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Longmead House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Longmead House is a care home providing personal care and support for a maximum of 23 older people. Accommodation is set over three floors all of which have access via stairs or a lift. On the day of our inspection there were 17 people living in the home, 12 of whom were living with dementia.

The inspection took place on 12 April 2018 and it was unannounced.

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.

There was a registered manager at the service at the time of the inspection. 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.

At our last inspection in April 2016, we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements to the care records they held on people, some of which were out of date or giving contradictory information about people's needs. Following the inspection, the registered manager told us they would introduce a new care plan format and review people's care records. We found that this had been implemented and saw some good examples of care records on this visit. The registered manager has recruited a deputy manager to support them with the record keeping and auditing the quality of care.

However, we found care planning and risk assessments needed to be more consistent and fully completed for all people. Other improvements that were needed at the last inspection had also not been fully implemented. The recording of mental capacity assessments were not always completed correctly in relation to the Mental Capacity Act 2005. People who had 'as required' (PRN) medicines still did not have a protocol in place. During and following our inspection the registered manager took steps to demonstrate to us they would put these things right. We will monitor this and check the improvements have been embedded into practice and sustained at our next inspection.

There were very good relationships between staff and people living at the home. Care was provided in an inclusive, person- centred way by staff, who were appropriately trained and supervised by a manager. There were sufficient numbers of trained staff to meet people's needs safely. The provider had carried out appropriate checks on staff to ensure that they were suitable for their roles.

Staff were able to tell us of the risks to people and what they did to keep people safe. Staff understood their responsibilities under safeguarding and how to prevent and report abuse. People's medicines were stored

safely at correct temperatures in locked cabinets, and the management of people's medicines was safe.

People were protected from infection and staff were practicing good hygiene. There were systems and checks in place to ensure cleanliness and to reduce the risk of infection.

The manager was working with staff to make changes in practice, using the learning from recent incidents.

People were receiving good and effective care. Each person had an assessment and care plan in place, and they were involved in deciding how their needs should be met. People were looked after by staff who had been well trained, and with the skills they needed to carry out their role.

People were supported to remain as healthy as possible. Staff enabled people to get specialist healthcare when it was required. There was evidence of good relationships with local health care professionals. The needs of people living with dementia were taken into account.

The building had been adapted to meet the needs of people living there whilst retaining a homely environment. Visitors and relatives were made welcome and people were supported to maintain relationships with people close to them.

People told us they were supported to live as they wished and be independent. Staff respected people's wishes and choices and acted to improve their quality of life. People's care plans were personal to them, and staff responded to their individual needs.

People said they felt able to complain or raise their concerns one of the managers.
There was a culture of open communication and the registered manager encouraged feedback, learning and support. The leadership style was person-centred and the care and welfare of people was the priority. Staff were involved in the running of the home and residents and relatives felt their views were heard and responded to.

We received positive feedback from staff, relatives and some healthcare professionals about the way the registered manager led the service. However, because we found continued inconsistency of governance and the recording of important information, we were unable to give a Good rating in all domains. The registered manager has taken action, but these changes need to be embedded and sustained within the practice of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's risks were known, recorded and acted upon.

The staff understood their role in relation to safeguarding.

People were cared for by a sufficient number of trained staff.

People received the medicines they required and medicines were stored correctly and safely.

Environmental and hygiene checks were in place daily and there was an evacuation plan in place.

Learning from accidents and incidents was happening.

Is the service effective?

Good

The service was effective.

Staff applied the principals of the Mental Capacity Act and people were asked for their consent.

The recording of decisions made on a person's behalf was being improved.

Staff were trained to ensure they could deliver care based on best practice.

People were provided with food and drink which supported them to maintain a healthy diet.

People received effective care had access to external healthcare professionals when they needed it.

The premises were adapted to meet the needs of people living there whilst retaining a homely environment

Is the service caring?

Good

The service was caring.

People were treated with kindness and care, respect and dignity.

People were supported to maintain relationships with people close to them.

Staff encouraged people to make decisions for themselves and they were given help when requested.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and ensured their choices, interests and activities were provided for.

People's care plans reflected personal history and interests and were holistic.

People were involved in making their own decisions about their care.

