SHC Clemsfold Group Limited

Longfield Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 19 July 2017. We returned on 26 July 2017 to complete our inspection. The registered manager was given notice of this date as we needed to spend specific time with her to discuss aspects of the inspection and to gather further information.

The inspection was bought forward as we had been made aware that following the identification of risks relating to people's care, the service had been subject to a period of increased monitoring and support by commissioners. The service has been the subject of 16 safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May and August 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Longfield Manor provides nursing care and is registered to accommodate up to 60 older people with a variety of physical and mental health needs. In the main building 14 beds are within a unit called Rosewood, which cares for people living with dementia. At the time of the inspection there were 39 people living in the main building and 11 people living in Rosewood. Bedrooms all have an en-suite toilet and sink. There are four lounges, a quiet room and a spacious dining room that overlooks well- tended gardens. Rosewood has its own lounge/dining room and access to a secure garden area.

We carried out an unannounced comprehensive inspection of this service on 11 October 2016 where it was awarded a rating of 'Good' in all domains apart from the 'Safe' domain which was rated 'Requires Improvement'. No breaches of regulations were identified but recommendations to improve aspects of medicines management were made. An overall rating of 'Good' was awarded.

During our inspection the registered manager was present. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst systems were in place to assess, monitor and improve the quality of the service, these were not always effective, as they had not identified the breaches of regulation we found at the time of our inspection. The deployment and routine of staff in the morning meant that some people's preferences, for example when they were assisted to get up, were not met. This issue had not been identified in any of the audits and checks completed by the provider or registered manager. Aspects of medicines management were not robust and these had not been identified by the provider or registered manager, despite monthly audits having taken place. Audits had not identified quality issues and safeguarding concerns prior to the

intervention of outside agencies. However, they had identified that staff had not received formal supervision and training but insufficient action had been taken to address this at the time of our inspection. There was evidence of improvements having been made in accurate record keeping, but further work was still needed.

The provider had increased the numbers of staff on duty in order to help address some of the quality and safeguarding concerns raised by West Sussex County Council (WSCC). As a result there were sufficient numbers of staff to provide safe care. However, staff were not deployed effectively to meet people's needs. Some people who required assistance from two staff due to moving and handling needs were routinely left until staff had assisted people who only required assistance from one staff member. This did not promote personalised care.

Staff said that they felt fully supported and that the registered manager was approachable. They said that they received sufficient support and training to undertake their roles and responsibilities. However, we found that, despite a training programme being in place, some staff had not completed annual safeguarding, Mental Capacity Act or dementia training as required by the provider. Some nurses had not completed training relevant to the needs of people who lived at the home. Further training had been arranged to take place later in the year. However, the registered manager was unable to demonstrate how she ensured staff with sufficient knowledge and skills were deployed on each shift.

People who were able told us that they felt safe and staff that we spoke with were able to explain the correct safeguarding procedures that they should follow if they thought a person was at risk of harm or abuse. Prior to this inspection, the registered manager shared with us action plans and details of steps that had been taken in response to the concerns raised by WSCC. At this inspection we found that, in the main, the action plans had been acted upon and safety and quality issues improved. Senior management shared learning from safeguarding situations that had occurred at other locations operated by the provider to ensure learning and practice improved across the organisation. As a result of the safeguarding situations, the provider had sourced a safeguarding expert and a new system was being implemented to ensure appropriate action was taken when incidents and events occurred. Regular meetings and communications were taking place with senior management and registered managers where safeguarding situations were being discussed and learning shared. The provider wanted to work collaboratively with other agencies. However we remain concerned that action to safeguarding service users was prompted by the feedback from external agencies rather than proactive monitoring of people's safety.

In the main, risks to people's safety and wellbeing were managed appropriately. Where required sensor mats were either next to beds or chairs that people were using. These alerted staff to people's movements who had been identified as being at risk of falls. People who were at risk of malnutrition or dehydration had drinks to hand and were given snacks and fortified meals. People who were at risk of developing pressure sores had pressure relieving mattresses in place that were set at the correct setting for their weight. Assessments, care plans and monitoring records were in place. However, some records were not accurate. By observing the care being delivered and talking to people and staff, we were satisfied this did not impact on people's safety, but was a records issue that could affect the quality of service provided.

People in the main, said that staff were kind and caring. We observed several occasions where care staff demonstrated a compassionate attitude with people. Staff spoke politely to people with lots of conversations heard. We observed staff knocking on doors and waiting for a response before entering and ensuring doors were closed when assisting people with personal care. Staff had ensured that people who were being cared for in bed had clean bedding and some had gentle music playing. Good attention had been paid by staff to people's personal appearance. We did observe two occasions when staff did not demonstrate a caring approach which we brought to the registered managers attention during our

inspection.

People's views on management of the home varied but people did say that the registered manager was nice and friendly. Throughout our inspection we found the registered manager to be open and transparent. She had made arrangements to increase the frequency of residents and staff meetings and during these had discussed the concerns raised by WSCC in an effort to be transparent.

Checks on the environment and equipment were completed to ensure it was safe. This included equipment used to help people to transfer. Where people required assistance to move using a hoist their records included details of the specific hoist and size of sling to be used, and we observed the sling to be in their room. As a result of the concerns raised by WSCC the registered manager had purchased additional bed rail covers which reduced the risk of entrapment and we observed these to be in place.

The home operated within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and staff put this into practice. Mental capacity assessments had been completed for people where required. Throughout the inspection staff were seen seeking people's consent and were able to explain what consent meant when we discussed this with them.

People had access to a range of healthcare professionals and services. People had access to a GP who visited the home on a weekly basis, to community psychiatric nurses, community Parkinson's disease nurses, and other community health professionals. Weekly clinical meetings took place where the nurses and registered manager reviewed the needs of individuals to ensure nursing care provided was effective.

People said that their concerns and complaints were listened to and acted upon. Three people expressed the view that improvements could be made in this area to reduce themes reoccurring. Feedback was obtained from people and their relatives through formal questionnaires and residents' meetings. Arrangements had been made for the frequency of meetings to increase from bi monthly to monthly and for these to be linked to an activity as it had been identified that more people attended when activities were involved. During the June 2017 meeting people's views were obtained in areas that included activities, meals and staff. The registered manager also discussed with people any concerns they had and WSCC visits to the home and offered people assurances that improvements were being made.

