Shankar Leicester Limited

Longcliffe Nursing Home

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?	Inadequate

Summary of findings

Overall summary

We inspected Longcliffe Nursing Home on 3 and 6 February 2017. The first day of the inspection was unannounced. This meant that the staff and provider did not know that we would be visiting. We told the provider we would be returning for the second day.

Longcliffe Nursing Home provides accommodation, care and support for up to 42 people who require personal care. During our inspection 24 people were using the service. Since our last inspection on 6 June 2016 the provider had chosen to no longer provide nursing care at Longcliffe Nursing Home and had deregistered this regulated activity in October 2016. The home is located on two floors with lift access to both floors. The home has two communal lounges and a dining room. During our inspection the lounge upstairs was in the process of being decorated so was not in use.

The service had 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 2008 and associated Regulations about how the service is run.

At the last inspection we carried out on 6 June 2016 we found that the provider had not met the regulations relating to good governance. At the inspection we found the provider had made some of the required improvements.

People were not always protected from risks relating to their health and safety. We found that not all risks had been fully assessed and control measures identified.

People were protected from the risk of abuse because staff could identify the potential signs of abuse and knew how to report any concerns. Accidents and incidents were recorded and reviewed to identify the cause to try and reduce the risk of reoccurrence.

Staff had not always been recruited safely. Pre-employment checks had not been thoroughly carried out before staff started to work at the service. These are important to make sure that staff are suitable to work with people who may be vulnerable. There was enough staff to keep people safe.

People's tablets and liquid medicines were stored safely. Where medicines were taken as and when required these had not been given in accordance with the protocol in place. Creams and liquids had not always been dated when opened.

Staff received support through an induction to the service and supervision. There was an on-going training programme to provide and update staff on safe ways of working. We found staff had not all completed training to give them the guidance and knowledge to meet the needs of people who used the service.

People were supported to access healthcare services. People were given sufficient to eat and drink. Where people's food intake needed to be monitored to reduce the risk of malnutrition the amount of food people had been given was not recorded. Where people had a specific diet this was not always followed.

People were usually asked for their consent before staff supported them with personal care. Where there was a reasonable belief that someone did not have the capacity to make a specific decision an assessment of their capacity had sometimes been completed. Where a decision had been made that was believed to be in a person's best interests the details of this had not been recorded.

People told us that the staff were kind. Staff members knew people well and were able to tell us about their likes and dislikes. Staff did not always pass private information to other staff in a discreet manner. Staff did not always respect people's choices in relation to their likes and dislikes.

Relatives and friends were able to visit when they wanted to and were made to feel welcome.

People took part in a range of activities that they enjoyed. Some people told us that they would prefer some other activities.

People had contributed to an assessment of their needs when they started to use the service. They had given information about their likes, dislikes and personal history. People had not been involved in the reviews of their care plans to make sure that information about them was current.
People and their relatives knew how to raise concerns. They did not always feel that these were listened to. People had attended meetings to discuss the service and to ask their thoughts on this.

Records relating to people's care were not fully completed and had not been updated to reflect changes even when they had been reviewed. The records did not reflect all care that was given. We found that checks that had been implemented to monitor this had not been completed effectively in order to identify that this had not been recorded.

Policies and procedures that give staff guidance on how to carry out their roles were not available at the time of our inspection as they were being updated.

The provider had implemented systems and processes to monitor and improve the quality of the service that had been provided. These did not identify concerns that we found during this visit.

We found one continuing breach and one new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

People were not consistently protected from risks relating to their health and safety. Where risks had been identified these had not always been assessed in detail to protect people from these.

People were protected from abuse. Where incidents had occurred that may cause concern these had been investigated. Policies were not in place. They were in the process of being updated. Guidance from the Local Authority about what to do if staff suspected someone was at risk of abuse was available. Staff were aware that they could raise any concerns with outside agencies.

Staff had not always had all pre-employment checks thoroughly completed before they started work.

People's medicines were stored safely. Medicines that were given as and when required had not always been given in accordance with the protocols for these. Creams and liquids had not all been dated when opened.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff felt supported within their roles and had an induction to the service. Training had not always been completed or been renewed to ensure that they staff had the required and up to date knowledge and practice.

Staff sometimes sought people's consent before supporting them with their care. Where there was reasonable doubt that someone may not have the capacity to make a specific decision assessments had sometimes been undertaken to check this. Where a decision had been made in someone's best interests there was no record of this.

