people living with dementia.

Service and service type:
Longfield Manor is a care home that provides nursing and residential care. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced. The inspection was a responsive inspection carried out due to information of concern received through notifications and enquiries to the Care Quality Commission.

What we did:
We reviewed information we had received about the service since the last inspection in July 2018. This included details about incidents the provider had notified us about, such as allegations of abuse. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

We spoke with nine people who lived at the service to obtain their views of the care they 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. 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 inspection, we spoke to the registered manager, deputy manager, clinical lead, four registered nurses, four carers, the activities coordinator and the chef. We also spoke to six relatives of people living at the service. During the inspection, we observed medicines being administered to people. We reviewed records about people's care which included care plans of 15 people. We looked at a range of clinical records as well as care and nursing notes, relating to the specific concerns we had received. We also looked at recruitment records and profiles, accident and incident reports, quality assurance documents and medicines records. After the inspection, we also contacted three professionals to gain their feedback on their experiences of working with people and staff at the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

When we last inspected the service in July 2018 we found a continued breach of regulation as not all had been reasonably done to mitigate risks to people. At this inspection we found the breach continued in relation to assessing risk, safety monitoring and management.

Assessing risk, safety monitoring and management

● Staff did not always ensure that people were supported to move and transfer safely, and we observed unsafe practices. For example, one person was being supported to stand from their armchair by two staff members. One agency carer had placed their hand underneath the person's armpit in preparation to lift them as they stood. Only the intervention of the second staff member to inform them that this was incorrect practice prevented them from doing so. Another staff member was observed supporting a person to mobilise along a corridor whilst supporting them underneath their armpit. Use of this lift can result to damage of the spine, shoulders, wrist and knees. For the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. Risk of fractures to the bone of the upper arm and dislocation of the shoulder is also a possibility. The Royal College of Nursing provided the following guidance about the use of this lift technique 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out'.

● We observed the transfer of one person that highlighted issues around safe moving and handling practices. The person was being supported by two staff members to be hoisted into a chair in the communal lounge. However, the distance to the chair, from the point of starting the manoeuvre, was significantly further than good practice would recommend in order to ensure a safe transfer. Therefore, both staff members needed to push and guide the hoist, with the person elevated, towards the chair. The impact of this was that the person's safety was at risk because one staff member could not safely support the person whilst elevated in the hoist and when they were being moved and transferred.

● As detailed in the Effective domain, staff had completed the mandatory 'manual handling objects' training although not all staff had undertaken the 'moving and positioning people' training. Agency staff were required to have a permanent member of staff supporting them when carrying out transfers that required two staff members. We observed that this was happening. However, we observed three occasions when agency staff needed to be corrected in their techniques or procedure before starting a manoeuvre.

●Staff told us however that they felt that moving and handling had improved at the service. We did observe some good examples of moving and handling where staff showed good awareness using the correct equipment and paying attention to what the agency carer was doing.

● At the last inspection, we found inconsistencies regarding how risks were being managed on behalf of people who were at high risk of pressure damage to their skin as they had 'fragile skin' and required support to mitigate this risk. The provider wrote to us and told us that repositioning charts were being reviewed by

the provider's quality team.
● However, at this inspection we found that the provider had not always ensured that risks associated with repositioning people and the periods that people spent in their wheelchairs were managed and mitigated safely. Many people at the service used wheelchairs to mobilise. The registered told us the amount of time each person can spend in their wheelchairs was written in their care plans.
● Following the last inspection, the provider's action plan confirmed that care plans were being reviewed and re written to reflect how long people they supported could remain in one position when out of bed. Although these repositioning timescales had been completed and recorded, records showed that repositioning protocols were not always adhered to safely. We reviewed people's turning charts which were used to record when people had been supported to reposition, to take the pressure off areas of their skin. One person's skin integrity care plan stated they could sit for 8-10 hours without causing pressure damage. Turn charts over a two-week period showed that the person had been sitting in a chair for between 12-13 hours on six separate days. Another person's turning chart recorded that they had been sitting upright in bed for over 13 hours then repositioned in the evening. Another person's turning chart over a two-week period highlighted eight occasions when there were longer gaps between repositioning than the frequency stated on their care plan.
● There was no positioning code for staff to record that people were sitting in wheelchairs, only 'CH' which is described as 'sat in a chair with appropriately placed supports'. Maximum amounts of time to spend in a wheelchair were not written at the top of turn charts.
● People's repositioning was not recorded clearly or within one specific document. Staff were recording people being repositioned on night observations charts as well as the turn charts. On people's fluid charts staff were also recording toileting and pad changes which would also require a position change. This meant there was a potential risk of inconsistencies in recording and a duplication of records that could provide an unclear and incorrect picture of someone's repositioning needs.
● We reviewed the wound management of one person's pressure sore. The provider confirmed, and records showed, that only one person was currently being supported with a pressure sore. Their wound care plan confirmed a history of pressure sores which had reoccurred in the weeks prior to this inspection. The wound had been identified following staff being alerted by the pressure mattress alarm, indicating that it had deflated. There was no recorded incident form completed of this incident.
● Their plan stated that staff were required to liaise with the tissue viability nurse (TVN) and take regular photographs of the wound. Over the period the wound was managed we only saw one photo taken by staff and the clinical lead confirmed there had been no TVN involvement. The person did not have a turning chart in place therefore there was no record of how long the person was spending in their wheelchair or seated in an armchair; or to show that they had been supported to reposition to take the pressure off their sore skin.