An activity programme was in place that offered people a choice of events that they could participate in and enjoy. These included external entertainers who visited the home such as musicians and pet therapy. Activities staff at the home also coordinated and provided events that included quizzes, craftwork, poetry and 'knit and natter' sessions. Plans were in place to introduce a breakfast club where once a week people could enjoy a choice of full fried or continental breakfasts and a weekly in-house cinema with sweets and ice creams.

Appropriate recruitment checks were undertaken before staff began work. Profiles were also in place for agency staff that confirmed they had the required checks completed on their suitability to care for people.

Efforts had been made to help people who lived with dementia to orientate around the home. Within Rosewood the corridors were decorated as street scenes and the doors to people's rooms were painted to look like a front door. Wall mounted memory boxes were located outside each room which contained items of significance to the person, including photographs and personal memorabilia.

People spoke positively about the meals provided. A five week menu was in place that offered choices including hot and cold meals, snacks and desserts. People were supported to eat their meals in line with

their assessed needs and preferences.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response to these breaches of legal requirements and will publish our action when this is complete.

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

Aspects of the service were not safe.

Medicines management was not always safe.

Sufficient numbers of staff were allocated to shifts to provide safe care but they were not deployed effectively to meet people's needs.

People told us they felt safe. Safeguarding procedures were in place that offered protection to people. The provider and registered manager responded positively to safeguarding concerns and took action to address these.

In the main, risks were assessed and managed safely, with care plans and risk assessments providing information and guidance to staff. Omissions in records had the potential to impact on the quality of service provided.

Appropriate recruitment checks were undertaken before staff began work.

Checks on the environment and equipment were completed to ensure it was safe.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Staff had not always received regular supervisions and some staff had not completed training or refresher training at the frequency determined by the provider.

Staff understood the requirements of mental capacity legislation and put this into practice.

Food was nutritious and catered for people's special dietary needs. People had a choice of what they wanted to eat.

People had access to a range of healthcare professionals and services.

Efforts had been made to help people who lived with dementia to orientate around the home.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

As much as they were able, people were involved in decisions relating to their care. Their preferences, likes and dislikes were recorded in their care plans and guided staff on how they wished to be supported. However, the deployment of staff of a morning impacted on some people's preferences with personal care.

People said they were treated with dignity and respect. On two occasions staff did not demonstrate respect when caring for people.

Positive, caring relationships had been developed between people and staff.

People's rooms reflected their individual preferences and backgrounds.

Is the service responsive?

Good

The service was responsive.

Most people expressed satisfaction with the service they received. The deployment of staff of a morning did however impact on personal care when people needed the assistance of two staff.

An activity programme was in place that offered people a choice of events that they could participate in and enjoy.

Care plans were person-centred and provided individualised information on how to care for and support people.

Complaints were managed and responded to.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

Systems were not being used to identify and take action to reduce risks to people and to monitor the quality of service they received at both location and at provider level. However, the provider and registered manager reacted positively in response to risks and quality issues raised by outside agencies.

People's views of management of the home varied. People and their relatives were asked for their views about the service.

The registered manager attempted to promote a positive culture which was open and inclusive. Staff felt supported and said that the registered manager was approachable.

Longfield Manor

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 was an unannounced inspection which took place on 19 July 2017. We returned on 26 July 2017 to complete our inspection. The inspection was undertaken by two inspectors, a specialist nurse advisor 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.

The inspection was prompted, in part, by notification of two deaths, the circumstances of which were raised as a concern in April 2017. There have also been 14 subsequent safeguarding and quality concerns raised by partner agencies. 12 of these concerns arose in June 2017 following a multi-agency visit to Longfield Manor which highlighted safeguarding concerns about people's hydration, pressure area care and hygiene. These incidents and safeguarding concerns are the subject of a police investigation and as a result this inspection did not examine the circumstances of specific incidents.

However, the information of concern shared with the CQC about specific incidents and safeguarding concerns indicated potential concerns about the management of risk related to mobility, skin integrity and challenging behaviours. The information also highlighted concerns about people's hydration, consistent monitoring of people's health conditions and maintaining people's dignity. Therefore we examined those areas and risks in detail as part of this inspection.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as the inspection was brought forward due to concerns we had received. 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.

During the inspection we spoke with 21 people who lived at the home, three visitors, the registered manager, the area manager, the nominated individual, four nurses and five care staff. We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon. We also spent time with 16 people who were in their rooms. We also observed a registered nurse giving people their medicines.

We reviewed a range of records about people's care and how the home was managed. These included 13 people's care records and eight people's medicine records. We also looked at staff training, support and employment records, audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we made a recommendation to improve the written guidance that related to people's medicines to ensure clear information was available to staff. This was acted upon immediately and we were supplied documentary evidence of body maps that had been completed to inform staff where topical creams were to be supplied. We were also supplied evidence of charts that had been implemented to ensure transdermal pain relief patches were rotated on people's bodies to promote their effectiveness.

Medicines management was not always safe. One person's Medicine Administration Record (MAR) chart was handwritten, and some of the medicine names were difficult to decipher, although all of the medicine on prescriptions on the MAR were signed and dated. A nurse confirmed that the person was a new admission, although the person's care plan revealed the admission date to be seven days prior to the date of the inspection. The agency nurse completing the medicine round had to ask another member of staff to decipher the MAR chart. We also noted that there was no photograph of the person with their MAR chart. This meant that it would be difficult for new staff or those unfamiliar with the home to understand which medicines were due to be given, and could result in the person receiving the wrong medicine or the incorrect dose.

Medicine stock reconciliation was not carried out safely. For example, a stock count was conducted on a medicine for one person. It was found that 14 tablets were received on 20 June 2017, and three tablets were seen remaining on 19 July 2017. As the medicine was prescribed for alternate days, the remaining stock count was found to be inaccurate by three tablets over the expected amount. A nurse confirmed that stock balances of loose and boxed medicines were not routinely checked. This meant that there was no stock reconciliation carried out as recommended within the guidance published by the National Institute for Clinical Excellence (NICE), and staff could therefore not track medicine errors accurately if they were to occur to ensure people received the correct amount of medicine.