People had enough to eat and drink. Where people had been identified as being at risk of malnutrition records did not always

record exactly what people had eaten. Where people had a specific diet this was not always followed.

People told us that they were able to access healthcare professionals and records confirmed that this had happened.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that the staff were kind. Staff did not always update other staff on people's needs in a discreet manner. They did not always respect people's likes and dislikes.

Staff members knew people well and were able to tell us about their likes and dislikes. This information was recorded in people's care plans.

People were not sure that they had been involved with developing their care plan and making choices about their care. Information about people's history, likes and dislikes had been recorded.

People's friends and relatives were able to visit when they wanted to and were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives had contributed to an initial assessment of their needs but they were not involved in reviews of this information.

People were able to participate in activities that were available. Some people told us there were some other activities that they would enjoy.

People felt that they could raise concerns but that these were not always listened to.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The service has not met CQC regulations since September 2013. This has been taken into account in the rating in this area.

We found that some action had been taken to improve the

governance within the service. Records relating to people's care were not fully completed and had not been updated even where reviews had taken place.

The provider had implemented systems and processes to monitor and improve the quality of the service that had been provided. These did not identify concerns that we found during this visit.

Staff felt that the service had improved and felt that they could raise areas for improvement with the provider.

Longcliffe Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The inspection took place on 3 and 6 February 2017 and the first day was unannounced. We told the provider we would be returning for the second day. The inspection was carried out by one inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the Provider Information return (PIR). The PIR is a form that asks the provider to give some key information about what the service does well and improvements they plan to make. We also reviewed information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service. We also contacted Healthwatch (the consumer champion for health and social care) to ask them for their feedback about the service.

We spoke with seven people who used the service and four relatives of other people. This was to gather their views of the service being provided. We observed staff communication with people and supporting them throughout the day. We spoke with the registered manager, the provider, a senior care team leader, two senior carers, two carers, the cook, a visiting health professional and the activities co-ordinator.

We looked at the care records of six people who used the service and other documentation about how the home was managed. This included policies and procedures and records associated with quality assurance processes. We looked at four staff recruitment files to assess the recruitment process.

Requires Improvement

Is the service safe?

Our findings

People sometimes received their medicines safely. Where someone had a medicine that was taken as and when needed there was guidance in place to tell staff when this could be taken, however this had not been dated or signed by the professional who prescribed the medicine. The senior care team leader told us that the guidance had been reviewed to make sure it was correct and was waiting to be signed by the relevant professional. We also found that where people had liquid and cream medicines that were stored on the medicines trolley these had not been dated to show when they had been opened. This is important to make sure that they are inly used for a certain period after being opened in line with the manufacturers' guidelines. The senior care team leader told us that checks were carried out on the liquids and creams that were stored in people's rooms to ensure that they had dates on them when opened but had missed doing these checks for the creams and liquids stored on the medicine trolley. They told us that they would ensure this was done immediately.

We looked at the Medicine Administration Record (MAR) charts relating to medicine and found there were times when staff had not signed to say that they had given a person their medicine. This had been identified through checks that had been carried out. We also found that when medicine was to taken when required that staff had not consistently signed for this, or recorded the reason why it had been given. For example we found that staff had signed the MAR chart to say a person had received a medicine three times in one day. However the records to show why this had been given only showed this had been given once. We saw that the records as to why the medicine had been given showed that the person had been given this four times the following day. However the staff had only signed the MAR chart to say it had been given twice. This meant that there was not a consistent record to show what medicine people had taken. We discussed this with the senior care team leader. They told us they would review the records and discuss this with the staff.

People told us that they were supported to take their medicines. One person told us, "I have tablets. They don't always give them on time. Today she was early and sometimes you are waiting and waiting. It can be from 9am to 10:30am.This makes all your tablets which are every 4 hours late. It has been a bit better lately" People also told us that they were sometimes given medicines for pain. One person said, "They come round every morning and ask if we are in pain." We found that arrangements were in place for the storage, administration and disposal of medicines. There was a policy in place which covered the administration and recording of medicines. Staff told us that they felt confident with the medicine administration that they were carrying out and that they had received training in this. Records confirmed that this training took place.

