Longwood Care Home Limited

Longwood Grange

Inspection report

Longwood Gate
Huddersfield
West Yorkshire
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Tel: 01484647276

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22 December 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Longwood Grange on 21 and 22 December 2016. The first day of the inspection was unannounced, which meant the service did not know we were coming.

Longwood Grange was last inspected in November 2015. At that time it was rated as 'requires improvement' in all aspects except Caring, which it was rated as 'good.'

At the time of this inspection, 30 people were living at the home; one of these people was there for respite care.

The home did not have a registered manager. The last registered manager left in June 2016. A new home manager had started work at the home two days before this inspection. Their intention was to apply to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found some aspects of the recruitment process for new staff could not be evidenced by the home.

Risk assessments and care plans did not always contain the level of detail staff needed to support people to move safely. This was also found at our last inspection in November 2015.

We found personal emergency evacuation plans or PEEPs did not contain the level of detail required for staff to support people to evacuate in an emergency. This was identified at our last inspection in November 2015. There had been no fire drills at the home in 2016 and less than half the staff had up to date fire safety training.

Care workers had not always received the training, supervision and appraisal they needed to support people effectively. Issues with access to supervision were noted at our last inspection in November 2015.

People who needed to be deprived of their liberty to keep them safe had the correct authorisations in place. Most mental capacity assessments and best interest decision documentation we saw was not correct. Some people's care files showed family members had made decisions on their behalf when there was no evidence they had the appropriate powers of attorney.

People told us they enjoyed the food and drinks served in the home. We observed people had access to drinks and snacks, and were provided with choices. Records showed one person was not supported according to a dietician's advice. People's food and fluid intake records were not sufficiently detailed to make them useful.

The home could not evidence it had fully investigated and responded to a formal complaint received from a person's relative in 2016.

By comparing accidents and incidents at the home with notifications made to CQC, we found three instances of physical abuse or threats of physical abuse involving people at the home had not been reported as is required.

A lack of consistent management and leadership at the home in 2016 meant there had been issues with record-keeping, staff access to supervision and the quality of audit.

At the time of this inspection ratings from the last inspection in November 2015 were prominently displayed in the home, but not on the home's website, as is required by the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015. We notified the registered provider who told us it had been an oversight when the website had been updated. We saw the ratings were reinstated on the website immediately.

Oral medicines, including controlled drugs, were administered and managed safely. Records for the administration of topical creams and lotions kept in people's rooms were incomplete.

Accidents and incidents had been investigated, although we identified gaps in documentation and times when interim managers had lacked oversight of incident records.

People and their relatives told us there were enough staff to support people safely and our observations supported this. Some care workers thought there should be more staff in the afternoons and evenings.

People's care plans were detailed and person-centred, but they were not always updated when changes in people's circumstances occurred. Daily records could not always evidence people were supported according to their care plans.

People, their relatives and staff had been given opportunities to feedback about the home, although general meetings with management had not been held on a regular basis. Senior staff representing each aspect of the home met briefly most days to share information.

People told us they felt safe. Care workers could describe the different forms of abuse and said they would report any concerns appropriately.

Checks had been made to ensure the building, its utilities and facilities were safe. Comprehensive records to evidence the checks could not be located during the inspection, but were provided shortly afterwards.

People and their relatives thought the home was clean and tidy. We found the home to be clean and odour-free.

People told us they had access to healthcare professionals, such as GPs and community nurses, and their relatives agreed. Care files we saw supported this.

People told us staff at the home were caring and respected their dignity and privacy. We saw staff knew the people well as individuals. The home had a happy and vibrant atmosphere.

People were asked for consent by staff before support was provided. People could decide when to get up,

where to spend their day and when they wanted to shower or bathe. People who struggled to make decisions had access to advocacy services.

People and their relatives were involved in planning people's care and support.

The home worked with GPs and community nurses to provide end of life care to people whose needs could be met in a residential care setting. The new home manager planned to request specialist end of life care training for care workers in 2017.

People told us they were happy with the amount and type of activities on offer at the home. We observed people enjoying activities during the inspection and records showed people regularly took part in activities.

Care staff told us they enjoyed working at the home and supporting the people who lived there.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014 and Care Quality Commission (Registration) Regulations 2009. You can see what action we have 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.

Issues with risk management identified at our last inspection in November 2015 relating to fire safety and moving and handling had not been addressed.

Recruitment records could not evidence the required checks had been made on new staff members prior to their starting at the home.

Oral medicines were managed and administered safely. Topical creams were not consistently recorded as applied by care workers.

People told us they felt safe and there were sufficient staff deployed to meet their needs. Care workers could recognise the signs of abuse and knew how to report concerns appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

We found issues with staff training and their access to regular supervision and appraisal.

The home was depriving people of their liberty legally. Most assessments of people's mental capacity and best interest decisions made for them were not in line with the Mental Capacity Act 2005.

People enjoyed the food at the home and we saw they were offered choices. One person was not supported to meet their nutritional needs. We found issues with the follow up of a referral to speech and language therapy.