Concerns about people being supported to move in an unsafe way and around repositioning have been raised in our reports of inspections of some of the provider's other services. This had not led to shared learning in order to improve the safety of care provided at Longfield Manor.

● Staff were not always given the correct information to support people in response to their changing needs. One incident had been recorded detailing the incorrect actions by an agency registered nurse in respect to the application of 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) protocols. DNACPR means that, should a person suffer a sudden cardiac arrest and their heart stops beating, no attempt will be made to resuscitate them. The clinical lead and another registered nurse confirmed that existing DNACPR information was not always handed over verbally to staff between shifts. However, the registered manager confirmed that staff were informed of changes in a person's status verbally at handover and changes were written in the communication book. We raised this issue at feedback and the registered manager confirmed that there was visual confirmation of people's DNACPR status outside their bedrooms but that this

information was not included in the induction of agency registered nurses. These actions had not been identified or implemented following the incident. However, the registered manager confirmed that this would now be completed and that a copy would be provided to inspection staff upon completion.

We have raised concerns about DNACPR status at inspections of a number of the provider's other services. This had not led to consistent actions to ensure clear and correct details were available to all staff at Longfield Manor.

● The provider had not fully assessed and developed strategies for some people who displayed behaviours that challenged. Some people at the service had been assessed as displaying behaviours that challenged but did not always have the appropriate guidance and care plans in place.
● People who displayed challenging behaviour were identified and included on the provider's weekly clinical risk document. However, only two of the five people identified had challenging behaviour care plans in place. There was evidence that those identified would have benefited from challenging behaviour care plans. For example, one person's mental health and well-being plan had identified that they could be verbally aggressive, and staff should ensure they recorded any incidents on their behaviour chart. However, there was no challenging behaviour care plan in place to provide guidance and strategies for staff to support them.
● Another person had been recorded as displaying verbal abuse and self-harm which had prompted a referral to the community psychiatric nurse. However, their cognitive care plan only stated that the person was 'anxious' and there was no challenging behaviour care plan in place.
●We have detailed within the effective domain the shortfalls in completion of challenging behaviour training by staff.

The lack of robust behaviour management plans has been highlighted to the provider following inspections of a number of their other services. This information had not been used to improve safety and quality in this area at Longfield Manor.

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

● Some people were at risk of falls. At the last inspection we found that there had been a lack of timely action to mitigate the risk of falling on behalf of one person. This was because one person's sensor mat had not been working correctly for twelve days. This meant if the person had fallen in this period or was at risk of falling, staff may not have been alerted.
● At this inspection, we found an improvement in the response of staff to ensure that issues with falls equipment were addressed in a more timely manner.
● We looked at records of people who were at risk of falls. People had risk assessments for falls and use of mobility equipment, as well as a falls screen assessment when needed. This assessment is for people who have presented for medical attention because of a fall, or recurrent falls.
● Although falls had been recorded on people's moving and handling assessment review sheets, the registered manager told us that they did not maintain a falls register or diary to record and monitor trends in falls activity in the service. The Social Care Institute for Excellence state that 'All care homes need to have falls prevention strategies in place and use them. This should include good systems to monitor and learn from falls occurring within the care home'. We discussed this with the registered manager during the inspection and they confirmed that this was something they planned to implement. The manager informed us following the inspection that a falls diary was now in place.