People knew how to raise their concerns or a complaint. These were responded to immediately.

People were encouraged to discuss their end of life care wishes.

Is the service well-led?

Requires Improvement

The service was not always consistently well led.

Improvements were needed in relation to the governance of people's mental capacity assessments.

Positive changes to care plans and the reporting of outcomes from incidents needed to be embedded and sustained within the practice of the service.

Staff felt supported by the registered manager and there was a culture of open communication.

Staff and people were given a say in the running of the home.

The leadership was person-centred.

Longmead House

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 to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 April 2018 and was unannounced. The inspection was carried out by two inspectors.

Prior to the inspection we looked at the information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events and incidents that the service must inform us about.

The provider had recently completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and any improvements they plan to make. We looked at the PIR as part of this inspection.

During the inspection, we observed the support that people received in the communal and dining areas. We spoke with six people, three relatives and one visiting friend. We also spoke with two care staff, the chef, the deputy manager and the registered manager. A number of people could not fully communicate with us due to their condition. We observed how staff interacted with them in order to understand their experience.

We received feedback from four health and social care professionals about the care and about the leadership of the registered manager.

We looked at the care plans for six people. We checked that what was detailed in these plans matched the experiences of the people receiving care. We looked for mental capacity assessments and any applications made to deprive people of their liberty.

We also checked policies and procedures that needed to be in place, accident and incident forms, three staff recruitment files, evidence of staff training, medicines records and recent quality and safety audits that take

place in the home.

Good

Is the service safe?

Our findings

People and visiting relatives told us this was a safe place to live. One relative said, "Staff do everything they can. I know they are safe." We observed staff practices that supported this. People were not left alone in the communal areas and staff were vigilant in observing people's needs throughout the day. One person told us, "I can always get help when I need it. If I push the button, they come and ask me "what's happened?"

Staff were able to tell us of risks to people, and how they kept people safe. One staff member told us, "I check the environment, I make sure people have a healthy diet and that they are getting their medicines on time." They added, "When I am on duty the number one thing is to make sure people are safe." Where people's needs changed, staff were knowledgeable of the need for a risk assessment and demonstrated awareness of the actions to take. The registered manager told us that a person, who had been independent, was now slipping off their chair onto the floor when mobilising. This was being investigated, risks were being assessed and a referral to the falls team had been made.

The risks people might face, and actions to be taken, were documented in their individual care plan. For example, we read, "I need one carer to make sure there are no obstacles…. that could cause me to trip when mobilising." We saw staff consistently supporting people to move around the building and taking action if they noted someone needed help to mobilise. Another person was at risk of social isolation as they spent a lot of time in their room and they had previously been at risk of depression. Their care plan stated staff should engage with them during the day and we could see that this was happening.

People were helped to stay safe because staff understood their role in relation to safeguarding. They told us who they would talk to in the case of any abuse. A visitor to the home told us, "I have noticed that staff, who don't know me, ask questions and watch where I go, to make sure people are safe." We saw that there were safeguarding policies and guidance in place and staff told us, "If I saw a situation between two people I would intervene."

People were cared for by a sufficient number of staff. The registered manager told us that they used one agency carer at night but the rest of the staff team were permanent staff. We looked at staff rotas over the past four weeks. These showed that all shifts were covered with the staff that were needed. We saw staff around the home and in the lounge, and did not see anyone waiting for attention. At lunch time people received their meal promptly. One person told us. "I never feel rushed. Sometimes I wait a few minutes, depends on how busy they are." Another said, "If I press the bell staff come quickly." Staff told us they felt there were enough of them on duty each day. We saw that staff prioritised the needs of people at all times. One staff member told us, "It's all about people's needs and if we were short staff people would still be cared for and it would be something like the washing that didn't get done instead."

People were cared for by staff who had gone through a robust recruitment process. Records demonstrated staff were recruited in line with safe practice. For example, we saw staff recruitment files that contained a past employment history, suitable references, identification and results of a Disclosure and Barring Service check (DBS). A DBS identifies if a person has a criminal record.

At our last inspection we gave a recommendation to the registered provider in relation to 'as required' (PRN) medicines. This was because people did not have individual protocols in place. This is important, particularly for people who may be living with dementia.

