Long Meadow (Ripon) Limited

Long Meadow Care Home

Inspection report

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Date of inspection visit: 8 April 2015
Date of publication: 29/12/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 8 April 2015 and was unannounced. We last carried out an inspection on 17 December 2013 where we found the home was meeting all the regulations we inspected.

Long Meadow is registered to provide residential and nursing care for up to 46 people. The home is in Ripon and is managed and owned by Long Meadows (Ripon) Limited. The building has been adapted and converted for its current purpose, providing modern facilities in a traditional, homely setting.

There was a manager in charge of the home who had only recently commenced in post but they had submitted their application to be registered to the Care Quality Commission. Since the inspection they have become registered. 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.

Summary of findings

A new care planning process was being implemented which had resulted in a lack of, or inconsistent information recorded about how people's needs were to be met. Specific areas of risk had not been assessed and addressed appropriately and this placed people at risk of harm.

There were sufficient staff available. However, there was an increased risk to the quality and continuity of care people received because of the lack of permanently employed qualified nurses and reliance on agency nurses to provide nursing care. .

Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to minimise the risk of staff being unsafe to work with vulnerable people.

Staff had received training with regard to safeguarding adults and they were able to tell us what they would do if they suspected abuse had taken place. Appropriate referrals to the local authority safeguarding teams had been made by the manager and we found evidence that they worked collaboratively with them.

The home had safe systems in place to ensure people received their medication as prescribed; this included regular auditing by the home and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was reassessed regularly.

Staff had received relevant training which was targeted and focussed on improving outcomes for people who used the service. This helped to ensure that the staff team had a good balance of skills, knowledge and experience to meet the needs of people who used the service.

People had good access to health care services and the service was committed to working in partnership with healthcare professionals.

Staff were kind and caring and they respected people's privacy and dignity and we observed this throughout our visit. Staff we spoke with knew people they were caring for well.

A lack of robust care planning impacted on people's health and wellbeing. Care plans lacked information or contained contradictory information for staff. This meant there was a risk people would not have their care needs consistently met.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

People and their relatives completed an annual survey. This enabled the provider to address any shortfalls identified through feedback to improve the service.

Changes to management arrangements had impacted on the service provided. There were good auditing and monitoring systems in place to identify where improvements were required and the service had an action plan to address these.

Summary of findings

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 safe.

A failure to assess and respond to risk placed people at increased risk of harm.

Although there were sufficient staff available to meet people's needs, a lack of permanent nursing staff increased the risk of people not having their needs meet safely.

The systems in place to provide people with their medicines were safe and effective.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to equip them to carry out their roles effectively and meet people's needs.

The provider had appropriate policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had received training and demonstrated understanding of the principles of the Act and people were supported to make decisions about their care, in line with legislation and guidance.

People were provided with a choice of nutritious food. Snacks and drinks were available at any time. People's dietary likes and dislikes were known by the staff. Health care professionals were involved in monitoring people's dietary needs where this was required which ensured people's nutritional needs were being met.

The home had developed good links with health care professionals which meant people had their health needs met in a timely manner.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected and staff were kind and attentive.

People looked well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere.

Is the service responsive?

Requires improvement

Is the service responsive?

The service was not responsive.

Lack of consistent information in care plans increased the risk of inappropriate care and support being provided.

Summary of findings

The service ensured that people were able to continue with interests and hobbies.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

The provider actively sought the views of people and collated them in the form of an action plan to improve the service.

Is the service well-led?

Good

The service was well-led.

The manager was new in post and had a clear vision about what was required and the standard of service they wanted the home to deliver to people.

Staff reported a supportive leadership with the emphasis on openness and good team work.

The provider had procedures in place for reporting any adverse events to Care Quality Commission (CQC) and other organisations such as safeguarding, police, deprivation of liberty, and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.

Long Meadow Care 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 was carried out by a single inspector and a specialist professional advisor with expertise in providing nursing care.

During our inspection we carried out observations of staff interacting with people and included two structured observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us.