Administration of 'as required' (PRN) medicines did not always follow best practice. For example, one person had a PRN prescription for Lactulose for the treatment of constipation, and although staff had signed each time it was administered, there was no corresponding explanation on the back of the MAR chart to detail why it had been given or what the outcome was. This meant that staff would not be able to refer to a history of use of this medicine, to ensure continuity and consistency of care. There was also no protocol for use of this medicine, which meant there was no guidance signed by a GP or pharmacist as to the best and safest way to use this medicine effectively for the person concerned.

The above evidence shows that medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monthly medicine audits had been completed none of which had identified the issues we found during this inspection. This is reported on further in the Well Led section of this report.

Despite the above issues we observed that a registered nurse gave people their medicines safely. The

registered nurse checked the instructions on people's MAR charts corresponded with the medicine directions on labels before administering to people and signed the MAR only after people had taken their medicines. The medicines trolley was locked at all times when unattended. For medicines which could have had a direct impact on a person's current symptoms, such as medicine prescribed for constipation, the nurse asked the person when they had last opened their bowels before giving this to ensure safe administration. Bowel movement monitoring charts were also completed for people with known risks in this area that could be used if the person was unable to verbalise their needs in this area, for example if they lived with dementia.

There were protocols in place for other PRN medicines. These included information on indications for use, maximum dosage and reasons for use. There was a system in place for monitoring and reviewing the use of homely remedies. This included a list of all medicines in use as a homely remedy, with the formulation, indications for use, dose, frequency, maximum dosages, and interactions with other medications.

Sufficient numbers of staff were allocated to shifts to provide safe care but they were not deployed effectively to meet people's needs. One person told us, "They don't have enough staff in the mornings to help with personal care so I can't have a shower before 8am even though I am up much earlier. Often the bathroom is free but there's no one available to help you. But, if my catheter comes undone in the night and I ring the bell they come and sort it out for me and clean and change me and the bed so that's something I don't have to worry about." A second person said, "Most of the staff are a delight but they're busy people so you don't see a lot of them. They are often very short staffed in the morning when you need help getting up and washed and there is no one around." A visitor told us, "There are gaps across the board in staffing and they don't check on (named) family member) enough. I have complained to the manager about it and things improve for a while then just revert to as it was. The regular staff are quite good. But some of agency staff aren't." Another person, whose room overlooked the courtyard garden, said that they had not been able to use this facility because there were not enough staff to support them to go out into the garden.

During the morning on the first day of inspection we walked around the home and observed seven people who were in bed. Three of these people commented that they were waiting for assistance to get up and that they required two staff to do this due to moving and handling needs. They and staff confirmed that it was the normal routine of staff to leave people who required the assistance of two staff until people who needs required only one member of staff's assistance had been supported first. For example, one member of staff said, "We do singles first then doubles." People told us that they accepted this was the normal practice within the home. The practice was task driven and did not promote personalised care. For example, one person who was still in bed at 11am told us that this was not their choice. The registered manager had completed regular checks on the care that was being delivered to people but this issue had not been identified. This is reported on further in the Well Led section of this report.

We observed people having their morning medicines. This was undertaken by an agency nurse who had not worked at the home before. There were two other registered nurses on duty during the inspection who were both permanent members of staff. Although the agency nurse had received an induction that morning that included medicines, they were unfamiliar with the home, people living there and with the medicine trolley. This resulted in morning medicines being administered over an extended period of time and was not completed until after 11.30am. Some people at the home were due to have their lunch time medicine at 12 noon which had to be delayed in order to allow a safe period of time between their morning and mid-day medicines. On several occasions during the medicines administration, the agency nurse had to ask one of the permanent nurses where certain medicines were kept, and also where syringes and other necessities could be found. Although there were three nurses on duty, the way staff were deployed did not make the best use of the local knowledge of permanent staff. We discussed this with the registered manager and the

rationale for using an agency nurse to give people their medicines when permanent nurses were on shift. She said that the agency nurse would have received an induction that morning including medicines and that one of the permanent nurses was allocated on shift to assist her with paperwork. The ineffective deployment of nursing staff meant that some people's medicines times had to be adjusted to ensure safe care was provided.

The above evidence shows that staff were not always deployed effectively to meet people's needs and preferences. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that staffing levels were decided using the Northwick Park dependency tool. The registered manager told us, and records confirmed, that staffing levels had increased in order to address the concerns raised by West Sussex County Council (WSCC). These now consisted of two registered nurses and 11 care staff during the day. At night there were two registered nurses and five care staff on duty. In addition to this, two or three days a week, an additional nurse was allocated on shift to cover the deputy manager vacancy. Separate domestic, kitchen, activity, administration and maintenance staff were also allocated in order that nursing and care staff could focus on delivering care to people. The registered manager monitored call bell response times in order to check that sufficient staff were available to assist people when needed. The records for July showed that call bells were responded to within 20 seconds to four minutes. Staff confirmed that the increase in staff had improved the quality of service provided to people. For example, one said, "Now is better as we can provide good care and do a good job."

We discussed staff vacancies with the registered manager and what actions she had taken in order that these did not impact on the safety or quality of care people received. The registered manager told us that in addition to the deputy manager vacancy there were also three full time nurse vacancies that were being covered by agency staff. In order to attempt to minimise the impact of this on people who lived at the home the registered manager always ensured one permanent nurse was on each shift. She said that when a permanent nurse was not available then she undertook the shift as she was a registered nurse. Staffing rotas that we viewed confirmed this.

Appropriate recruitment checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home. Confirmation was also in place that nurses were registered to practice with the National Midwifery Council. Profiles were in place for agency staff that confirmed they had the required checks completed on their suitability to care for people.

People who were able told us that they felt safe. One person said, "I feel safe as houses here, I know things go on here, it's predictable." A second person said, "I've got one of these lovely mattresses and covers on my rails so I don't bang myself. They get me up with a hoist. I told staff I don't particularly like that but they told me they have to use it as it's the only way they can move me safely. The girls are very good." A visitor said, "Yes, we feel mum is safe here."

Staff we spoke with told us they had received adult safeguarding training. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "Safeguarding training? Yes when I started. They are very sensitive in Rosewood and we need to be careful. If I saw anything I would report it. I would explain to the person and report to nurse,

follow line of management. Also write it down. I would call CQC if I thought nothing was done about it." A second member of staff said, "Immediately report to manager. Write everything down. Call the police if needed, the family and try and explain to the person why you must report."