People's care plans included risk management plans and some control measures to reduce the risk. However, we found that some risks had been identified and not considered fully. Some assessments had very limited or no control measures. For example, we found that the use of a recliner chair had been identified as a risk for one person. The assessment identified that the person could fall out of bed and there was no indication of what the actual risk to the person was from them using the chair. There were no control measures identified. We discussed this with the registered manager and the provider. They told us that they would review the assessments. Where more detailed management plans were in place these provided staff with a description of the identified risk and guidance on how people should be supported in relation to this.

These included assessments about how staff could assist the person to move safely and how to reduce the risk of falls. Risk assessments were reviewed monthly unless a change had occurred in the person's circumstances. This was important to make sure that they information included in the assessment was based on the current needs of the person.

The provider had recruitment procedures. However they had not followed these consistently. Most staff had undergone recruitment checks as part of their application process and these were documented. We looked at the files of four staff members and found that references had not always been sought from previous employers to show evidence of good conduct. For example, we found that one person had previously worked in a care setting. However, a personal reference had been used instead of contacting the previous employer. Where a prospective member of staff has worked in a similar setting it is good practice to seek feedback from the previous employer as this is relevant to their conduct in this type of role. We also found that another staff member had received a reference from a previous employer that provided different information to what the member of staff had provided in their application. This had not been discussed with them. We discussed this with the provider. They told us that they would use more appropriate references and follow up where there were any discrepancies. Disclosure and Barring Service (DBS) Checks had been completed prior to staff starting work. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who used care services.

People told us that they felt safe. One person said, "Oh Yes I feel safe." A relative told us, "Yes, [person's name] is safe here." Another relative commented, "[Person's name] wouldn't be here if I didn't think they were safe." People were protected from the risk of harm because there were contingency plans in place in the event of an untoward event such as large scale sickness or accommodation loss due to flood or fire. Staff knew the fire response procedure and this was practised to make sure that everyone knew what to do in an emergency. Personal emergency evacuation plans were in place for people living at the home. These provide a guide for staff and emergency workers in regards to the assistance people require in the event of a fire. We saw that regular testing of fire equipment had taken place.

Where people used equipment such as hoists, the required checks had been completed to make sure that these were safe for people to use. We found that there was a Legionella risk assessment in place and appropriate safety measures to reduce the risk of legionella had been completed.

People and their relatives told us that they felt that there was enough staff to meet their needs safely. One person told us, "The staff come to me quickly if I press the bell." Another person said, "If I press it three times it means emergency. They come to me." One person commented, "They are busy here. On the go all the time." Relatives agreed with this. A relative said, "Yes there are enough staff. They have time to sit with [relative's name] and talk with them." Another relative commented, "At the weekends there are slightly less staff but it doesn't concern me at all." Staff told us that they felt there was enough staff to meet people's needs. One staff member said, "I think there are enough staff. We are getting more night staff." The rota showed that suitably trained and experienced staff were deployed. We saw that staff responded to peoples requests in a timely manner. We found that staff had time to talk with people and support people when they asked for this.

Staff members we spoke with had an understanding of types of abuse and what action they would take if they had concerns. All staff we spoke with told us that they would report any suspected abuse immediately to the registered manager or external professionals if necessary. One staff member said, "My responsibility is to protect people. I would report any concerns to the manager." Staff told us they had received training around safeguarding adults. Records we saw confirmed that some staff had completed training in this area. However, six staff members still needed to complete this or complete a course to refresh their knowledge.

The provider was not able to provide a policy to describe how concerns about people should be dealt with as this was being updated. We saw that there was guidance on actions to take if anyone suspected that a person was being placed at risk of harm on notices around the service.

Most staff we spoke with told us that they understood whistleblowing and felt they could raise concerns. We saw information about who to contact was available around the service. The provider did not have a procedure in place as this was being updated. The registered manager had an understanding of their responsibility for reporting allegations of abuse to the local authority and the Care Quality Commission. We saw that the registered manager had reported concerns appropriately to the local authority safeguarding team. The concerns had been investigated either internally when this had been requested by the local authority or by the local authority.

Where accidents or incidents had occurred these had been documented and investigated. The documentation included a description of what had happened and actions that had been taken. Where these investigations had found that changes were necessary in order to protect people these issues had been addressed and resolved promptly.

Requires Improvement

Is the service effective?