● We found that other risks to people's safety had been managed well, such as the management of people's epilepsy. Epilepsy care plans detailed the signs and symptoms of people's seizures and what actions staff should take in the event of seizure activity. Staff were knowledgeable of these triggers, what signs to look out for. and what actions to take when a seizure occurred.
● Risks associated with bowel management and people's constipation were safely managed. Bowel charts were completed correctly, and staff understood when people required additional support according to their constipation care plans. We looked at a number of bowel management records which showed that clinical support was sought at the appropriate timescales for people when it was needed.
● Some people at the service were at risk of choking. Appropriate risk assessments were in place for those people with swallowing difficulties. People with complex eating needs being protected from risks. For example, we saw one person who had difficulties swallowing food being appropriately supported. The service had arranged for the SALT team to assess the person. All actions had been applied in a timely manner following this visit including the kitchen being updated of the person's requirements for a soft diet and a referral to a dietician. One relative told us, "Mum can't swallow easily, so has pureed food, and she eats very well."
● At the last inspection, the provider had not always ensured that people's baseline scores had been recorded for the National Early Warning Score (NEWS) system. The NEWS 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. Following the last inspection, the provider had told us that the clinical lead had been reviewing NEWS and baseline observations. Records we looked at included these observations on medical care plans and NEWS recording charts.

● The equipment used to support people, such as hoists and slings had been monitored, checked and serviced regularly.
● Risks from fire were managed well. Equipment was tested and maintained, while staff received evacuation training and regular drills to ensure that they could respond appropriately in the event of an emergency. People had individual personal evacuation plans to ensure that they were supported properly in the event of an evacuation.

Learning lessons when things go wrong
● There was evidence of some learning when required improvements had been identified. The last inspection had identified issues around the medicine records relating to one person posing a potential risk they would be administered a medicine they were no longer prescribed. The provider had learnt from this and ensured that medicine management and auditing identified these issues.
● However, there remained an inconsistency in learning lessons and ensuring changes were made when things went wrong.
● We reviewed one recorded incident between two people at the service. Actions required for all staff to be informed that one person was not to be sat with male residents in the future. This was to ensure the safety of the person following unwarranted physical contact. We spoke to two staff members who would have daily contact and interaction with the person, but neither staff member was aware of this directive. One staff member was not aware of the incident at all. However, during the inspection we did not observe the person sitting with a male resident.
● These incidents demonstrated that actions and information were not always conveyed to staff or acted upon to ensure that lessons were learnt.
● Accidents and incidents, where appropriate, had been shared with external agencies such as the local authority safeguarding team. When an incident occurred, it was also sent to the quality team for their review.

Staffing and recruitment

● The registered manager told us that they no longer used a dependency tool to inform them of the required staffing levels that would meet people's needs. At the last inspection in July 2018 we were informed that the management was using a dependency tool to calculate staffing levels based on the level of people's need. Records showed that a dependency tool had not been used since April 2018. The manager stated that current staffing levels were based on full occupancy of the service and that the dependency tool was not being used as the service was restructuring its staffing and responsibilities.

● Throughout the inspection we observed there were enough staff working across each of the units to ensure people's needs and requests were responded to. Staff had time to interact with people and respond when people needed them. We observed enough staff supporting people at mealtimes.

● However, people, their relatives and staff shared mixed views on the staffing at the service. They informed us that staff were supportive and attentive but that there were still too many changes within the staff team. They told us that the use of agency staff sometimes impacted on their care. This was because agency staff did not know people as well or understand their needs in the same way as the service's regular staff. One relative told us, "There are frequent changes. They get some staff in and you get to know them and they disappear." Another said, "They are quite short of staff. The night staff are not experienced like the permanent staff. When I look back we had far more proper full-time staff than what we have now." A third relative told us, "There appears to be a reliance on agency staff at the weekends. I've never seen anyone lacking attention as a result however. Still see the same level of engagement from agency staff."

● Some staff also indicated that numbers deployed at the service were variable. With regards to whether sufficient numbers of staff were available to support people, one staff member said, "It depends on the day. There are a lot of agency staff, but most of them we know." Another staff member told us, "We are very short staffed, we try and get the same agency, but it is hard to build relationships with agency."

● Staffing rotas we looked at showed that the numbers of staff required, as indicated by the provider, had been consistently fulfilled on each shift.

● Recruitment checks were robust and ensured people were supported by staff who were safe to work before they started work at the service.

● Checks were made to ensure staff were of good character and suitable for the role. This included obtaining suitable references and undertaking Disclosure and Barring Service (DBS) criminal record checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable individuals from working with people who use care and support services. Registered nurses all had valid NMC (Nursing Medical Council) pins to ensure that they were qualified to undertake their clinical role.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. The provider had reported any incidents of bruising to the CQC and the local safeguarding adults team in a timely manner.

● Staff told us that they understood their responsibilities under safeguarding. Staff had a clear understanding of the different types of abuse, how to recognise these and what to do should they witness any poor practice. The provider had safeguarding adult's policy and procedures and staff were aware of this.

