Dwell Limited

Long Lea Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 November 2017 and was unannounced.

Long Lea is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Long Lea Residential Home provides personal care and accommodation for up to 35 older people.

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

From July 2017, the home was under new ownership, and a new management team was appointed. The new manager became 'registered' with us in November 2017.

People's medicines were not always administered as prescribed, and medicines records did not always demonstrate that medicines were administered consistently. Some prescribed creams were being administered by care staff and were not recorded, and stock checks of medicines were not accurate. Audits designed to check medicines practice was safe and in line with best practice had not identified some of the issues we found.

Risk assessments were in place where risk had been identified, but had not always been reviewed in line with the provider's policy and procedure. However, staff knew about people's risks and managed them effectively.

People told us they felt safe with the staff who supported them, and we saw people were comfortable with staff. Staff received training in how to safeguard people and understood what action they should take in order to protect people from abuse. The provider ensured staff followed safeguarding policies and procedures.

There were enough staff to meet people's needs effectively, and staffing levels had recently been increased following feedback from staff. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people. Staff told us they had not been able to work until these checks had been completed.

People were asked for their consent before staff supported them. Where people lacked capacity to make particular decisions, this had been assessed to ensure people were protected. Where people lacked capacity and had been deprived of their liberty to keep them safe, the provider ensured they applied to the relevant authority to ensure this was done lawfully.

Effective induction of new staff was not yet in place, and staff were not always supervised according to the provider's policy and procedure. The provider had a plan in place to ensure this happened by the end of December 2017. The provider was moving towards a new training system, and plans were in place to ensure staff received the training they required to update their knowledge and skills.

People and relatives told us staff were respectful and treated people with dignity. We saw this in interactions between people, and records confirmed how people's privacy and dignity was maintained. People were supported to make choices about their day to day lives. For example, they were supported to maintain any activities, interests and relationships that were important to them.

People had access to health professionals when needed and care records showed support provided was in line with what had been recommended. People's care records required updating to support staff to deliver personalised care and give staff information about people's communication needs, their likes, dislikes and preferences. People were not always involved in how their care and support was delivered, but the provider had plans in place to ensure this process was completed by the end of December 2017.

Systems to ensure the service was effective and continued to improve were not yet working as they needed to. The new management team had been in place since July 2017, and had made some improvements. These had been positively received by people, relatives and staff, and the provider had an action plan in place to ensure this continued.

People, relatives and staff told us the management team were approachable and responsive to their ideas and suggestions. The home had a warm, friendly and inviting atmosphere which people appreciated and responded well to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always administered and stored safely or as prescribed. Audits designed to check medicines management were not effective and had not identified the concerns we found. Risk assessments were in place, but had not always been reviewed as required. Staff managed risks effectively which ensured people were supported safely. Staff knew what action to take to safeguard people from the risk of abuse, and the provider had measures to ensure they recruited people who were suitable to work in the home. There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Effective training and induction systems were not yet in place, and staff supervision had not taken place as per the provider's policy and procedure. The provider had plans to ensure action was taken to address this. People were offered a choice of meals and drinks that met their dietary needs, and where they were at risk, their food and fluid intake was recorded and action taken where required. People received timely support from appropriate health care professionals. Where people lacked capacity to make day to day decisions, this was assessed and documented. Staff understood the need to obtain consent from people in relation to how their needs should be met. DoLS applications had been made as required. The provider had taken steps to tailor people's environment to their needs, in line with current best practice.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs and showed respect for people's privacy, and the provider ensured they had the time, resources and support to do so. People were supported to be as

independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received personalised care and support but this had not always been planned with their involvement or regularly reviewed. The provider had plans to ensure this happened, as care plans were being transferred to a new written format. Staff responded to people quickly and effectively on a day to day basis, and as people's needs changed. People were supported to maintain hobbies, activities and interests. People knew how to raise complaints and were supported to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People, relatives and staff felt able to approach the new management team and felt they were listened to when they did so. They told us the new management team had made positive changes and that they were confident this would continue. Staff felt well supported in their roles and there was a culture of openness. Management quality and safety systems were not always used effectively.

Long Lea Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 23 November 2017 and was unannounced. The inspection was conducted by two inspectors.