The registered manager demonstrated understanding of her responsibilities to protect people from abuse and to provide safe care. Prior to this inspection the registered manager shared with us action plans and details of steps that had been taken in response to new concerns raised by WSCC. At this inspection we found that in the main, the action plans had been acted upon and safety and quality issues improved. This included reviewing procedures for ensuring pressure relieving mattresses were set correctly for people at risk of tissue breakdown, ensuring people had access to sufficient fluids, that bedrails had appropriate covers and people had access to emergency call bells. Staff meetings were held in June and July 2017 where staff were reminded about safe moving and handling, call bells, drinks, turning and fluid charts and mattress settings. However, we were concerned that this action was directly prompted by feedback from external agencies rather than a proactive approach to monitoring the safety and dignity of care that people received.

During the inspection we visited 16 people who were in their rooms. All had covers on their bedrails which protected them from injury and those people who were using pressure relieving mattresses had a record of their weight which was reflected in the setting of the mattress to help reduce skin damage. People also had drinks to hand to help reduce their risk of dehydration. We did note that five people did not have call bells within in reach. The registered manager informed us that four people would not be able to use a call bell to summon assistance. The registered manager confirmed that staff regularly checked on these people but that the inability to use call bells had not been formally assessed or documented and said that this would be addressed.

With regard to the fifth person who the registered manager confirmed was able to use a call bell, they told us that they had pain in their legs. They had been unable to call for assistance as the call bell was on the floor next to their bed. They told us, "It should be here (pointing to their side). I need it beside me but it falls out." We offered to use the call bell to summon assistance. The person agreed and a member of staff came within two minutes; pain relief medicine was provided. The person suggested a device be fitted either to their bed or to the bed tray in order that the call bell would be secure and always accessible. We fed this back to the registered manager who agreed this was a good idea and said this would be acted upon.

We found examples of risks being managed appropriately. One visitor told us, "She (family member) wants to be independent and move around. It's a risk because she doesn't see well but she knows it's a risk, we know it's a risk and the home know it's a risk but it's what she wants. So they've taken steps to minimise the risk by using pressure cushions and mats so they know when she gets up and a member of staff will attend her."

When visiting people who were in their rooms we saw that, where required, sensor mats were either next to beds or chairs that people were using. These alerted staff to people's movements who had been identified as being at risk of falls.

One person's records confirmed that they were known to be at risk of falls. It was well documented in the care plan that reduced eyesight, compromised hearing and poor balance were contributory factors in falls. There was an individual risk assessment for use of their walking frame, appropriate footwear and sensory mats. The falls risk assessment was scored at 16, moderate risk. The handling assessment was 14, medium risk. As a result of three falls in June 2017 the person received first aid and, for one of the falls, treatment at hospital. A referral was made to the falls prevention team and the person was also seen by a physiotherapist

who advised that the person was 'significantly at risk of falls.' We spoke with a member of staff who was supporting the person and they were able to explain the support the person needed to manage the risks associated with falling. They also confirmed that the person was on 15 minutes observations and a monitoring chart was in place that also confirmed this. We spoke to this person about the care they received and they said, "It's lovely here, they are all so nice." Although appropriate action had been taken to ensure the person received safe care, their risk assessment had not been reviewed to reflect the increase in risk of falling. This is report on further in the Well Led section of this report.

The same person had also been identified at risk of malnutrition after a weight loss was identified in May 2017. Their Malnutrition Universal Screening Tool (MUST) was reviewed and weekly weighing implemented and advice sought from a GP. By June 2017 the person's weight had increased and their MUST reviewed again with monthly weights reverted back to. We observed that the person was given snacks between meals which helped to meet their nutritional needs.

Another person who was living with dementia had also been identified as being at risk of malnutrition as per their MUST assessment. There was a hydration care plan in place to ensure the person had at least 1500 mls of fluid a day along with fluid and food charts used to monitor intake. We did note that fluid output was not recorded. The registered manager and a registered nurse informed us that this was due to the person wearing continence aids. Neither the registered manager nor the registered nurse had considered weighing a continence pad in order to monitor fluid output and agreed this was an area for improvement. There was evidence of input and guidance from a dietician who confirmed staff were following their recommendations. The person's nutritional care plan included instructions for a soft diet, food supplements' and for staff to offer high calorie snacks in between meals. Records confirmed that as a result of the support given the person's weight had increased and therefore risks of malnutrition had reduced.

There was positive evidence of people being supported to manage behavioural risks that was not medicine based. A Community Psychiatric Nurse wrote when reviewing one person's care 'Staff shows good observational skills of this resident and knowledge of her behaviour, including how she takes food, drink and medication' and 'I think the continued skilled interventions of care staff to try to minimise the distress caused to both (named person who lived at the home) and others is the best approach'.

This person had both a moving and handling and a falls risk assessment in place which identified them as being at medium risk in these areas. Appropriate equipment had been provided in order to minimise risks that included a wheelchair for longer distances, a four wheel walking frame and a sensory mat. We observed staff using equipment to support the person to mobilise in line with the contents of their care plan and risk assessment. The person said of the member of staff who was assisting them to move, "She's a good driver!"

The same person had a Waterlow assessment which gave a score of 15, which meant they were at high risk of skin damage. The daily records for this person stated that a bruise was noted by staff on 20 June 2017. A body map was in place that detailed the site of the bruise. However a photograph was not taken of this until 24 June 2017 and this did not include a measurement, despite guidance on the form instructing these should be included. We discussed this with the registered manager who confirmed that the person had no medical conditions that would make them prone to bruising. She also told us that staff had not reported this to her. As a result, she had not referred this unexplained bruise to any other agency. The registered manager assured us this would be done as a matter of priority and we received written confirmation that this had occurred within 24 hours of our inspection.

Another person who was at risk of skin damage had a pressure relieving mattress in place that was set at the correct setting for their weight. We observed that the person had dressings on their legs and their records

included photographs of wounds, observation records and dressing changes. However there were no measurements of the wounds and no care plan for the management of the wounds. We drew this to the attention of the registered manager and on the second day of inspection a wound care plan had been implemented.

By talking to people, staff and the registered manager and by observing care provided we were assured that risks associated with people's health and care needs were being managed safely but that records did not always support or promote safe care. This is reported on further in the Well Led section of this report.