People told us and records showed they were supported to access other health professionals in order to maintain their general health.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff at Longwood Grange were kind and caring. We saw interactions between staff and people were warm and supportive. There was a happy and welcoming atmosphere in the home.

People were supported to maintain their dignity and independence by staff. They could request to have a bath or shower when they wanted one. People told us, and we observed, staff respected their privacy.

People had access to advocacy services if they needed them. Care workers understood the importance of end of life care and the new home manager planned to arrange specialist training in this area.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were detailed and person-centred, but were not always updated when people's needs changed. Daily records could not always show people were supported according to their care plans.

People were happy with the choice of activities on offer at the home and said they had enough to do.

Records could not evidence a written complaint received in 2016 had been investigated or responded to according to the registered provider's policy and procedures.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Inconsistent management and leadership at the home in 2016 had resulted in issues with record-keeping, care plans and staff access to supervision and appraisal. A new home manager had started one day prior to this inspection.

People and their relatives had been given opportunities to feedback about the home, but residents' and relatives' meetings had not been held regularly in 2016.

Three statutory notifications had not been made as is required by the regulations.

Longwood Grange

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 22 December 2016. The first day was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience on the first day of inspection and one adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had been a user of healthcare services for many years and had supported adult social care inspectors on numerous other inspections.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team and the Clinical Commissioning Group. They did not share any concerns with us. After the inspection we also contacted one other healthcare professional involved with people using the service. They said they felt the home had improved over the last two months and were hopeful it would continue to do so.

During the inspection we spoke with 11 people who used the service, six of their relatives, five care workers, the new home manager, the deputy manager, the housekeeper and kitchen manager. We also spoke with the registered manager of a nearby home run by the same provider who had been helping to oversee Longwood Grange in the absence of a home manager, and a peripatetic nurse who was completing a week-long audit on behalf of the provider.

As part of the inspection we looked at four people's care files in detail and selected sections of four other people's care files. This included their risk assessments and care plans. We also inspected five care workers'

recruitment and supervision documents, the home's staff training records, seven people's medicines administration records, accident and incident forms, and various policies and procedures related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Longwood Grange. One person said, "I feel safe and looked after", and a second told us, "I'm not worried about anything."

As part of the inspection we reviewed the recruitment records of five staff who worked at the home. Of the five recruitment files we inspected, two did not contain appropriate references and two did not contain a full employment history, as is required by the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. We initially experienced problems obtaining complete records as they could not be located, for example, one employee's file did not contain information about their Disclosure and Barring Service check (DBS) or proof of their right to work in the UK. These were supplied by the end of the inspection. The DBS helps employers to make safer recruitment decisions. We spoke with the new home manager about these issues. They said they were committed to making improvements and would start by adding a checklist to each recruitment file of all the required tasks and documents needed to establish a prospective employee was suitable.

Issues with safe recruitment were a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected building, utilities and equipment maintenance records to see if regular safety checks were made. We found the servicing of equipment such as fire extinguishers, hoists and the lift were up to date, and the safety checks of the gas and electrical supply were up to date, however there were problems initially with finding this information. Evidence of checks on the call buzzer system, emergency lighting, wheelchairs, water temperatures and the flushing of the water system could not be located at the time of our inspection, but were provided shortly afterwards.

The deputy manager explained there had not been a maintenance person employed at the home in recent months which meant no fire drills had taken place at the home in 2016. The training matrix for the home showed less than half of the staff had completed fire safety training and all three of the care workers we asked said they had not been trained to use the evacuation chair situated at the top of the stairs. In addition, less than a third of staff had completed health and safety training.

People's files included documents called personal emergency evacuation plans or PEEPs. However, these did not contain adequate information for emergency services to use in order to support individuals to leave the building in an emergency. This was a finding at our last inspection in November 2015. We discussed these issues with the new home manager. They said they would update fire procedures and training as a priority. We noted on the second day of inspection a fire alarm test was conducted by a newly recruited maintenance person.

Issues with fire safety procedures and training were a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2015 we did not find any specific risk assessments for the use of equipment such bath hoists or shower chairs. Care plans for moving and handling also lacked detail about methods staff should use and did not specify the exact equipment to be used. This is needed to ensure staff can support people safely. At this inspection we found these issues persisted. One moving and handling risk assessment we saw was detailed, explaining what hoisting equipment was needed and how it should be used, whereas other risk assessments and care plans simply listed the required equipment. We did not find any risk assessments or care plans which detailed how bath hoists or shower chairs should be used.

One person's care plan noted that sometimes they could stand with assistance and sometimes they needed the hoist, but gave no information on how care workers should assess the level of assistance required. When we spoke with care workers about this person, they could all describe when the person should be hoisted. We observed moving and handling practice around the home for two days and had no concerns about the competence of the care workers to support people safely. However, at times risk assessments and care plans are used by staff unfamiliar with people, for example agency workers, so they must contain sufficient detail about people's needs. We discussed our concerns with the new home manager. They said an audit of care files was underway and this issue would be addressed as a priority.