Prior to this inspection, a request for a new PIR was not made. During our inspection, we gave the provider an opportunity to supply us with key information, which we then took into account during our inspection visit. The PIR 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.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

During our inspection visit, we spent time observing interactions between people and staff. We spoke with six people who lived in the home, and with four relatives. We also spoke with two directors, the registered manager, the deputy manager, four care staff and the activities co-ordinator.

We reviewed five people's care records, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

At our inspection in September 2016, we found people's medicines were not always administered safely or as prescribed. We also found risk was not always assessed or managed effectively to keep people safe. This was a breach of the regulations. We went back to the home in March 2017 to check what progress had been made, and whilst there remained areas for improvement we found the provider was no longer in breach of the regulations.

We found that, whilst action had been taken in some areas of medicines management, the provider was again in breach of the regulations because medicines were not always managed safely or effectively.

We found stocks of some boxed medicines did not match those documented on the Medicines Administration Record [MAR]. We counted 10 people's medicines to check the amounts in stock, matched those on the MAR. We found stock balances for seven people were not correct. For example, one person's medicine records informed us they should have had 31 tablets in stock but we found there were only 20. There was no explanation for the discrepancy.

Records we reviewed did not record the quantity of each medicine received into the home. For example, one person's MAR did not record the receipt of any medicine for the month of November. However, two tablets had been recorded as administered and there was a stock of two tablets. This meant we could not be sure people had received their medicines as prescribed.

Some people were prescribed creams and lotions [topical medicines] which were applied directly to their skin. We were informed care staff applied topical medicines and completed records to show when these had been applied. We were told these records were kept in people's bedrooms. However, whilst staff told us they applied people's prescribed topical medicines, they confirmed they did not keep records of when they had done so. One staff member said, "No one has ever told me I need to write it down." The registered manager told us care staff were required to complete 'topical medicine administration records' and was surprised this was not happening. They told us they would look into this.

We also saw prescribed topical medicines in people's bedrooms which did not have an open or use by date. This information is important to ensure medicines remains safe and effective.
We reviewed the 'medication returns' book and saw 30 items of medicine were waiting to be returned to the pharmacy. We asked the deputy manager where these items were stored whilst they were awaiting collection. The deputy manager was not able to locate the items. They later confirmed the items had been collected from the home by the pharmacy who had 'forgotten' to sign the medication returns sheet.

The registered manager told us people's medicines were administered by senior care workers. We found some senior care workers were administering people's medicines without completing the training required to ensure they did so safely. The home's training record also showed medicines training for other senior care workers was not up to date. We discussed our concerns with the registered manager. They told us medicine training for 'some' senior care workers had been planned for the last week in November 2017.

The registered manager told us they had completed 'medicines competency assessments' with senior carer workers to ensure they continued to have the knowledge and skills needed to administer people's medicines safely. Records confirmed competency assessments had been completed with some but not all senior care workers.

We found this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were medicine plans which instructed staff how to administer medicines prescribed on an 'as required' basis to protect people from receiving too little, or too much medicine, and to ensure consistency in medicine administration practice.

We discussed our findings with the registered manager, who told us they would take immediate action to address our concerns. During our visit the registered manager provided us with an 'Interim draft action plan for medication' this included reviewing current medicine stock balances. This action was completed during our visit. Following our inspection visit, the registered manager sent us more detailed information about how they were addressing the issues we found. This information showed, for example, schedules were in place to ensure medicines competency assessments were carried out with senior care workers.

People told us they felt safe living in the home. Comments included; "Just being here makes me feel safe." They explained this was because the home was secure and 'nobody could get in to do any harm'; "I'm safe. They [staff] are always here for me whatever I need." Relatives told us people were safely looked after and this gave them confidence and reassurance. One relative said, "Oh [Name] is safe. I once accidently stepped on the alert mat in the bedroom. Staff were there instantly."

Staff knew how to keep people safe, and understood their responsibility to do so. One staff member commented, "We are all responsible for keeping people safe. As soon as you step in the home it becomes your responsibility."

Risk assessments had been completed for people and, whilst these were not always detailed, they included information about what actions staff should take to keep people safe. However, risk assessments had not always been reviewed monthly in line with the provider's policy and procedure. For example, two people who were at risk of falls had not had their risk assessments reviewed since July 2017. We raised this with the registered manager who assured us these would all be reviewed by the end of December 2017 when all care plans were transferred over to a new care plan system.

