Dwell Limited

Long Lea Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Long Lea Residential Home is a care home providing personal care and accommodation for up to 35 adults living with dementia or mental health needs, physical disabilities and sensory loss. The care home is a two-storey building with en-suite bedrooms and communal facilities. At the time of our inspection visit there were 26 people receiving care.

People's experience of using this service and what we found
Since our previous inspection there had been changes in the management team. The previous registered manager had left in March 2021, another manager had been in post for three months but left in June 2021 when the current manager started in their role. The management team worked alongside other agencies to drive required improvements. However, the provider still needed to make further improvements to ensure they maintained sufficient oversight of the service. For example, risks associated with people's care were not always identified and assessed and governance systems to monitor the quality and safety of the service continued to require improvement.

People spoke positively about the staff and the care they provided. Staff felt supported by their management team. People were positive about the new manager's leadership.

Care records were recorded both on paper and electronically and some staff had not read paper risk assessments which provided guidance for staff about how to keep people safe. Some care records were not accurate and had not been reviewed.

Incident logs were not up to date which meant the system to analyse why incidents may be occurring was not effective.

An 'infection prevention control' audit was carried out by CQC during the inspection. We found the provider was not always following government guidelines. Improvements had been made to infection prevention and control practices following support from the local authority (LA) and the local clinical commissioning group (CCG). However, further improvements were still required to keep people as safe as possible and minimise infection control risks associated with COVID-19.

There were enough staff on duty to meet people's physical needs, but on occasions people waited for support.

The new manager was open and explained they had worked hard to make required improvements in a short time. They understood further improvements were still required. They took some immediate action during and following our inspection visit where significant shortfalls had been identified.

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 12 February 2021) and there were two breaches of regulations.

Why we inspected
At our last inspection of this service, breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance in the home.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led.

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.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches of the regulations in relation to the safety of people's care and the management of the service.

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, the local Clinical Commissioning Group (CCG) and the local authority (LA) to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Long Lea Residential Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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
The inspection was carried out by two inspectors who visited the home and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience contacted relatives by telephone to gather feedback on their experiences of the home.

Service and service type
Long Lea Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided and both were looked at during this inspection.

At the time of the inspection visit there had been a manager in post since June 2021. They were applying to the CQC to become the registered manager. The registered provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Our inspection was announced. We gave the service 60 minutes notice of our visit because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of the home's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and any recurrent themes of concerns. We sought feedback from the local authority and commissioners who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We carried out observations to assess people's experiences of the care provided. We spoke with the manager, the deputy manager, a director of the provider company and nine staff including care, activities, catering and housekeeping staff. We spoke with three people who lived at the home to gather their experience of the service.

We reviewed five people's care records and nine people's medicines records. We looked at a sample of records relating to the management of the service including training data, improvement action plans, health and safety checks, policies and procedures and a sample of completed audits and checks.

After the inspection
We spoke with seven people's relatives via the telephone. We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed

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

At our last inspection, we found systems and processes were not sufficient to demonstrate risk associated with people's care was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and there was a continuing breach of regulation 12.

• Although some improvements had been made in risk management, we identified continued concerns where some risks was not always identified, assessed and managed effectively.
• Most people we spoke with told us they had been involved in managing risks to their relatives. For example, one person told us they had requested a review of their relative's medicine by the GP because they complained of increased pain. Staff supported the person to be reviewed and their medicine was changed. However, one person explained they were not aware how risks to their relative were being managed following recent falls. We raised this with the manager for clarification.
• People were at risk of potential harm as some staff were not fully aware of what risk assessments people had in place and how to mitigate risks. Systems in place to ensure staff had read and understood assessments were not effective.
• Some known risks had not been assessed. For example, one person lived with dementia and had on occasions displayed behaviours that put staff supporting them at risk of harm. There had been no assessment of risk for this behaviour and therefore no guidance for staff to follow to minimise the risk when these events had occurred. Following our inspection, the manager provided evidence the person's care needs had been reviewed and an assessment of risk put in place, but it was not clear how this information had been shared with staff.
• There were significant discrepancies in the same person's weight in their nutritional assessment. These discrepancies had not been identified by senior staff, which meant risks related to this person's nutrition had not been accurately assessed.
• Some risk assessment were not sufficiently detailed to provide guidance to staff about how to support people safely. One person's diabetic risk management plan did not include information about the type of foods they should be supported to eat to stay healthy. Some staff were able to tell us about how nutritional risks for this person were managed, however one member of staff was not able to tell us and had not undertaken training in this area. We asked the manager why the risk assessments contained gaps. They responded, "I didn't get round to doing it, we are trying to work to get everything done."
• One person who was at risk of malnutrition and dehydration, had food and fluid charts to monitor their safe nutrition. There were gaps in the recording on the person's charts, so it was not clear how much the

