Longview Care Home Limited

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Longview is a care home which provides accommodation for up to 28 older people who require personal care. At the time of the inspection 28 people were using the service. All of the people who lived at the service needed care and support due to dementia, and others also had sensory and /or physical disabilities.

There was a registered manager at the service. The owner of the service is also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

We inspected Longview on 6 and 7 June 2017. The inspection was unannounced. The service was last inspected in October 2015 when it was rated as 'Good', and was found to be meeting the requirements of the regulations.

People and their relatives told us the service was safe and staff were supportive.

Staff had been suitably trained to recognise potential signs of abuse. Staff told us they would be confident to report concerns to management, and thought management would deal with any issues appropriately. However we were concerned there should have been more proactive contact with the safeguarding authority about two matters, and these should also have been reported to the Care Quality Commission through our notification procedure. There was no system in place to enable the registered manager to have an overview of any incidents that occurred in the service. We have made a recommendation about the monitoring of incidents in the report.

People received their medicines on time. Medicines administration records were kept appropriately and medicines were stored and managed to a good standard.

Staff training was delivered to a good standard. Staff received updates, at regular intervals, about important skills such as moving and handling. Staff also received training about the needs of people with dementia, but we have made a recommendation about staff training on the subject of dementia.

We were concerned about some moving and handling procedures for example, how some people were assisted in and out of their chairs. We saw some cases where people who used wheel chairs did not have foot plates which put people at risk of injury.

Recruitment processes were satisfactory as pre-employment checks had been completed to help ensure people's safety. This included written references and an enhanced Disclosure and Barring Service check, which helped find out if a person was suitable to work with vulnerable adults.

People had access to medical professionals such as a general practitioner, dentist, chiropodist and an

optician. People said they received enough support from these professionals.

There were enough staff on duty and people received timely support from staff when it was needed. Call bells were answered promptly and we observed staff being attentive to people's needs.

We had mixed views of the care we saw. Although there were examples were care practice was good, we did see some instances where people were ignored or their privacy was not respected. Views of people we contacted were all positive. For example people told us, "It is lovely here," "Staff do their best for everyone," and "They are ever so kind to me." Relatives told us: "Longview is excellent in every respect," and "The care has been outstanding." A professional told us, "Staff are friendly and courteous."

The service had activities organised. A structured activity took place at least once a day These activities included musical entertainers, African drumming, fitness and art sessions.

Care files contained information such as a care plan and these were regularly reviewed. The service had appropriate systems in place to assess people's capacity in line with legislation and guidance, for example using the Mental Capacity Act (2005).

People were happy with their meals. Everyone said they always had enough to eat and drink. People were provided with some choice of meals (for example if they did not like, or eat, what was on the menu, they were provided with an alternative). However, support people received at meal times was not always appropriate. For example staff did not always sit with people, or talk with them, when they were assisting them.

People, their relatives and external professionals we contacted said if they had any concerns or complaints they would feel confident discussing these with staff members or management. They were sure the correct action would be taken if they made a complaint.

People felt the service was well managed and had generally suitable quality assurance systems in place to ensure the service received feedback from people involved with the service. Relatives told us "(The owners) are very professional, very caring people." A staff member said," "(The owners are) Very fair…very much involved." Professionals told us: "The owner is a man of the utmost integrity and is absolutely passionate about providing a first class service." We have however stated that management approaches do need improvement, particularly in relation to the monitoring and improvement of some staff practices, concerns which we have highlighted elsewhere in the report.

We identified breaches of the regulations. 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 always safe

We were concerned that on occasion safe moving and handling procedures were not used correctly when people needed assistance.

There were satisfactory numbers of suitably qualified staff on duty to keep people safe and meet their needs.

Staff knew how to recognise and report the signs of abuse. However we were concerned that CQC and the local authority had not been kept informed about two matters which could be considered as safeguarding issues.

The service was clean and well maintained. Health and safety checks and procedures to assist the prevention of infection and cross contamination were to a good standard.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff supported people to maintain a balanced diet appropriate to their dietary needs and preferences. However support provided to people at meal times was not always appropriate.

Staff received a good range of training although training about dementia care could be improved, and staff did not receive any training about how to deal with aggression.

People's capacity to consent to care and treatment was assessed in line with legislation and guidance.

People had access to doctors and other external medical support.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we did see examples of good care, and received

positive feedback from many people about care we did witness less positive examples of care where people were not always respected or their privacy maintained.