Staff spoke confidently about how they managed risks associated with people's care, and about systems to escalate risk if they felt action needed to be taken. One staff member said, "We learn about any new risk in handover [meetings that take place between staff when shifts change]. So you get information verbally and it's written down so you can go back and check." Another staff member commented, "If I was worried there may be something risky I would talk to the senior of the manager so they could do an assessment."

Other risks, such as those linked to the premises, or activities that took place at the home were assessed and actions agreed to minimise those risks were in place. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. The provider ensured equipment was safe for people to use. For example, we checked records of maintenance of hoisting equipment, and found this was up to date.

There was a plan for emergencies so the provider could continue to support people in the event of a fire or other emergency situation. Staff knew what the arrangements were in the event of a fire and were able to tell us about the emergency procedures they would follow. People had Personal Emergency Evacuation Plans (PEEP's) so staff were clear what support people as individuals would require in the event of a fire or other emergency.

The provider's recruitment process ensured risks to people's safety were minimised, as they took measures to try and ensure new staff were of 'good character.' Staff told us they had a DBS check which the home completed and they had to wait for their references to be returned before they were offered employment. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

Staff had received training to protect people from abuse and understood their responsibilities to report any concerns. They understood how to look for signs that might be cause for concern, and were aware of their responsibilities to report any concerns to the management team. Staff knew about the provider whistleblowing policy and procedure and said they would use it. One staff member said, "I would go straight to CQC."

People and relatives told us there were enough staff on duty to meet their needs. One person commented, "They [staff] are always here when you need them." Another person said, "Occasionally it takes them a while to help if they are busy but they come as quick as possible." A relative explained, "I can't recall ever visiting and staff not being available."

We saw there were adequate numbers of staff available at all times to care for people safely, and meet people's care needs promptly. Staff confirmed there were enough staff on each shift, including at night, to care for people safely. They also told us staffing levels had been increased recently, which they felt had improved things. One staff member commented, "Yes, we have enough staff now the levels have been increased. It means you have time to spend with residents and don't have to rush."

The provider ensured people were protected from infection. At the time of our inspection visit, the home was clean and tidy. Staff used PPE [Personal Protective Equipment], for example when handling foods or supporting people with medicines, and ensured they used fresh PPE for each task undertaken. Staff also carried clinical waste in sealed bags. There were handwashing signs displayed in toilets, and foot operated bins were available in toilets and bathrooms. These measures reduced the risk of cross contamination. There was a cleaning schedule in place to ensure the home remained clean and tidy.

The provider had systems to ensure lessons were learnt where incidents occurred. For example, from October 2017, the registered manager checked all incidents, accidents and falls that took place in the home. Records showed monthly audits of were completed which identified actions required across the home, as well as actions required to keep individuals safe. For example, two people had been referred to their GP following falls so possible causes could be investigated.

Requires Improvement

Is the service effective?

Our findings

At our inspection in September 2016, we found the home ran effectively, and the rating was Good. At this inspection, we found improvements were now required.

Effective structures were not yet in place to ensure new staff received a planned induction when they started working at the home. For example, we saw the provider had devised an 'induction/foundation checklist'. The checklist identified key areas about the home and the people who lived their which new staff needed to know. However, when we asked to see these records for new staff we were told they were not available. We spoke with one newly recruited member of staff, who told us they had felt well supported when they started working in the home. They explained they had the opportunity to read care plans, 'shadow' experienced members of staff, and had regular opportunities to speak with senior staff when they started.

New staff had not undertaken the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The registered manager and one of the directors of the home informed us they understood recommended good practice was for staff inductions to be linked to the Care Certificate and they were planning for an external trainer to implement this. The Care Certificate requires observed practice so that the person in charge of the training can be assured that the new member of staff has the attributes which are necessary to provide high quality of care. The registered manager showed us a 'service improvement plan', which showed the need for more effective induction and the introduction of the Care Certificate had been identified, and plans were in place to introduce this, with timescales attached. The director explained the Care Certificate was in use and managed effectively in their other homes, and they were confident it could be introduced at Long Lea within the timescales indicated.