Ongoing issues with the content of risk assessments, and the care plans in place to manage those risks were a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified a breach of regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014, as three people were receiving medicines covertly without the correct procedures being followed. The people needed to have their medicines crushed and hidden in their food because they were living with dementia and would often refuse to take medicines they needed to stay well. At this inspection we found one person was receiving medicines covertly and all the correct mental capacity assessments and best interest decision documentation was in place. The involvement of relevant healthcare professionals was also recorded. This meant the decision to provide medicines covertly had been made correctly.

People told us they received their medicines on time. As part of this inspection we observed a medicines round and checked medicine records and medicine storage facilities. We saw medicines were administered to people in a caring and supportive way; each person was provided with an explanation of what medicines they were being given and not rushed to take them. Most medicines were received from pharmacy in blister packs, which list the date and time they should be taken. Others came in boxes or bottles. We saw the care worker checked the medicines each person needed against their medicines administration record (MAR) and only signed the MAR when the person had taken their medicines. We saw one person refused to take one of their tablets. The care worker could explain the procedure for recording the refusal of medicines and the safe disposal of the tablet. We checked seven people's MARs and found they were completed properly.

We reviewed the home's procedure for recording and administering controlled drugs, such as morphine, and found this was also done correctly. Boxed medicines we counted tallied against records kept by care workers. Medicines were stored secured and at the correct temperature. The care worker who was the medicines lead at the home explained the system for ordering and returning drugs to pharmacy, and we saw excess stock was returned when this was identified. This meant oral medicines and controlled drugs were administered and managed safely by the home.

We identified issues with the way the application of topical medicines was recorded at Longwood Grange. Some creams on MARs did not have directions on how and where to apply them. For example, instructions

such as 'apply as needed' or 'as directed' were recorded. This meant care workers did not have sufficient instructions to apply the topical medicines and may not have done so safely. We discussed this issue with the new home manager; they said they would contact people's GPs to make sure their topical creams were prescribed with full instructions for staff.

People's MARs listed the topical creams they were prescribed and we saw the care worker administering medicines apply certain topical medicines, such as eye drops and painkilling gel. However, some creams, such as prescribed barrier creams and moisturisers, were kept in people's rooms where they were applied by care workers when they supported people with personal care. We saw cream charts and body maps in people's daily records were not always completed. For example, records for one person with continence problems prescribed a barrier cream to be applied 'as directed' showed it had not been documented as applied for over five weeks prior to this inspection. Care workers we spoke with told us they applied the creams in people's rooms, indicating the issue was with recording rather than administration. This meant records at the home could not evidence people were receiving some topical medicines as prescribed. We raised this with the new home manager who said they would implement staff training around record-keeping as a priority. After the inspection the registered provider evidenced efforts made in the months prior to this inspection to ensure care workers recorded the topical medicines they applied for people. However, cream charts we saw showed records were not being kept at the time of this inspection.

We reviewed records of incidents and accidents that had occurred at the home over the four months prior to our inspection. The filing system was not well structured and we found it difficult to locate all the information. We also noted there had been issues with oversight of records by interim managers at the home. For example, none of the incidents logged for November 2016 and only half of the incidents logged for October 2016 had been reviewed and signed off by a manager. Incidents and accidents appeared to have been investigated correctly, although some records were incomplete. For example, two incidents in December 2016 where one person had displayed challenging behaviours towards another person did not include the names of both parties involved. This meant it was not possible to see if there was a pattern to these events. We did note one example where positive action had been taken to support a person who had regularly displayed behaviours that challenged others. Changes had been made to the person's pain control and no issues had occurred since.

People and their relatives told us they thought there were enough staff at Longwood Grange to meet people's needs. One person said, "There are always enough for what I need", and a second told us, "Yes, there are enough. There are no long waits." Relatives told us, "There seem to be enough every time I've been", "As far as I'm concerned there are enough staff", and, "There is a quick response to the bell."

Care workers' feedback about staffing levels was mixed. One care worker felt there were enough staff but they struggled when care workers rang in sick. Most care workers commented that afternoons and evenings were an issue as there was one member of staff less than in the mornings. They felt it was a particular issue in the winter months as a lot of people liked to get washed and changed ready for bed earlier so it resulted in people waiting. One care worker who said they would like more staff in the afternoons told us, "We could spend more time with them (the people). Some are lonely and they want to talk to people." Another care worker told us they had raised an issue of low staffing for the evening meal, in that one care worker was serving food leaving two care workers to support people. In response management had provided catering support until 6pm which freed all care workers to support people directly. The care worker told us, "Now it's so much better. The cook does the teas and we can support people. They listened to us."

We asked the new home manager if they thought there were enough care workers to meet people's needs. They told us, "Yes, from what I've seen. I think they could be better organised." They explained the rota

system and dependency tool used to us, and described changing the role of the deputy manager so in future they will do 24 hours a week supporting people directly, thus adding to staff numbers. Our observations during the morning, afternoon and early evening over two days plus feedback from people and their relatives showed there were sufficient care workers to meet people's needs.

Care workers we spoke with could describe the forms of abuse people living at the home might be vulnerable to. They told us they would report any concerns appropriately. Training records showed all staff had received safeguarding training. This meant staff at the home knew how to identify potential abuse and how to report concerns.