People were encouraged to make choices about how they lived their lives.

Visitors told us they felt welcome and could visit at any time.

Is the service responsive?

Good

The service was responsive.

People received care and support responsive to their changing needs. Care plans were kept up to date.

People told us if they had any concerns or complaints they, or their representatives, would be happy to speak to staff or the manager of the service. People, and their representatives, felt any concerns or complaints would be addressed.

There were suitable activities available to people who used the service.

Is the service well-led?

Requires Improvement

The service was not entirely well-led.

People, their representatives, staff and external professionals all said management ran the service well, and were approachable and supportive. However we were concerned that some staff practices needed improvement, and these matters had not been suitably addressed before the inspection.

There were systems in place to monitor the quality of the service.

People, and their representatives who we contacted, said communication was very good.

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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.

We visited Longview on 6 and 7 June 2017. The inspection was carried out by two inspectors and a specialist nurse inspector who had knowledge and skills of working in dementia. An Expert by-Experience also assisted with the inspection. 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 inspection was unannounced.

Before visiting the home we reviewed the Provider Information Return (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service. We also reviewed notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

During the inspection we only had limited discussions with people who used the service. This was because people were unable to fully engage in conversation due to their dementia. 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 were able to have some conversations with six people who were able to answer straightforward questions such as did they like living in the home, and did they like the food and so on.

We had contact (either through email or speaking to) with nineteen relatives. We also spoke with the registered manager and seven members of staff. Before and after the inspection we had written contact with ten external professionals including GP's and other health and social care professionals who visited the service regularly. We inspected the premises and observed care practices during our visit. We looked at

seven records which related to people's individual care. We also looked at three staff files and other records in relation to the running of the service.

Requires Improvement

Is the service safe?

Our findings

We were concerned that records showed there had been several incidents over the last few months of one person kissing others in the service. We were concerned that some people may not have always welcomed this. The registered manager had discussed the matter with the local authority safeguarding team, but incidents were still occurring six months after this discussion. The Care Quality Commission had also not been previously informed of these concerns, as is required by law. After raising these concerns the registered manager agreed to refer the matter again to the local safeguarding team. We were also made aware of another incident, where there was a physical altercation between two people. This was not reported to the local authority under their safeguarding procedures, or notified to the Care Quality Commission. The systems in place to protect people from the risk of abuse were not effectively operated.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We had some concerns about how people were moved, and assisted in and out of chairs. For example we witnessed several occasions when staff members went to assist people to get up from their chairs by putting their hands under people's armpits to lift them. On some of these occasions staff changed what they were doing when they saw they were being observed. We also saw one incident where a carer was observed to initially hold someone's wrist before releasing the hold and taking the person's hand.

Staff from the district nurse service said some people had skin tears and bruising on their arms which was possibly symptomatic of poor manual handling practice by staff, and staff not using handling belts and slide sheets, when these were required.

We saw staff using hoists to help people out of chairs, when the person was unable to move themselves. Staff generally used the equipment to a satisfactory standard. Each person had their own sling and slide sheet, which were clearly labelled, and were easily accessed by staff. However we did observe some occasions when staff did not speak with the person they were helping, or provide explanation of what actions they were doing. Staff said they had received training about moving and handling, and we were able to check this was the case from the records we inspected.

We also saw several occasions where people who were using wheelchairs, did not have the foot rests in place. This is potentially dangerous as people's feet can get caught underneath the chair when it is moving. We discussed this with the registered manager, who said it was not possible to use foot rests for some people. However, there was no record of this in the care plan of at least one of the people concerned.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.
The service had a satisfactory safeguarding adult's policy. Staff members had received training in safeguarding adults. The staff we spoke with demonstrated they understood what to do if they thought a person was being subject to abuse. Staff told us they thought any allegations they reported would be fully

investigated and satisfactory action taken to ensure people were safe. Relatives told us; "I have never witnessed any disrespect to any residents or any force being used," and "The service is very safe. The more delicate people are always assisted with the greatest of care." Staff we spoke with said they had not observed any bad practice, "Staff are very patient,"They told us the registered manager was; "Very concerned to see that people are treated well," "He would not tolerate it" (poor practice), and "He really cares about the residents…I am quite impressed by that. If there are any problems he will try to find a solution." Professionals told us; "(The owner) strikes me as being passionate about providing a good and safe service," "I have visited this home many times over the years. I have not had any concerns regarding (the care provided). The home manage many difficult behaviours (and care for people that other homes have declined to care for), and I have never seen them manage people with anything other than respect and understanding," and "I have never witnessed any approaches to care that have concerned me."