Our findings

Some people told us that staff asked them for their consent and offered them choices about their care. One person said, "They ask me if I want a bath, or just a strip wash." Another person told us, "They just do it [provide care] automatically." One person commented, "They ask me and they do what you want." Staff told us that they asked people for consent. One staff member said, "I always ask. If they don't want it doing you can't do it. I would write it on their chart. Of course people can say No." Another staff member told us, "I ask consent. People get a choice. If they say no, I will not do it. You do have to consider if the situation could put them at risk and work in the person's best interests." We observed that throughout the day of our inspection staff member's sought people's consent prior to assisting them. Care plans reminded staff to gain consent before providing care. For example, we read that one person could nod or shake their head to show that they did or did not consent to their care. However, this was not completed consistently. We found that one person's care plan identified that they could give consent by nodding their head, or through facial expression. The care plan did not explain how they may refuse care, or what staff should do if this happened.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that DoLS had been requested for people who may have been at risk of being deprived of their liberty. The manager showed an understanding of DoLS which was evidenced through the appropriately submitted applications to the local authority. However, we found that where the application had been authorised conditions had been put in place to protect the person. These had not been recorded in the person's care plan and there was no guidance for staff on how to meet this condition.

We checked whether the service was working within the principles of the MCA and found that there were some areas where the provider needed to ensure that information was recorded in detail. We found that for some people where there was a reasonable doubt about their capacity to make a specific decision a mental capacity assessment had been carried out and recorded. However, we also found that these had not been carried out in all cases where there was a reasonable belief that someone did not have the capacity to make a specific decision. We also found that where assessments had been completed there was no follow up action. For example, where a capacity assessment had confirmed that the person was not able to make the specific decision there was no decision made about what decision would be in the person's best interests to make sure that their care was provided in line with their wishes.

Where capacity assessments had been completed these did not always show the reasons why there was a

belief that the person did not have capacity to make the decision. For example, we saw one capacity assessment recorded the reason the person was not able to retain information due to a diagnosis of Alzheimer's. While this diagnosis may mean it could be harder for the person to retain information there should be evidence that they had been supported to try and retain the information and what had been done to help them with this. Under the MCA a person must be presumed to have capacity unless there is evidence to the contrary. A lack of capacity must not be presumed solely because a person is living with Alzheimer's or dementia. We discussed these areas with the registered manager and provider. They told us that they would review the information in the capacity assessments and work with staff to make sure that assessments of capacity were completed where needed, details about decisions that had been made in people's best interests were recorded and capacity assessments contained evidence to show why a person could not retain information and did not rely on a diagnosis.

We also found that family had been asked to agree to their relative's care without having the legal authority to do so. For example, we found that one relative had agreed to [person's name] care plan and them receiving the care identified in it without having the Lasting Power of Attorney (LPA) to do this. An LPA has been given authority by the court to make decisions on behalf of someone who does not have the capacity to do so. We discussed this with the provider. They told us that they would follow up with the relatives to make sure that where this authority was in place that documentation was provided to show this. They also told us that they would only seek agreement from relatives where they had an LPA.

We saw that food charts were in place and were being completed where people had been identified as being as risk of malnutrition. However, these did not accurately record what people had to eat as they did not record the quantities people were given. We saw that staff had recorded that one person had liquidised meat. It did not say what type of meat or how much had been given. This meant that people's dietary intake was not being effectively monitored.

We looked at records where concerns had been identified with people's swallowing and people had been referred to the speech and language therapy team (SALT). We saw that for some people specific diets had been identified and were being followed. For example, we saw that one person should have a soft fork mashed diet. However, their care plan identified that this person enjoyed sausage rolls and pork pies. These are foods which are not suitable for someone who has a softened diet. We discussed this with the registered manager and the provider. They told us that the person enjoyed these foods. They did agree to discuss this with the SALT team to make sure that the person could eat these foods safely without a risk of choking. We spoke with the cook. They told us that they had detailed information about each person's diet and guidance from the SALT team about what foods were suitable to be given as part of the diet. The cook told us that people had been asked what they liked to eat and this information had been used to develop the menu. They told us that they sometimes changed the menu to add more variety and people enjoyed this.