Staff were not supported in their roles through individual support meetings [supervision] with the management team. This meant staff were not given formal opportunities talk about their role, raise any concerns they had or discuss their training and developmental needs to help guide them with their work. One staff member told us, "No, I haven't had supervision with the new manager. I think they will do them soon." Another staff member said, "I haven't had a planned supervision but I know I can go and talk to management if I have a concern." When we spoke with the registered manager about staff supervisions, including observing staff practice, they acknowledged these had not yet been completed. They added, "This is an area we are planning to address with all staff by Christmas." The provider's 'service improvement plan' identified the need for supervisions to be completed by the end of December 2017.

People told us staff had the right skills and knowledge to support them effectively. One person commented, "Most of the staff are well-trained and know what they are doing." The registered manager had started to keep a record of training staff were required to undertake and when this was next due. As the training system and provision was different to that in place under the previous ownership of the home, this was a 'work in progress', and had been added to the 'service improvement plan'. The registered manager explained they had inherited large gaps in staff training, and had planned to roll the new training schedule out before Christmas 2017, focussing initially on essential training to ensure staff kept people safe.

We saw staff put some training into practice. For example, we saw staff supported people to move using a hoist on three occasions. On each occasion staff explained what they were doing and gave verbal reassurance, ensuring this was done safely. However, other training, such as medicines training and associated competency assessments had not been completed and had not been implemented effectively.

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).

People told us staff asked their consent before supporting them, and respected the decisions they made. One person said, "The girl's always ask me what I want. Sometimes I say a lie in and they leave me be." Throughout our inspection visit, we saw staff sought consent from people. For example, staff asked people discreetly if they were ready for assistance with going to the bathroom and, if they were ready for assistance to move to the dining room.

Capacity assessments were completed to determine what capacity people had to make decisions for themselves. Staff demonstrated they understood the principles of the MCA and DoLS. For example, one staff member commented, "It's about if they can make their own decisions. We can't take that away and have to respect the decisions made." Another staff member told us, "We ask if they [people] want our help. If they decline we respect that but we would always go back and offer our support again."

Where people were being deprived of their liberty, the registered manager had ensured applications were made to the 'supervisory body' so this could be done lawfully. Where there had been delays in assessments taking place by the supervisory body, the registered manager had contacted them to seek advice on how this should be managed.

Where people had risks associated with their food and fluid intake we found these were managed effectively to ensure people were protected. We saw drinks and snacks were freely available to people throughout our inspection visit. We heard one person comment they felt 'peckish'. A staff member also heard and approached the person to ask what they would like to eat. The staff member responded to the person's request and provided a banana and a small plate of biscuits. The person said, "Oh that's wonderful. It will keep me going until tea. Thank you."

During mealtimes, staff were available to support people when needed. Tables were laid and had a number on them. One staff member said the table numbers had been added to try to make it feel like a 'restaurant'. People told us they thought this was a positive change. Where people left some of their meals, staff offered alternatives. One person chose to have a sandwich, for example. Staff were seated when they provided support to people, and people chatted amongst themselves and with staff. The atmosphere was relaxed and not rushed.

Some people told us they liked the food, whilst others said they felt a change was needed to widen the choice on offer. The provider explained they wanted to move towards fresh food, prepared and cooked on the premises. However, they told us there had been some resistance to this, with some people telling them they preferred the pre-prepared meals that were delivered to the home. The provider told us they would look at this again, in conjunction with people and their relatives and make a final decision.

People, relatives and staff told us the provider worked in partnership with other health and social care professionals to support people. One relative explained they felt their family member was supported effectively because staff dealt with the need for medical attention 'promptly and efficiently'. They added, "If it wasn't for the 24 hour monitoring of staff I don't think [Name] would still be here." Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people had seen their GP, dietician, chiropodist and dentist when required. Staff made referrals to health professionals in a timely way.

The provider was taking steps to ensure people had control of their living environment, and was investing in resources and equipment to improve people's lived experience, in line with best practice guidance. They told us they recognised this was important for people who may feel they had lost control in other area of their lives. For example, most rooms had thermostatic heating controls so people could decide how warm they wanted their room to be. They told us they would ensure these were in every room as soon as possible. The provider had also introduced a 'multi-sensory living experience' which played sounds in the home such as bird song at times of the day where you would expect to hear this, to help orientate people who might, for example, be living with dementia. The system could also play soft, quiet music in the morning, for example, to help wake people gently where they had told staff this was what they wanted.