Risk assessments were in place for each person. For example, to prevent poor nutrition and hydration, skin integrity, falls and pressure sores. Risk assessments were generally reviewed monthly and updated as necessary.

People's medicines were administered by staff. We observed people receiving their medicines on time, and the service had satisfactory stocks of medicines so medicines did not run out. Medicines were stored in locked cabinets, and trolleys. Medicine Administration Records (MAR) were completed correctly. A satisfactory system was in place to return and/or dispose of medicine. Medicines which required refrigeration were appropriately stored, and the temperature of the refrigerator was checked daily. Training records showed that staff who administered medicine had received comprehensive training. Staff said they felt competent to carry out the administration of medicines. The pharmacist had checked the system, and their report said its operation was satisfactory. The pharmacist told us: "In general I have found the team want to keep on top of their medication knowledge and the latest procedures, and any suggestion made to them is always implemented." People's medicinal creams were kept in baskets in their bedrooms. Creams were dated when they were opened. On medication administration sheets, there were body charts which highlighted which part of the body the creams needed to be applied to.

Incidents and accidents were recorded in people's records. Accident forms were completed and filed. Incidents, for example if someone showed behaviours which could put them or other people at risk, were only recorded in people's daily notes. This subsequently made it difficult for us to assess the type and frequency of incidents, and specifically how these were managed. The registered manager demonstrated a good knowledge of people's needs. However there was no system in place which showed how the registered manager monitored incidents. This would be useful to identify any patterns or trends which could be addressed or, where necessary, what action was needed to reduce any apparent risks.

We recommend a system to record and monitor incidents is set up.

The service did not keep monies or valuables on behalf of people. When people needed to purchase items, such as toiletries and hairdressing, the person's representative arranged this, or the service invoiced the person's representative for the cost.The registered manager kept suitable records and receipts for expenditure. The registered persons' did not act as appointee, or as a signatory for financial purposes for any individual. No staff had access to PIN numbers for any individual.

There were enough staff on duty to meet people's needs. A relative told us, "The staff turnover appears to be low." Rotas showed there was three care staff on duty from seven in the morning, until nine in the evening. In addition there was a senior care assistant. The staff rota showed on five of the seven days a 'befriender' member of staff was on duty during the day until early evening. This was a new role within the staff group

which provided people with some one to one time, and assisted people with eating and drinking. During the night there was two care staff on waking night duty. The registered manager, and his wife lived in the house next door, worked at the service, and were available outside working hours if there was an emergency. Ancillary staff such as catering, cleaning, administrative and maintenance staff were also employed. At the time of the inspection staff appeared unrushed and attended to people's needs promptly. A relative told us, "The staff are calm and obviously know their residents well and respond to them in a caring way….The staff at Longview have been hardworking, very supportive and caring."

Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check.

The environment was very clean and well maintained. Appropriate cleaning schedules were used. Hand gel was available to assist in minimising the risk of cross infection. Staff wore uniforms and had aprons available to them to assist in preventing cross infection. We raised a concern with the registered manager that some of the care staff wore protective gloves at times such as when they were assisting people with eating, or to move around the service. This was not appropriate as at this time there was no infection control risk. The registered manager said he would discuss the matter with relevant members of staff to ensure they only wore protective gloves when there was an infection control risk; for example assisting people with going to the toilet.

Relatives told us the laundry service was efficient, and people's clothing had not gone missing. We saw there were appropriate systems in place to deal with heavily soiled laundry. There were no offensive odours.

The service was warm, and had sufficient light. The boiler, gas appliances and water supply had been tested to ensure they were safe to use. Portable electrical appliances had been tested and were safe. A current gas safety certificate was in place. The electrical circuit had been tested and was deemed as safe. Records showed the passenger lift and manual handling equipment had been serviced. There was a risk assessment to minimise the risk of Legionnaires' disease, and systems were in place to take action to minimise the risks identified. There was a system of health and safety risk assessment in place. There were smoke detectors and fire extinguishers on each floor. Fire alarms, emergency lighting and fire extinguishers were checked by staff, the fire authority and external contractors, to ensure they worked.