● There were comprehensive safeguarding and whistleblowing policies in place. Staff told us that they received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. Staff we spoke to were aware of guidelines and contact details of the local authority safeguarding team, and this information was displayed around the service. One staff told us, "I have done my safeguarding training and I will report anything wrong. I know what to do."

Using medicines safely

● At the last inspection, we identified issues with medication records that posed a potential risk to one person that they would be administered a medicine they were no longer prescribed. This was previously a breach of Regulation 12. The management and clinical lead had worked to making the necessary improvements and medicines were managed consistently and safely in line with national guidance.
● We observed people receiving their medicines safely from registered nurses who were knowledgeable about the people they supported. Staff were aware of good practice guidelines. One registered nurse told us, "We take medication very seriously, it is a big responsibility and I am very careful. We have support."
● Medicines administration record (MAR) charts were completed. MAR sheets contained sufficient information such as photographs and allergies of each person to ensure safe administration of their medicines.
● Medicines were ordered, stored and disposed of safely and appropriately. They were kept securely in locked trolleys and rooms and administered by trained staff.
● Staff followed the guidance in place on managing 'when required' medicines for each person and documented the reasons why they had administered the medicines. There were instructions for staff about giving medicines that people could take as and when they were needed, which ensured people had prescribed access to pain relief with suitable spaced doses.

Preventing and controlling infection
● Staff ensured that the service was well maintained and remained clean. The service had a cleaning schedule in place to ensure ongoing prevention and control of infection.
● The service was odour free throughout the inspection and staff kept areas tidy and clean.
● Staff were observed wearing personal protective equipment when supporting people and ensured that they used antibacterial hand wash and used the appropriate clinical waste bins.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. At the last inspection we found that the provider was in continued breach of regulation as not all staff had been provided training opportunities specific to the needs of people in the service. At this inspection we found that the breach of regulation continued.

Staff support: induction, training, skills and experience

- When we last inspected the service in July 2018 we found breaches of regulation as systems were not always effective in ensuring that staff received appropriate training to enable them to carry out their duties. We previously found that not all staff had undertaken dementia training, in particular a high number of agency staff who supported people at the service. The provider's action plan had ensured that permanent and agency registered nurses had completed dementia training, although this had not covered the provision for care staff.
- The provider describes the service as providing 'care for older people with nursing for people with more complex needs' and that it has 'a specialist 14-person unit for people with dementia'.
- At this inspection we found that while there had been some progress to ensure that agency staff had undertaken dementia training, we identified that seven staff members had yet to complete this.
- As identified in the provider's last inspection report, 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.'
- Our observations of, and discussions with, staff showed for the most part a good level of understanding of how to support people with the difficulties of living with dementia. One staff member described how people at the service demonstrated different communication methods to convey their needs and how to identify physical and emotional triggers.
- However, there were occasions when staff's approach and language highlighted shortfalls in the skills and understanding needed to support people with dementia. As detailed within the caring section of this report, staff discussed on two occasions the toileting needs of one person in the presence of other people within the Rosewood unit. This was done in such an open manner as to suggest that others present would not understand or be affected by the conversation. Also detailed in the caring section was the use of childlike language by a staff member to a person living dementia to confirm that they needed to use the bathroom. Our conversations with one staff member regarding the abilities of those with dementia told us, "They can swear at you, but it's not what they mean to say. They've lost their mind."
- This meant that not all staff were able to demonstrate the skills and knowledge required to provide person centred and specific support to those people with dementia. All staff, including agency staff, are required to make decisions throughout the day in relation to the care provided to people living with dementia. It is therefore essential for staff to have the correct training, approach and understanding of how having dementia impacts on a person and how to deliver care that meets their needs.

● The provider had implemented systems to address some of the shortfalls previously identified of agency staff not having the appropriate training to support those living with dementia. A monthly audit had been introduced that identified where staff had not yet completed dementia training and ensured valid registered nurse PINs were in place. Actions were recorded to demonstrate how this was to be completed.

● Records showed that conflict management training was mandatory for staff, although only eight staff across the service had completed this. Only half of the permanent registered nurses had undertaken 'behaviours of concern' training although this was not deemed by the provider to be mandatory.
● In the safe section of this report we highlighted that a number of people at Longfield Manor displayed behaviours that challenged. It is therefore essential for staff to have the correct training, approach and understanding of how to support people who exhibit behaviour that challenges and how to deliver care that meets their needs.
● The National Institute for Health and Care Excellence (NICE) produced updated guidance in June 2018 for those supporting people living with dementia. Care providers should provide additional face-to-face training and mentoring to staff who deliver care and support to people living with dementia. This should include initial training on understanding, reacting to and helping people living with dementia who experience agitation, aggression, pain, or other behaviours indicating distress.