People and their relatives told us they thought the home was clean and tidy. One person said of the home, "It's spotless", and a relative added, "It's really clean." We looked in bathrooms, toilets, communal areas, in people's bedrooms (with their permission) and at the equipment used to support people, and found no issues with cleanliness or odours.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they thought the care workers were well trained. One person said, "They are well trained – of course they are", a second person told us, "They know how to care for us", and a relative told us, "From what I have seen they are well trained and everything runs smoothly."

Care workers we spoke with described the training courses they had attended; these were mainly online but with some practical and face-to-face. One care worker described their induction process, which had involved shadowing more experienced care workers, reading care plans and completing training. The deputy manager had recently been promoted to their current role. They described their induction and told us, "I'm supernumerary for two months so I can learn."

The home had purchased a laptop computer for care workers to use to complete online training courses whilst they were at work. Records showed the home used a training company which provided care workers new to care with the training they needed to complete the Care Certificate. Records showed staff who administered medicines had been assessed for their competency to do this; we observed the peripatetic nurse who was auditing the home on behalf of the provider during this inspection checking the medicines administration competence of care workers.

Staff personnel files did not contain comprehensive evidence of the training courses they had attended so we reviewed the home's training matrix. Whilst completion rates for core training courses such as moving and handling and safeguarding were 90% or higher, it was much lower for other essential courses. For example, less than a third of staff had completed food hygiene training, and less than half had done first aid training. We also noted staff had not received training in supporting people's nutrition. We raised the lack of training in some areas with the new home manager. They said they would assess the requirement for training amongst the staff and ensure it was completed as soon as possible.

At the last inspection we noted staff did not receive supervision at least four times a year, as per the registered provider's policy. We checked the personnel records of five staff members and reviewed the supervision and appraisal matrix at the home. Care workers told us they had not had regular supervision and had either never had an annual appraisal or could not recall when their last one was. One care worker said the lack of supervision was due to all the changes in management that had occurred at the home since the last registered manager left in June 2016. Another said they had had negative experiences with supervision at the home in 2016 but things had much improved in the last two months and they now felt supported by management. They told us, "The staff are happy now, a lot happier. A lot were looking for other jobs but now they've stopped."

We noted there was a six month period in 2016 when only one care worker had received supervision, but this had increased since August 2016. The supervision and appraisal matrix showed three of the 19 care workers had received four supervisions in 2016; most others had received either two or three. Only one care worker had not received supervision in 2016. The appraisal matrix showed less than a third of the care staff had received an annual appraisal in 2016. We noted supervision of the care workers was done by either the

deputy manager or senior care workers, although none of them had received training at the home about how to provide supervision and training to others. We discussed supervision and appraisal with the new home manager. They highlighted all staff now had supervision and/or appraisal booked in and committed to reviewing the competence of supervisors/appraiser to undertake this role.

Gaps in staff training and continued issues with access to supervision were a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We reviewed the care files of five people living with dementia, to see if the home had complied with MCA and DoLS procedures. We found the home was compliant with DoLS. Records for MCA were not consistent and, in places, were incomplete. For example, two people had mental capacity assessments for their ability to make 'informed decisions.' We saw there was no information on what this meant and no best interest decisions had been made to ensure both people were supported in the least restrictive way. Mental capacity assessments and best interest decisions must be made on a decision-specific basis. One of these people had another mental capacity assessment for care and treatment, which included support with continence needs, maintaining their skin integrity and mobility. There was no best interest decision to show how care and treatment would be provided in the least restrictive way. The person's care file did contain a best interest decision for the use of bedrails and referenced their care and treatment mental capacity assessment, although we noted the use of bedrails had not been included in this assessment. Another person living with a diagnosis of dementia had no mental capacity assessment or best interest decision for support with care and treatment.

In the nine files we reviewed we found only one document which proved family members had been granted Lasting Power of Attorney (LPA) by a court to make financial and/or care-related decisions for their relative at Longwood Grange. In one person's care file it was recorded two family members had LPA for finances for the person, but a different relative had signed the person's consent for bedrails. A second person's care file did not record if any relatives had LPA for them, but we noted their resident bedroom access consent form had been signed by a relative. A third person's care plan approval form had been signed by a relative. Relatives can be consulted during best interest decision-making for family members if a person lacks capacity, but they cannot be the sole decision-maker unless they have the correct LPA.

We found care workers' knowledge of MCA and DoLS was appropriate for their roles. All could describe how they supported people to make decisions by providing choices and all knew the process for making decisions on a person's behalf if they lacked capacity. During our inspection we observed people were supported to be as independent as possible by staff, who provided them with options and choices. We raised the issue of poor quality and inconsistent MCA documentation with the new home manager. They said they would review all care files to make sure evidence of relatives' LPA was obtained and all decisions made in future were compliant with the MCA.