During the inspection visit we reviewed five people's care records, three staff recruitment files, records required for the management of the home such as audits, minutes from meetings and satisfaction surveys, medication storage and administration. We also spoke to the manager and the general manager; eight members of staff including registered nurses, care staff, an activities organiser and kitchen staff. We also spoke with four people who lived at the service and three relatives. On the day of the inspection 27 people living at the home; 17 of whom required nursing care.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said "I didn't feel safe at home on my own, now I know there are staff around to help me." A visitor told us "I have no doubt (name) is safe here, staff are very attentive."

Prior to the inspection the manager had informed us they had raised a safeguarding alert with the local authority safeguarding team because of concerns about the quality and consistency of nursing care provided. We spoke with the manager about staffing arrangements at the home. They told us the home did not have any Registered Nurses directly employed and available, and were thus heavily reliant on nursing agency staff for care provision to a large number of the people living at the home. The manager explained that and they had successfully negotiated with the agency to provide some degree of stability in the nursing staff provided to improve the consistency of care for people living in the home. . On the day of the inspection the manager confirmed there were twenty seven (27) people living at the home, seventeen (17) with nursing needs and ten (10) with residential needs. The manager told us they had now recruited two nurses themselves who were due to take up post within the next two weeks.

We spoke with the two registered (agency) nurses on duty on the day of the inspection, one of whom had been working regular shifts at the home for some months intermittently. The second nurse had worked 6 or 7 shifts in the last month. Although there was some continuity of nursing care we found there were some issues around a lack of organisation and communication between some agency staff, each other and with management.

The use of agency staff in this way is not suitable in the longer term for providing continuity of care, particularly for people who rely on staff who know them as they are not always able to make their needs known directly.

We reviewed the staffing rosters and saw in addition to nursing staff there were four care staff plus 1 trainee for the early morning shift and then three care staff for the afternoon and early evening shift with two care staff awake overnight. The service employed an activities organiser for 16 hours per week. Care and nursing staff were supported by four domestic and laundry staff, a cook plus a kitchen assistant seven days a week. The manager explained in order to determine the numbers of nursing staff on duty at any given time they used the RGN (Registered General Nurse) to patient ratio tool. Therefore during the morning/ early afternoon shift there were two nurses on duty and in the late afternoon/ early evening there was one nurse on duty and one nurse on duty overnight. We discussed the deployment of staff and responsibilities which would take them away from providing direct care. Such duties may include report writing, responding to phone calls, contacting professionals and answering the door to visitors.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager explained that they had reviewed care planning documentation and was in the process of implementing a new care planning format. We found examples that this process was placing people at risk of harm. Care plans were disorganised, and contained large amounts of paperwork which was not current and relevant. Information was not placed in chronological order. This had the potential to cause delays in identifying documents to assist staff in providing safe and appropriate care. We found that some risk assessments regarding direct care were limited and did not accurately measure the risks that could affect service user safety and wellbeing. For example for one person we saw recorded "(name) is aware of some risks but requires support to manage others." This meant there was insufficient detail to ensure safe care. We have provided more examples of this shortfall and its impact on people in the responsive section of this report.

Discussion with both nursing and care staff indicated that there was a good awareness of both the expectation on them to report, and the process of reporting or highlighting incidents or concerns. The manager had an effective system to record and analyse incidents and accidents, looking for specific trends.

There were risk assessments in place relating to the safety of the environment and equipment used in the home. For example hoisting equipment and the vertical passenger lift. We saw records confirming equipment was serviced and maintained regularly. We observed staff moving people in several rooms in the home; this was mainly wheelchair/ chair/wheelchair, and one bed to wheelchair. Moving was undertaken in a safe manner, and clear explanations were

Requires improvement

Is the service safe?

given. The service had in place emergency contingency plans. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals.

Staff we spoke with told us they had received training with regard to safeguarding adults. They were clear about their responsibilities in keeping people safe and were able to explain the action they would take if they suspected or witnessed abuse. One member of staff said 'it's what we're here for, to protect them, I would have no problems in reporting any abuse.'