● Concerns highlighted in the safe domain of this report demonstrate an inconsistency in the standard of moving and positioning ability and knowledge, as well as pressure area support. Staff had completed training in the core 'manual handling objects' training, although training in 'moving and positioning people' had only been completed by 8 out of 14 care staff while pressure ulcer prevention, also mandatory had only been completed by 2 out of 14 care staff. Training records of the staff member observed using poor manual handling techniques in the safe section of this report showed that they had completed moving and handling training within the previous six months. Despite this, their practice had been unsafe.

Concerns about the lack of sufficient staff training in some subjects has been highlighted to the provider in a number of our reports about some of their other services, including Longfield Manor. This has not led to the improvements needed to provide people with consistently effective care and treatment.

● The above evidence demonstrates that 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.

● Staff received training in a wide range of areas which were considered mandatory by the provider. These included courses such as health and safety, safeguarding, fire safety and infection control.

● New staff worked with established staff members until they were assessed 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider carried out assessments regarding people's physical, mental health and social needs prior to them moving into Longfield Manor. The provider had ensured that protected characteristics were explored and recorded appropriately. 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.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Where DoLS applications had been submitted, the registered manager monitored when they needed to be renewed and how conditions on authorisations were being met by staff. Records showed that staff were meeting the conditions on the relevant authorisations.

● Consent to care and treatment was sought in line with legislation and guidance. 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 if a person lacked capacity to make a decision about a specific restriction that was necessary for their safety.

● Staff had a good understanding of the need to obtain consent before providing care. One member of staff said, "We assume that people here have capacity and are able to make their own decisions. We always ask and explain what we are going to do and people are willing to accept support even if they do not have capacity, we still explain."

Adapting service, design, decoration to meet people's needs

● People's needs were mostly met by the design and decoration of the service.

● Our observations of people's support in communal areas highlighted some difficulties staff experienced in moving and handling transfers. There was a lack of space on some occasions for staff to appropriately support people to transfer. We fed back this issue to the management team at the end of the inspection.

● Adaptions had been made within the Rosewood unit to ensure a more dementia friendly environment. Walls had been covered in prints of different landscapes that provided calming environment for those people within the unit.

● People had memory boxes outside of their room containing items of importance to them including photographs of family members.

● People's doors were decorated to look like front doors in different bright colours to support people living with dementia to navigate themselves back to their rooms.

● Rooms and corridors were appropriate to safely support people with physical disabilities.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to have enough to eat and drink and told us that they liked the food they received. One relative told us, "The food is fine." Another relative said, "The chef is very conscious of providing the food that appeals to people and provides choice."

● People were given choices of what they wished to eat and were provided alternatives if they requested this. One family member said, "The food has really improved with the current chef, in terms of choice and content." The food provided looked nutritious and appetizing.

● People's specific dietary needs were known and met effectively by kitchen staff and care staff. The chef demonstrated that they were aware of some people's complex needs and how their food should be prepared to ensure they remained safe. They told us, I am updated weekly by the nurse."

● People were observed enjoying mealtimes and were not rushed by staff. Staff supported people who required direct support to eat their food while others were supported when necessary. Staff were patient in

encouraging people to eat when necessary. We observed one person coming later than others to lunch and kitchen staff bringing their covered food to their table as they were settling, ensuring that their food was fresh and warm. One relative told us, "The chef and his staff are excellent, even the way that they ask residents what they would like to eat the next day is done in a kind and patient way."

● Some people were at risk from malnutrition. Following concerns raised in the last inspection that accurate records were not always kept, the provider took steps to work with nutritional specialists to implement systems that closely audited nutritional records, meal times and menus. Further details are within the well-led section of this report.

Supporting people to live healthier lives, access healthcare services and support

● People were supported to access a range of community healthcare professionals when required.

● Records showed that referrals to specialist services like SALT (Speech and Language Therapists) and dieticians were made in a timely manner.

● Staff recorded and followed advice and instructions following interventions from these specialist services.

● People's needs were detailed within hospital, or care passports which provided details to clinical staff as to what the persons current health and social care status was should they be admitted to hospital.

● People and their family members told us that they had access, and were supported, by medical professionals when needed. One relative told us, "Mum previously had some difficulty swallowing her medicines and staff were quick to respond to this." Another relative said, "The duty nurse comes to me when there is a change in need or condition. They are quick to respond to weight loss and manage this." A third family member said, "She gets good treatment. They always get the doctor quickly."