Another person had a catheter care plan that was up to date and included information about the frequency of changes needed to the catheter bag and management of leg bags and night bags.

Checks on the environment and equipment were completed to ensure it was safe. These included equipment used to help people to transfer, fire tests and small portable electrical items. An emergency contingency plan was in place that gave staff information of the action to take in emergency situations that included fire and floods. This meant the provider had plans in place to reduce risks to people who used the service in the event of emergency or untoward events. Where people required assistance to move using a hoist, their records included details of the specific hoist and size of sling to be used, and we observed the sling to be in their room.

Requires Improvement

Is the service effective?

Our findings

People expressed satisfaction with the care they received. One person said, "I wash and dress and shave myself so I don't need a lot of help - it's nice to know they're there if you need them." A second person said, "They look after me well, the staff are mainly female and seem very efficient and I think they are quite well trained." A relative said, "We are really impressed with some of the carers, and all of the nursing staff are excellent."

Some people commented about the skills of some staff that worked at the home. One person said, "New staff need more training and there are language problems, they don't understand what to do. You have to tell them and then you're not always sure they've understood." A second person said, "I don't really need a lot of help because I'm still quite independent but the girls are good, pleasant and kind. I don't join in the activities because I prefer the quiet of my own room and they don't mind that. They're not always popping in and out interrupting me. They have basic training to look after older people."

Staff said that they received sufficient support and training to undertake their roles and responsibilities. This included three monthly one to one supervision sessions and group staff meetings. One member of staff said, "I have lots of support. I work in Rosewood and get support from the team leader. We are like a family. Every day I get to know the residents better. If not happy we talk to each other. I get support from the manager as well. Training is always being offered, it's for our benefit." Another member of staff said, "My induction was four days and included training on mental capacity, dementia, infection control, moving and handling and fire. I had a meeting every six weeks with my manager to see how I was doing." An agency member of staff told us that they regularly worked at the home. They confirmed that they had received an induction when they first started and that the agency who employed them had provided training in dementia awareness.

Records and discussions with staff confirmed that they received training and support; however, they also showed that some staff had not completed their training as needed to ensure that care to people was effective. A training programme was in place and the provider has its own academy that sourced and provided training to staff. All staff had completed an induction and training in areas that included fire safety, moving and handling, health and safety but a number of staff had not completed refresher training at the frequency determined by the provider. For example, of the 45 staff employed, 22 had not completed annual safeguarding training and seven had not completed annual Mental Capacity Act training. As the home provides care to people living with dementia the provider had identified this training was required annually. Only four care staff had completed refresher training at this frequency. Of the five permanent nurses employed (including the registered manager) four had received diabetes and wound care training and two catheter care and venepuncture. All had completed medicines training. Therefore not all staff had completed the mandatory training they needed to enable them to carry out the duties they were employed to perform.

Further training had been arranged to take place later in the year. However, when we asked the registered manager how she ensured staff with sufficient and current training were deployed to each shift to ensure people's needs were met effectively she confirmed that she did not have a system in place. She explained

that she would need to look through each staff member's individual records to confirm this. Therefore the registered manager could not be assured of the knowledge and skills of staff deployed on each shift.

Two of the nurses on duty said that the registered manager had provided some information on revalidation with the Nursing and Midwifery Council (NMC) but that there had been no formal workshops or seminars to ensure nurses understood their responsibilities with regard to continuing professional development. Both nurses confirmed they had received training in areas that included fire safety, safeguarding and moving and handling. One nurse said that they had also received training which included palliative care, catheter care and wound care. One staff member did say that they had not been able to attend refresher training due to staff vacancies impacting on their availability to attend.

The provider's policy stated that staff would receive three supervision sessions and an appraisal each year. The registered manager gave us a supervision matrix and confirmed this detailed any formal supervision or appraisal that staff had received in 2017. Not including staff who were currently completing their probationary period, only one nurse and two care staff had received two supervisions in 2017 and the remaining four nurses and eight care staff had received one. Therefore, staff did not always receive regular supervisions to ensure their competency was assessed. This put people at risk of receiving care from staff who had not been assessed as competent to carry out their roles.

The above evidence shows that staff did not always receive appropriate support, training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Efforts had been made to help people who lived with dementia to orientate around the home. This included written and picture signage used to indicate bathrooms and toilets. The walls also held pictures of stars from the fifties and sixties eras which may have been recognizable to the age group living at the home. Within Rosewood the corridors were decorated as street scenes and the doors to people's rooms were painted to look like a front door. Wall mounted memory boxes were located outside each room which contained items of significance to the person, including photographs and personal memorabilia.

People spoke positively about the meals provided. One person said, "The meals are usually very good and the chef gives us a feedback form every few weeks asking us whether we liked this or that and if we say 'no' he doesn't do it anymore." A second person said, "The meals are okay but there's no finesse. They usually put on a choice of two things and if you don't want either they will offer to do you an omelette so they will be flexible."

We observed the lunch time experience and saw that people who required help received this in a timely manner. In the main dining room staff offered assistance either by helping people to put food on their fork or by encouraging them to eat. When supporting a person who was cared for in bed we noted that food was delivered slowly and patiently and the member of staff spoke quietly to the person to encourage them to eat. A five week menu was in place that offered choices including hot and cold meals, snacks and desserts. We observed that the meals provided during our inspection reflected those on the menu. Special diets that included liquidised and fortified meals were also provided to people who required these.

Consent to care and treatment was sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people had been assessed as lacking capacity, then applications for DoLS had been completed as needed. Where necessary the registered manager had followed up on applications that had been submitted and not yet approved in order to promote people's rights. At the time of inspection five applications had been authorised.

Care records evidenced that when decisions needed to be made in a person's best interest efforts were made to seek the views of family members. Mental capacity assessments were in place and included the involvement of staff at the home, the registered manager and the person's GP, as well as relatives where possible. This was particularly evident where a person had been assessed as not being suitable for resuscitation, or where the person's liberty had to be deprived to ensure their own safety.

In another person's care plan, the use of bed rails had been identified as a safety requirement, and a mental capacity assessment had been completed to ascertain if the person could consent to their use. This showed that the registered manager understood how equipment could be considered restrictive and understood how to apply the MCA.