person had eaten or drunk. The manager told us they checked the electronic records every day, but there was no record of these checks or how the person's intake was evaluated to ensure they ate and drank enough to maintain their health.
• People were at risk of potential harm because when incidents happened, they were not always reviewed, so plans may not be put in place to reduce the risk of further harm.
• Since our previous visit there had been a fire in the grounds of the home. Following the fire, the home had been reviewed by the local authority (LA) Fire Team in May 2021 and by an external consultant contracted by the provider. Significant improvements were identified by the Local Authority and the external consultant and the provider completed a programme of works to minimise the risks of fire.
• During our visit we found two fire doors were propped open and did not close properly. We raised this with the provider who did a full check of all fire doors on the day of our visit. Although senior staff checked doors on their daily walk round of the building, there was no audit in place to check fire doors closed properly. The provider put this in place on the day of our visit.
• The provider had no record of which staff were qualified fire wardens or if a warden was available on each shift. The manager was not aware of the recent local authority (LA) Fire Team visit and did not have access to their report.
• The provider had systems in place to prevent visitors from catching and spreading infections and to meet shielding and social distancing rules, however, these were not always effective. On the second day of our inspection two members of staff did not wait until their COVID-19 test result was fully processed before entering communal areas of the home. This posed a risk of spread of infection.

This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

Staffing and recruitment
• Concerns were raised at our previous inspection because several permanent members of staff had left the service at short notice. This meant remaining care staff were asked to work longer hours and there was an increased reliance on agency staff to fulfil the staff rota. Although improvements had been made and more staff had been recruited, there were still concerns because staff were very busy.
• We observed there were enough staff to provide support to meet people's needs, however some call bells rang for several minutes before being answered. On the first day of our visit some people complained about waiting to be assisted to the toilet.
• All care staff we spoke with told us they were very busy. Comments from staff included, "We are run off our feet, it is unbelievably busy" and "We are short quite a lot…People have had to wait for things."
• The manager showed us the tool used to calculate how many staff were required to support people. The manager told us they would seek support from the provider if they felt there were concerns with staffing levels.
• Improvements were required in recruitment processes. Five members of care staff did not have a verified reference from their previous employer to help ensure they were of good character. The manager and deputy manager told us they were responsible for recruitment checks, however they agreed there were gaps in their knowledge. The manager and deputy manager had not read the provider's recruitment policy. The provider was not aware of these issues and scheduled some training for both managers. By the second day of our visit, the manager had checked all staff references and verified them all apart from one which was in progress.

Preventing and controlling infection
• The home had received an IPC audit in November 2020 by external agencies, where significant improvements were identified. While many actions had been taken to address these shortfalls, we found further improvements were required. The manager and provider were aware and continued to work

together with those agencies to complete the actions.
• The provider had systems in place to meet shielding and social distancing rules.
• No one had been admitted to the service since the manager had started their role due to the agreement the provider had with the local authority (LA) commissioners. When we asked the manager about their admissions policy, they were not sure of the details in line with current guidance. However, they updated us with clear guidance following our inspection visit.
• Guidance for effective hand-washing techniques and the correct use of personal protective equipment (PPE) were on display. Staff were observed wearing PPE correctly.
• The provider was accessing testing for people using the service and staff.
• Improvements had been made to promote people's safety in the layout of the home and hygiene practices. The number of dedicated cleaning hours had been increased, however there were some areas which were not clean, such as specialist equipment in people's bedrooms and mops were not stored according to best practice. The manager acted straight away to improve cleaning procedures.
• Some staff had received online infection control training and training in safely donning / doffing personal protective equipment (PPE) from the local authority (LA). However new staff had not received this training. Further local authority training was scheduled for new staff who had recently started.
• There were gaps in people's COVID-19 care plans and assessment of risk. This was not in accordance with current government guidance and the provider's policy.
• We have signposted the provider to resources to develop their approach in assessing infection risks for people.

Using medicines safely
• At our last inspection we found some processes to support safe medicines practice needed to be improved. We found improvements had been made and overall, records showed people received their medicines as prescribed. One person told us, "If they think you need something they give it you, but only if it has been prescribed by a doctor."
• The same person had two Medication Administration Records (MAR) in place for their patch medicine, making it difficult to identify if their medicine had been administered as prescribed. The deputy manager acted straight away to ensure the MAR was accurate.
• There were gaps in recording on MARs for some prescribed topical creams. The manager had already identified this issue and was supporting staff to improve their recording practices.
• Handwritten amendments to MARs had not been signed by the staff member or countersigned by a second staff member to confirm their accuracy. This did not accord with NICE guidelines for managing medicines in care homes.
• Medicines were stored securely and safely.

Systems and processes to safeguard people from the risk of abuse
• Some staff had received training about the different types of abuse. However, new staff had not yet completed training. Staff we spoke with were able to explain what action they would take if they had a concern.
• The manager understood their obligation to report their concerns and any potential allegations of abuse had been reported to the local authority (LA) and CQC.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection, the provider had failed to maintain sufficient oversight and their systems and processes to manage and monitor the quality and safety of the service were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and there was a continuing breach of regulation 17.

