SHC Clemsfold Group Limited

Longfield Manor

Inspection report

West Street
Billingshurst
Horsham
West Sussex
RH14 9LX

Tel: 01403786832
Website: www.sussexhealthcare.co.uk

Date of inspection visit:
01 December 2020
03 December 2020

Date of publication:
14 January 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Longfield Manor is a residential care home and provides personal and nursing care for up to 60 people. At the time of inspection, 28 people were living at the service in three separate wings. People were aged 60 and over and lived with a range of mental health and physical health needs including age related frailty, diabetes and degenerative conditions such as dementia and Parkinson's disease.

The building was purpose built over two floors. The building and courtyard garden were fully accessible, and the first floor was accessed by a lift. One of the wings specialised in providing care to people living with dementia.

Longfield Manor is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation in relation to incidents that occurred between 2016 and 2018. The investigation is on-going, and no conclusions have yet been reached. These investigations do not include Longfield Manor.

People's experience of using this service and what we found
There was not an adequate process for assessing and monitoring the quality of the services provided and ensuring that records were accurate and complete. People's epilepsy was not always managed safely, and we have made a recommendation to the provider about this. Processes for clinical oversight were not robust to identify discrepancies with people's medicines.

The service was welcoming, and people told us that they felt safe. They said there were enough staff to look after them and they were listened to and treated with kindness. Systems were in place to protect people from the risk of abuse and improper treatment and staff knew how to identify potential harm and report concerns.

Positive and caring relationships had been developed between staff and people. People were treated with kindness and compassion and staff were friendly and respectful. People and their relatives spoke positively about staff and the care they received. People were treated with dignity and respect by a kind, caring staff.

Since the last inspection a new manager has been appointed. The new manager commenced in September 2020 and are in the process of registering with the Care Quality Commission to become the registered manager for the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 7 May 2020) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

The service remains rated requires improvement.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 17 and 18 February 2020. A breach of legal requirements was found in relation to Regulation 17, Good Governance. The provider completed an action plan after the last inspection to show what they would do and by when, to improve their governance processes.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection. This is the fifth consecutive inspection where the service has been rated requires improvement.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Regulation 17 , Good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led section below.

Longfield Manor

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Longfield Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The new manager was in the process of applying to CQC to become the registered manager of the service. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and eight relatives about their experience of the care provided. We spoke with eleven members of staff including the chief operating officer, manager, clinical lead, assistant manager, registered nurses, senior care workers, care workers and the chef. 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 reviewed a range of records. This included eight people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We sought feedback from five professionals who had experience of working with the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● At the last inspection on the 17 and 18 February 2020 a recommendation was made to the provider to consider best practice guidance for people with behaviours that may challenge and people with a risk of falls. At this inspection we found the provider had taken measures to improve practice in these areas.

● Behaviour support plans provided guidance to staff to enable them to support people's behaviour in a safe and consistent way. For example, a person's behaviour support plan described their behaviour and guided staff to consider the reasons for it. It also described the support the person would require, and actions staff may need to consider such as seeking medical advice. The safety of other people around them was also considered and where appropriate guidance signposted staff to consider people's medicine protocol for 'as and when required' (PRN) medicines. The person's care records showed where this consistent approach had been applied it had been effective in reducing the person's behaviour and avoiding the need for PRN medicines.

● Falls risk assessments had been undertaken and measures were in place to mitigate identified risks. This included how people moved and any equipment they needed to do this safely. Bed rails and pressure mats were in place for people who were at risk of falling, and people had falls prevention care plans. We observed people being supported to transfer using equipment such as hoists. Staff were competent with using the equipment and supported people to transfer in a safe and dignified way.

● People could not be assured of receiving safe epilepsy support. Risks to people with epilepsy were not being monitored, assessed or managed safely. For example, where individual care plans identified the need for people with epilepsy to be monitored at night through regular checks, these were not being undertaken. We spoke with the manager about this. Subsequent to the inspection the manager arranged for a medical practitioner to review people's epilepsy support needs and medicines. Individual epilepsy medicine protocols and risk assessments were updated in line with GP advice. Equipment and operating protocols were put in place to alert staff to a person experiencing a seizure during the night and ensure administration of emergency rescue medicines in a timely way. This remains an area of practice that needs to improve to ensure these positive changes become embedded and sustained in staff practice .

We recommend the provider consider best practice guidance for supporting people with epilepsy and update their practice accordingly.

● Other risks to people were assessed, and measures were taken to mitigate these. For example, we observed people received their fluids and meals at the correct consistency to mitigate their risk of choking. A person living with diabetes told us they received appropriate support and felt staff had a good understanding of their needs. Their diabetes care plan was detailed and provided clear guidance for staff in

how to respond to complications and when to seek support form external health care professionals.
● Staff understood how to support people to take positive risks. For example, staff told us how important it was for one person with dementia to maintain their independence by walking with purpose around the service. We observed his person was provided with discreet supervision to ensure their safety was maintained whilst enabling them to move around the service freely.
● Regular health safety and maintenance checks were completed to ensure equipment and the premises were safe to use.