People told us they got a choice of meals. One person told us, "The meals are very good. Sometimes I have a light meal. You have a choice." Another person said, "The food is good. It is better some days than others." One person commented, "They ask you the day before what you want. You can have a jacket potato or sandwich if you want." A relative commented, "The food is good. [Person's name] particularly likes the puddings." Staff asked people what they wanted for lunch the day before. We saw that people had a choice of two main meals or could ask for an alternative lighter meal. However, we found that people were not always reminded what they had ordered and what they were being given. The menu was displayed on the wall in the main corridor and was not available to people in the dining room as a reminder of what they were eating.

We observed lunch time over both days of our inspection. On the first day we saw that staff assisted people

in their rooms and spent time with each person. This meant that there were limited staff in the main dining room and we found that people who chose to eat in this room were not encouraged to eat their meals and the room was very quiet with little conversation. On the second day we found that the activities co-ordinator spent time in the main dining room talking with people, encouraging them and they put music on. This improved the dining experience for people in the dining room. We discussed this with the registered manager and the provider. They told us that they would review the experience for people in the dining room.

People told us they always had enough to drink and eat. One person told us "We are offered biscuits in the day time. I just have a drink." Another person told us, "Snacks come round on a trolley and drinks twice a day. We also have a drink of Horlicks later at night." We saw that people were provided with drinks and biscuits from a tea trolley during the morning and again in the afternoon.

People told us they had access to healthcare professionals. However some people felt this was only possible on set days. One person said, "The doctor visits us. I have seen him." Another person told us, "I can't see the doctor at any time. You have to be ill on Friday." A relative commented, "[Person's name] sees the doctor and a chiropodist. They go to any arranged appointments." Staff explained that the doctor visited the home every week on a Friday but was available at other times if needed. We spoke with a visiting doctor. They told us, "We have a call at the start of the week to see who we may need to see on a Friday. They call us if someone else needs us. They take advice from us and do what we ask. There has been changes since there are no longer any nurses here and it has got a little worse. They do things like blood pressures and weights." Records confirmed the involvement of various health and social care professionals in people's care. We saw that people had received support from the GP's, chiropodists and district nurses when required.

People told us that staff understood their needs. One person said. "The staff know what to do." A relative told us, "They are as good as they can be. They understand that [person's name] does not always want to be with others." Staff told us that they received the training that they needed to enable them to carry out their roles. One staff member told us, "I have done lots of training. They sit us down to go through it together. We have done booklets. I do prefer classroom training." Another staff member said, "The training is good quality." We looked at the training records that were kept for staff. We saw that all staff received an induction to the home when they first started and some staff had attended training courses to help and support them to carry out their roles. However, we also saw that some staff needed to attend courses that would give them knowledge and practice about the people who used the service. For example, we found that seven staff members had not completed training in how to move people safely. We also saw that most staff had not completed training that was specific to the needs of people who were living at Longcliffe Nursing Home. For example, we found that some people who used the service were living with dementia. Most staff had not completed training in this area that would have given them understanding about this diagnosis and how to support people effectively with their needs. This may have led to people receiving inappropriate care.

Staff told us that felt supported within their roles and received supervision from their manager. They told us that in these they discussed their work and any concerns they had in relation to their work. They went on to tell us that they were supported in these areas and received guidance and advice as that they needed. Records showed that supervision meetings had taken place although the frequency of these varied for each staff member. The provider told us that they were holding supervision meetings with staff when they were needed.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. One person told us, "They get cross when I have to use the toilet. They say I'm being annoying and call me a nuisance." We discussed this with the registered manager. They told us that they would discuss this with the person to find out which staff had said this so it could be followed up. We saw that a member of staff was supporting someone to have a drink and they had rap music on in the background. When we asked if the music was what the person enjoyed the member of staff told us, "I will go and change it. It is usually Smooth FM or some CD's." This meant that staff had not respected the person's preferences for music. We also saw a person who asked three times if they could be taken to the toilet from the dining room. There was not any care staff in the room at the time. One of the kitchen staff told the person they would ask a member of care staff when they came back into the room. However, when care staff returned to the room this request was not passed to them.

Staff did not always keep information about people private, or discuss it in a discreet manner. We heard one member of staff give another feedback from a GP appointment for one person. This was done loudly in the dining room where other people were present. Information included personal care that the person needed and what the GP had said. We discussed this with the registered manager and the provider. They told us that they would address this with the member of staff.