Throughout the inspection staff were seen seeking people's consent. For example, staff asked people if they would like to watch or join in with the entertainment that was taking place at the home and only supported people to attend after obtaining their agreement. When one person appeared unwell, a nurse asked the person if they could check their blood pressure. The person lifted their arm to imply they consented before the nurse carried out the procedure. Staff confirmed that they received MCA training during their induction and were able to explain what consent meant. For example, one member of staff said, "Some people can't make certain decisions so you need to help and decide for them. You must try and explain and respect them. We tell them everything we do before doing. Some may smile and that can mean they understand." A second member of staff said, "Some people cannot explain their needs so you have to try and understand by body language. If they refuse help, try and speak to them and explain the importance. For example with personal care. Never force, I have to respect they are human beings. I leave for a while, offer alternatives, give them a little time then try again, it's important. I report to the nurse, the manager and put in the care notes."

People said that they were supported to maintain good health and had access to a range of healthcare professionals and services. One person said, "They're very good if you do need anything, they'll arrange for you to see the doctor if it's necessary and things like that." People's records included a hospital passport which contained specific information that would ensure hospital staff could provide effective care. Staff confirmed that this was used whenever the person had to move between services including spending time in hospital. Records also evidenced that people had access to a GP who visited the home on a weekly basis, to community psychiatric nurses, community Parkinson's disease nurses, and other community health professionals. Weekly clinical meetings took place where the nurses and registered manager reviewed the needs of individuals to ensure nursing care provided was effective. This also included ensuring appointments with other health professionals were made and followed up on.

Requires Improvement

Is the service caring?

Our findings

Most people said that staff were kind and caring. One person said, "The girls are very good, very gentle." A second person said, "The regular staff are mostly very kind although some staff can be bolshie." This person could not elaborate further when we asked. A relative said, "We have seen some good interaction between staff and dad and we do feel they care about him. We have watched one staff member helping him and she was very patient with him." A second relative said, "Good staff who are very caring and patient." As reported in the Safe domain the deployment of staff of a morning impacted on the preferences of some people with regards to their morning routines and personal care. The task driven approach did not promote a caring and personalised service.

When spending time with people, one person sat with us smiling when staff were assisting others. They said, "It's fine here. She's (nurse) very nice, most of them are." When we asked what made staff nice the person touched their heart and smiled.

We observed several occasions where care staff demonstrated a compassionate attitude with people. We observed one member of staff talking to a person who, though dressed, had chosen to lie down again in their room. The member of staff enquired gently whether the person would like to get up and join in an activity and maybe listen to some music, making it clear that it was the person's choice. The member of staff told us that the person tended to become sad if left on their own in their room, but if with others that their mood improved. The member of staff clearly knew the person well and had a very positive approach. An hour later we noted that the person had joined others and was seen to be enjoying the activity that was taking place. Staff spoke politely to people with lots of conversations heard. We did note one occasion when one member of staff spoke abruptly when assisting a person to stand. We fed this back to the registered manager who gave us assurances that this would be addressed.

Staff promoted people's privacy and dignity. We observed staff knocking on doors and waiting for a response before entering and ensuring doors were closed when assisting people with personal care. Staff had ensured that people who were being cared for in bed had clean bedding and some had gentle music playing. Good attention had been paid by staff to people's personal appearance. People were seen to be freshly washed, their hair was clean and brushed and people wore clothing that was freshly washed and ironed. Some women had their nails painted and one person told us that staff had done this for them. Another person was wearing a hearing aid and again confirmed that staff had ensured this was in place when assisting them with personal care. One person was particularly proud of their appearance and confirmed they always liked to wear a tie, jacket and shirt. We did observe one instance where a person's dignity was compromised. They were seen being assisted back to their room after washing without wearing a top. The member of staff told us that the person did not usually want to wear a top after washing. However, there was no mention of this preference in the person's care plans. We fed this back to the registered manager who agreed this was not acceptable and who gave us assurances that this would be addressed.

Staff were able to explain the importance of promoting dignity and respect. One member of staff said, "You

must treat with kindness, try and make lives comfortable. When helping to wash and dress smile, don't rush and try to make the person feel comfortable. Smiling makes them happy."

Care plans recorded people's likes and dislikes and information was provided to staff on people's preferences. For example, one person's plan detailed how intimate personal care was only to be provided by female staff. Discussions with staff and examination of records confirmed this preference was applied.

People were supported to express their views and to be involved in decisions relating to their care. There was evidence that staff at the home worked in partnership and liaison with people and relatives to ensure a seamless transition upon admission, and continued partnership working after admission. Residents' meetings took place where family members were also invited to attend. When the last meeting took place a cheese and wine event was also held. This resulted in more people attending the meeting. As a result, arrangements had been made for all future meetings to be linked to an activity and for the frequency to increase from bi monthly to monthly. During the June 2017 meeting people's views were obtained in areas that included activities, meals and staff. The registered manager also discussed with people any concerns they had and WSCC visits to the home and offered people assurances that improvements were being made.

People's rooms reflected their individual preferences and backgrounds. For example, one person's room had an abundance of flowers, ornaments and photographs of their life before they moved into the home. Another person's room had lots of soft toys which we observed them touching. It was apparent that the person got pleasure from this. A third person had a large television in their room and they told us, "It's mine. You can bring your own furniture if there's room. That chair's mine too."

Good

Is the service responsive?

Our findings

In the main, people expressed satisfaction with the service they received. One person said, "I'm really comfortable living here. I manage by myself with washing and dressing and so on and I don't have any medicines to take so they don't need to do that for me. But I'm well looked after, spoilt even." A second person said, "I think the support they give me meets my needs. They help me with showering and dressing which I can't easily do myself because I'm a bit unsteady on my feet and of course I get my meals." Some people did comment about the deployment of staff in the morning impacting on personal care preferences. We have reported on this in the Safe domain.

On the first day of inspection we were informed of one person whose needs had changed as they were nearing the end of their life. The registered manager informed us that the GP had visited the person the day before and prescribed medicines to manage any pain. By the second day of our inspection the registered manager had obtained the views of the person's family regarding wishes for end of life care as the person was unable to express these and a care plan had been put in place.