Requires Improvement

Is the service effective?

Our findings

At lunch time we observed most people receiving appropriate support to eat their meals. However we were concerned about the support received by some people. We saw one person, who seemed reluctant to eat, was being given heaped spoons of food. The spoon was pushed to their mouth by a member of staff who was standing over them. Once the food had been taken the member of staff walked away to assist someone else. The person was left with food on their face on several occasions. There was no attempt to make the meal a pleasant occasion or to protect the person's dignity. The member of staff did not attempt to socially engage with the person at any time.

At least five people required one to one assistance from staff. This meant that staff would often have to assist two people at a time as there was not enough staff to help people individually. We were concerned people were helped while the staff stood up preventing them from establishing eye contact with people. Again this did not assist the meal time to be a relaxed, pleasant occasion. This last matter was discussed with the registered manager, at the end of the first day of the inspection, and the registered manager ensured staff were sitting down to assist people, on the second day of the inspection.

We also received reports that meal times were at a set time, and there was sometimes an expectation that meals should be finished by a certain time. We were concerned that people may have to subsequently wait for breakfast if they were up early, and may be go hungry until breakfast was served. We were also concerned that people may not be able to eat after a certain time if they had not finished their meal when staff wanted to clear up. However we did observe, when people did not want to eat a meal which was served, staff offered them an alternative such as a sandwich, or a banana and some bread and butter, which the person would subsequently eat.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People said they were happy with their meals. At lunchtime we observed that everybody had enough to eat and drink. Lunch appeared to be hot when served and the people who lived in the home appeared to enjoy it. However on the first day of the inspection we did feel the meal provided was rather unconventional (poached egg, butternut squash and tinned tomatoes). We were told staff knew what likes and dislikes people had, so would ensure people had some choice of main meal. For example if they did not like what was provided they were given something else. People were regularly offered cups of tea, coffee or a cold drink. A relative told us; "The food is wholesome, balanced and well prepared."

Staff had received suitable training to carry out their roles. New staff had an induction to introduce them to their role. The registered manager said when people started to work at the service he spent time with them to explain people's needs, the organisation's ways of working, and policies and procedures. New staff also worked alongside more experienced staff before being expected to complete shifts. Different staff members told us their induction had lasted between three days and two weeks, but all the staff we spoke with said they had found it useful in teaching them how to do their jobs.

The registered manager said he was aware of the need for staff, who were new to the care industry, to undertake the Care Certificate. The Care Certificate is an identified set of national standards that health and social care workers should follow when starting work in care. The Care Certificate helps ensure all care staff have the same introductory skills, knowledge and behaviours to provide necessary care and support. The registered manager said where necessary, new staff were required to do the Care Certificate and several of the new staff had completed this. Some of the staff we spoke with confirmed they had completed the Care Certificate since starting at the service. The Care Certificate was completed as soon as the member of staff started working at the service to ensure it was completed within a suitable timeframe.

We checked training records to see if staff had received appropriate training to carry out their jobs. The registered manager said the majority of the training was delivered 'face to face' by an external trainer, although food handling training was completed on line. Records showed that people had received training in manual handling, fire safety, health and safety, infection control, safeguarding, and first aid. All staff had also undertaken further training about dementia awareness. Staff who administered medicines, and who handled food had received suitable training. Most of the staff had completed a diploma or a National Vocational Qualification (NVQ's) in care, or were in the process of completing this. The summary of training we were provided with also included records that staff had completed training about for example equality and diversity, epilepsy, fluids and nutrition, privacy and dignity, person centred working, communication and 'duty of care'. Staff members, we spoke with, were all very positive about training provided. For example we were told "I have done loads of training," and "The training is really helpful."

We had some concerns about the dementia training which was provided. Staff were provided with a one and a half hour session which covered dementia, learning disabilities, mental health, mental capacity and deprivation of liberty safeguards. No further dementia training was provided. Issues about how staff should manage verbal or physical aggression were not covered. At the time of the inspection we were told none of the people at the service were regularly physically aggressive. However we did note several incidents, in the records, of verbal aggression. Staff had not received any training in this area on how to deal with this. Similarly issues about how staff should talk with, and encourage people with dementia were not covered. These matters were discussed with the registered manager who agreed to review the current training provided.

We recommend current dementia training is reviewed and as necessary expanded to cover a wider range of matters about how staff work with people with this diagnosis. Training about the management of aggression also needs to be considered.