At this inspection we found three bottles of liquid medicine that did not have the opening dates written on them. This meant staff would not know if they became out of date. We also found that the homely remedies (medicines that be bought over the counter) policy needed to be reviewed by the GP as it was last done in 2015. People who had PRN medicines again did not have a protocol in place. The deputy manager said, "I know people need them." Before the end of our inspection they showed us a PRN protocol sheet they had developed and said they would ensure these were done straight away. They also told us they would ask the GP to review the homely remedies policy.

People received the medicines they required. One person told us that they knew what medicines they take. They said, "They (staff) always tell me what I am taking and when." This person knew they could ask for paracetamol for pain in their wrist and shoulder if necessary.

We looked at the management of medicines and the medicines administration records (MARs). There were no gaps on people's MAR charts and any handwritten changes to prescription information had been signed by two staff members. Medicines being given were in line with what was written on the MAR. For example, one person's notes said that they had two paracetamol due to dental pain and these had been written up correctly. People's allergies were also recorded on the MAR. We found medicines were stored safely in a locked cupboard and the temperature of the cupboard and the fridge were being checked and recorded.

People were protected from infection and staff were practicing good hygiene. As soon as we arrived, we were asked to use the hand sanitiser for visitors. We saw that gloves and aprons were accessible in bathrooms and that staff were using these. Staff said, "There is always a good supply of personal protective equipment". Bathrooms were clean and people's rooms also looked clean and clutter free. We saw signs to remind staff to change their tabards and wash their hands before going into the kitchen. Alcohol hand sanitisers were available in corridors and there were clinical waste bags available in the bathrooms. The service also had a food hygiene rating of 5, "Very Good" awarded in October 2017.

People were also protected from risks associated with their environment and any equipment they may need. We saw that there was an evacuation plan in place on the notice board and each person's needs had been identified. In one bathroom there was a sloped ceiling with a sign warning people and staff to "mind their head", and there were instructions in the building to keep fire doors closed. The fire and door alarm testing and checks were being carried out that day and routinely at least once a week. The call bell system was also checked weekly.

The reporting of accidents and incidents to learn from events was happening in practice. Following a recent incident, when a person left the building unnoticed by a side door that was unalarmed, the registered manager told us they had all learnt from this. They had put in place actions to stop this happening again. A daily door alarm check was now in place and staffing presence in communal areas had been increased. The registered manager had organised the trainer to do a safety and safeguarding review with the staff. The registered manager told us, "People feel safe in our care. However we are never complacent and always feel there is room for improvement."

Good

Is the service effective?

Our findings

At our previous inspection, we issued a recommendation in relation to the timely completion of mental capacity assessments under the Mental Capacity Act 2005 (MCA). We found, at this inspection, some work had been done and the staff were applying the principals of the Act. For example, people were asked for their consent before staff carried out any care. One staff member told us, "People can express themselves in different ways," and "Everything must be done in people's best interests." However, we discussed with the registered manager further steps that were needed to ensure they were fully compliant with the Act in the way they recorded capacity assessments and decisions made on a person's behalf.

The Mental Capacity Act (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 people 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). Two recent applications under DoLS had been submitted by the registered manager to the local authority, with another in process, but we could not find the mental capacity assessments prior to the decision to put restrictions in place. Following the inspection the registered manager sent us records of where individual capacity to make decisions had been assessed. These included the best interest decision for constant supervision, use of sensor mats, and locked doors prior to a DoLS application.

People were receiving effective care and their individual needs were being met. Each person had an assessment of their care and support needs before they began using the service meaning that their essential needs could be met. One person, who recently moved in, had been underweight. Their care plan said, "Needs extra calories", and to be, "weighed weekly." There was evidence to show this was happening and they had already put on weight.

A detailed care plan, including guidance for staff carrying out any care, had been put in place. These were being reviewed each month. We saw how all aspects of a person's life affecting their day to day care was covered; including their mobility, communication, eating and drinking, personal care, psychological support , their sexuality and end of life care wishes. This demonstrated that, where possible, people were involved in their care plan and some statements were recorded in their own words. For example, "Allow me to be as independent as possible." Another recorded that the person, "likes to be dressed well and express her femininity."