An activity programme was in place that offered people a choice of events that they could participate in and enjoy. These included external entertainers who visited the home such as musicians and pet therapy. Activities staff at the home also coordinated and provided events that included quizzes, craftwork, poetry and 'knit and natter' sessions. Plans were also in place to introduce a breakfast club where once a week people could enjoy a choice of full fried or continental breakfasts and a weekly in-house cinema with sweets and ice creams. A barbecue with entertainment was planned for August where people's relatives had been invited.

During the morning in Rosewood we observed good interaction between staff and people who lived there. An activity co-ordinator played a game of 'finish this phrase' in which the member of staff started a well-known phrase such as "birds of a feather" and then people attempted to finish the phrase. People appeared to enjoy this activity with many joining in or smiling and observing others. During the afternoon in Rosewood, we observed that staff interacted positively with people. Music was playing and staff were seen dancing with people and encouraging conversations.

During the afternoon we observed staff inviting people to attend a music session that was being provided in the main communal dining area. A musician and the activities coordinators entertained people singing along to the music and encouraging them to join in; the event was well attended and enjoyed.

Corridors in the home displayed pictures of people participating in various activities that had taken place as well as information about the home, its staff and aims. A cheese and wine afternoon had recently been introduced that was well attended and more events of this kind were being planned.

Care plans were person-centred and provided individualised information on how to care for and support people. For example, it was noted that one person liked to have small jobs to do around the home, so staff had ensured that the folding of towels and napkins could be assigned to this person. Care plans

demonstrated involvement of relatives in care plan reviews, and specifically where a person required decisions to be made in their best interests. Some parts of people's care records were incomplete. We did not find evidence that this had impacted on their safety, but it did have the potential to impact on the quality of care provided. This is reported on further in the Well Led section of this report.

People said that their concerns and complaints were listened to and acted upon. For example, one person said that if they were not happy about something they would complain to the registered manager who was "very kind." However, another person who lived at the home and two relatives expressed the view that improvements could be made in this area. For example, one relative said, "I have raised complaints about things like the way they manage (named family member) personal hygiene with the manager. She's a nice person but it's hit and miss. She always says she'll deal with it but it doesn't always get done."

We asked the registered manager how she monitored that concerns were dealt with in order to minimise the risk of them reoccurring. She explained, "If families raise any concern either verbally or written I try and reassure them, try and resolve on the spot. If not, I inform my area manager and see if they can suggest more I can do. I let staff know and record in the communication book. Sometimes the area manager comes in; other times it may be I just give advice." The registered manager then gave an example where two people had raised concerns about the building work that was being undertaken adjacent to their rooms. Both people were offered two solutions to this and both accepted different ones. In an effort to minimise concerns being repeated the registered manager explained that she reminded staff of issues during daily handovers, at staff meetings and also in residents' meetings. Records confirmed that complaints were responded to. However, we have given feedback to the registered manager about comments made to us during the inspection about this area.

Requires Improvement

Is the service well-led?

Our findings

People's views of management of the home varied. One person said, "I think it's very well led, the staff are brilliant. I think our views do get taken on board - at least with the food. He (chef) sends out this questionnaire about the meals he's made and if we say 'no' we didn't like this then it's not served again. The manager is a kind woman, very friendly." A second person said, "The manager is a nice woman, I've never seen anyone else from management here and I've never been asked to fill in a feedback form except for the dining room one which asks what you think about the meals you've had. I don't think they have enough staff and the ones they do have are under pressure." A visitor said, "No, we don't think it's well run. The manager is a nice woman, but things don't always get passed on when one person goes off duty and another comes on."

At this inspection we found there were systems in place to assess, monitor and improve the service but these were not being operated effectively as they had not prevented the breaches of regulation we identified from occurring.

We asked the registered manager how she ensured the home was well led. She said, "I try to be transparent in every area. Make myself seen daily. Have daily meetings with reps from each department so I can keep an overview of issues. My times of work are not fixed so for example I get to meet night staff so they don't get information second hand. I try and deal with issues on the spot. Then I go and do walk around to see service users, see if they have issues, find out if they are happy. Also I do regular supervision and monitoring of staff. I try and make myself approachable. If you have happy staff you have a happy home. If I hear a call bell ringing I tell staff to address it or answer it myself. I give my help whenever I can. I check my audits are in place. I do as I'm asked to do by my area manager. If outside agencies are involved, I always respond. Make sure it's a safe, clean environment, adequate training. I hold meetings with each department to speak about specific issues as well as general meetings. We have relatives and residents' meetings as well to be sure things are running smoothly. If I need help I go to my area manager."

Monthly medicine audits had been completed, none of which had identified the issues we found during this inspection. The registered manager had completed observation checks during May, June and July. These confirmed that the registered manager had checked on people, staff and the environment. No issues were identified that reflected the concerns that were raised by West Sussex County Council (WSCC) when they visited the service or any of the issues that we identified during this inspection. They had not identified issues with the deployment of staff and the task driven practice of leaving people who require two staff to assist them, until people who required one staff had been supported first.

Monthly quality assurance audits were completed by representatives of the provider. The format for these reflected the domains of this report and was linked to the key lines of enquiry. The audits completed in February and March did not identify any issues. The April audit identified improvements were needed in areas that included some people's care plans, fluid monitoring and accident and incident monitoring. An action plan was in place that stated this had been addressed. The audit completed in May identified areas that needed improving that included care records and the action plan stated these had been addressed in

June. The audit completed in June also referenced the concerns that had been raised by WSCC. This audit identified more areas that required improvement than any of the previous audits. Although this evidenced that the provider had reacted positively to the concerns raised it also demonstrated that previous audits had been ineffective at identifying and responding to issues relating to quality and risk.

Records were not always accurate or up to date. This included two people's pre admission assessments that had not been completed in full, one person's repositioning chart not completed fully, fluid output for people who wore continence aids and were at risk were not recorded and two people did not have wound care plans. As a result of the feedback we gave on the first day of inspection, the registered manager started to address these areas. However, these had not been identified by the registered manager as areas for attention within the quality monitoring systems and audits that had been completed.

We found that a number of improvements had been made to the service following safeguarding allegations that had been brought to the registered manager and provider's attention. The provider and registered manager had taken prompt action to implement specific actions following recommendations made from external agencies and professionals. However, we remain concerned that the improvements identified were due in large part to the interventions and recommendations made by external parties and not as a result of on-going, proactive quality monitoring by the provider and registered manager. Therefore the provider had missed opportunities to address issues relating to quality and risk as a result of robust governance systems not being operated effectively.

