Roseberry Care Centres GB Limited

Long Meadow

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Long Meadow is a residential care home providing personal and nursing care to up to 41 people. The service provides support to older people, some of who are living with dementia. At the time of our inspection there were 33 people using the service.

People's experience of using this service and what we found
We found several concerns around the management of people's medicines, including people not receiving their medicines safely and record keeping. People were at increased risk from the environment; fire safety and infection prevention and control risks were not always managed. People's health-related risks were not always consistently monitored, increasing risks to people. The provider had not always made safeguarding referrals to the local safeguarding adults team. This meant people were not always protected from the risk of abuse. We found there were enough staff to meet people's needs and staff were recruited safely.

The provider did not always follow their accidents and incidents, infection prevention and control and falls policies. This meant procedures to promote people's health, safety and wellbeing were not always operated effectively. Audits on people's medicines did not always promote sustained improvement where concerns had been found. Relatives mostly felt staff cared but shared concerns about people's personal items going missing. The staff did not always receive consistent supervisions to reflect on their practice. However, the provider held regular team meetings and sought feedback from people using the service and their relatives. The provider worked in partnership with external healthcare professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection and update
The last rating for this service was requires improvement (published 3 March 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

We found no evidence during this inspection that people were at risk of harm from concerns we received about staffing. However, we have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. The provider took action to mitigate risks to some of our concerns during the inspection, however concerns remained in other areas.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Long Meadow on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed. We have identified breaches in relation to people's safety, safeguarding and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Long Meadow

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Long Meadow is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Long Meadow is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service. We observed how staff supported people. We spoke with 10 relatives about their experience of the care provided.

We spoke with 8 staff during our inspection including domestic staff, maintenance staff, kitchen staff, carers, senior carers, admin staff, the deputy manager, the registered manager and the regional operations manager.

We reviewed 5 people's care records. We looked at 2 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including health and safety checks, medicines records and incidents and accidents.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not always managed safely.
- People did not always receive their medicines when they required them. For example, one person had 2 loose tablets in their medication container; they had not received these when they needed them. We counted another person's medicine and found staff had not correctly counted tablets. The person had also not received this medicine when they required it.
- People were not always supported to have medicines delivered before they ran out. We found a person had not received the medicine they needed for their health-related needs for 3 days.
- Cleanliness of medicines administration areas was not always maintained by staff. We found dried and sticky residue on one person's liquid medicine bottle. In addition, cleaning records of another person's inhaler spacer had not been completed since 1 July 2022.
- Medicines documentation was not always completed in line with best practice. Records showed 2 staff members had not signed handwritten medicines administration records to confirm instructions had been correctly recorded. This increased the risk of people not receiving their medicines correctly.
- Protocols for medicines taken by people on an as-required basis were not always in place. This meant staff may not know when people needed these medicines.

Preventing and controlling infection

- Infection prevention and control measures were not effective.
- People and visitors were not always effectively prevented from catching and spreading infection. During the inspection, there was a current COVID-19 outbreak in the service. However, signage had not been displayed to inform people, staff and visitors of this. Two members of staff we spoke with did not know who had tested positive for COVID-19. This meant they could not take precautions like using increased personal protective equipment (PPE) to help prevent the spread of infection.
- Staff did not always use PPE in line with national guidance. On the first day of our inspection, we found staff did not always wear facemasks to cover their mouths and noses fully. We also observed a member of staff who had not been bare below their elbows and had worn jewellery on their wrist. This was not in line with effective hand hygiene practices and increased the risk of infection spreading.
- The home had not been effectively cleaned. On the first day of our inspection, we found communal lounges had excess dust, debris and stains from drinks spillages. Two communal bathrooms had signs of brown residue. People's bedrooms had not always been sufficiently cleaned. For example, one person had a used continence pad under a radiator at the side of their bed. These areas increased the risk of infection harbouring.