Staff told us they felt supported in their roles by colleagues and senior staff. There were records of individual formal supervision with a manager. We were told formal supervisions occurred at least twice yearly. There was always a senior member of staff on duty should staff have any day to day concerns, and the registered manager worked at the service on a day to day basis. The staff we spoke with said they felt supported, and could approach senior staff if they had any problems or concerns.

Some restrictions were in place due to the nature of people's mental health. For example the front door was locked for security reasons and to maintain people's safety. Staff said they tried to help people have choices about issues such as what they wanted to eat, what they wanted to wear, the time they got up or went to bed, and if they wanted to join in with activities which took place. We were told the majority of people could make simple choices about their lives.

People's capacity to consent to care and treatment was assessed in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager said, where necessary, applications had been submitted to the local authority to assess people who may lack mental capacity to make decisions for themselves. The staff we spoke with demonstrated a basic awareness of the legislation. Training records showed staff had received training about the Mental Capacity Act and Deprivation of Liberty Safeguards.

People told us they could see a GP if requested. A relative said, "When there is any health problem, the care home will call the doctor." We were also told that other medical practitioners such as a chiropodist, dentist or an optician visited the service. Records about medical consultations showed that people saw, where appropriate, GP's, opticians and district nurses regularly. The registered manager said when people had to go to hospital, a staff member would always accompany them if the person wanted this, and hospital staff would be offered support at meal times if the person was an inpatient. An external professional told us, "There is always evidence of regular liaison with community health services, and (the registered manager) appears to have a good working relationship with them."

The home had appropriate aids and adaptations for people with physical disabilities such as bath chairs to assist people in and out of the bath, and a passenger lift. There was currently no usable bathing facility on the first floor of the service. The registered manager said people tended to have a bath in either the morning or the afternoon and would be assisted to get changed in one of the downstairs bathrooms. The registered manager said he was considering either installing an assisted bath or walk in shower on the first floor. There was a specialist bath and a walk in shower on the ground floor. We received one comment that some people did not like using the downstairs specialist bath because it was small, and some people would be "frightened." However other staff said other people enjoyed using it. The registered manager said he was considering replacing it with either another specialist bath, or making the room a walk in shower facility.

The service used aids to assist people with dementia. These included large clocks, and a reminiscence board which informed people what the day, date and weather was (although the menu section was not completed).

The home's environment was maintained to a good standard. All areas were well decorated, with clean and comfortable furnishings and fittings. Decorations were well maintained. The home was spotlessly clean and tidy. There were no offensive odours. In the lounge there was a large fish tank, a music centre and a television. A relative told us "On my visits the home has always been warm, light, airy clean and tidy, and smells like an ordinary home."

Bedrooms were furnished according to individual preferences. People could bring their own belongings to the service. The people we were able to speak with told us they liked their bedrooms. At the time of the inspection the registered provider was having an area in the garden upgraded, so it could be used more easily by the people who lived in the home. Since the last inspection, there had been some upgrading in

decorations and furnishings. For example carpets and floor coverings had been replaced in some of the corridors. The registered manager said some of the bedrooms had also been redecorated. We were told there were plans to replace windows, install a new kitchen, resurface driveways, and upgrade some of the other bedrooms.

Requires Improvement

Is the service caring?

Our findings

We had mixed conclusions about the care provided. Elsewhere in the report we judged that some approaches, from some staff, could be improved at meal times, and when they were helping people to get up and/or move around. People were observed generally having their privacy and dignity respected. However we did observe some staff making some comments about people which did not include them, such as, "Pop her there as I need to take her to the toilet," and another senior member of staff saying in front of people, "Can you feed that one," rather than address the person by their name. On one occasion a member of staff spoke to a person, with a raised voice, because they assumed the person had a hearing impediment. When the person corrected them, the member of staff carried on with the raised voice as if the person had not said anything. We also observed two male carers assisting both male and females to use the bathroom. It was not clear whether the women concerned were happy to receive personal care from male carers. We found the staff approach on these occasions disrespectful, overtly functional and not person centred.

There were also times when we observed a lack of interaction between staff and people. For example when staff did speak with people it was generally to ask if they would go to the toilet or complete some other essential task. There were occasions when people were asleep and were woken up to be asked to go to the toilet. There were also two occasions noted where staff did not respond to people when the people spoke to staff. For example one person asked, "Where are you" (to the staff member), but the staff member did not respond. On another occasion one person said they were cold, the staff member said they would check the window, but they walked away.