The above evidence shows that systems were not always effective in assessing, monitoring and improving the quality of the service. Records relating to people's care were not always completed accurately. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the registered manager confirmed that people who had moved into the home had not always been informed of safeguarding investigations. Of the seven people who had moved in four had been made aware but three had not. We questioned the appropriateness of this with the registered manager who confirmed that she would ensure everyone was made aware in order to be open and transparent in the spirit of duty of candour. Duty of candour places a requirement on registered persons to act in an open and transparent way when things go wrong. We received confirmation that the manager would do this on 28 July 2017.

The registered manager submitted statutory notifications to us when events and incidents occurred. She had submitted notifications for expected deaths and injuries to people, however she had not submitted a notification when there was an allegation of theft. There was documentary evidence in place that confirmed that the registered manager had investigated the alleged theft in order to resolve this matter. After the inspection the registered manager submitted the required information and informed us that an item that had been missing, in relation to an allegation of theft, had been found and therefore this matter had been closed with no further action.

The registered manager completed her registration with CQC on 24 April 2017. She told us that she received lots of support from representatives of the provider which included the area manager and nominated individual in order to fulfil her role and responsibilities. She said, "I have had lots of support. Everyone just wants a safe service."

The registered manager gave examples of senior management sharing learning from safeguarding situations that had occurred at other locations operated by the provider to ensure learning and practice improved across the organisation. We were shown the minutes of a managers' meeting held in July 2017

that was attended by senior management, area managers and registered managers where examples were shared of care plans for specific health needs that had been developed as a result of safeguarding situations in another home. During this meeting the nominated individual also discussed how lessons could be learnt and shared in relation to record keeping, following policies and procedures and training. We were also shown an email from the nominated individual that was sent to all registered managers in July regarding the removal of generic MCA assessments and an email from an area manager to the registered manager, again sent in July, informing her to observe and document moving and handling practices. At this inspection we found that people had decision specific MCA assessments in place and we observed safe moving and handling practice. This demonstrated that learning from other safeguarding situations had started to be applied at Longfield Manor.

Further evidence of action having been taken across the organisation in response to serious events was evidenced. In response to a meeting held with WSCC on 20 March 2017 the head of quality emailed all senior managers and registered managers on the same day and advised them to ensure that as part of the monitoring with each home that all prescriptions were signed by the GP or other relevant professional prescribing. That nurses countersigned all care plans and that care plans for people who use respite services were robust and reviewed accordingly. Also, that detailed care plans were produced for all people who required suctioning. These issues were also discussed at a managers meeting on 21 April 2017. The registered manager said and records confirmed that this information had been shared in meetings with nurses at the home and action was evidenced of changes that had occurred. For example, we noted that nurses now countersigned care records completed by care staff. However, gaps in care records were still apparent which demonstrated further work was still needed to fully imbed improvements.

An audit to review compliance with CQC standards and regulations was completed on 29 and 30 June 2017 by an external auditor commissioned by the provider. This was an additional audit in response to the safeguarding concerns raised by WSCC in May 2017. The audit confirmed that actions had been taken in response to the concerns, but that further work was required in relation to records. An action plan was put in place and staff were informed of the areas of work that had been delegated to them. At this inspection, as previously reported on in other sections of this report, we found that improvements had been made, but that further work was still needed to ensure all records were accurate and up to date.

As a result of a visit to the home by representatives from WSCC and the police in June 2017 the registered manager completed a significant event analysis in order to look at learning that could be used to drive improvements at the home. The report explored what happened and why, how things could have been different, what could be learnt, and what changes were needed. The report identified that improvements were needed with documentation, monitoring of air mattresses and availability of fluids. An action plan was put in place which in the main we found was met at this inspection.

Staff said that they felt fully supported and that the registered manager was approachable. For example, one member of staff said, "She is always available if I need help or have problems. She says I can speak to her anytime." A second member of staff said, "She is ok, she's like my mum."

The registered manager had increased the frequency of staff meetings as a result of the involvement of WSCC and the police as she was aware that this could affect staff morale. She explained, "We have had lots of staff meetings to keep the team together. It's about not only making improvements but sustaining." Records were in place that confirmed daily handovers, heads of department meetings, and observation checks (known as 'managing by walking around your care home') were completed by the registered manager. During the handovers and heads of department meetings, subjects were discussed that included any staffing issues, complaints, nursing and clinical issues and visits from other professionals. In addition to

these, regular nurse and staff meetings took place in order that information could be shared.

We asked the registered manager how she ensured she maintained her knowledge and kept up to date with best practice in order to provide a quality service. She said, "I like to be trained. I've just signed up with WSCC Gateway. I am booked to attend their safeguarding enquiry officer training on 5 September. I've just completed level 5 diploma in leadership. I did WSCC infection control champion training. I have attended academy training updates. I read journals such as the Nursing Standards." The registered manager showed us tissue viability guidance and informed us that she wanted to share this with nurses as an addition to wound care training that had been provided recently.

We asked the registered manager about the quality monitoring systems in place at the home. She explained that a range of audits took place. These included audits of medicines, accidents, incidents, safeguarding, pressure wounds, deaths, fractures, hospital admissions, coroners, complaints and health and safety. In addition to these, monthly audits by the area manager were completed and audits by an external auditor commissioned by the provider.

Records confirmed that accidents, incidents, falls, manual handling incidents, drug errors, safeguarding, violence and aggression and choking incidents were audited on a monthly basis. The form allowed for details in relation to date, name, details, action taken, explained or unexplained, if safeguarding or CQC notification raised and details and outcome that is, closed, on-going or no further action. The form also included a section for recording any details of any trends developing and noted actions taken. In addition, the form had a section for the area manager's analysis of the report. For example, the audit of hospital admissions and ambulance call outs for May and June 2017 identified that one person had required treatment on three occasions in a six week period. A referral to a cardiologist was made and followed up and changes to the person's care package implemented. The registered provider had employed a new data analyst who was introduced to managers within the organisation during the February meeting. Part of the analyst's role was to review information sent by registered managers within the organisation in order to monitor trends at service and provider level.

People's views were obtained in order to drive improvements at the home. Three people had completed surveys since March 2017. All commented positively about the service provided. One person commented about building works that were taking place and evidence was in place that demonstrated this comment had been responded to.