Staff working with other agencies to provide consistent, effective, timely care

● Staff worked with local authorities and health agencies to ensure that people moved from the service when their needs or circumstances changed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.
At the last inspection, we reported an occasion whereby caring approaches were not applied by staff supporting people. At this inspection we observed further practices that did not promote the dignity, respect or confidentiality of some people. We found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- At the previous inspection we highlighted concerns around observations of the approach of staff that was insensitive to people in that information about them was not treated discretely or in a confidential way.
- Whilst our observations of staff's interactions with people over the two days of the inspection were mostly positive, there were occasions when staff did not always ensure that people's dignity and privacy was preserved. We observed two staff members talking to each other in the communal lounge and informing each other that a specific person needed the toilet. The staff member then gave this same information to another staff member some minutes later. Both incidents occurred in front of other people in the lounge.
- In another communal lounge, we observed a similar approach by a staff member that did not promote the person's dignity or privacy whilst using language that was child-like and lacked respect. In front of other people, the staff member said to one person, "Let's go for wee-wee." The registered manager told us following the inspection that two people have documented that they used this language when requesting support from staff to use the bathroom. However, this does not require staff to use the same language towards the person when asking if they required support.
- We observed a staff member approach a person seated and offer them a biscuit. When the staff member put the biscuit near the person's mouth, the person said 'no' but the staff member proceeded to put the biscuit in their mouth. The person did not bite down and the staff member was observed applying downward pressure so that the biscuit broke off in their mouth. This practice continued until the person had eaten two biscuits. The observations demonstrated a lack of respect for the person and a disregard for their expressed wish of not wanting to eat.
- We observed a number of people sitting in their wheelchairs for long periods throughout the inspection. We have dealt with the risks associated with this within the safe domain. However, this practice was not dignified for people and opportunities for them to sit in communal chairs was not explored for everyone.

- The above evidence demonstrates that staff did not always treat people with dignity or respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had been responsive in encouraging participation and interaction for one person who had been reluctant to leave their room following their arrival at the service. Staff used a befriending service from a local church associated with the person's chosen faith to encourage the person. A professional told us, "Staff did things to make (the person) feel more valued. She told me, 'They really care about me'." The

impact of this was that the person felt more confident to spend more time in communal areas and socialise with others.

● People were encouraged to make day-to-day choices and where appropriate, people's independence was promoted according to their abilities. For example, several people over the lunchtime period were supported to maintain their independence to eat their meal at their own pace without being rushed in any way.
● Staff had responded compassionately to ensure that two people at the service experienced a special dining experience on valentine's day. Staff liaised with family members and set up a private table with flowers for them and made cards for each to exchange.

Ensuring people are well treated and supported; respecting equality and diversity
● Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. Despite the issues highlighted above, we did observe occasions throughout the inspection where staff communication with people was warm and friendly, and showed caring attitudes.

● People told us, and we observed, that staff had great affection for the people they supported. One person said, "Staff are very good. They look after me." One staff member told us, "They are my family, and I treat them as such'. We saw staff providing caring support such as personalised nail care and hand massages. We observed that when a staff member came into the room to speak to a person, they knelt down to the person's level and established good eye contact before speaking. Staff noticed when a person become nervous, they immediately went to comfort and calm them.
● People's diverse needs were identified and addressed when these arose. Staff were proactive in ensuring that people's religious requests and needs were met, especially for those who found it difficult to leave the service regularly.

Supporting people to express their views and be involved in making decisions about their care
● People were supported to express their views and be involved in decisions around their care.
● People were involved in their care as much as they wanted to be. Relatives confirmed that they were invited to reviews, were able to have their say, and received copies of review notes. Family members also told us that they were invited to convey their views. One relative told us, "I go to relative's meetings whenever they have one."
● Relatives spoke positively about the approach of staff towards involving people and gaining their views. One family member told us, "They treat them like adults. They ask them if they want to be involved and respect that decision. It's maintaining the element of choice, where it's safe to do so for them."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations were not met.

When we last inspected the service in July 2018 we found a breach of Regulation 9 as the provider had failed to ensure that people received care or treatment that was personalised specifically for them. At this inspection we found that, while the provider had made a number of changes to introduce activities and engagement for people improvements were still needed to implement and promote personalised support and activities for people.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Information about people's care and support needs and their ability to convey those needs were not always clearly recorded. For example, one person's 'expressing sexuality' care plan failed to capture this information but gave details on how to support the person with choosing their clothes. We identified the same information on a number of other people's care plans. This is an issue we identified, and raised, at the previous inspection. The providers action plan stated that each person's expressing sexuality care plan would be reviewed for those who required support in this area. However, the above observations demonstrate that this had not been done for all people.
- Another person's 'expressing sexuality' care plan stated that they were unable to express their feelings and preferences, although their communication care plan contradicted this and stated that the person was 'able to communicate needs, feelings, preferences verbally'. This indicated that there was no clear assessment, or knowledge, of the person's ability to communicate their preferences and wishes.