People were looked after by staff who had been well trained, and with the skills they needed to carry out their roles effectively. One staff member told us, "The training is good. We do quite a lot of it. There is nothing holding me back from doing my job." The registered manager told us they employed staff with the

right skill mix to respond to people's needs. We learnt that they encouraged professional development. A staff member said, "Anytime we want training the (registered) manager puts us forward for it."

The training folder showed that this year staff had received training in person-centred care, end of life care, dignity and food hygiene. There was also an equality and diversity course booked. Staff were able to tell us about regular supervision with their line manager and that they received an annual appraisal. For example, one staff member told us, "At my last supervision we talked about doing daily audits on medicines."

The registered manager remained up to date with new legislation and good practice guidelines by being members of the National Care Homes Association and Croner Care Home Management. They attended care seminars and received regular updates. Staff said that, "They (the registered and deputy manager) feed information back to the staff team about latest practice."

People were supported to remain healthy through the actions of staff. The care plans evidenced weight monitoring and the use of screening tools to identify risks for people such as diabetes and Parkinson's. Staff told us, "I can always speak to the GP or the chemist if I have any queries about anything. They will give me guidance and information." We found evidence of good working relationships with local GPs, the pharmacist and community nurses. One person told us, "They (staff) will call the GP and I have to tell the GP what's up with me." One healthcare professional said that staff were, "On the ball" with medicines and followed up promptly to any new prescriptions that people needed.

People received support from specialised healthcare professionals when required. For example, one person had a community psychiatric nurse involved in their care. On the day of our visit, staff were monitoring a person's health closely as they were having unexplained nosebleeds. The staff had accompanied the person to hospital the day before and were in communication with the GP. There was evidence through discussions with the registered manager that they were in contact with the hospital if people were admitted.

People had access to sufficient food and drink and their nutrition and dietary needs were recorded on admission. Staff had access to practice tools and information on monitoring nutrition. They could tell us the signs of dehydration and knew what to do about it. The menus showed that a good range of foods was made available to people. One person said, "The food is very good and I know what is on the menu."

The chef told us they met people when they moved to the home and learned people's tastes. One person said, "The chef asks me every day what I want to eat… it can be a bit difficult as there are things I can't eat." People living with dementia were helped to choose meals with the use of pictures. If someone was on a pureed diet, the chef would usually puree the same meal that everyone else had. We observed the lunchtime and found that people enjoyed their food and staff were attentive. The registered manager told us that they responded to people's feedback about their food, in whatever way they could and took into account the time of day, cultural or special needs when planning meals and snacks.

The premises were adapted to meet the needs of people living there whilst retaining a homely environment. The needs of people living with dementia were taken into account. For example, there were pictorial signs displayed to show people where the dining room and lounge were. There was sufficient space for mobility aids in the communal areas and there was a lift to enable access to the other floors. We noted that one person had their own specialised chair. The outside space was accessible and level. The registered manager's office was near the front door and they took an interest in ensuring the building was well maintained. They told us, "I do daily checks. If I identify issues I can sort these out immediately." Improvements to the outside and redecoration of people's rooms had taken place since the last inspection

as planned.

Good

Is the service caring?

Our findings

People told us they were treated with kindness and patience by the staff. One person told us, "Staff come and chat to me. There is nothing much they could do better." Another said of one of the staff, "She is so attentive to us. I can tell my troubles to her." One healthcare professional said they, "Frequently, observe the manager and the care staff treating the residents with kindness, respect and dignity."

People experienced positive and caring actions by the staff. We saw how concerned staff were about a person who was unwell that day, often checking back on them and making sure they were as comfortable as possible. Another person was being given their medicines. Staff approached them with the tablets and a drink of water, crouched down to their level to explain that they had their tablets and waited until they took them. We saw staff laughing with people, hugging them and sitting closely with them whilst chatting. There were good relationships between people and staff. People looked content.

People were supported to maintain relationships with people close to them. We saw several visitors arrive during the day and they said they always felt welcomed by the manager and staff. A friend who was visiting said, "If I had to go into a home, I'd be very happy here. The staff are very good." A relative told us, "The staff always talk to her and treat her well... it is difficult to find fault."

