CareQuality Commission

Shankar Leicester Limited

Longcliffe 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
Longcliffe care home is a residential care home providing accommodation and personal care for up to 42 older people some of whom had physical disabilities. At the time of the inspection 16 people were using the service.

People's experience of using this service and what we found
People's risk assessments required improvement. Records were not always updated to reflect people's current needs and information within records was contradictory. This meant staff may not have the information they need to provide safe care.

Some infection control practices did not mitigate the risk of contracting and spreading COVID-19 within the care home. Staff were observed not wearing appropriate personal protective equipment when supporting people with medicines and failing to wear face masks or ensure these were fitted correctly. Medicines were not always administered safely.

People were protected from abuse. However, the provider had not always submitted notifications of serious incidents and accidents to the Care Quality Commission. This meant we could not ensure timely action had been taken to keep people safe.

Oversight of the service required improvement. Not all concerns found on inspection had been identified through the providers' audits and checks.

Staff were safely recruited to ensure they were suitable to work in the staff. The provider had implemented contingency planning to ensure sufficient numbers of staff were deployed to meet people's needs.

People and their relatives felt the service was safe and provided personalised care. People and relatives gave examples of positive outcomes as a result of the care provided. Staff felt supported and engaged in the service. The management and staff were open and transparent throughout the inspection. They agreed to ensure changes were made to improve the service.

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 25 August 2018)

Why we inspected
The inspection was prompted in part due to concerns received about care and support. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 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.

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

Follow up
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**

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Detailed findings

Background to this inspection

The inspection
We carried out this focussed 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
This inspection was carried out by one inspector and an Expert-by-Experience who spoke with people's relatives via telephone. 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
Longcliffe 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.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a deputy manager in post who was overseeing the day to day running of the service.

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 and professionals who work with the service. 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 three people who used the service and three relatives about their experience of the care provided. We spoke with five members of staff including the deputy manager, the activities co-ordinator and care staff.

We reviewed a range of records, this included three peoples' care plans and records and sampled medicine records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including quality assurance and safety checks were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training data, policies and procedures and evidence of safety compliance.

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.

Preventing and controlling infection
● We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. We observed the morning medicine round and saw staff failed to wash or sanitise their hands between administering medicines to people. Where people required their eye drops to be administered, a staff member did this without wearing gloves or washing their hands before or after the task. Staff did not wear aprons when supporting people with their medicines, food and drink.
● Staff were observed wearing appropriate face masks but these were not worn consistently or correctly. For example, staff were observed without face masks conversing with people in communal areas or wearing face masks under the nose, rendering them ineffective.
● Staff were not following current Public Health England guidance, based on current legislation, which aims to inform staff on the measures they need to take to protect people from the risk of infections, including COVID-19.

There was a failure to ensure robust infection prevention and control practices to ensure people's safety and protect people and staff from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was accessing testing for people using the service and staff. Regular testing was in place for people and staff and this was in line with government guidelines for testing within care homes.
● Visiting was subject to lateral flow testing and screening and people were supported to go on external visits to friends and family.
● We were assured the provider was promoting safety through the layout, and hygiene practices, of the premises. The premises supported good hygiene and cleanliness to prevent the spread of infection.

Assessing risk, safety monitoring and management
● Risks to people had been identified. However, information within people's care records was inconsistent and contradictory and did not support safe care. For example, one person's handover notes stated the person was at risk from falling out of their wheelchair through 'wriggling' and required equipment to re-position them. The person's moving and handling assessment identified they were at high risk of falls but had not been updated to include the risk of falling from their wheelchair. This meant staff may not be aware of the measures they needed to take to protect the person from the risk of harm.
● A second person had been identified as being at high risk of falls and requiring equipment to transfer following a change in their needs. Their dependency assessment had not been updated to reflect this

change in need. The person's falls risk assessment had not been updated as they were still assessed as medium risk and walking with aids. This meant staff who were not familiar with the person's needs, such as new and agency staff, may not have the up to date information they needed to provide safe care.
● A person's mobility care plan informed staff the person may become anxious during transfers which affected their ability to co-operate and listen to instructions. The person had recently experienced head injuries during transfers. The deputy manager described how staff needed to respond and reassure the person during transfers and protect the person's head from the boom of the hoist. This information was not included in the care plan to support safe transfers.