The manager told us although staff had completed safeguarding adults training they had also arranged refresher training provided by North Yorkshire County Council Safeguarding team. The manager had made appropriate referrals to the local authority safeguarding teams and we found evidence that they worked collaboratively with them.

Staff also talked to us about whistleblowing policies and procedures. (Whistle blowing is when staff tell someone in authority about their concerns about care). One member of staff said they had looked at this during their induction and felt any poor practice reported would be listened to and acted upon.

We looked at the recruitment records for three staff and found they had all completed an application form. Application forms included details of former employment and all applicants had attended an interview. Two references and DBS (previously criminal records bureau) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed.

The home had safe systems in place to ensure people received their medicines as prescribed; this included regular auditing by the home and the dispensing pharmacist. Medication was stored in a locked room in a trolley secured to the wall when not in use. There was a lockable fridge for medicines; this was locked. All medicines in the fridge were appropriate to be kept at this temperature and where there were eye drops and creams, the date of opening was recorded on the box and the tube. Records were kept of room and fridge temperatures to ensure they were safely kept.

Medicines were supplied in a bio dose system; each person's medication dispensed into a sealed pot. Alongside this were medication administration sheets (MAR) for each person, which included their photograph so that this could be used to identify them and a description of each medicine and what it was for. We checked MAR sheets and saw they had been signed and appropriate codes were used; for example, if people refused their medication.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Two members of staff signed when medicines were administered as prescribed. We completed a random stock check of two people's medicines and they tallied with the records. Where people were prescribed pain relieving patches which required rotation of where the patch is applied body, maps were completed to indicate the site of the patch and the date it was applied.

The home was a large older style building with some newer extensions to the rear. Bedrooms varied in size and design, the majority being en-suite. Some ground floor rooms had French windows that opened out into a pleasant courtyard. The home had several areas of narrow corridors with little room for manoeuvring of equipment. Double doors into people's bedrooms had been installed to enable use of hoists and other equipment.

People's bedrooms, and bathrooms, and toilet areas were generally clean and well maintained. However, there were some areas of the home with lingering odour noted; this was discussed with the manager. We also observed that some areas of corridor carpet were worn and frayed and were a tripping hazard for people. The manager agreed to action these matters immediately.

Staff were observed to wash their hands before and after aspects of personal care. Gloves were also used by both care staff and ancillary staff when required. Gloves and aprons appeared to be readily available.

Good

Is the service effective?

Our findings

We asked the manager about staff training arrangements. They told us training was provided via e learning with competency testing through written tests and observations. For example staff completed e learning with regard to assisting people to eat, with competence assessed via a series of observations. The manager explained they had competed refresher training with all staff with regard to privacy and dignity in providing personal care. They explained this was an opportunity for them to establish with staff their expectations as a new manager. Newly appointed staff completed a twelve week induction which included mandatory health and safety training such as moving and handling, first aid and safeguarding adults. The provider encouraged staff to complete National Vocational Training (NVQ)/Care Certificate and the manager explained they were hoping to re configure the home to group people according to their needs. They explained they would like to develop a specialist dementia care area and as such planned to enhance the senior carer role to manage and lead staff teams. One senior carer told us they had just registered for NVQ level 5 and registered to complete medication administration training. The manager was committed to provide specialist training and had sourced a new training provider to deliver end of life care, dementia awareness and the Mental Capacity Act (2005) training. The manager showed us a training matrix which recorded the training staff had completed and a system which alerted them when staff were due for updates. Staff we spoke with told us there were good opportunities to attend training which was relevant to their role.

However, we saw recorded in one person's care plan that an agency nurse did not feel skilled or confident enough to carry out the task of re-catheterisation. This meant there was a risk people would not have their needs met in relation to this area of their care.

The manager told us they had commenced some supervision meetings with staff but these were at an early stage of completion. Staff told us they had received some supervision but this was not yet at regular intervals. They did confirm the sessions they had received encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. This meant that staff were well supported and any training or performance issues identified.