People were encouraged to make decisions themselves where they could, and given help when requested. One person said, "I have my room exactly how I want it….I can chat to staff as an individual." We noticed that some people went out whenever they liked. One person, whose care plan stated, "I want to remain independent", told us that they went out to the high street on their own during the day.

Staff showed respect for people and their wishes. They adapted their communication for people living with dementia. A staff member explained, "I always ask people. I look into their face and I keep explaining whilst I am doing things." We observed that a person wanted to visit another, who was unwell in their room. Staff went to ask whether the person was, "Ready for a visitor and chat." Another person, who was used to a specific routine, said that that staff were aware they needed to have things on time. They told us, "Staff are always spot on time wise." One person told us they chose to sit in their room most of the time and staff respected this.

Staff were able to tell us the importance of confidentiality in their work. One staff member said, "I always keep people's individual information private. It's all about people's privacy and respecting them."

Good

Is the service responsive?

Our findings

We received positive feedback from a relative on our inspection, which read, "Great care home. The care offered is personalised. It always feels homely. The staff know the residents."

People's personalities, their likes and dislikes were well understood by staff. One person told us, "Staff know me undoubtedly. They know I like the same towel back in my bathroom and they do that. They know that I like black sweet coffee with a biscuit and they know that when they change my bedding I don't like a flowery duvet cover." Through the keyworker relationship, staff took a personal interest in an individual and ensured their choices were respected. We saw that people's rooms were personalised with people's belongings and had individual taste in the décor.

People's care plans were made personal to them as well as covering their needs in a holistic way. There was a section "My Life Before you Knew Me" where aspects of the person's life, their history, significant relationships, occupation and interests were recorded. We saw that these were completed with relevant information such as," I worked many years managing a grocery store." And, "I enjoy time alone in my room." In one person's plan, there was guidance for staff on arm exercises that the person needed to do three times a day. When asked, staff were able to describe what was needed. "We always do them with (person) in the morning and we choose our times to do them other times during the day because they don't really like doing them."

One person who was a Christian told us they were supported to practice their faith, and attend their own church. Staff knew when they must be ready and someone from the church came to collect them to attend church with friends. The home also held a monthly church service, but the registered manager was clear that it was a matter of personal choice to take part. People had their communication needs met in different ways according to their needs. We saw that staff were talking closely with people, and using physical touch appropriately to engage with people who were living with dementia. The chef told us how they went to talk to each person individually to find out their food preferences.

There were notice boards in use, displaying menus, activities and the complaints process, but staff recognised that this information was not very accessible to many people living with dementia. One staff member told us, "We always talk to people to make sure they understand." And people told us they can, "Always talk to someone here." And, "I can chat to staff as an individual."

People said they felt able to complain or raise their concerns with one of the managers. There were no recorded formal complaints. The registered manager said that this was because they always respond to concerns immediately. They told us, "We deal with it straight away; on the spot." One person told us that they had verbally complained to the registered manager and, "I never saw the staff member again." Another person also said they had complained about when they had been upset by another resident. They said, "The (registered) manager really helped me."

People told us how the staff responded to their individual needs. One person was not sleeping well and

feeling uncomfortable in a single bed. They requested a double bed. The registered manager undertook to resolve this. Within a week, a double bed was provided for them and the person now slept well and was much happier. This person told us, "Anything I've needed I've always had a chat to staff about and they sort it."

People enjoyed some formal activities during the week. We observed a Music for Health session. People were engaged, clapping to the music, singing along and answering questions about bands and musicians. We heard from people that they enjoyed these sessions. Staff told us that some people, "Don't really want a lot going on. We will sit with someone for example and do knitting with them and try to get them involved." We saw that staff engaged with people in the lounge and people were happy and relaxed.

Although there was no one being cared for at end of life at the time, people were encouraged to discuss their wishes and these were recorded in their care plans. The registered manager said this was done sensitively and respecting some people would not want to discuss this. We noticed that there was information displayed on the office door inviting people to talk about it if they wished. Staff were trained to support people at end of life and to enable people to remain at the home for as long as possible as they wished.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we made recommendations to the registered provider in relation to care planning and their mental capacity assessments. Improvements had not been fully or consistently implemented. The recording of mental capacity assessments were not always completed correctly in relation to the Mental Capacity Act 2005. People who had 'as required' (PRN) medicines did not have a protocol in place.