People were not sure if they had been involved in developing their care plans and making decisions about their care and support. One person told us, "I don't know about a care plan. It is secret. They would tell me if they needed information." Another person said, "I can refuse my care if I want to or if I am not happy with the carer." A relative said, "A care plan – I haven't seen one." However another relative told us, "They asked us for information before [person's name] moved in." The provider told us that people were asked about how they wanted their care as part of the assessment process. The staff told us that people were offered choices. One staff member said, "I always offer a choice. Even if someone asks me to pick their clothes I still encourage them to pick what colour they want to wear."

People had information within their care plans that provided details about their life histories and events of importance to them. Staff knew this information about people and used it to start conversations with people on some occasions. A relative told us, "I hear them. They don't know I am there in the corridor. They sit and talk to [person's name] and about their life. It is nice."

People told us that the staff were kind. One person told us, "They are good they talk to me." Another person said, "The staff are very caring. Particular ones are very good to me." One person commented, "They listen to me mostly." A relative told us, "[Person's name] has good relationships with the staff. She does like them." Another relative said, "They are all friendly and know you by name." A visiting GP told us, "The staff seem to know the residents well. People seem very fond of the carers. "Staff knew people at the service well and were able to tell us about their likes and dislikes. One staff explained to us how important it was for one person to have things how they liked them in their room. We saw that staff spoke with people in a kind manner and encouraged people while they were supporting them. One staff member was giving someone clear instructions about what they needed to do in order to get to the dining table. The member of staff was

patient and pleasant during this. Where people became anxious we observed that staff offered reassurance and assistance and used techniques that were identified in the person's care plan. This meant that staff were responding to people's needs.

People told us that staff respected their independence. One person told us, "I still wash and dress myself. They help me. I say if I want it the next day." Another person said, "I do for myself what I can do. I ask for some help with things." We saw that where people were able to do things themselves they were encouraged to do them. Staff told us that they tried to encourage people to do things for themselves. One staff member told us, "I always promote independence." Care plans contained information about things that people could do for themselves. This offered staff guidance on what to support people with and what to encourage them to do.

People's visitors were made welcome and were free to see them as they wished. One person commented, "My family visit me most days." Another person explained that their daughter visited them twice a day. A relative told us, "I feel welcome - very much so. It feels like a home." We saw that visitors came throughout the day of our visit and staff spoke with the visitors and seemed to know them well.

There was information on display at the service in relation to external support groups that were available and about advocacy and people's rights. An advocate is a trained professional who can support people to speak up for themselves. People were aware of advocates but were not using one at the time of our inspection. One person said, "I don't have an advocate."

People's sensitive written information was being handled carefully. We saw that the provider kept people's care records in a locked room or in their own room.

Requires Improvement

Is the service responsive?

Our findings

People had contributed to an assessment of their needs when they started to use the service. This included information about their life history, likes and dislikes and how they wanted their needs to be met. However, people were not involved in reviews of this information. This meant that the service could not assure themselves that the care they were providing continued to meet people's needs. We had raised this with the registered manager at our previous inspection on 14 and 15 December 2015. The provider told us that people could be involved in their reviews if they wanted to be. They told us that care staff completed the reviews as they provided care to people and knew them well. The provider agreed that they would offer people more opportunity to be involved in reviewing their care and record that this had been done.

Most people told us that they were happy to raise any concerns and felt these would be listened to. However, other people felt that they could not complain. One person said, "I had a complaint about my bedroom. I spoke with [registered manager]. She told me that it could not be done yet but it will be done. They play fair." Another person said, "I have raised a few little things. I feel I can talk to [Provider] she is nice." One person told us, "They complain if I complain. They say I am being a nuisance." Relatives we spoke with all told us that they were happy to raise any concerns. A relative told us, "I had concerns a while ago. I spoke with [registered manager] but did not get a response. I spoke with the staff. It has been sorted." Another relative said, "[Person's name] complained about a member of staff. They kept us informed the whole time and we are happy with the outcome." One relative commented, "I would be happy to raise anything with [registered manager]."
The provider told us that they had not had any formal complaints in the last 12 months. There was a complaints procedure in place although this was in the process of being updated.

Some people told us that they participated in activities that took place at the home. One person told us, "We have games with [activities co-ordinator] and I have my puzzles. We don't talk about the past. I would like that." Another person said, "We have church services here. They came at Christmas." Other people told us that they either could not, or chose not to attend activities with others. Relatives told us that people were offered things to do in their room. A relative said, "[Person's name] has a paper every day. They can hardly open it now. They can't operate the television remote but staff put it on for her. They know she's addicted to snooker."

