CareQuality Commission

Hill Care Limited

Longmoor Lodge Care 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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Longmoor Lodge Care Home is a residential care home providing personal and nursing care to 18 people aged 65 and over at the time of the inspection. The service can support up to 46 people.

The accommodation is over two floors with lift access to the first floor. It is in a residential area of Sandiacre with access to public transport and local facilities.

People's experience of using this service and what we found
Arrangements for maintaining the environment and management of infection prevention and control was not suitable. There were some areas of the home which were not clean, and carpets and flooring needed to be fitted securely to ensure these could be cleaned effectively. Arrangements to oversee the quality of the service were not always effective and timely actions had not been completed to act on concerns and the improvements which had been identified.

Staff wore personal protective equipment (PPE) to keep people and themselves safe. Arrangements were in place for staff to put on and take off PPE. Systems were in place for people to have their medicines as prescribed. There were enough staff who had been safely recruited to ensure they were suitable to work with people.

People had good relationships with staff, who knew how to provide their care. Relatives felt people were supported well and they were able to keep in touch with relatives whilst there were restrictions on visiting the home. The staff worked with health care professionals to ensure people's health was monitored and treatment was provided promptly when needed.

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 28 February 2020).

Why we inspected
We received concerns in relation to infection prevention and control and governance of the service. As a result, we undertook a focused inspection to review the key questions 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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Longmoor Lodge Care 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 monitor the service.

We have identified breaches in relation to how the provider reviewed the quality of service provision, maintained the home and managed infection prevention and control.

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 for 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 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Quality Commission

Longmoor Lodge Care 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. 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 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
Two inspectors carried out this inspection.

Service and service type
Longmoor Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received since the last inspection. We sought feedback from the local authority and Infection, prevention and control team. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with eight members of staff including three care staff, two auxiliary staff, one kitchen assistant, the registered manager and the regional manager. We reviewed a range of records. This included three people's care records and medicine records. We looked at two staff files in relation to recruitment.

After the inspection
We continued to seek clarification from the registered manager and provider to validate evidence we found. We received additional information relation to infection control, quality audits, staff training and governance of the service. We spoke with two relatives on the telephone about the quality 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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

Preventing and controlling infection
● We were not assured that the provider had systems in place to effectively clean the home and maintain suitable hygiene standards. Some areas of the home, including the sluice, were not cleaned effectively and cleaning products were not always diluted correctly to ensure adequate infection control.
●The vinyl flooring in the sluice, some bathrooms and ensuite toilets and were not sealed which meant effective cleaning could not take place. Carpets in communal areas and hallways were dirty, stained and not correctly fitted.
● When areas of the home had been cleaned, this was not recorded and there was no oversight of this system. When domestic staff were not working, an effective cleaning regime was not in place to ensure high risk areas such as 'touch points' were regularly cleaned.
● There were areas of the building that needed repair and redecoration. It was difficult to ensure areas were cleaned where handrails, walls and paintwork was damaged.
● Environmental Health had completed an audit of the kitchen and food preparation in 2019 and identified improvements were needed. We saw all action had not been taken to ensure food preparation and cooking was carried out safely.

Due to poor oversight and management of Infection control, this was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to an outbreak of COVID-19, the home was not currently receiving visitors. Systems were in place for visitors to wear PPE and testing would take place. There were no people or staff who currently had COVID-19.
● The layout of the home had been reviewed to maintain social distancing. Where people had been unwell with COVID-19, they had been supported in their bedrooms.
● We were assured that the provider was using PPE effectively and safely and staff understood how to put on and take PPE off safely.
● We were assured that the provider was accessing testing for people using the service and staff. The registered manager understood that where people had tested positive for COVID-19, no further tests should take place for a 90-day period.

Learning lessons when things go wrong
● An infection prevention and control audit had been carried out following an outbreak of COVID-19 and identified improvements. However, action had not been taken to ensure improvements were made and to

keep people safe.