When asked whether there was a choice when people could get up, or a set routine, one member of staff said they would leave the person to lie in, but would return regularly to check if they wanted to get up. It was not clear to us if this created an impression to people that they needed to get up, or if people had a meaningful choice. The registered manager said people did have a choice, and there was no set routine. On the first day of the inspection it did appear the majority of people were up, dressed and having breakfast by 8:30, and the majority of people were assisted to get up by this time, from when we arrived at 7:30.

Staff did not always make an effort to interact with people. One member of staff was seen standing in the corner of the lounge watching people but not engaging with anyone. A relative said "There is no downside that I can think of, although if they were able to take more time when interacting with residents it might help the residents."

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We received many positive comments about care received. People told us care was; "Good," there were "Very nice staff," and "Staff do their best for everyone." Relatives described staff as; "Excellent, very helpful," "Staff are fantastic," "The care has been outstanding," and "You cannot fault the care (our relative) gets in any way." A professional told us, "Staff are friendly and courteous." Another relative said, "I go to the home

about once a week to take (my relative) out, usually for Sunday lunch. The staff bath (my relative) that morning and wash her hair and put on clothes I have put aside for her to wear. I always feel very proud of (my relative) when I pick her up. On these visits all the staff are kind, caring and friendly not only to the residents but to me also."

Staff provided personal care discreetly. People's bedroom doors were always shut when care was being provided. The people we met were all well dressed and looked well cared for. Relatives said, "If (family member) has 'an accident', or spills food over themselves while eating, they are cleaned up and put into fresh clothing," "You don't ever see anyone (residents) dirty here;" and "Mum's personal care is so good I know I could not do better myself."

Care plans we inspected contained enough detailed information so staff were able to understand people's needs, likes and dislikes. There was information about people's background, and life prior to moving into the service. This information is useful to staff to help to get to know the person when they move into the service. The registered manager said where possible care plans were completed and explained to, people and their representatives.

We did see many positive examples of good care. For example one person returned from the hairdresser, and numerous staff members commented on how lovely the person's hair looked. The person concerned clearly enjoyed the attention, and was laughing and showing off her hairstyle. We also witnessed several occasions where staff reacted very professionally when working with people who were presenting behaviours which could challenge others, were aggressive or anti-social, for example if people were shouting, swearing and so on. Staff would subsequently react very calmly, not reprimand people, and continued to work positively with people.

Family members told us they were made welcome and could visit at any time. For example we were told: "As the home has open visiting times we can get here every day, whatever the time to visit." When we visited the service, people received lots of relatives and friends who came to visit them. This helped to make a homely pleasant atmosphere at the service. When people had visitors they could go to their bedrooms, the dining room or the main lounge to meet with visitors.

Good

Is the service responsive?

Our findings

We received many positive comments about the care people received from staff. For example people told us: "Yes I love it (here)," and it is, "Fantastic." Relatives told us, "We visit every day and are pleased with the care provided," "The care has been exceptional," "(My relative) has improved immensely. She is now affectionate and very chatty and is looking healthier. This is due to the patience of the staff….The staff always appear to be very gentle…. and are faultlessly cheerful." An external professional told us, "Residents do very well and improvements are often seen in a short space of time, for example an increased appetite and weight gain, or more settled behaviour."

Before moving to the service the registered manager told us he, or one of the other senior staff went out to assess people to check the service could meet the person's needs. People, and/or their relatives, were also able to visit the service before admission. Copies of pre admission assessments on people's files were comprehensive and helped staff to develop a care plan for the person.

Each person had a care plan. All records were stored in the staff room. The registered manager said all staff could access these. Care plans contained appropriate information to help staff provide the person with individual care. Care plans also contained appropriate assessments for example about the person's physical health, personal care needs, and moving and handling needs. Risk assessments were also completed with the aim of minimising the risk of people having inadequate nutrition, falls and pressure sores. Records also contained guidance, where appropriate, to how staff should respond to any verbal or difficult behaviours people may present.