Good

Is the service caring?

Our findings

At our inspection in September 2016, the rating in this area was Good. At this inspection we found it remained Good.

People and their relatives told us staff treated them with kindness, dignity and respect. Comments from people included, "Staff are wonderful. They are nice, no edge."; "They are kind. They do their job properly and they are always friendly."; "We have a happy home.", and, "It's very homely here. Everyone is so friendly. They [management and staff] are really interested in us." One relative said, "It's a nice place. You find the residents always have a smile on their face and the staff are so welcoming." The home had a warm, friendly and welcoming atmosphere which encouraged people and their visitors to feel relaxed and comfortable.

People's family and friends were welcome visitors to the home. One person commented, "Our visitors can come and go as they like. They are always looked after and offered a drink." We saw visitors being offered drinks and snacks throughout our visit, which helped them feel welcomed into the home environment. We also saw visitors sharing conversation and laughter with people, staff and the registered manager. There was a warm, friendly atmosphere where people felt comfortable and relaxed.

Throughout the day we saw examples of staff altering their approach, voice and position to effectively engage with people. This demonstrated staff had a good knowledge and understanding of people and their individual needs.

Staff understood the important part they could play in enhancing people's lives. One staff member explained, "People, relatives and staff are like a family unit. Relatives are very in touch with their family members which is good." Another staff member said, "I always remember I am coming into their [people's] home and I respect that."

The registered manager talked with us about ensuring people were treated equally and that no discrimination took place in the home. They told us they did not feel anyone would be deterred from coming to live at Long Lea as there was such as welcoming atmosphere. They added their new training system included 'equalities' and that once staff had completed basic training, they would move on to completing equalities training to ensure staff had the right approach. The deputy manager told us as part of their interview the provider had discussed their approach to equality and diversity. They deputy manager told us the provider had explained it was important all new staff understood and shared the providers values and ethos. They added, "The provider made it clear 'everyone' was welcome at the home."

The provider ensured people's cultural and religious preferences were met, and empowered people who lived in the home to make decisions about how they wanted their needs met. For example, one person explained, "We [people] have been speaking to the preacher and agreed with him that he will come into the home. I have spoken to the activities lady about it and we are organising it."

People told us they were as independent as they wanted to be. One person said, "I bathe regularly. I run my

own water but they [staff] help me get in and out." We saw staff promoted people's independence and only offered support when people needed it. For example, people were encouraged to eat their meals without the assistance of staff. However, where people required assistance staff stepped in and asked them if they would like support. Staff also encouraged people to try new experiences and join in with what was happening in the home because they recognised how this could enhance people's lives. Staff also respected people's choices and decisions. This helped people feel more confident. One person said, "The girls give me time to do thing things I can." They added, "I make choices every day. What to wear, what to do, what to eat."

People's dignity and privacy was respected by staff. For example, people were supported to go to bathrooms or their rooms if they needed support with their personal care. Staff ensured people could speak with them privately and discretely if they wanted to discuss something personal. To help ensure people's privacy and dignity was maintained, people's care plans were kept securely and were only accessed by those who needed to access them.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in September 2016, we rated this area as Requires Improvement. At this inspection, we found people's care was more responsive to their needs than previously, but that improvements were still required.

People told us staff understood their needs and supported them in the ways they preferred. One person said, "Staff know me well. They understand me." Another person explained, "I have been here a long time so all the staff know my likes. The little things that are important." However, people and relatives told us they had not always been involved in putting together and reviewing people's care plans, though they were part of regular discussions with staff about how they and their relatives were supported. One relative told us, "We aren't invited to discuss [Name's] care plan but I would like to be."

We raised this with the registered manager, who explained they had started to look at reviewing care plans. They acknowledged the care plans had not always been sufficiently detailed or up to date, and this had been identified when they took over the running of the home. They told us that, as part of the review process, they would be meeting with people and, where appropriate, their relatives. They explained they had a huge amount of work to do since taking over the running of the home in the summer, but were now at a point where this work could begin. They told us they felt people and their relatives had not always been involved in putting together care plans historically, but that this would change.