The home was not compliant with the Mental Capacity Act 2005. This was a breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people and their relatives about the food and drinks provided at the home was positive. Comments included, "Beautiful suppers. The food's not bad with good enough choices", "Very, very good. Excellent. Like a three star hotel", and, "Not bad. Hot and a good choice." We observed three mealtimes and our expert by experience had lunch with people at the home. The dining room was clean and well decorated; tables had tablecloths and vases of flowers. People were offered a choice of hot and cold drinks and had access to condiments. Choices provided for the breakfast meal included cooked options as well as toast and cereal. People were asked for their lunchtime meal preference mid-morning by kitchen staff, and had the choice of two main course and two pudding options. Our expert by experience noted their food was hot, an adequate portion with meat that was well-cooked and tender. They heard one person eating the same meal say it was, "Good and tasty."

Care and kitchen staff knew which people had special diets and how their food should be prepared. The kitchen manager explained how foods were fortified for people at risk of weight-loss and the various options provided to people with diabetes. Care staff could explain how people's weight was monitored and when referrals should be made to other healthcare professionals. Records showed GPs, dieticians and speech and language therapists had been involved in the care of some people at the home.

However, we did identify issues with documentation and referral follow up relating to people's nutritional needs. For example, one person was referred to speech and language therapy (SALT) in September 2016 and records show this was chased in November 2016. However, at the time of our inspection in December 2016, it was not clear if the person had been reviewed by SALT. People who had lost weight or who were at risk of weight loss had food and fluid charts which were to be completed after each meal, snack or drink. We reviewed the food and fluid charts of the person awaiting SALT review and found they were not completed such that the information was meaningful, as the amount consumed was not recorded or was poorly recorded. This meant the person's daily dietary records could not be used to evaluate changes in their weight.

A second person known to choke when eating and drinking had not had their choking risk assessment updated or been weighed since September 2016. The person's care file described how the person had been advised by SALT to consume food and fluids modified to make them safer to swallow but had decided not to. Care workers told us they observed the person to make sure they were safe when they ate and drank and the person confirmed this, however, this requirement was not recorded in the person's care plan. This meant the person's risk of choking and weight-loss had not been regularly assessed and gaps in their care plan could mean they may not be supported safely by staff unfamiliar with their needs.

Records for a third person at risk of weight-loss and with swallowing issues were confusing. A SALT assessment in October 2016 recommended a pureed diet and normal consistency fluids for the person. Their care plan, dated September 2016, still stated they took a soft diet with thickened fluids. A dietary information sheet in the person's care file had 'soft, liquidised, thickened' diet highlighted, but not which one. The kitchen manager had this same information sheet but knew the person needed a pureed diet. In October 2016 a dietician had recommended the person be offered fortified milky drinks and two nutritious snacks each day. The care plan had yet to be updated and food and fluid charts showed this was not happening. This person's admission assessment and continence care plan stated they should be served decaffeinated drinks; it was also written on their fluid charts in bold red type. At the time of this inspection there were no decaffeinated hot drinks options at the home and the person's fluid charts showed they were regularly served tea and coffee. We pointed this out to a care worker, they told us, "I haven't seen that." The

amount of foods consumed by the person was also not recorded on their food charts. This meant the person was not being supported to meet their nutritional needs.

These issues had also been noted by a visiting healthcare professional, who told us, "I kind of think the staff need a bit more education, and checks to make sure they're doing what needs to be done." We discussed our concerns with the new home manager. They told us people's care files would be reviewed as a priority to ensure their care plans were up to date so that care workers were aware what support people needed.

People's nutritional risks were not always managed adequately by the home. This was a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they had access to other healthcare professionals and they said they did. One person said, "They have arranged several calls for the GP", and a second told us, "It's quick and easy to see doctors or others." Relatives agreed, telling us, "They sorted the GP out very quickly and the nurse comes every other day", and, "They call in the GP when he is needed and [my relative] sees the optician and chiropodist." We observed GPs and community nurses were in and out of the home during our inspection.

People's records evidenced the involvement of a wider healthcare team. The senior staff team had a brief meeting each morning at which the day's appointments and healthcare visits were discussed. We also sat in on the handover meeting between the night staff and day staff and heard how updates on people's health and wellbeing were provided. This meant people had access to healthcare professionals to help maintain their general health.

Some of the people at Longwood Grange were living with a diagnosis of dementia. We noted doors had pictorial signage and most people's rooms had memory boxes outside, containing various objects or mementos special to them. Upstairs, bedroom doors had been painted different colours and all toilet doors were yellow, to help people find them. Doors to rooms not accessible to people living at the home had been painted the same colour as walls to make them less obvious to people living with a diagnosis of dementia. This meant the home had taken steps to make the environment dementia-friendly. One issue we did come across was the upstairs layout of the home as there was a confusing array of corridors without any signage. The new home manager said they would ensure additional signage was provided to help people navigate upstairs.

Good

Is the service caring?

Our findings

People and their relatives told us the staff at Longwood Grange were kind and caring. Comments included, "Very kind, caring girls. I'm amazed at their patience. They go over and above", "Very kind and have a laugh", "Very caring, all are welcoming", and, "Very nice and pleasant. Kind and caring."

We observed how care workers and other staff at the home interacted with people and their relatives during our inspection. We saw care workers spoke to people with warm, yet professional, familiarity and it was clear all staff knew people well as individuals. Care workers and other home staff could describe people's likes, dislikes and preferences, as well as their personalities and personal histories. People's care files contained personal histories in 'This is me' documents, which contained information about their upbringing, careers and families. We saw some of this information, for example, people's food preferences, had been incorporated into their care plans.