The home had recruited volunteers to assist with providing activities. They had carried out essential training, for example with regard to privacy and dignity and safeguarding before these volunteers engaged with people. We saw the records confirming this.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are proposed restrictions on freedom and liberty, then trained professionals assess whether the restriction is appropriate and needed. The manager told us they had a good working relationship with the local authority DoLS team and Community Mental Health Team. There was one DoLS in place at the time of the inspection and we discussed with the manager how they were addressing a more complex Best Interest decision currently being assessed. (These decisions are made in line with the Mental Capacity Act (2005) to ensure they are in people's best interests). These discussions demonstrated a good understanding of the authority to make decisions on a person's behalf, mental capacity and DoLS. We reviewed the approved deprivation and saw the appropriate processes had taken place and reviews were scheduled. We saw as part of the care planning process that people had their mental capacity assessed with reference made to legal guidance.

The manager told us all staff had received training with regard to Mental Capacity Act (2005) and DoLs. When we spoke with staff they demonstrated a good understanding of the issues with particular regard to day to day care practice ensuring people's liberty was not restricted.

We observed the lunchtime experience and saw that people were given time to enjoy their meal and it was a social and relaxed occasion. There was a choice available to people and people told us that staff asked them what they would like to eat. Those people who needed it were given discrete assistance with eating their meal and we saw people using adapted cutlery and plate guards in order that they could be independent when eating their meals.

We spoke to the chef who told us all food was fresh and locally sourced. They baked every day to ensure fresh cakes

Good

Is the service effective?

and high calorie smoothies were available to supplement people's diet where they were at risk of weight loss. They told us they had a good relationship with people and they knew people's preferences. Whilst we were at the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals and we heard staff encouraging people to drink sufficient fluids.

During this inspection the care records we looked at included those of people who had nutritional risks associated with their health and well-being. We saw people had a nutritional risk assessment completed. Care plans included how often people needed to be weighed, whether food or fluid charts needed to be completed and any recommendations from the speech and language assessment if this had been completed. We saw plans had been reviewed regularly and amended as required, for instance one person had changed from needing a soft diet to a blended diet and food supplements, however we did see two people's records where no action had been taken despite a record of weight loss. Failing to take action could impact on the person's health and wellbeing.

Staff reported good working relationships with local health professionals. We spoke to a visiting district nurse who said referrals from the service were appropriate and staff followed district nurse advice and completed appropriate records such as food and fluid, continence and re positioning records which helps to ensure that people receive appropriate treatment. They also commented on how well the home worked with the local GP surgery and district nurses in providing end of life care.

People's care plans included information about people's access to chiropody, hearing specialists and opticians. We also saw that where people were at risk of malnutrition appropriate referrals had been made to speech and language therapist and dieticians.

The home was an adapted manor house with a purpose built extension. As such some parts of the home were less accessible than others. The manager explained the provider was exploring establishing a distinct unit for those people living with dementia. The manager felt this would provide a specialist environment which would enhance people's wellbeing. These plans were at early stage. The manager acknowledged some areas of the home were looking a bit tired and we saw redecoration and refurbishment had been identified on the home's annual development plan. The manager was also mindful of the impact highly patterned carpets had on people living with dementia and how research suggests it can affect orientation and spatial awareness which the manager told us was another reason for the refurbishment. We noted handrails to assist people to walk independently and appropriately fitted grab rails in toilet and bathrooms. There was ramped access to the garden areas which had seating areas for people to rest and enjoy the garden.

Good

Is the service caring?

Our findings

Some people living at the service with dementia were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found people responded in a positive way to staff. We observed staff treating people with kindness and compassion, staff spoke with people at a pace which appeared comfortable to them; staff knelt down enabling them to make eye contact and used physical contact appropriately regardless of whether permanent, agency staff or ancillary staff.

We observed one person who sat in their room calling out. We observed every time a staff member went past they called in, spoke and reassured them. However, they did not appear to have sufficient time to sit for any length of time with them which may have reduced the person's agitation. We did see some people who sat for long periods during the morning and afternoon with only occasional contact when staff spoke to them in passing. During this time we noted staff were busy with other tasks.