There was an activities co-ordinator employed by the service who worked alternate mornings and afternoons. They spent time with people engaging them in activities and offering encouragement during lunch. The activities co-ordinator told us, "We have lots of games that people enjoy doing. I come every day and work for five or six hours. We have sensory balls that people can use for posture and we do card games, or we read or play trivial pursuit." We saw that on the day of our inspection 'games' were taking place. These included ball games and activities. The registered manager told us as part of the information that t hey had provided before the inspection that people had participated in the Twilight games that had been organised by Leicestershire and Rutland Sports. They told us that these had been run alongside the Olympics to encourage people to participate in sport and had been designed for older people. People who participated had been given a 'spirit of the games' award and continued to play the games. We looked at the activities

that the home provided. We saw that planned activities took place at times throughout the week. There were activities such as a bingo session, armchair aerobics, a weekly quiz and crafts.

People had attended residents meetings. One person told us. "We have meetings. Not often though." Another person said, "We have meetings here or in the dining room. We can bring any complaints." We saw the minutes from the last meeting that had been held in January 2017. The minutes showed that people had been asked for their opinion on the activities, meals and care plans. At the previous meeting which had We saw that people had been given feedback about the most recent CQC inspection. This meant that people had been given some opportunity to discuss the service, been asked for their opinions on this and given updates on what was happening. Meetings were held approximately every six months. We saw that a newsletter was written monthly to tell people about what was happening in the service and this included birthdays and activities.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in April 2014 we found that the provider had not met the regulations in relation to management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines; which following legislative changes of 1 April 2015 corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In our inspection prior to this in September 2013 we found that the provider had not met the regulations in relation to management of medicines and records. This was a breach of Regulation 13 and Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines and Records: which following legislative changes of 1 April 2015 corresponds with Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This means that the service has not met CQC regulations since September 2013. We have taken this into account when considering our rating in this area.

At our previous inspection carried out on 6 June 2016 and our inspection on 14 and 15 December 2015 we found that the systems and processes in place were failing to assess, monitor and improve the quality of the service. We found that an accurate, complete and contemporaneous record for each person who used the service was not being kept. This was because records were not being completed to record all care that had been given; audits had not been completed consistently. We also found that records relating to health and safety had not been completed when people first started to use the service and a complete assessment of their needs had not been undertaken.

These matters were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made some of the required improvements. However, we continued to identify a number of areas where improvements had not been made.

We saw that records were not completed accurately, completely or contemporaneously. We looked at the records for turning charts for two people for the month of January 2017. There were in place for people who had been assessed as being at high risk of developing pressure sores. We saw that there were periods of time where no turns had been recorded. Information in care plans was not consistent. For one person we saw that their care plan said they should be turned every 2 to 3 hours. However, there was a note as part of a review that said that turns should be done every 3 – 4 hours. This information was not recorded within the care plan to give staff guidance in this area. The gaps in the records ranged from 5 hours to7 hours where there was not record that staff had offered people support to turn. It is very important the people are offered this support as if they are unable to turn themselves and are not turned at regular intervals they can develop pressure areas on their skin which can have associated health problems including infection. We discussed this with the registered manager and the provider. They told us that staff were providing the care but were not always recording this. They told us that following the previous inspection checks were meant to be completed on the paperwork to ensure that a full record of all care offered was in place and this had not been completed fully. This check had also been implemented following our inspection in December

2015 and had not been maintained when we returned in June 2016.

We found that care plans had been reviewed but errors had not been identified and information had not always been updated when people's needs had changed. Audits had been completed on the care plans. These audits had not identified that information had not been updated. For example, we saw that one person had a relative identified as having applied to have a lasting power of attorney to make decisions on behalf of the person for finances. The care plan recorded that no paperwork had been seen for this. The care plan have been reviewed monthly and audited in December 2016. We found paperwork in the file that had been in place for a number of months. This stated the relative had been granted a lasting power of attorney to make decisions relating to welfare for the person and not for finances. In another person's care plan which had been audited in January 2017 we found that guidance was in place to support the person to eat and drink safely from health professionals. The care plan relating to eating and drinking contained most of this information. However, it did not identify that the person required an open beaker to be used when they were having a drink. This is important information to enable risks to the person to be reduced and was not identified. We also found that guidance around turns was not consistent and this had not been changed in the care plan to reflect exactly what care the person required to meet their needs and to keep them safe.