Preferences, interests and give them choice and control

- People's likes and dislikes, as well as information about their lives, were captured in some people's care plans when they moved into the service. However, the quality of information varied within the care plans we looked at. For example, there was no life history captured for one person, while another person's interests and history had been recorded but there was no social care plan developed as a result. This issue was highlighted at the last inspection.
- The lack of information about people's history and their likes, dislikes and preferences had meant that activities could not always be developed that were personalised to meet their interests and hobbies. A number of social care plans that we viewed instructed staff to, 'Please discuss with (person) their likes and dislikes'. This meant that this information was not being captured in order to develop structured social care plans.
- Management and staff had begun to address this area by providing people and their family members with life story questionnaires to complete which would then inform staff to develop personalised activities. However, this remained a work in progress and not all information had been obtained to ensure that personalised activities and engagement was being provided.

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 continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and staff had introduced new activities and means of social interaction following the shortfalls identified in the service's last inspection. At the last inspection, we found that there was little in the way of activities that provided stimulation for people within the Rosewood Unit. The registered manager told us that there had previously been a 'rigid' fortnightly programme in place which had impacted on the activities people received.
● Some improvements had been made in the provision of activities for people. Staff were working with a wellbeing organisation called Oomph, which supports service's like Longfield Manor to enhance the mental physical and emotional wellbeing of people in care through social and physical activities.
● We observed people actively engaged in one of the three weekly Oomph sessions, where staff supported people in movements and exercise, through telling a story around music. The activities coordinator told us that people were supported with movements that simulate other activities such as making a cake to encourage a range of arm movements.
● Staff worked with the Oomph wellness organisation to identify shortfalls in activity support and worked on an action plan to implement changes. This was reviewed to ensure that changes had been implemented.
● People and their relatives spoke positively about the changes and improvements in activities support that had been introduced in the service. One relative said, "I think, from what I have heard and read in the new newsletters, that the activities programme has considerably widened and improved for the residents." One family member said, "My mum has quite advanced Alzheimer's now, but likes one to one interaction to look at her memory book and photographs, hand massages and just someone to sit and hold her hand at times, and I'm told that she continues to enjoy this type of activity."
● We observed activity boards showing people enjoying activities such as a pub and quiz night in a room at the service renamed 'Longfield Arms'. Comments from people included, "The gin tasted lovely and made my day" and, "It was a lovely day – something different." One relative told us that their family member had been, "Just so happy about the pub night."
● Staff had introduced an initiative called the Golden Ticket. This encouraged staff to capture and record caring moments between themselves and people at the service. These would then be shared and appreciated within the team.
● The management team had made changes to how the wider staff were able to work with activities staff in order support people with activities. The registered manager had sought to address a lack of interaction between activities staff and care staff which had impacted on the support people received. Involvement in facilitating activities by care staff, as well as kitchen staff ensured that people were well supported throughout the day. The activities coordinator told us that this allowed more activities to be undertaken in the evening and that people had been more receptive of this. One relative told us, "They are making an effort. They have stepped up the number of people in activities team. Chefs go out on some of the activities as well kitchen staff. They are stopping in, chatting and reminisce with them."

Improving care quality in response to complaints or concerns
● Complaints were acknowledged and responded to appropriately. There was clear record of complaints that had been received and what actions the management team had taken.
● There was a complaints policy in place which was available to both people and their relatives.
● People and their relatives told us they felt comfortable raising any issues and that they would be dealt with appropriately. One relative said, "Yes. Even when I ask for small things, they happen straight away. If I ever had to make a complaint I am sure that this would also be the case."

End of life care and support

● People were supported sensitively and compassionately at the end of their lives.
● Only one person at Longfield Manor was receiving end of life support. Discussions had taken place with people and their relatives about their wishes and preferences for support at the end of their lives and these were documented in their advanced care plans and planning future care documents.
● People were supported to have medicines in place in anticipation of their end of life needs.
● Some people had been supported to register with Echo, an NHS initiative that aims to improve the coordination and delivery of end of life care for people by linking service providers together and providing advice and support.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

When we last inspected the service in July 2018 we found a breach of regulation in relation to the provider being 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. At this inspection the regulation had still not been met.