Using medicines safely
● At the last inspection on the 17 and 18 February 2020 there were some inconsistencies in the way people received their medicines. This was in relation to PRN medicines and medicines that were administered covertly. At this inspection we found the provider had taken measures to improve practice in these areas.
● Covert administration is when medicines are administered in a disguised format. Covert administration is only likely to be necessary or appropriate where a person actively refuses their medicine, that person is judged not to have the capacity [determined by the Mental Capacity Act 2005] to understand the consequences of their refusal, and the medicine is deemed essential to the person's health and wellbeing.
● Where people received their medicines covertly, processes were in place to ensure this was in line with the principles of the Mental Capacity Act (MCA) and were the least restrictive option for the person. For example, we saw evidence of an MCA assessment and multidisciplinary best interests meeting for a person who sometimes required their medicines to be administered covertly. The MCA assessments demonstrated the person did not have the capacity to understand the consequences to their health and well-being if they did not take their medicines. The agreed best interests decision provided step by step guidance for staff and ensured medicine was only administered in a disguised format after all other less restrictive options had been tried first.
● PRN protocols were in place and provided information and guidance to ensure PRN medicines were administered appropriately. We looked at people's Medicine Administration Records (MAR), care plans and PRN protocols and information was consistent across these. This ensured people received their PRN medicines as intended by the prescriber.
● Processes in place to mitigate the risk of errors and omissions had failed to identify MAR's were not always completed in line with requirements. For example, we identified gaps in people's MAR's that were unexplained and a discrepancy in a medicine count that had not been explored. Processes had failed to identify if these were due to a recording error or medicine administration error. We spoke to the manager about this and they told us they would take immediate action to address the concerns we had raised. People's care records did not evidence any negative impact to people where the gaps in the MARs had occurred.
● We observed medicines being administered safely and in line with best practice guidance. Medicines were administered by nurses who received refresher training in administration of medicines and who were knowledgeable about people's medicine needs. People were administered medicines in a personalised and compassionate way. For example, we observed people being asked in a discreet manner if they needed PRN medicines such as those for pain relief.
● Anticipatory medicines were in place for people reaching end of life. These were reviewed by a GP on a regular basis. Medicines were kept in a locked cupboard room and temperatures were recorded daily to ensure the correct temperature for storage of medicines was maintained.

Learning lessons when things go wrong
● The provider did not always ensure shared learning across the organisation. For example, where we had found concerns about managing people's epilepsy in some of the providers other services, the actions and learning outcomes arising from these had not been implemented at Longfield Manor. The failure to ensure

lessons were learnt across the provider's services had led to a failure to ensure people received safe epilepsy support at Longfield Manor. We have explored this in more detail in the Well-Led domain in relation to the provider's systems for continuous learning and improvements to care.

● Action was taken following accidents or incidents to help keep people safe. The registered manager monitored all accidents and incidents. This ensured robust and prompt action was taken and lessons were learnt.

● Staff told us incidents and accidents were discussed with them. Staff were encouraged to provide feedback on the circumstances that may have led to the incident and how a further occurrence could be avoided.

● Relatives told us they were kept informed of accidents and incidents affecting their relative. Learning outcomes from these, and measures taken to mitigate any further risk, were discussed and shared with people and their relatives.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes protected people from the risk of abuse. Staff understood how to report any concerns they may have to relevant professionals and worked in line with the local authority safeguarding policy and procedures.

● Staff were clear about their responsibilities in relation to safeguarding and were confident that they would be listened to if they raised a concern. Safeguarding training was completed by new staff during induction and there was a system to ensure staff undertook refresher training. Staff knowledge of safeguarding reflected up to date information and guidance.

● People and their relatives told us that they felt safe. People told us they were treated with kindness by caring staff. One person said, "I feel safe here and they are so kind" and another said, "I feel safer here than living at home." Feedback from relatives included, "We are truly happy that they care, and we know he is safe", and "absolutely safe," adding since moving to Longfield Manor their loved one felt much safer than they had when living at home.

Staffing and recruitment

● People were protected by safe recruitment processes. New staff were appointed following pre-employment checks which ensured they were of good character to work with people who had care and support needs. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references. Checks were made to ensure nurses were registered with the Nursing and Midwifery Council (NMC) and were fit to practice.

● New staff followed an induction process and all staff completed training that included health and safety awareness and fire safety. We observed new staff undertaking induction training and a shadow shift during the inspection. A shadow shift is when a new member of staff works alongside an experienced member of staff. New staff told us they felt supported by the provider and were being equipped with training, information and opportunities to enable them to undertake their new role.

● There were enough staff on duty. People received care and support in a timely way, and we saw staff taking the time to sit and talk to people. Call bells were answered promptly and people we spoke to confirmed this was usual. The rota reflected the staff that were on duty.

Preventing and controlling infection

● We undertook an audit of the providers infection control processes and observed staff practice.