It was approaching Christmas during our inspection and we noted there was a constant stream of people's relatives and visitors in and out of the home, although people and staff said it was always like that. Relatives described how they were always made to feel welcome and we noted there was a vibrant and bustling atmosphere at the home. People we spoke with described the atmosphere as, "Pleasant and friendly", and, "Marvellous." The building was decorated for Christmas and one afternoon we observed the kitchen manager offering people a choice of chocolates or mince pies. When a person asked why, the kitchen manager responded, "On the run up to Christmas I squeeze lots of chocolates onto the shopping list!" This showed staff at the home liked to treat the people who lived there.

People told us care staff supported them to maintain their dignity and also respected their privacy. We observed people were dressed appropriately for the time of year in clean clothing. One person said, "They definitely show respect and look after my dignity. I can't fault them", and a second person told us, "They always knock on the door and say who they are." During the inspection we saw care workers always knocked on people's bedroom doors before entering, this included an occasion when we were with a person in their room without the care worker's knowledge. This meant staff at the home respected people's privacy and dignity.

People described how care workers supported them to remain independent and asked for consent before providing support. One person said, "You can make your own choices up front", and a second commented, "You can do what you want." Relatives described how their family members living at the home were supported to be independent. One relative said, "They encourage [my relative] to wash [themselves]", and a second said, "They support [them] to do what [they] can." During the inspection we noted some people remained in their rooms and had their doors open. We checked their care files and found their preferences for the door open or shut was documented. People also told us, "I want to stay in my bed. They ask me but if I don't want to get up I don't", "I want my door open", and, "Staying in my room is my choice." This meant people make choices and how and where to spend their time.

We asked people if they could have a bath or shower whenever they wanted one. They told us they could.

Comments included, "You can have them (baths or showers) when you want", and, "I'll say 'I'll have a shower this morning' and they help me."

People told us they and their families had been involved in designing and reviewing their care plans. One person said, "I have a care plan. [My relative] is involved in it", a second person told us, "They do talk to me about my needs. I know I have a care plan but I haven't seen it recently. I would just talk to the office if I wanted something changed", and a third person said, "I have one (a care plan). It is in the office but nothing has changed so it hasn't." Relatives we spoke with all said they had been involved in planning their family member's care; one relative said, "The care plan is in the office and we have annual reviews." The care files of people who retained mental capacity contained evidence they had been consulted and had consented to their care plans. However, this was less clear in the files of people living with a diagnosis of dementia, although we could see family members or people's appointees had been involved. The new home manager said they planned to review how people's participation in care planning was documented.

Care files showed people who lacked capacity had received the support of advocates when bigger or more complex decisions needed to be made. Care workers could describe when people might need an advocate and how to refer them. Information about advocacy services was available at the home. This meant people could access independent advice and support to make decisions if they needed it.

We asked the new home manager and deputy manager how they promoted equality and diversity at the home. They said no one currently residing at the home had specific needs relating to their culture or sexuality that they were aware of, although both could provide examples of when they had supported people previously. We noted equality and diversity training had already been planned for all staff in January 2017 and the new home manager said they wanted to the home to be welcoming and inclusive to all.

'Do not administer cardiopulmonary resuscitation' or DNACPR forms were clearly displayed in the care files of people who had them. Relatives told us they had been asked for this information by the home and to provide details of their family members' preferred funeral arrangements. The home did not often provide end of life care and there was no one receiving end of life care at the time of this inspection. The new home manager said end of life care was possible if a person's needs could be met adequately by the care staff. We noted a GP had prescribed medicines for one person thought to be approaching the end of their life; these were stored at the home ready to be administered by community nurses when they became necessary. One care worker said, "End of life care is a lot more attentive. We check every half an hour and make sure they're comfortable. They need a lot of emotional support."

We viewed feedback provided by a relative of a person who received end of life care at the home in 2016 posted on a care home feedback website. It was extremely complimentary, stating staff had, "All looked after [my relative] with love, dignity and respect." The new home manager told us staffing would be increased if a person went onto end of life care so their needs could be met. They also planned to contact the local hospice to request specialist training for staff on how best to support people at the end of life. This meant people had been supported to die at the home if their health needs could be met, and the new home manager had plans to upskill staff in this area of care.

Requires Improvement

Is the service responsive?

Our findings

Care files we reviewed were indexed and had a consistent structure which made them easy to navigate. Each person had been assessed for a range of support needs, including moving and handling, eating and drinking, continence and skin integrity. In most cases assessments included an evaluation of risk to the person and if risks were identified, a care plan had been put in place. Care plans were person-centred. They described the person's existing ability, gave a summary of the support required, and included a more detailed plan of care and a list of outcomes or goals.

We saw people's care plans had been evaluated each month via the home's 'resident of the day' system. This meant on a set day of each month one person's designated key care worker would review and evaluate each of their care plans. Other staff at the home were also involved in the resident of the day review process. A care worker told us, "We have a review log book and the cleaner has to write about their (the person's) room and cook has to write about their diet and nutrition."