We observed that staff spoke to people in a kind and respectful manner and clearly knew them as individuals. We observed staff knocking on people's doors before entering and staff put up a sign on bedrooms doors when personal care was being provided to afford people additional privacy. We also observed people expressing their wishes about what they were going to do during the day and what they wanted to eat and drink.

We observed that staff regularly consulted with people about what they preferred to do, whether they were comfortable or needed anything. One person required assistance using a hoist. We observe staff give verbal and physical reassurance; talking to them about what was about to happen in a patient and reassuring manner. We saw people were offered blankets or were assisted to ensure their clothing protected their dignity. During lunch people were offered protective clothing before being assisted.

We saw evidence in care plans that people had been involved in determining how they wanted their care provided and their personal preferences. 'All about me' documents had been completed which reflected this, along with a document titled 'my daily preferences.'

The manager said they were committed to giving people and their relatives an opportunity to influence how the service operated and improved. They had held one relative's meeting and feedback from relatives we spoke with was positive. One relative said "there is a new manager and we are seeing improvements almost on a daily basis."

On the day of inspection, there was one person receiving end of life care. We were able to speak to their relative briefly who spoke highly of the level of care being provided. They had been provided with a room to stay overnight in, and they said that staff communicated with them at all stages. This relative praised the nursing and care staff for their kindness and attention. They particularly mentioned that a fellow resident, had developed a friendship with the person at the end of their life, and was given the opportunity to visit and pay their respects in the later stages.

During the day we saw visitors coming and going; they were offered a warm welcome by staff. We spoke to two visitors; one said, "there is a lovely atmosphere here, it's really warm and friendly." Another said, "staff take the time to make sure people have everything they need."

We saw people's bedrooms were personalised with their own furniture and possessions or family photographs.

We were told people had access to an external advocacy service if required and the service promoted an open door policy for people and their relatives.

Requires improvement

Is the service responsive?

Our findings

The manager acknowledged the need to review and improve accuracy of information in care plans and reiterated they had identified this as an area for improvement when they first started in their role.

The manager explained that when they were first in post they made a revision of care plans their priority. The original format was a commercial 'Standex' format but the manager told us they were currently introducing a new format, based on 'Activities of Daily Living' model. They told us the purpose of this was to move away from a clinical model of care towards a more person centred model.

We reviewed the records for three people in detail. We found some files had loose record sheets with a potential for important information to be lost. Each record contained a photograph and a comprehensive set of assessments including; Activities of Daily Living, Moving and Handling , Falls Risk, Nutritional Risk Assessment (MUST), Continence Pressure Area (Waterlow), and Infection Control Risk Assessment. From these assessments we saw a number of specific care plans. Care plans were personalised with 'All about me' detailing likes and dislikes as well as a social history. Also present was 'My Care Plan' which is a GP computer generated care record highlighting medical conditions and treatment.

However, there was evidence of contradictory or incorrect information recorded in care plans which had the potential to place people at risk of harm. This risk could be exacerbated because of a lack of continuity of care due to a lack of permanent nurses employed by the home and a reliance on agency nurses. For example it was noted in one person's care plan that the GP 'My Care Plan' included a DNAR (do not attempt resuscitation) instruction, however, this had not been clearly transferred into the standard care plan records, and was not in the standard DNAR format generally kept in records. Therefore for this particular person there were conflicting instructions indicating that they wished to be resuscitated, and in another document an instruction not to resuscitate.

We saw in one person's care plan an entry by a registered nurse 'Due for re-catheterisation today, but nobody adequately skilled to perform'. This date had passed. We raised this with the manager who clarified the due date was incorrect and the catheter was not yet due for change.

We saw in two people's care plans records that they had both lost weight over a period of time. Despite significant weight loss, no additional care plan had been generated, however one nurse told us that for one person blood tests had been undertaken and the weight loss discussed with the person's doctor.