Assessing risk, safety monitoring and management Learning lessons when things go wrong

● Window restrictors were not fitted to all windows. We found window restrictors were not fitted to 2 windows in 1 hallway. This increased risks to people who could fall out of windows. In addition, we found a window restrictor fitted to an unlocked double patio door, creating a risk where people could fall and get injured.

● Risk assessments had not been completed for 4 people using portable heaters at the time of our inspection. This meant people could have been at increased risk from hot surfaces.

● Fire safety was not always maintained. During the inspection, we reviewed the provider's fire risk assessment. We found not all actions had been completed. This included repairing walls where pipework travelled across rooms and ensuring fire doors were to the required standard. This increased fire-related risks to people.

● People were able to access areas where they could potentially be injured. Storage cupboards which should have been locked were not always secured. We found the kitchen door keypad lock could be opened without a code. This increased risks to people who could be at risk from hot surfaces and sharp utensils.

● People did not always receive consistent support with repositioning. People are repositioned to help reduce pressure and prevent skin from breaking down, leading to pressure ulcers. We found a person was not always repositioned as often as their recording document stated they needed to be. In addition, their care plans did not contain information about how often they should be repositioned. This increased the risk of the person not receiving consistent support to prevent pressure-related skin damage.

● Health-related monitoring was not always completed consistently. For example, we found that people's Malnutrition Universal Screening tools were not always completed monthly. Likewise, another person's falls risk assessment had also not been completed monthly. This increased the risk of people not getting timely support for their health-related needs.

● Incident and accident forms were not always sufficiently detailed or completed. For example, we found an incident and accident form did not detail who was involved in an incident where a person behaved aggressively towards others. This means risks to service users were not always assessed and mitigated following incidents and accidents.

● Lessons were not always learnt from incidents and accidents. For example, a person's care plan had not been updated following concerns of the person not taking their medicines and relatives finding them on their bedroom floor. This meant staff may not have known the best way to support this person to take their medicine, or if they refused them, arranging for these to be returned to the pharmacy safely.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate environmental and health-related risks, and ensure people received their medicines safely. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to some of our concerns during the inspection. For example, they sought medical advice, where we highlighted people had missed their medicines. They arranged for medicines to be brought back into people's stock. They began carrying out supervisions with staff to address concerns in relation to medicines, PPE and record keeping. In addition, they introduced signage to inform people of the COVID-19 outbreak and reviewed their fire risk assessment.

● The provider held 'health and safety huddles' daily. These meetings were held with staff on duty to discuss any incidents and accidents and how risks could be mitigated. In addition, the provider had systems in place to document handovers between shifts. This promoted people's needs being met and highlighted any concerns being mitigated.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse.
● Safeguarding referrals were not always made. We found unreported safeguarding concerns in people's daily records and by speaking to the registered manager, which should have been referred to the local safeguarding adults team. This meant the safeguarding adults team were not always aware of these safeguarding concerns to independently review how they should be investigated.

Systems and processes were not used consistently to protect people from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw evidence the provider had investigated other safeguarding concerns and taken appropriate action. This included seeking support from medical professionals in response to identified mental health support needs.
● Information was available in the reception on whistleblowing and reporting concerns. This included contact details for senior managers, directors and contact details for the local authority safeguarding adults team.
● Staff had received safeguarding training and could tell us how and when they would report safeguarding concerns.

Visiting in care homes
● The provider was supporting visits in line with current national guidance. During the inspection, we saw visits taking place. Relatives we spoke with did not share any concerns about visiting.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
● There were enough staff to support people. We carried out this inspection in part due to concerns we had received about staffing. However, we did not find any concerns in relation to staffing during the inspection. Recent staff schedules showed the service had been staffed consistently. We observed staff provided prompt support to people when they needed it.
● Staff were recruited safely. The provider had carried out checks by obtaining references from previous employers, right to work documentation and Disclosure and Barring Service (DBS) checks were also contained on staff files. DBS checks provide information, including details about convictions and cautions held on the Police National Computer.
● There were arrangements for 'on-call' support from a manager. This meant staff could contact management for any out of hours concerns they needed advice about.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure that systems and processes were in place to drive quality and improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements Continuous learning and improving care