• Following the findings of our previous inspection, the service has been monitored and supported by the local authority (LA), the local Clinical Commissioning Group (CCG) and CQC, to make improvements.
• Since our previous inspection there had been significant changes in the management team, creating a lack of consistency in governance systems. The previous registered manager had left in March 2021. Another manager had been in post for three months but left in June 2021 when the current manager started in their role. The manager was currently applying to become a registered manager with the CQC.
• The manager was open and honest and told us they had worked very hard to make improvements after being at the home for a short time. They understood further improvements were required and acknowledged there were gaps in their professional knowledge in some areas, including complaints and recruitment. The provider was not aware of these gaps which meant there had been a lack of oversight of the manager's induction and training to undertake their role effectively.
• At our previous inspection we found the provider had failed to maintain sufficient oversight of the service and had not identified risk management was ineffective. We found this concern had continued.
• The provider had a new electronic system for auditing aspects of the service. However, we identified shortfalls during our visit which the provider had not. For example, potential risks to people's safety not being assessed. The provider felt that the electronic monitoring was not working as expected, and they would revert back to paper audits.
• Governance systems were ineffective and had not identified that staff were not always accessing information about risk management, or that the risk assessments were not accurate. For example, they had failed to identify discrepancies in one person's weight in their nutritional assessment and so the calculation of nutritional risk for that person was not accurate.
• The manager acknowledged these issues following our feedback and put a new care plan audit in place.

We discussed with the manager that the new audit did not include checks of assessments of risks associated with people's care and would therefore remain ineffective. The manager further reviewed the audit to include assessment of risks.
• Audits to monitor the health, safety and welfare of people and the environment in which they were supported were not always effective. For example, people and staff had not been individually assessed for risks to their health regarding COVID-19. People's care plans did not include information about their essential care givers in line with current government guidance and the provider's policy. These issues had not been identified despite the manager and provider carrying out their own monthly infection control audits.
• Medication audits had not identified all the concerns we found during our visit in relation to the management of medicines.
• The provider understood their legal responsibility to offer an apology when things went wrong. However, we found one complaint had not been actioned in accordance with the provider's policy. We discussed this with the manager who acknowledged there were gaps in their knowledge of responding to complaints and they were not familiar with the provider's policy. The provider agreed to arrange further training and support for the manager.

We found no evidence that people had been harmed. However, the provider's oversight continued to be ineffective and governance systems were not established or effective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Whilst we identified that improvement continued to be required in the overall governance of the service, we found learning had taken place. The management team showed us improvements made to the physical environment to reduce the risk of infection and their plans to improve their governance system having sought advice from external consultants who had reviewed their governance processes.
• The management team understood their responsibility to be open and honest when things had gone wrong. They took some immediate action during and following our inspection visit to make improvements where significant shortfalls had been identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There were processes in place to capture the views of people, relatives and staff, such as meetings and quality assurance questionnaires. However, it was not clear how the information had been analysed to identify any areas for improvement. For example, in a resident's meetings on 30 April 2021, people commented, 'We don't like the doors banging all the time…6.00am in the morning is too early to hear doors slamming.' During our inspection we identified several doors that banged shut. This demonstrated that whilst people were asked for their views, their concerns were not always acted on. The provider acknowledged that analysis of data needed to be more meaningful in order to drive improvements. The provider took some action to reduce the noise doors made following our feedback during the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Staff felt supported by the management team and were positive about the new manager's leadership. Two members of staff told us, "I think the staff morale is a lot better. The staff who are here at the present feel their opinions matter" and "We were deflated but (manager's name) has been brilliant."
• Most relatives were satisfied with the service provided. One person told us, "(Name of person) is incredibly happy at the home and has put on weight." Relatives spoke positively about the manager. One person told us, "(Manager's name) always responds to my emails within 24 hours. It never used to be like that."

• The provider understood their obligations for reporting important events or incidents to relevant agencies, including the CQC.
• The provider had identified staff retention was important to maintain consistent care and had encouraged staff to undertake their training by rewarding them a bonus.

Working in partnership with others
• The management team worked well with and welcomed suggestions from the LA and the local CCG to make improvements.
• The provider worked with other health and social care professionals. This supported people to access relevant health and social care services and improved links with commissioners and infection control teams who provided support throughout the pandemic.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not adequately assess and protect people against risks by doing all that was practicable to identify and mitigate such risks. Regulation 12 (1) (2) (a)(b)

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems or processes were established or operated effectively to assess, monitor and improve the quality of the service and mitigate the risks relating to health, safety and welfare of service users. The provider had not maintained accurate and complete records in respect of each service user. The provider had not evaluated or acted on feedback from people to improve the service. Regulation 17 (1) (2) (a)(b)(c)(e)(f)

The enforcement action we took:

We served a Warning Notice on the provider.