We found issues with unsigned and undated documentation; this was noted at our last inspection in November 2015. Whilst risk assessments and care plans had been evaluated they were not always updated when people's circumstances changed. For example, one person had become unable to walk and was mainly nursed in bed. We noted their mobility care plan had been updated with this information but their moving and handling risk assessment still said they could walk with two staff. The same person needed support to turn over in bed to prevent pressure damage. Their care plan dated November 2016 stated the person needed support to reposition every hour, whereas it was recorded on the care plan evaluation a community nurse had extended this to two hours at the start of December 2016. We noted the person's daily records showed they were being supported to turn in bed every two hours by staff and care workers we spoke with all knew the correct repositioning regime for the person. However, care plans need to be updated in case staff unfamiliar with the person are required to support them.

As discussed earlier in this report, we found some issues with how people's care and support was evaluated on a daily basis. This was because food and fluid charts were not completed properly and care workers did not always record when they applied the prescribed topical creams kept in people's rooms. Other daily records we saw, such a repositioning charts and general daily notes, did evidence people were supported according to their care plans, although it was not possible to evidence people had been supported to bathe or shower on a regular basis. During the inspection we observed most people were supported according to their care plans. For example, people were mobilising with support as described in their care plans, those who needed spectacles were seen wearing them, and people had the specialist equipment they required to maintain their skin integrity. This meant the majority of people were supported to meet their needs despite issues with recording and the updating of care plans.

After our last inspection in November 2015 we recommended the home seek guidance on how to provide people with appropriate meaningful activities. During this inspection we asked people if they liked the activities on offer and had enough to do. People said they did, or, if they did not take part in activities it was their choice. People told us, "There are a lot of things put on to entertain us", "There is plenty going on", "We

play games at times and there is enough to do", and, "We have singing, bingo and quizzes." Relatives agreed with this; one told us, "There are plenty of activities." During the inspection we observed people playing dominos, having manicures and watching films on television. People had also formed friendships with others at the home, and we saw people sitting together chatting comfortably.

We found records kept of people's participation in activities could evidence their regular involvement. The new home manager told us the hours worked by the dedicated activities coordinator had been increased and they sought feedback from people about what they'd like to do. At a residents' meeting in August 2016 people said they'd like to make hanging baskets, celebrate bonfire night, have a barbeque, have more quizzes and for the men to have access to manicures. Records showed all of these things had happened or were ongoing. This meant the home had improved people's access to meaningful activities and people were happy with what was on offer.

People we spoke with during this inspection told us they had never made formal complaints about the home but felt confident to do so if required. Two people said they had made minor complaints to staff and both issues had been resolved satisfactorily. Relatives also told us they had never had cause to complain; one told us, "No complaints. If I had I would just go to the manager."

We looked at how the home had managed the written complaints and compliments it received. Since the last inspection we saw one formal complaint had been received in writing from a relative of a person at the home. Records showed the complaint had been acknowledged with a holding response which included an initial apology. However, there was no evidence a thorough investigation had been undertaken and completed, or that the complainant had received a written outcome to their complaint. After the inspection the registered provider was unable to provide any further documentation. We discussed the complaints policy with the new home manager. They could describe the correct procedure for dealing with complaints and said they would ensure any future complaints were dealt with properly.

At the last inspection in November 2015 we noted compliments received by the home in the form of letters and thank you cards were not been date stamped so inspectors were unable to tell how old they were. At this inspection we found one written compliment. It had not been date stamped so we could not tell when it had been received.

Requires Improvement

Is the service well-led?

Our findings

Feedback we received from people and their relatives about the management and running of the home was entirely positive. Comments included, "It's well managed. I can't find fault", "It's definitely well run, no doubt about it", "It's well managed and the standards are maintained", and, Everything suits me and [my relative]."

The home had been without a registered manager since the last one left in June 2016. Since then another manager had been appointed and left and various other managers for the provider had helped to oversee the running of the home. One day prior to this inspection, a new permanent home manager had been appointed who told us they intended to apply to be the registered manager. All staff we spoke with at the home commented on the changes in management at the home in 2016. A healthcare professional who had visited the home told us, "They've had that many managers in the last few months I'm dizzy!" The new home manager said of the home, "It needs stability, definitely." They also told us they were committed to the role and to making any improvements required.

The impact of a lack of consistent management and leadership was evident throughout the findings of this inspection. This included the poor record-keeping by care workers, lack of care plan oversight, lack of accident and incident oversight, and limited staff access to supervision and appraisal. Issues with management effectiveness and oversight were also evidenced by the failure of audit to address areas of concern at the home in 2016. For example, regular compliance visits made by the operations manager and quality manager for the provider had identified issues with care plans not reflecting people's current needs, risk assessments not being person-centred, the lack of assessments for people with mental capacity problems and the low uptake of training by staff. These issues formed part of an extensive service improvement plan implemented in August 2016 which we saw had been regularly reviewed and updated since that time. However, evidence gathered as part of this inspection in December 2016 showed these issues had not been addressed.