● The provider had not given enough thought to arranging the environment to support social distancing. We have signposted the provider to look at the way they managed and used their environment to minimise the risk of infection transmission.

● We were assured that the provider was preventing visitors from catching and spreading infections.

- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection on the 17 and 18 February 2020 we found a continued breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 as the provider had not ensured that systems and processes to monitor quality and compliance operated effectively.

At this inspection although some improvements had been made in relation to falls prevention and behaviour support, the provider had not made enough improvement and there was still a breach of Regulation 17.

Continuous learning and improving care

● At the last inspection there was a failure to ensure processes to monitor quality and compliance operated effectively. Following the inspection, the provider sent us an action plan to inform us of the actions they were going to take and by when. At this inspection the provider had not undertaken all of the actions they told us about. This included undertaking a full review of people's care plans and involving people and their representatives in this process.

● There remained a failure to implement an effective and systematic approach to regular care plan auditing. Quality monitoring processes had failed to identify concerns found during our inspection regarding people's epilepsy management in spite of this being a theme of concern at other locations operated by the provider. There was not a robust process for reviewing epilepsy care plans. Current processes had failed to identify people were not receiving safe care and support in line with the requirements of their care plan.

● Audit processes had failed to identify some of the concerns found at inspection including those designed to identify and explore medicine discrepancies. Quality checks, including the weekly medicine audit and nurses daily check list had failed to identify and explore the discrepancies we found on people's MAR's. These discrepancies were not reflected in the provider's monthly audit and there was no corresponding incident forms. We spoke to the manager about this and they were not aware of the discrepancies we had found. This is a demonstration of how the provider's own processes were not always effective in ensuring clinical and management oversight and driving service improvement.

There remained a lack of consistency with respect to some quality monitoring. This meant that systems and processes to monitor quality and compliance did not always operate effectively. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

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

regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Since the last inspection there had been a change of manager. The previous registered manager remained within the company and provided clinical support to the service from an operational level. A new manager commenced in September 2020 and was in the process of applying to CQC to be the registered manager for the service.

● There was a clear staffing structure with identified management and clinical roles. Staff demonstrated an understanding of their roles and responsibilities and told us they had confidence in the new manager.

● Staff performance was observed to check policies and procedures were being followed. Staff had one to one supervision and performance reviews providing the opportunity to discuss operational matters as well as their own well-being and learning and development needs.

● The manager understood their responsibility to notify us of significant events, as they are required to by law. Notifications had been sent to us in a timely manager and were completed in line with requirements. The manager understood their responsibility to notify local authority safeguarding of concerns. Records showed that this had happened appropriately and in line with safeguarding guidance.

● The manager understood their responsibility to be open in the event of anything going wrong. They reviewed any feedback and incidents, so any learning would be taken from them and the service would continue to develop. Outcomes were shared with people and staff to ensure lessons were learnt.

● Staff told us the manager promoted transparency and honesty and they always felt able to speak to any of the management team. Staff knew how to whistle-blow and knew how to raise concerns with the local authority and Care Quality Commission.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The service had a positive and welcoming atmosphere. The service was led by an open and transparent manager who actively supported the care staff in their roles. Staff told us the manager was approachable and they felt very supported. Throughout the inspection we observed positive communication and supportive interaction between the whole team.

● Staff understood the vision and values of the service. They described working in a person-centred way and putting people's needs and wishes first. People spoke highly of the service they received, their comments included, " They look after me very well, they are friendly bunch," and "The staff seem to know what they are doing and it's good to have nurses to hand."

● The culture of the service focused on providing person centred care and support to people. Staff demonstrated passion and a commitment to providing people with compassionate care and improving the quality of their lives. We observed some very responsive and compassionate support to people who were living with dementia. People were treated with respect and dignity and time had been taken to ensure the environment was conducive to people's needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's views were sought about the care they received. Feedback was sought from people's relatives, friends, professionals and staff. We observed a residents' meeting where people were discussing how they could enjoy Christmas celebrations within the restrictions of Covid19. The idea of having a pantomime shown on a big screen and creating a theatre experience was popular and was being actively pursued by the care team in order to make this happen. A socially distanced carol concert was also being arranged in the courtyard.

● People, relatives and staff were encouraged to make suggestions for improving the care offered and told us they were listened to. For example, the chef had been working with people to incorporate their ideas in to

planning a new menu. People's feedback on how to improve their mealtime experience had also been acted upon and new tableware, flowers and menu boards had been implemented to create the feeling of being in a restaurant.

Working in partnership with others

● The service worked in partnership with other agencies. These included healthcare services as well as local community resources such as the local hospice, medical centre, rotary club and community groups.

● Records showed staff had contacted a range of health care professionals. This enabled people's health needs to be assessed so they received the appropriate support to meet their continued needs.

● Staff told us prior to the restrictions of Covid19 they had supported people to make local community connections and accessed local resources. During the pandemic the local community had provided gifts and messages of support and praise to people and staff. Staff told us they had really appreciated this. Children from the local school had sent paintings and cards which we were told had really boosted people's morale and cheered people up.