Longfield (Care Homes) Limited

Longfield Residential Home - MD

Inspection report

Longfield
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Longfield Residential Home – MD is a residential care home providing personal care to 13 people aged 65 and over at the time of the inspection. The service can support up to 24 people. The service specialises in caring for people living with dementia. The service is in a residential area close to Blackburn town centre and local amenities.

People's experience of using this service and what we found
We were not assured the provider was preventing visitors from catching and spreading infections. We found Personal Protective Equipment (PPE) stations were not always adequately stocked and staff were not always wearing PPE correctly. Staff had not always had training in infection control.

The environment was not clean. We found dirty bedrooms, a dirty bathroom, dirty bedding, and dirty chairs. Staff told us the home was not clean. The laundry room contained a sluice area which was extremely dirty and was not suitable for use, therefore staff were using a toilet and a person's bedroom as separate laundry areas. A relative also raised concerns with us, shortly after the inspection, about the unclean state of their family member recently.

Some staff told us they were not asked to complete and had not completed a polymerase chain reaction (PCR) or lateral flow device (LFD) tests on a regular basis. Records showed a number of staff had not completed PCR or LFD tests but were still working in the service. One relative told us, "We have not been able to visit for some time, they keep in contact by phone, hopefully we can visit soon." The manager told us staff had inadvertently given incorrect information about visiting and previous local Government guidance.

People using the service were not always safe from the risk of fire. We requested immediate action was taken to remove combustible materials from exposed hot pipes in the laundry room and raised concerns with local fire safety officers, who attended the service the following day. They also requested immediate measures were put in place to address some fire safety concerns. Staff did not always know how to respond in the event of a fire or emergency situation and Personal Emergency Evacuation Plans were not always accurate.

Risks to people's health and safety were not always assessed and managed. For example, those at risk of weight loss were not being weighed as frequently as required. People were at risk due to incorrect moving and handling procedures from staff.

Medicines were not always managed safely. We found a specific medicine was not being stored correctly. One staff member was unsure what a certain medicine they were administering was prescribed for. We have made a recommendation about the safe management and administration of medicines.

The provider had not always notified us of safeguarding incidents that had occurred in the service. We have

made a recommendation about the management of safeguarding notifications.

The service did not have sufficient staff to meet the needs of people using the service. One staff told us, "There are not enough permanent staff employed. We use a lot of agency staff. However, agency staff often don't show up or let you down at the last minute." Staff also told us they did not have enough time to spend with people.

Staff had not always been adequately trained to meet the needs of people using the service. Agency staff were not always given an appropriate handover to ensure they were aware of risks to people's health and safety, people's needs or to ensure they were aware of action to take in an emergency.

The service was not caring. People were not treated with dignity and respect. We found people presented with food on their clothing and around their mouth's. The local safeguarding team had also reported seeing people with dirty clothes, food around their mouths, unkempt and with significantly dirty feet. One relative raised concerns with us about the presentation of their family member and stated, "[Person's] dignity has been compromised."

We found some mattresses were too big for the bed base and were hanging over. People's clothes had not been folded neatly into drawers or wardrobes. We found previous resident's clothing still in wardrobes. Some people had very little clothing or underwear. People did not always have privacy. We looked in one bedroom and found there was no curtain for the window. One person's bedroom was being used as part of the laundry, to arrange clean clothing. We saw one person was going in and out of other people's bedrooms, sometimes when the other person was in their bedroom.

Some audits had identified shortfalls, but no action had been taken and other audits had not identified the shortfalls we found. Records were often incomplete, such as audits and risk assessments. An action plan documented some actions had been completed but we found they had not. Records related to people's care were not always accurate and up to date. The service did not promote a positive culture and people did not achieve good outcomes. All the staff we spoke with told us about how the low staffing levels and use of agency was affecting their roles. There was no evidence to show the service was continuously learning and improving. There was limited evidence of staff meetings, no resident's meetings and limited evidence of surveys to gain feedback.

All of the staff we spoke with told us they would not be happy to have one of their family members living in 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 requires improvement (published 24 May 2021).