This meant that an accurate, completed and contemporaneous record for each person was not being kept.

This constituted a continuing breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

We found that the most recent CQC report was not on display at the service. We spoke with the registered manager and the proprietor about this who told us this had been an oversight and thought it had been on display. They told us that they would display this. We also found that the provider had not displayed their rating on their website. This is a requirement under the regulations. The provider had been advised of this following the last visit. They told us that they would display the rating. At the time of writing the report the rating was not displayed on the website.

This constituted a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Requirement as to display of performance assessments.

We found that the provider had not always notified CQC of events they were required to notify us of. It is a requirement that providers tell CQC when certain events happen within the service. This includes allegations of abuse, events that affect the service and when an application to deprive someone of their liberty is approved. We found that the provider had notified CQC of most events. However, we found applications had been approved to deprive people of their liberty and we had not been notified of this. The registered manager told us they would submit the required notifications.

The provider told us that no policies were available at the time of the inspection as they were in the process of being reviewed and updated. This meant that staff did not have access to guidance and procedures that the provider asked them to follow. This included areas such as protecting people from abuse, whistleblowing, medicines management and human resources policies such as absence and disciplinary. The provider told us that these would be available as soon as possible.

We looked at the audits that had been completed. We saw that a range of audits were in place to monitor the quality of the service that was provided and the environment. These had identified areas for improvement and action to be taken. We found that not all actions had been recorded as being completed. For example, we found with the environmental audit that had taken place in July 2016 that actions such as

cleaning the carpet had been identified and had not been recorded as being completed. We also found that actions were not always identified. For example, we saw that one person had lost a significant amount of weight in January 2017. The reasons for this had been identified. However, there was no recorded action to say that the person had been referred to the GP or a dietician for advice which would be good practice. Where audits had been completed these had not always identified the concerns that we found. For example, where care plans had not been updated and also checks had been completed on the medication every two weeks and had not identified that medication that was given as and when needed had not been given in accordance with the protocol for this and that creams had not been dated when opened. This meant that audits were taking place but were not always effective at identifying and completing actions that were needed.

People had not always been asked for their thoughts on the service that they received. One person told us, "They don't ask what I think of the service." Another person said, "I had a questionnaire a long time ago. One person commented, "They have never asked me for my opinion." A relative told us, "I haven't been asked for my opinion but I can talk to [registered manager] and [provider] to tell them what I think." The provider told us that questionnaires were to be sent out to ask people for their opinion on the service. They told us that people and their relatives had the opportunity to speak to them and the registered manager at any time to provide feedback or through the residents and relatives meetings.

People and their relatives told us that they felt that the service was improving. One person said, "They are improving the night service since Christmas. We have more regular staff now." A relative told us, "We are happy with [person's name] care. We had some niggles but it has got better." Following our last inspection in June 2016 the provider and the registered manager had made a decision to no longer provide nursing care at Longcliffe Nursing Home. They had done this in order to try and improve the service that was delivered. They deregistered this element of the service in October 2016. The provider told us that staff were adjusting to their roles and new responsibilities as previously nursing staff had completed some tasks that staff were now being trained to carry out. The provider had made improvements to the environment since our last inspection to offer better facilities to people who used the service. This included a new bathroom that had been designed to be accessible, improvements to another bathroom, new sinks and taps in all rooms and a new kitchen.

Staff told us that staff meetings took place and they felt able to contribute to these meetings. One staff member told us," We have team meetings. I find them useful." We saw records from the staff meetings. We found these had been held approximately every 3 months. Topics for discussion included good practice, record keeping, activities, staff cover and feedback from inspections and visits by professionals. The staff we spoke with felt the management team were approachable, listened to their views and had made improvements. One staff member told us, "I can approach [registered manager]. I feel I can talk to her. If staff ask for things they will try and do it." Another staff member said, "They are doing their best. We have a lot of the necessary things we need to provide good quality care."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to maintain an accurate, complete and contemporaneous record, including a record of the care and treatment provided to people who used the service.

The enforcement action we took:

We imposed a condition to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not display their ratings from the most recent inspection on their website.

The enforcement action we took:

We issued the provider with a fixed penalty notice.