As was acknowledged by the registered manager, care plans and other care records we reviewed were not always up to date, and did not always reflect people's needs. For example, one person was prescribed medicine to thin their blood. This was not reflected in the person's care plan. Staff knew the person took this medicine, and it was administered safely and as prescribed, but risks associated with it were not clear in the person's care plan. Another person's care plan indicated it was important to record the food and fluids the person had. However, records intended for staff to record this so it could be monitored had some omissions. Another person was assessed as needing to be checked hourly to ensure they were safe. Again, there were omissions in their supplementary records, so it was not possible to ensure this happened. In both cases however, the people concerned had not experienced any harm as a result, and staff told us they did what was required, even if it was not always recorded.

The registered manager explained they had reviewed and updated one person's care plan, and had put this together in the new style of plan they intended to introduce for everyone. This care plan was clear, provided staff with the detail they needed to meet people's needs, and was personalised so staff knew about the person's likes, dislikes, history and preferences. This new style care plan documented the person's wishes should they be living in the home at a point where they needed end of life care. The registered manager told us these discussions would happen with people and their relatives, with agreement, when all care plans were updated.

As a result of our concerns about the majority of care plans we reviewed, the registered manager told us they would prioritise this work. They assured this would be completed by Christmas 2017. Staff were aware

this work was underway and were positive about the difference this would make. One staff member said, "Care plans are being changed. This will be good because they will have more information."

People were supported to maintain activities, interests or hobbies, and were encouraged to try new experiences and were offered a range of activities the provider hoped would stimulate them. One person explained, "Oh yes, there are always things going on here. Yesterday, there was a singer who came in, there is a pianist today. It's nice." On the day of our inspection visit, a pianist came to the home and played to people in the communal lounge area. People responded very positively to this and joined in with singing, dancing and tapping their feet.

A newly appointed activities co-ordinator told us that, where people did not want to take part in group activities, they visited people and engaged in one to one activities with them. They commented, "There is always something that might trigger a response." They told us they looked at care plans to get an idea of people's history and background, but that they were now in the process of completing a 'lifestyle and interests' checklist with people and their families in order to tailor group and one to one activities to people's needs.

The provider had a system to monitor complaints and to identify any trends and patterns, so that action could be taken to improve the service provided. The provider's complaints procedure was on display in the reception area which informed people, relatives and visitors how to raise a concern or complaint and how this would be managed. Information about who to contact if they were not satisfied with the outcome of their complaint was available. One person told us, "They [management] want to know if things are not right or if you're not happy. Any worries they put them right." There was one complaint recorded by the provider, and this had been dealt with in line with the provider's policies and procedures.

Relatives told us they were confident action would be taken if they raised any concerns. One relative said, "As a family we have no concerns. I wouldn't hesitate to raise an issue with the management. I know if Mum or Dad had a concern they would talk to the staff." Another relative commented, "We have met [registered manager] I feel they would listen to our concerns if we had any."

Requires Improvement

Is the service well-led?

Our findings

At our inspection in September 2016, we rated this key question as 'requires improvements' found the provider was in breach of regulation 17, Governance. This was because the provider had some systems to monitor the quality of the service provided, but had not ensured these were effective, and opportunities to identify where action was required to implement improvements were missed. We issued the provider with a Warning Notice in relation to medicines management, requiring them to take action to improve this.

We went back to the home in April 2017 to check what progress had been made, and we found the provider was no longer in breach of the regulation. We also found the warning notice had been met. During this inspection we found this key question still required improvements.

In July 2017 new directors and a new registered manager took over the running of the home. At this inspection, people and relatives told us they felt the new management team had made a positive difference in the home. One person said, "I think they [new management] have done well in the time they have been here. They are just trying to make things happier for us." They added, "I have very good conversations with [directors name], [deputy manager] and [registered manager]. They are the special three." Another person told us they thought it was too early to be sure, but that they felt there was potential for improvement. They commented, "There was a lack of management in the past perhaps. But, I did raise something with the new manager and the director and it was resolved. I now know I can contact the director when I need to. I have confidence in that." One relative said, "It's too early to judge the new management but from what I see I am hopeful." Another commented, "I do feel the management are responding more. I feel they are getting there, in all fairness."

