Bramling Cross Care Limited

Lound Hall

Inspection report

Town Street
Lound
Retford
Nottinghamshire
DN22 8RS

Tel: 01777818082
Website: www.graycaregroup.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Lound Hall is a residential care home providing accommodation for persons who require nursing or personal care to up to 30 people. At the time of the inspection the home was not providing nursing care. The service provides support to people older adults, some of whom were living with dementia. At the time of our inspection there were 22 people using the service. Lound Hall is an adapted building accommodating people over three floors.

People's experience of using this service and what we found
There were not always enough staff. Staff, people and relatives all felt, and our observations confirmed, there could be more staff on each shift to be able to support people in a more personalised way. Risks associated with the environment were not always being identified and mitigated. People who had been admitted into the service most recently did not always have risks associated with their health and wellbeing assessed.

We made a recommendation around risk management.

The home did not have a manager in post at the time of inspection. This resulted in some managerial duties not being completed and a general lack of day to day oversight in the service.

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.

Staff supported people to take their medicines in a safe way. The home was kept clean and measures where in place to prevent the spread of infection. Staff understood how to protect people from the risk of abuse.

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

Rating at last inspection
The last rating for this service was good (published 3 May 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lound Hall 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 the management and oversight of the service as well as staffing. Please see the action we have told the provider to take at the end of this report.

We have published a recommendation in relation to risk management at the service.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Lound Hall

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
The inspection was carried out by an inspector 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
Lound Hall 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. Lound Hall is registered as a care home with nursing care, however at the time of the inspection nursing care was not being provided at the service. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 25 May 2022 and ended on 16 June 2022. We visited the location's service on 25 May 2022.

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. 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 two people living at the home about their experience of the service. We observed interactions between staff and people. We spoke with four members of staff including care staff, a cook and the clinical operations lead.

We reviewed care plans and associated medicine records for multiple people. We requested further documentation including information relating to training and the quality monitoring of the service and reviewed these off-site. We sought feedback from a further three members of staff. We spoke with seven relatives about their experience of the service.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. 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.

Staffing and recruitment

● On the day of inspection, we had concerns about the level of staffing at the home, particularly at mealtimes. We raised this with the provider who informed us following the inspection they had increased support during busier times.

● The home had several vacancies which meant care and auxiliary staff were picking up extra duties. These vacancies were being actively recruited to. Staff said, "It would be nice to have extra staff on both shifts because it would be a lot safer for residents" and "I don't think people are checked on enough as there is not enough staff."

● Relatives told us, "There are times when they could do with a few more [staff]" and "There are times when I've rung the home and it's been difficult to make contact with anyone."

●The provider was unable to show us a completed dependency tool based on people's individual needs and the one provided indicated they were below the suggested staffing hours.

The provider failed to have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service. Whilst we did not find anyone had come to harm due to staffing levels, it did place people at increased risk. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely and the provider had completed all required pre-employment checks such as seeking references and Disclosure and Barring Service (DBS) checks. DBS check provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management

● On the day of the inspection we found risks had not always been assessed, monitored and managed safely, however we found there was no direct harm or impact on people as a result.

● The home was undergoing refurbishment and as a result we found some areas that posed a safety risk. For example, a very hot radiator without a cover and a bathroom with no call bell. We highlighted these to the provider who has provided assurances these risks have now been mitigated.

● People had personal emergency evacuation plans (PEEPS) on the electronic system, however we found these weren't readily available in the event of an emergency, for example in an emergency grab bag. We raised this with the provider who has immediately ensured everybody's PEEPS were accessible in the event of an emergency.

● Maintenance checks had not been carried out regularly for over six weeks, these including checking water temperatures and flushing of water outlets to manage the risk of water borne diseases such as legionella. We raised this with the provider who arranged for these to be carried out following the inspection.
● People had risk assessments and detailed care plans in place to guide staff on how to support them safely. However, we found one person who had been recently admitted did not have these in place, we raised this with the provider and they implemented these.

We recommend the provider consider current guidance around managing and monitoring both environmental and individual risks in a care home.

Using medicines safely
● Medicines were stored, administered, managed and disposed of safely.
● Where people took medicines as and when required, such as painkillers, guidance was in place to support staff on how and when to administer these. We noted for one such medicine the guidance was missing, we raised this and on the day of inspection it was put in place.
● Some people were on medicines to help manage their mood or reduce anxiety, we reviewed these and saw they were being used minimally and in line with guidance.

Systems and processes to safeguard people from the risk of abuse
● The provider understood their duty to protect people from the risk of abuse.
● People felt safe living at the home and relatives told us they believed staff kept their loved ones safe.
● Staff understood how to spot signs of abuse and the process to follow to report any concerns.

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. 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.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● People were supported to have visitors within the home. Relatives continued to be encouraged to show they had completed a negative lateral flow test, however they were still able to visit if they did not wish to take a test. We observed visitors to be supported to follow guidance in relation to PPE.

Learning lessons when things go wrong

● Incidents and accidents had been logged and reviewed.

● Analysis was carried out on certain areas, such as falls, and trends were looked for to establish whether any changes in care was required. Although these processes had not continued in the absence of a manager.

● Relatives told us they were informed when things went wrong with their loved ones.

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 good. At this inspection the rating has changed to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- At the time of the inspection there was not a manager at the home. The provider had arranged for the clinical operational lead to support the service; however we found some the managerial responsibilities and duties had not been carried out since the previous manager had left.
- Audits and quality monitoring processes had not been carried out since the previous manager had left, some had not been carried for longer than that. The concerns we found around risk management, maintenance checks and risk assessments had not been picked up or addressed prior to our feedback. There was no auditing system in place for call bell response times, this meant the provider lacked this information to inform decisions around staffing levels.
- We found there was some confusion over the delegation of duties. For example, it was unclear who was responsible for checking the pressure relieving mattresses were set at the right weight for the people using them, we found a few people's whose were not on the right setting. We raised this with the provider who implemented a new process to ensure these no longer went unchecked.
- Due to staffing levels and refurbishment works, staff felt, and we observed, people were not receiving as person-centred care as they could have. Staff said, "We have no time to sit and chat with them [people]," and "There's been so many changes, people are being moved to different rooms." We observed people left in communal areas, for over 15 minutes with no staff interaction.

Whilst systems had been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service, these had been neglected in the absence of a manager. This placed people at increased risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People, their relatives and staff were not always involved in the service.
- There had not been any resident or relative meetings and relatives told us they had not been invited to complete any form of feedback surveys. Relatives felt they were not always supported to communicate with their loved ones. A relative explained, "There should be more digital communication, but we are not getting any help with that." Other relatives explained they had difficulty contacting the home as the phone was not always answered.

● Staff meetings had occurred; however, some staff did not always feel supported, included or listened to.
● A healthcare professional told us, "We have always had a good working relationship with the home and a good rapport with the care home staff."

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; Continuous learning and improving care
● The provider understood their responsibility under the duty of candour to be transparent.
● Whilst relatives felt they weren't always communicated to about changes at the home, they did tell us they were contacted if anything happened to their loved one.
● The home had instructed an external agency to evaluate the care being provided and to give feedback so they could learn and improve the care provided.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems and processes that had been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service, had been neglected in the absence of a manager.