- The provider was not always operating their policies effectively. We found the provider did not adhere to their infection control, accident and incident, and falls policy. Aspects of policies which promoted people's safety, health and welfare were not followed. For example, the infection prevention and control policy stated signage should be in use for infectious outbreaks and we found this had not been the case. Furthermore, as cited in the safe section of this report, accident and incident forms should have been documented with complete details.
- Accurate, complete and up-to-date records were not always maintained. As stated in the safe section of this report, we found health-related monitoring was not always consistently completed. This increased health-related risks to people.
- Management oversight of required actions from the provider's fire risk assessment was not effective. The provider had not ensured actions signed off were fully completed to reduce and manage fire-related risks to people.
- Systems and processes to audit people's medicines had not been effective at promoting sustained improvement. The registered manager had completed a recent medicines audit and found actions were needed in relation to record keeping and cleanliness. However, we found that any actions taken had not resulted in sustained improvement due to the medicines concerns we found.

Systems had not been established or operated effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at increased risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not always met requirements to submit statutory notifications to CQC. We found that the provider had not notified us of all allegations of abuse and pressure damage to people's skin. Statutory

notifications give CQC important information about key events in a service, including actions taken to mitigate risks. This information can also help inform us of when we will next inspect. We will continue to monitor this.

● The registered manager completed weekly and monthly reports, which included information about complaints, health and safety issues, and incidents and accidents. This information was reviewed by the provider to support risks being mitigated and the development of the service.

● The registered manager had recently completed training on investigations and disciplinaries. This promoted effective and consistent handling of investigations and people's care improving following concerns being received.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives gave us mixed feedback about the culture in the service. Most relatives told us they felt the staff were caring. However, relatives also told us of less positive experiences, like people's items going missing. People's personal items which had gone missing ranged from mobile phones, watches, glasses and clothes.

● During our inspection, we observed staff interacting with people positively. Staff were patient with people when supporting them to mobilise; they encouraged people to use their walking aids where needed to promote people's safety and mobility. People enjoyed their interactions with staff, and we observed staff singing and dancing with people throughout our inspection.

● The manager told us they had an open-door policy and a member of staff we spoke with felt comfortable they could raise concerns with the registered manager and deputy manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff did not always receive consistent supervisions from managers. This meant staff did not always have regular opportunities to reflect on their practice, share concerns and be supported with their continued professional development.

● Relatives were mostly positive about how the service communicated with them and kept them informed. Relatives told us they were informed if relatives had a fall or if they attended any appointments. Relatives also told us they had been informed about the COVID-19 outbreak at the time of our inspection.

● Staff were recognised for their achievements. For example, the provider used an 'employee of the month' initiative to recognise when staff had excelled in their roles.

● There were systems in place to share information with people and receive feedback about people's experience of the care they received. The provider carried out annual surveys. We also saw a recent newsletter displayed, which contained good news stories, such as a recent Halloween party and details of upcoming events, such as planned activities and people's birthdays.

● Staff had the opportunity to attend regular team meetings. We reviewed recent team meeting minutes where staff had discussed teamwork, people's care needs and staff scheduling. This gave staff an opportunity to share concerns and make plans for improvements to the overall running of the service.

Working in partnership with others

● We saw evidence of the provider working in partnership with others. This included making referrals to external health professionals such as dieticians and physiotherapists. The registered manager felt they had good relationships with social workers and district nurses.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider's policies and procedures supported an open and honest approach to communicating with

people when things go wrong. We found no concerns in relation to the duty of candour at this inspection.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not used consistently to protect people from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate environmental and health-related risks, and ensure people received their medicines safely. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Warning Notice to the provider for this breach in regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established or operated effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at increased risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a Warning Notice to the provider for this breach of regulation.