The new directors and registered manager explained the first four months since they took over the running of the home had been 'tough'. However, they explained they felt their initial focus on ensuring the safety of the building, dealing with staff who needed to change the ways they worked, and on ensuring staff understood and were 'on board' with what they wanted to achieve, had been correct. They told us they knew things were still not right, but that they had a plan in place to work towards where they wanted to be. One of the directors explained, "I want to know what is happening, what the problem is and I want to be part of the solution."

The new management team had not used the systems in place to check and improve the quality of the service effectively, but some progress had been made. A range of audits to monitor and improve the quality of the service had been introduced; for example, a health and safety audit had been completed in November 2017. This had identified that, for example, safety tests such as those relating to fire alarms and emergency lighting had not been completed weekly as required. We discussed this with the registered manager, as we could not see any evidence in the audit of how or when actions had been taken to address this. They told us they were working with senior staff who were responsible for completing such tests as, under the previous management of the home, senior staff lacked direction and clarity. The registered manager explained auditing and actions thereafter would be more effective as this work proceeded.

Other audits had identified areas of concern, and clear action had been taken as a result. For example, on 1 August 2017, a check had identified three slings used to support people to be hoisted when transferring, were no longer to be used and needed to be 'disposed of'. The audit recorded these had been disposed of and replacements had been ordered. We checked to ensure this had taken place and confirmed new slings were now in use.

Some systems and processes to underpin the management and development of the home had not been used effectively so insufficient progress had been made to update care plans to ensure they reflected people's current needs and risks, effective induction including the Care Certificate was not yet in place, and some audits had not been effective in identifying some of the concerns we found. For example, monthly medicines audits had been regularly completed, but had not identified any of the issues we identified. Ineffective medicines management had been a significant concern at previous inspections, but the provider had not ensured this was managed effectively.

Some relatives felt progress that had been promised early on had not always been made. For example, one relative said, "We met the new manager when they started. They told us about cooking fresh food and having a resident who was a chair person. We thought these were good ideas but we haven't heard anything since. So we don't know what's happening." We raised this with the directors and the registered manager, who agreed it was important to keep everyone updated on promises they had made and areas for development. They explained they would arrange for written and verbal updates to go out as soon as possible.

Staff were positive about the support they received from the new management team, and assured us they were approachable and responsive. Staff also felt there was an open and honest culture within the home which the new management team had helped to create, and reported improved morale and leadership. One staff member told us, "The new management are very supportive. I feel able to go to them and talk about any concerns or ideas." For example, staff told us they had spoken with the management team about having extra staff on duty, which had been actioned. One staff member commented, "We have had lots of new staff which is a good thing because the old staff were perhaps suited to other jobs, shall I say."

Speaking with us about the positive impact they felt the new management team were making, staff told us, "Things are changing which is great. Like new menu boards, menus on tables, notice boards with lots of information and activities. We've even got speakers around the home so we can play relaxing music.", and, "Things are improving it's a lot better. I came over in the early days to help out and I can see the changes. We still have a way to go but now the new staff are settling in the improvement will continue."

Staff told us they were able to share their views at regular staff meetings. Records confirmed staff meetings took place regularly. One staff member said, "We have had a several meeting with the new management. They shared information about all the changes and plans. It's good because you can discuss any concerns or ideas and get answers. If all the staff are there we all hear the same message."

The registered manager told us they had started to hold weekly 'residents meetings' over coffee, to give people a more relaxed way to share their views and make suggestions. We saw a 'you said, we did' noticeboard which included actions taken in response to feedback from people and relatives. For example, people had raised concerns about the security of the building, so the provider had installed key pads at all entrances and exits shortly after they started running the home. Records of a recent 'residents meeting' showed people had been asked to re-name areas of the home. The new names had been suggested and voted on. The provider told us they would shortly be arranging signage to go up in the relevant parts of the home in line with this.

The provider understood it was important for people's voices to be heard and to ensure they were part of their local community. For example, they told us people had been supported to submit comments on a proposed housing development near to the home. The provider also told us they intended to appoint a person and a relative as 'experts by experience' who could act as representatives and feed back to the provider and registered manager, as well as represent people and relatives as appropriate.

The registered manager was familiar with the 'Accessible Information Standard' [AIS]. The AIS aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support they need. They acknowledged this was not something they had yet considered in detail at Long Lea, but assured us they would attend to this as they completed the review and update of all care plans.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were stored, administered and managed safely and effectively.