Why we inspected
We received concerns in relation to lack of personal care, staffing levels, cleanliness of environment, incorrect moving and handling procedures, infection control risks and lack of stimulation for people. As a result, we undertook a focused inspection to review the key questions of safe, caring 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 requires improvement to inadequate. 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 Longfield Residential Home - MD 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 breaches in relation to infection control, risk assessing, fire safety, medicines, staffing, respect and dignity, and overall governance 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 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Longfield Residential Home - MD

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
This inspection was carried out by two 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
Longfield Residential Home - MD 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 at the time of the inspection. A new manager was in post but had not submitted their application to register with us.

Notice of inspection
This inspection was unannounced. We made a telephone call from the car park of the service on the day of inspection to check there was no COVID-19 outbreak in the home. The first day of inspection (11 August 2021) was on-site, we continued the inspection remotely until 18 August 2021.

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, including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 were unable to speak with people who used the service due to all of them living with dementia and lacking capacity. However, we spoke with four relatives about their experience of the care provided. We spoke with eight members of staff including the provider, the manager, senior care workers, care workers, agency staff, the chef and the housekeeper. We liaised with the local fire safety officers and infection control teams in relation to concerns.

We reviewed a range of records. This included seven people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider and manager to validate evidence found until 27 August 2021. We looked at numerous amounts of records relating to the health and safety of people using the service, policies and procedures, training and support for staff and overall governance . Some records we requested were not available or were not sent to us. We continued to liaise closely with the local safeguarding team and quality assurance team within the local authority, both of which were regularly visiting the service to ensure people were safe and improvements were being made.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● We were not assured the provider was preventing visitors from catching and spreading infections. During the tour of the building, we found Personal Protective Equipment (PPE) stations were not always adequately stocked. For example, one identified area had no gloves and another had hand soap instead of hand sanitiser. Staff were not always wearing PPE correctly. For example, we observed staff with masks under their chin and under their nose. We found used PPE, such as gloves, left in one person's bedroom drawers and wrapped in a ball on a table in the lounge. The local safeguarding team found people in an unclean state which evidenced they had not been bathed or showered. A relative also raised concerns with us, shortly after the inspection, about the unclean state of their family member recently.

● Records we looked at reported another outbreak of head lice within the service. The manager confirmed this was the second outbreak in the home. We advised the local safeguarding team as they were attending the service on a regular basis.

● We found dirty bedding and chairs in people's bedrooms and bathrooms were not always adequately cleaned. All the staff we spoke with told us the home was not clean. Comments we received included, "The cleanliness of the home could be better" and "It is not clean enough, I am quite concerned." Records showed and staff confirmed some of them had not received training in infection control.

● The laundry room contained a sluice area which was extremely dirty; the sluice contained what appeared to be dried on faeces which suggested it had been there for some time. The laundry was not suitable for use, therefore staff were using a toilet and a person's bedroom as separate laundry areas.

● Some staff told us they were not asked to complete and had not completed a polymerase chain reaction (PCR) or lateral flow device (LFD) tests on a regular basis. Records showed a number of staff had not completed PCR or LFD tests but were still working in the service.

● One relative raised concerns with us, shortly after the inspection, that they were not being permitted to visit their family member inside the service. Another relative told us, "We have not been able to visit for some time, they keep in contact by phone, hopefully we can visit soon." The manager told us staff had inadvertently given incorrect information about visiting and previous local Government guidance. However, we looked at the visiting policy, dated June 2021; this was not up to date and reflective of current Government guidance.

● We raised our concerns with the local infection control team. They attended the service on the 23 August 2021 and had concerns about the lower ground floor area, laundry, and general cleanliness. They gave the service an action plan with two weeks to complete this.

We found no evidence that people had been harmed however, the provider had failed to ensure people using the service were protected from the risk of infections. This is a breach of Regulation 12 (Safe care and