The provider had not ensured risk assessments relating to the health, safety and welfare of people were completed and reviewed regularly. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong
● People told us that they felt safe. One person said, "Yes, I feel safe. I have a walker to get about and need staff help. One staff member walks with me and another has the wheelchair at the back of me. This makes me feel safe." A second person told us they felt safe because staff always made sure they had the call buzzer within reach to summon help when they needed it.
● Relatives felt their family members were safe. One relative told us, "[Name of family member] is safe because staff are supporting her 24 hrs. [Name] had a couple of small falls and staff informed me about it immediately."
● Systems were in place to protect people from the risk of abuse. Policies were in place about safeguarding adults and whistleblowing.
● Staff had undertaken training about safeguarding adults and were aware of their respective responsibilities with regard to this.
● Staff told us they could raise any concerns or issues with the provider or deputy manager and these were listened to and timely action taken to keep people safe.
● The provider had notified the local authority but not other agencies, including CQC, of incidents or accidents that required notification. This is important to enable agencies to review and ensure appropriate, timely action has been taken to keep people safe.
● The deputy manager was able to describe actions taken in response to incidents and accidents. Falls were assessed and evaluated to identify measures which may reduce the risk of further falls. However, records did not always reflect actions taken in response to more specific incidents.

Using medicines safely
● We observed a medicine round in progress.The staff member did not follow safe infection prevention and control procedures including washing their hands and was not wearing PPE whilst administering people's medicines.
● The service had made improvements to medicine records and processes following a recent pharmacy visit and assessment. However, we found continued gaps in staff signatures on medicine administration charts. This demonstrated improvements were yet to be embedded into staff working practices.
● Medicines were stored safely and administered in line with people's preferences.

Staffing and recruitment
● There were safe systems and processes for the recruitment of staff. The service followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references.
● Our observations were there were enough staff on duty to meet people's personal care needs. Staff were

observed to be busy with the majority of time spent meeting people's personal care needs. An activity staff member engaged with people to provide the social stimulation and interaction people needed.
● The provider had utilised staff roles, such as laundry and housekeeping, to ensure sufficient staffing levels were available at peak times to help people get up. Agency staff were also used to fill staff vacancies as recruitment was on-going.

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 good. At this inspection this key question has now deteriorated 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.

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
● Services that provide health and social care to people are required to inform CQC of important events that happen in the service in line with regulatory requirements.
● The provider had informed adult social care of significant events but had not always informed the CQC. For example, we found incidents such as head injuries and fractures that had not been notified to us. This meant we could not check that appropriate action had been taken to ensure people were kept safe. This is being reviewed under our processes for failing to notify.

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.
● Systems and processes to ensure oversight required improvement. Audits had been completed by the compliance manager, but these were not always effective in identifying and driving improvements.
● Audits had failed to identify some care plans were in need of updating to provide the guidance staff needed to keep people safe. Safeguarding notifications had not always been submitted as required to CQC to help us ensure timely action was taken to keep people safe. Audits and checks had failed to identify some staff were not consistently complying with safe guidance in terms of personal protective equipment or practicing safe infection control.
● The provider did not have a systematic improvement and action plan to identify and address areas which required improvement
● The service had not had a registered manager in post for some time. The service is required to have a registered manager as a condition of registration. The provider, a deputy manager and a compliance manager were all overseeing the service on a day to day basis. Attempts had been made to recruit to the position but had so far proven unsuccessful.

Systems and processes to assess and monitor the service were not sufficiently robust or operated effectively to improve the quality of service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were clear on their roles and responsibilities. People and relatives felt the service provided personalised care which achieved good outcomes. One relative told us, "Longcliffe is a very family oriented

home; the staff genuinely care about the residents."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The provider had completed formal surveys for people. We saw people were able to comment on all aspects of their care and service and action was taken where improvements were required. For example, changes had been made to the meal service as a result of people's feedback.
● People and relatives were kept up to date regarding changes and improvements being made to the service.
● Relatives told us they were kept up to date with relevant information regarding their loved one. A relative said, "The manager is very approachable and staff communicate in the best way for me. Communication is always via telephone and any changes in [Name of family member] care, or the service are communicated to me."
● Staff told us they felt involved in the service. One staff member commented, "Longcliffe is like an extended family. The managers are very supportive and approachable. I like the way they put the service users first and also look after the staff."

Continuous learning and improving care; Working in partnership with others
● All staff involved were open and transparent throughout the inspection. Concerns raised during feedback were considered and actions put into place.
● The provider had plans in place for improvements to the environment and service delivery
● We saw referrals were made to external professionals as required and their advice was followed.

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 failed to ensure robust infection, prevention and control processes were followed to protect people and staff from the risk of infections. The provider had not ensured risks relating to the health, safety and welfare of people were completed and regularly reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess and monitor the service were not sufficiently robust or operated effectively to improve the quality of the service.