The service arranged organised activities for people. A monthly schedule of activities was published. These included visits from entertainers such as a visit from Truro City Brass Band, singers and various instrumentalists. There were also art, massage and fitness sessions. On the days of the inspection there was a violinist, an African drumming session, and a visit by a guitarist. We received many positive comments about the activities provided although we did receive two comments that activities offered tended to be observational rather than participative, and one comment was that it would be good if staff could assist people to get more involved in the activity. This was not the case with the African drumming session where people were encouraged to drum along, and staff were involved in the activity, although when we observed two activities where musical entertainment was provided staff involvement or engagement in conversation was limited.

The registered manager had developed a new role at the service of 'Befriender.' The rota showed there was a befriender on duty on five of the seven days of the week of the inspection. The focus of these staff was to assist people with one to one support with meals, but also to provide one to one activities with people. One of these staff, who we spoke with, said she had been asked to complete a 'Life History Project.' This included developing documents for individuals outlining what happened in their lives. It was anticipated this would stimulate people's memories and help staff develop a life story book with them. The member of staff also said she would play a lot of games with people, do painting, talk with people and help to paint people's nails.

Relatives said if they had any concerns or complaints they would feel confident discussing these with staff members or management. Relatives said they felt confident appropriate action would be taken if they raised a concern. For example we were told: "I know I could approach Mr Patel with any problems and he would investigate it." A record of any complaints made was kept, with a record of what actions were taken to resolve the concern.

Requires Improvement

Is the service well-led?

Our findings

We have stated that management approaches do need improvement, particularly in relation to the monitoring and improvement of some staff practices, concerns which we have highlighted elsewhere in the report. The registered manager should have picked up the issues we have highlighted, and ensured practices changed for example through supervision, guidance and training.

People, their representatives, and staff had confidence in the registered manager, who was also the owner of the care service. We were told the registered manager was approachable, and helpful. The registered manager was observed engaging very well with people who used the service. Comments included; "(The registered manager) is the most caring, good willed, dedicated and excellent care home manager I have worked with in my (professional) career….Longview is an excellent service…I highly recommend and commend (Longview) for the(ir) fantastic care and support." External professionals told us; "He is a good advocate for his residents" and "He is very efficient." A staff member said the registered manager is "Very fair…very much involved. Relatives were positive about the management and culture of the service. For example we were told, "(The owners) are very professional, very caring people."

Staff were positive about the culture of the team. Staff members said; "Everyone works together and helps each other. I am supported and quite happy," "Everyone is lovely here," and "Everyone is really helpful." A recently employed member of staff said the standard of care was good and they; "Did not expect it to be so good," "Staff are nice," and the team "Care about the residents." One professional said, "(The registered manager) has a fantastic team of staff and working with (the team) is always a pleasure." None of the staff we spoke with had ever witnessed, what they would see as, any poor practice, and all said if they had they were confident this would be immediately addressed by management. Staff members said morale was good within the staff team. Staff told us that if they had any minor concerns they felt confident addressing these with their colleagues. They said major concerns were addressed appropriately by the registered manager.

The registered manager was the owner of the service and worked in the service full time alongside staff. The registered manager said he was on call when he was not at the service. His wife also was involved in the management of the service on a day to day basis, and we were told management responsibilities were clearly divided between them. The registered manager described their management approach as, "Hands on, we put ourselves on the shift. These are our roots."

Several relatives confirmed communication between staff and families was good, and all said they were informed of any concerns staff had about people's health and welfare. For example a relative told us: "I have found the home to be very proactive in keeping me up to date with any issues that might crop up on a day to day basis."

The registered manager monitored the quality of the service by completing regular audits of infection control and standards of cleanliness; care records, health and safety, training provision, accidents and falls. An annual survey of relatives, staff and professionals was completed to find out their views of the service. Results of previous surveys were all positive. A 'dignity audit' was completed by an external consultant which

included periods of observation, discussion with staff, and care records. No concerns were highlighted as part of this work.

There were formal handovers between shifts, and the registered manager said he attended these regularly. There were records that staff meetings had occurred in the last year.

The registered manager was registered with the CQC in 2010. CQC had a record that notifications, such as deaths or serious accidents had been received, but, as reported elsewhere, we had not been informed of some concerns which the registered provider is required by law to inform us of.

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 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and respect were not always promoted by staff. For example how staff spoke with people, and how staff assisted people with eating and drinking.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Procedures to assist people to be moved and handled were not satisfactory.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Issues which required reporting to CQC and the safeguarding authority were not notified as required according to multi agency guidelines and CQC regulations