A failure to implement care plan actions or failure to identify changes in people's needs can be linked to a lack of continuity of care and poor communication. In addition both nurses and care assistants need to be able to review records and care plans quickly, they therefore need to be concise and in a logical order.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a programme of activities available for people. This included group activities and individual one to one sessions. On the day of inspection we joined a group in a painting session. During this session people talked about the activities on offer. They told us about baking sessions and the activities they had done over Easter; Easter bonnets and Easter egg decorating. People said they enjoyed the group activities, especially baking. One person said "we all sit round and have a good laugh." We spoke to two people who told us they were volunteers. They said they came into the home to support activities either in groups or with individuals. They gave examples of reading to people, arranging flowers or helping with a jigsaw. During the day we observed staff spending time with people chatting about their interests, daily routines and daily news items on the television.

We found that the service had a Complaints Policy in place and that all staff we spoke with knew how to advise people on how to make a complaint. People told us they would feel confident in raising concerns with managers or staff. One visitor we spoke with said "the new manager is very approachable I would feel happy discussing any concerns with them."

We looked at the complaints log and saw the home had not received any complaints since November 2014. Those prior to this date were recorded with details of investigation and the outcome reported to the complainant. All were resolved to the satisfaction of the complainant. The manager explained they had developed policies and

Requires improvement

Is the service responsive?

procedures in relation to the implementation of a new regulation of the Health and Social Care Act 2008, Duty of Candour which requires providers tell people who use services when something goes wrong and to apologise.

The provider completed an annual survey of people who used the service and their relatives to gather feedback on all aspects of the service provided. We saw feedback from this survey with comments 'my relative is very happy at Long Meadow and the staff are so kind and caring'. And 'I feel the home is pleasant and friendly.'

We saw evidence in staff meeting minutes and staff supervision of 'lesson's learned.' The manager told us it was their wish to develop an open culture where the service took an opportunity to learn from mistakes. Staff we spoke to confirmed they felt able to discuss with the manager individually or bring issues up in team meetings.

The manager had held a relatives and residents meeting in order to introduce themselves and share their vision for the future of Long Meadow. The manager said they hoped to develop the involvement of people in how the service was run but this was at an early stage of development.

Good

Is the service well-led?

Our findings

The service was undergoing significant change, both in existing staffing at all levels, and also in its design and delivery of care. The present manager had been in post since the end of February 2015. The manager told us when they first started in post they carried out an audit of the service against the Key Lines of Enquiry published by the CQC. They shared this with us with their action plan. The manager told us they had a clear vision of how they wanted the home to improve, with a stable staff team, particularly nursing staff, who had the necessary skills and experience being a priority. They also wanted to review and improve the quality of care plans. They told us they had shared their vision with the staff team and those staff we spoke with were positive and enthusiastic about the proposals.

The manager told us they planned to enhance the role of senior carer and had already identified staff to undertake further training to equip them for the role, this included management training and safe administration of medication. They said they hoped the senior care role would work alongside the nursing staff. They said they were also planning to develop lead roles in the areas of dignity and infection control. The manager said they felt staff morale was improving, but the lack of permanent nurses was placing stress on care delivery, particularly the responsibilities which have historically been assigned to the nurse's role which could be undertaken by other staff within the staff team.

Staff confirmed the manager spent time on the floor talking and working alongside staff. They said they felt it important to have a visible presence and an open door policy.

The manager explained that as Long Meadow Care Home is the only service registered with this provider they did not have the same support networks that larger providers have. The manager told us they took responsibility for these themselves. They were a member of the local ICG (Independent Care Group) who provide support and information about new legislation. They said they utilized the internet to keep up to date with NICE guidance and up to date current good practice. They told us they were proactive in developing good working relationships with partner agencies in health and social care. The feedback we received from these agencies supported these statements.

The manager explained there were a range of quality assurance systems in place to help monitor the quality of the service the home offered. This included formal auditing, meeting with the provider and talking to people and their relatives. Audits ranged from regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, firefighting and detection equipment. There were also care plan and medicines audits which helped determine where the service could improve and develop. Audits confirmed some of the issues we had identified during the inspection with regard to the detail of care plans and risk assessments.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding team, police, deprivation of liberty, and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider failed to provide sufficient skilled and qualified staff to ensure the safe delivery of care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not take steps to plan and deliver care in such a way that it ensured the welfare and safety of people.**