During this inspection we identified issues with care plans not being up to date so we checked how they were audited. We found this drafted in a tick list format designed to establish whether the various aspects each care file should contain were present. It did not evaluate the care plans' quality or relevance, or look for common issues which may highlight a staff training need. A peripatetic nurse was partway through a week-long visit to the home when we arrived; their role was to audit care files and medicines, and to check care workers' medicines administration competence. They commented on the impact of changes in management in 2016 and told us, "All the managers have audited the first 10 care plans. I've noticed the bigger numbers (care plans 11 to 30) aren't as good."

We discussed the issues with audit and managerial oversight at the home with the new home manager. They told us, "There are so many action plans and none are complete." The new home manager could describe the purpose of effective audit and was committed to updating documentation so it could demonstrate how audit had been used to evaluate safety and quality, and to drive improvement. They said they felt supported by the registered provider to make the changes that were needed.

Issues with record-keeping, the effectiveness of audit and management oversight were a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we compared the accidents and incidents that had occurred to the notifications send to CQC. Under the CQC Registration Regulations 2009, services are required to notify CQC of various events and incidents, for example, instances of abuse involving people using the service, occasions when the police are called, and deaths. We found three incidents in December 2016 involving physical abuse or threats of physical abuse between people using the service had not been reported to CQC. The new home manager said they would review how the oversight had occurred and ensure future notifications were made correctly.

Failure to report incidences of abuse or threats of abuse to CQC demonstrated a breach of Regulation 18 (1) and (2) (e) of the Care Quality Commission (Registration) Regulations 2009.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both their care home and on their websites. We saw the ratings from our last inspection were displayed in the entrance foyer to the home as is required. However, the home's website did not include information about CQC or the ratings from the last inspection. We contacted the registered provider who informed us there had been an oversight following recent changes to the website. As a result of our feedback the ratings were added back onto the website immediately.

People had been given opportunities to provide feedback to the home about the service they received. A general residents' survey in November 2016 had asked people for their opinions about the home's environment, the food and the activities provided. Feedback was positive, although four people said they did not know what they home's complaints policy was. People were also surveyed about the food at the home in in November 2016; we saw the feedback was mainly positive. The new home manager told us there had not yet been time to evaluate and act upon any feedback in the surveys, but said they would put a copy of the complaints policy on the residents' noticeboard.

There had only been two residents' meetings in 2016. One was a general meeting in August 2016 where people had discussed the activities available, levels of staffing and the home's décor. As discussed earlier in this report, activities feedback was acted upon. A follow up meeting was held in November 2016 for people to choose the new wallpaper for the lounge area. Only one relatives' meeting had been held in 2016 and one completed survey was available for us to review, although a relative we spoke with said they had one at home to complete. We noted the foyer of the home contained feedback cards which could be completed anonymously (if preferred) and posted to a care home review website. Only two had been completed in 2016 but both provided glowing reviews of the home. This meant people and their relatives had been consulted about events and changes at the home, but not on a regular basis. The new home manager told us they planned to implement regular meetings for people and their relatives.

Staff had also been given opportunities to feedback about the home, although for most this had also been sporadic. There had been two general staff meetings and a workshop for care workers in 2016. Five care workers had completed a survey in 2016. All had commented on the changes in management at the home, but all said they felt valued as employees at the home. A senior care worker told us about the '10 at 10' meetings which happened most days. They said, "We try to do a 10 at 10 every day. That's seniors (senior care workers), the cook, the cleaner, the activities coordinator and manager, for a quick update." Minutes from these meetings showed information about the day's menus and activities were discussed, along with maintenance issues and people's healthcare appointments. Information was then cascaded by attendees to

other staff members. This meant general staff meetings had not been held regularly, but the staff team were updated most days about events at the home. A senior care worker told us meetings between all senior care workers and the newly appointed team leader were planned for 2017 and the new home manager told us they planned to arrange regular staff meetings for the wider team.

We noted the values of the home were displayed in the foyer of the home. We asked the care workers about them and why they chose to work at the home. One member of staff, "I do it for the residents. I like caring", and, "I love my job." A second member of staff told us, "I love these people. I know you're not supposed to say 'love', but I do", and a third said, "It's like a big family. Staff and residents all get on", and, "I love it." This showed us staff understood the values of the service. Feedback and our observations demonstrated this underpinned the care and support they provided to the people at Longwood Grange.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to report incidences of abuse or threats of abuse in relation to service users to CQC. Regulation (1) and (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not compliant with the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found issues with fire safety procedures and training. Regulation 12 (1) and (2) (a) (b) Not all risk assessments, and care plans in place to manage those risks, contained sufficient detail for staff to support people safely. Regulation 12 (1) and (2) (a) (b) People's nutritional risks were not always managed adequately by the home.

Regulation 12 (1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment records could not evidence the required checks were made prior to new employees starting work at the home. Regulation 19 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found gaps in staff training and continued issues with staff access to supervision. Regulation 18 (2) (a)

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 We found issues with record-keeping, audit and management oversight at the home. Regulation 17 (1) and (2) (a) (b) (f)

The enforcement action we took:

We served a warning notice on the Registered Provider. They were told they must become compliant with the Regulation by 12 April 2017.