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People using the service were not always safe from the risk of fire. During our inspection visit, we found three bedrooms, a toilet and the laundry in the lower ground floor. The laundry, which was also a boiler room, had exposed hot pipes due to damaged heat protective covers; there was combustable materials stored against them. We asked for these to be removed immediately due to the fire risk and reported our concerns to the local fire safety officers. The fire safety officer visited the service on 12 August 2021 and requested measures were put in place immediately that day to ensure the safety of people whose bedrooms were in the lower ground floor. Staff also told us they had safety concerns about people being in bedrooms in the lower ground floor. Shortly after our inspection visit, the local safeguarding team advised us they had insisted people were moved out of these bedrooms.
● Whilst the training matrix showed most staff had received fire safety training and those staff spoken with said they would know how to respond; the fire safety officer reported staff did not know how to safely evacuate people in the lower ground floor rooms. We looked at Personal Emergency Evacuation Plans (PEEPs) for a number of people. We found these did not always give an accurate and up to date account of how to evacuate people in the event of an emergency situation.
● Risks to people's health and safety were not always assessed and managed. For example, those at risk of weight loss were not being weighed as frequently as required, a person at risk of dehydration and falls had blank assessments and some risk assessments were only partially completed.
● People were at risk due to incorrect moving and handling procedures from staff. The local safeguarding team witnessed three staff using incorrect techniques to support a person. Records we looked at showed some care staff had not received moving and handling training but were undertaking this.
● Records reviewed throughout the inspection did not evidence lessons learned or how this was shared with the staff.

We found no evidence people had been harmed however, the provider had failed to ensure adequate management of risks to people using the service. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The service did not have sufficient staff to meet the needs of people using the service. The manager told us they had five care staff vacancies and needed to use agency staff in the interim. Staff told us, "We are often short staffed. If a staff member phones in sick, the senior will contact the agency but sometimes they cant supply anyone, which means it is one carer and one senior for the shift" and "There are not enough permanent staff employed. We use a lot of agency staff. However, agency staff often don't show up or let you down at the last minute." We observed staffing issues on the day of our inspection; a night staff member had stayed on past the end of their shift and staff from a sister home also arrived to cover.
● Staff told us, "We don't have any time to spend with people", "Some staff rush people as we are short staffed" and "We do get time to sit down and talk with people, but it is reliant on agency staff turning up." We observed one agency staff sitting with a person, painting their nails, however, we did not see any meaningful interactions from staff other than task based actions.
● Staff had not always been adequately trained to meet the needs of people using the service. For example, only one staff member had received training in allergy awareness, despite a number of people having allergies. Agency staff were not always given an appropriate handover to ensure they were aware of risks to people's health and safety, people's needs or to ensure they were aware of action to take in an emergency. A staff member told us, "Agency staff are not giving proper care as they don't know residents. They are unreliable. I have to keep my eye on them."

We found no evidence people had been harmed however, the provider had failed to ensure sufficient numbers of suitably competent, skilled and experienced staff were deployed. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● In the main, were managed safely. However, we found a specific medicine was not being stored correctly; this was in a 'pod' system and should have been stored separate from other medication. We received confirmation that action had been taken to address this, shortly after the inspection visit. One staff member was unsure what a certain medicine they were administering was for and could not tell us where an Epipen (a life-saving medicine used when someone is experiencing a severe allergic reaction) was located should they need if for those with identified allergies. The manager assured us they would address this with all staff.

● Not all staff had received training in medicines administration. The manager told us night staff were not responsible for administering medicines. We queried how people would receive 'as required' medicines, such as for pain relief, at times when no trained staff were on duty. The provider assured us all night staff had undertaken medicines training.

● Records showed the medication policy was due to be reviewed. However, there was no evidence to show this had been completed.

We recommend the service considers current best practice guidance in relation to the safe management and administration of medicines.

Systems and processes to safeguard people from the risk of abuse

● One relative told us, "I think [Person] is safe. [Person] was hit by another service user 3 to 4 months ago. I was told the Police were informed. [Person] was not seriously hurt." We had not been notified of this incident however, we saw evidence that the local safeguarding team had been notified.

● Records showed not all staff had completed safeguarding training. The service had a safeguarding policy and procedure in place.