Systems and processes to safeguard people from the risk of abuse
- People felt their care was safe, and relatives felt family members were supported safely. Due to current visiting restrictions, family members kept in touch with people on the telephone and through emails. Relatives told us the staff ensured they were kept up to date and notified of any significant concerns.
- Staff understood the principles of safeguarding and felt confident to raise concerns within the service and to external bodies when needed. Information about safeguarding leads and who to contact was displayed in the home.
- The registered manager reported any allegations or abuse to the local authority safeguarding team and notified us about this. The provider had policies on safeguarding people from the risk of abuse and whistleblowing, and staff knew how to follow these.

Assessing risk, safety monitoring and management
- Risks to people's health and wellbeing was assessed and reviewed. People and relatives were included in the review process. One relative told us, "The staff will call and we discuss the plan so I know what is happening; I can comment on any changes they feel they need to make."
- Where people needed assistance to move, we saw they were supported to move safely. The staff were patient and spent time explaining to people why and how they were going to use equipment to assist them.
- Staff knew about people's individual risks in detail and how to provide their support to keep them safe.

Staffing and recruitment
- There were enough staff to keep people safe. The registered manager reviewed staffing levels according to how many people used the service. We saw people were supported by enough staff, which included when people needed support to eat, needed reassurance, or wanted to participate in activities.
- Pre-employment checks were completed to help ensure prospective staff were suitable to care for people. This ensured staff were of good character and were fit to carry out their work.

Using medicines safely
- Medicines systems were organised and people received their medicines as prescribed.
There were safe protocols for the receipt, storage, administration and disposal of medicines.
- When medicines were administered, we saw the staff took time with people and explained what the medicines were.
- Some people were prescribed medicines to take 'as required'. Staff asked some people if they wanted these and there was clear guidance in place to support staff to know when these were needed.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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
● Quality monitoring systems were in place to help to identify issues in the home, although we saw these were not always effective. The audits and checks had failed to identify some of the issues we found in relation to infection prevention and control, maintenance and record keeping.
● Necessary work to raise and maintain standards, which had been identified by the Infection Control Team and from internal quality audits, had not been completed in a timely manner.
●The monitoring systems had identified further work was needed to comply with an Environmental Health Inspection, although this remained outstanding, Food was not always stored correctly and records of food preparation and foods cooked was not maintained.

Due to poor governance of the service, this was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People's care plans were improved, and people were consulted in the development of their plans. End of life plans had been developed in consultation with people and family members.
● Good relationships had been developed with people and we saw kind interactions. Staff demonstrated they had a good understanding of people's care needs and preferences and we saw them talk about family and events that were important to people.
● Staff felt able to raise any concerns and understood they could share concerns externally if they felt they needed to, this is known as whistle blowing.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
● Relatives felt people were happy living in the home and they were informed of any concerns or if there had been any incidents.
● Due to current restrictions on visiting the service, relatives told us they received regular newsletters and photographs of people being involved with activities in the home. Relatives welcomed this open communication and felt they would be able to discuss any concerns.

● Staff spoke positively about the support they received from the registered manager. We observed supporting interaction between the registered manager and staff.
●Staff meetings were being held to allow staff to raise issues and share information.

Continuous learning and improving care
● There were improvements made in the development of care plans and care plan reviews were current from the last inspection. The registered manager ensured that people's care plans reflected their current needs.
● The manager had informed us of significant events in a timely way which meant we could check that suitable action had been taken.

Working in partnership with others
● Records indicated people were being supported by community health professionals and had been referred to specialist services where required.
● The registered manager had developed good relationships with relatives and made arrangements to facilitate family visits for people nearing the end of their life, with consideration for COVID-19 restrictions.
● There were arrangements in place for people's health needs to be reviewed and met by the GP through virtual visits, in order that people's health could be monitored.

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 17 HSCA RA Regulations 2014 Good governance Systems and processed had not been established and operated effectively to ensure the quality of services was assessed, monitored and improved.

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 Care and treatment had not been provided in a safe way for service users. The provider had not suitably assessed, prevented or detected the risk of controlling the spread of infections.

The enforcement action we took:

We issued a warning notice.