Continuous learning and improving care

- The management team had looked to improve the systems that ensured quality care was provided following the last inspection. However, quality assurance audits had not been effective in highlighting the shortfalls and areas of concern we have identified in this report. This had exposed people to the risk of harm. Quality checks and audits had failed to identify that practice and recording of repositioning, skin integrity management, behaviour management and moving and handling had not always been safe. This is the third consecutive inspection where regulation 12 about safe care and treatment has been breached.
- Gaps in training had been identified during the inspection that had not been addressed through the current auditing systems. This was despite assurances that the provider had given in its action plan following the last inspection. This is the third time the provider is in breach of Regulation 18 on staffing. Management had completed detailed care plan audits, but these had not been fully successful in identifying the issues raised earlier in this report.

The provider has been made aware of concerns about many of the issues raised in this report at inspections of their other services. This includes issues relating to: repositioning, moving and handling, behaviours that may challenge, DNACPR and staff training. Despite this, information had not been effectively shared with Longfield Manor so that improvements to the safety and quality of care provided could be made.

The above evidence demonstrates that the provider was unable to evidence 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 continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team has made some improvements to the quality assurance systems in place.
- Audits were effective in ensuring effective and safe medicine management, while records showed a robust oversight of infection control procedures. The service had a ten-point check list audit for medicines, and these were completed weekly and monthly. We saw that actions had been recorded and followed up. For example, one recent audit had identified that some bottles did not have dates on them. On this inspection we reviewed this and saw that actions had been taken to rectify this.

● People and relatives spoke positively about the changes and improvements made by the management team. One family member said, "I'm hoping that the past issues have given the owners a bit of a wakeup call. Now, I think that the care home is in a much better place in terms of its caring, staffing, activities and general ambience, it feels like a happier place and one where I'm happy to trust them to care for my mum." Another relative told us, "They are trying to change the place and have changed different things. It's coming along quite nicely." Another family member said, "I've got nothing but praise for them and the energy and commitment that they have put into addressing the improvements."
● At our previous inspection we had identified that some people were at risk of malnutrition but that records relating to people's weight were not always accurately maintained. The management team had worked closely with the NRICH (Nutrition Resources in Care Homes) team within the NHS trust to address these shortfalls. Audits of MUST (Malnutrition Universal Screening Tool) documents had been completed regularly. Analysis showed that there had been a significant improvement in the accuracy and completion of MUST documents which the NHS trust had acknowledged.
● One professional told us, "The new manager and deputy are trying to change how the service works. There are a lot of noticeable improvements put in place."
● Some lessons had been learned and action had been taken to put things right. Since the new management team have been in place they had focused on improving activities and engagement for people. Activities staff were now working with care staff to ensure that a more comprehensive programme of engagement was being implemented. These improvements had not yet been fully embedded but there remained a commitment from management to support activities staff in delivering on these changes.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
● The registered manager and deputy manager both demonstrated an awareness of the day-to-day culture of the service and the need to maintain and review this.
● People, relatives and staff told us they felt comfortable approaching the management team if they needed to. One family member told us, "They are really open honest and transparent. They are open about what they can and can't do."
● Staff and relatives told us that the leadership was visible and supportive of staff around the service. One staff member said, "Management are efficient. The manager is on the floor, approachable and someone you can go to if you have a problem or a concern." One staff member told us, "The manager demonstrated a good understanding of the residents she was looking after."
● Management worked with staff within formal supervisions to raise issues and questions that they may have. The provider had a whistleblowing policy in place to ensure that staff could raise any concerns they had about the running of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, their relatives and staff were involved in developing the service and there were formal systems in place to capture people's opinions and feedback.
● There were regular resident's meetings and relative's meetings where areas such as activities and people's food were discussed. People and their family members had been consulted about the decoration of some aspects of the communal areas.
● Relatives could speak to staff and management when they visited and they told us that management were responsive to any requests. One relative told us, "Family meetings are regular and I attend these. They are open to feedback and suggestions at these meetings. I am invited to care plan reviews. They genuinely want to hear thoughts and ideas." Another family member said, "They are really responsive coming back with emails. Absolutely accessible and amenable."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager understood their responsibilities in submitting the appropriate notifications to the Care Quality Commission.

● The service's most recent rating was displayed during the inspection.

● There was a registered manager in post. They were supported by a deputy manager and senior staff who understood their roles and the responsibilities that came with these.

● The provider shared information appropriately and safely and had systems in place to ensure this could be done confidentially.

Working in partnership with others

● The registered manager and deputy manager told us that they worked alongside partner agencies including health and social care professionals, as well as the local safeguarding team.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received care or treatment that was personalised specifically for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had been provided training

opportunities specific to the needs of service users.