We recommend the service follows the necessary guidance when managing safeguarding notifications to ensure all necessary people are informed.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- The service was not caring. We received concerns about the care and treatment of people prior to our inspection. We raised these concerns with the local safeguarding team, who visited the service. They reported their findings to us, which included concerns about the care and treatment of people using the service.
- People were not treated with dignity and respect. The local safeguarding team reported seeing people with dirty clothes, food around their mouths, unkempt and with significantly dirty feet. The manager told us she was very new in post and when she saw people's feet, "It looked as if they had not been washed for months." We also found people presented with food on their clothing and around their mouth's; the inspector spoke with senior staff to ask them to arrange for people to be cleaned and clothes to be changed. One relative raised concerns with us that their family member had presented at hospital with faeces under their finger nails, wearing another person's clothes, which had holes in, another person's slippers which were too big and with other people's clothes in their bag. They told us, "[Person's] dignity has been compromised."
- We found some mattresses were too big for the bed base and were hanging over. We pointed this out to the provider and manager on the day of the inspection. The provider told us they would ensure these were replaced. We checked if this had been completed on the 26 August 2021 and were told it had not been done. We received confirmation from the provider shortly after that this had been requested.
- People's clothes had not been folded neatly into drawers or wardrobes. We found previous residents clothing still in wardrobes, despite another person being in the room. One person's wardrobe contained catheter equipment that belonged to a previous resident. Some people had very little clothing or underwear. The local safeguarding team requested the service take action to address this.
- People did not always have privacy. We looked in one bedroom and found there was no curtain for the window. Records showed this had been highlighted in April 2021 but no action had been taken. One person's bedroom was being used as part of the laundry, to arrange clean clothing. We requested this practice was stopped immediately.
- We saw one person was going in and out of other people's bedrooms, sometimes when the other person was in their bedroom. During feedback at the last inspection, the provider was advised about installing privacy locks, so that people could be afforded privacy in their own bedrooms. However, no action had been taken to address this.
- Records showed, not all staff had completed privacy and dignity training.

We found no evidence people were harmed however, the provider failed to ensure people were well cared or and treated with dignity and respect. This is a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 now 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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; Working in partnership with others

- The service did not have a registered manager at the time of the inspection. A new manager was in post however, we had not received an application by the time of this inspection. The manager had only been in post since the 2 August 2021. This situation is a ratings limiter for the well-led key question. The provider had a nominated individual who had been managing the service until the new manager was in post. However, one staff told us, "There was no manager and the staff had just let the home go downhill." We noted the last inspection report was not on display; the previous report was displayed showing an incorrect rating.
- The provider's systems to assess, monitor and improve the quality of the service had not identified and addressed the shortfalls highlighted in this report. Some audits had identified shortfalls, but no action had been taken and other audits had not identified the shortfalls we found. Records were often incomplete, such as audits and risk assessments. An action plan documented some actions had been completed, but we found they had not.
- Records related to people's care were not always accurate and up to date. We found some care plans and risk assessments were not up to date or were missing important information about risks to people and their care needs.
- The service did not promote a positive culture and people did not achieve good outcomes. All the staff we spoke with told us about how the low staffing levels and use of agency was affecting their roles. Not all the staff felt they had previously been supported by a manager who was approachable. However, some staff did give us positive feedback about how the new manager had started to make some small improvements; but noted there was a long way to go. All of the staff we spoke with told us they would not be happy to have one of their family members living in the service.
- There was no evidence to show the service was continuously learning and improving. Training was not being delivered within timescales set by the service and some staff had not undertaken any training since being in post. There was no evidence to show staff were asked to complete surveys. Records showed there had only been one staff meeting in 2021 and one staff told us, "There are no staff meetings at present and I have not had a supervision." We received mixed views on how well the service communicated with relatives. As evidenced in the safe domain, one relative told us how they had not received a response to their queries.
- The provider did not always act on the duty of candour. For example, we were not always informed of

notifiable incidents which occurred in the home.
● The service did not always work in partnership with others. We saw times when referrals should have been made, which had not been done in a timely manner. For example, when people had been losing weight.

We found no evidence people were harmed however, the provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Surveys were being sent out to relatives and records showed there had been a low response. The provider had also emailed relatives during the pandemic to invite them to zoom calls.
● Records showed there had been no resident meetings. The provider told us, staff had been undertaking one to one discussions and telephone calls with residents/relatives. Whilst we did not see any documented evidence of these calls, we saw actions taken for one person as a result of a call with relatives.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

The enforcement action we took:

Warning Notice

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 people were protected against the risk of infections. The provider failed to ensure risks to people's health and welfare were appropriately assessed, managed and reviewed.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were in place to assess, monitor and improve the service.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient suitably competent, skilled and experienced staff

The enforcement action we took:

Warning notice