Accident and incident reporting was being done. However, the use of accident and incident forms was inconsistent. Some were recorded in an accident book and others in a more comprehensive incident form. It was not always easy to identify what the outcome of an incident was and what action staff had taken to avoid reoccurrence. We saw that two forms stated people went to A&E following a fall but there was no further information. One of these people had been injured and the manager had submitted a notification to us. The correct care and treatment had been provided but this was not added to the incident record. The inconsistent records meant that it was difficult for the manager to look at patterns of incidents across the home and monitor outcomes.

We also found a record in one person's care plan which referred to a recent incident between two people. During this, one person had told staff that the other person had, "hurt her left arm". There was no accident/incident form completed and no safeguarding notification drawn up. We brought this to the attention of the registered manager who said they continually assessed the relationship between these two people.

Although improvements were being made to the care plans and we saw some good examples, we also saw that a risk assessment and care plan for a person who had been there for four months on respite care was not comprehensive. This person was living with dementia and had been recently injured after leaving the home unsupervised. We had been notified of this incident, but the person's risk assessment had not yet been updated, even though this was one of the actions identified to prevent further similar events. The registered manager agreed to address this and sent us a review of the person's risks and a full care plan immediately after the inspection.

A person who had moved into the home a week ago did not have a detailed care plan in place yet. For example, there was a nutritional risk assessment form which was blank. The person had a diagnosis of macular degeneration but there was no further information about this. There was a hospital discharge note with a body map which showed some marks on their body when they moved in, but there was no further detail on what, if any, care was needed. The manager said they would usually complete care plans within 2 days of a person's admission and they were aware this needed to be completed.

We received positive feedback from staff and healthcare professionals about the way the registered manager led the service. A healthcare professional said, "The manager leads by example in showing compassion to the residents and supporting them to remain independent where possible."

The manager had developed effective working relationships with other professionals. They said they spoke

with the local authority on a regular basis and had good working relationships with the GPs. They also attended the Surrey Care Forum. One professional told us, "From my experience, the manager engages with our service, attends the forums we facilitate, and sends staff to training events. Residents are not admitted to hospital unnecessarily ….liaising with health care professionals appropriately."

Staff told us how the manager was supportive and made them feel valued. There was a culture of open communication and the registered manager encouraged learning and support. A staff member told us, "She deals with staff fairly and promptly." The staff felt they could contribute and make suggestions or raise questions. One staff member said, "We have regular staff meetings. We talk about the house, improvements, concerns and whether people are happy." The registered manager also held a daily catch up meeting with staff to keep abreast of immediate issues about the care of people.

Although we received positive feedback from people, relatives and staff about the management we were unable to give the service a Good rating in Well-Led. This is because of continued inconsistency of recording important information about people's risks and their capacity for decision-making. The registered manager and deputy manager provided information and have taken action, but these positive changes need to be further embedded and sustained within the practice of the service

The leadership approach was person centred. We saw that the registered manager's priority was always the care and welfare of the people who lived at Longmead House. This was also evident in the staff meeting topics that we saw discussed, as well as how the staff and the registered manager interacted during our visit. The registered manager said they aimed to continually improve the service. Staff also told us, the registered manager, "Wants to make a difference", and is, "Open to new ideas."

Quality assurance audits were in place with either daily, weekly or monthly checks carried out by the registered manager or the deputy. For example, we saw there were daily checks on moving and handling, staff uniforms, cleanliness of communal rooms and toilets, home maintenance and access to cleaning materials. There were monthly checks on the equipment and mobility aids, food and kitchen hygiene and water temperatures.

People and their relatives had a say in how the service was run and were consulted about suggestions for improvement. One relative had fed back concerns about the use of a hoist. The manager had responded by inviting the relative in to see how staff used this with the person concerned and offered training for new staff. Feedback from the last annual survey were very positive, with 100% agreeing that people were, "Kept safe and well protected", and that the service communicate clearly and, "Worked in partnership with them."