Community Therapeutic Services Limited

Longton Court

Inspection report

8-10 Longton Grove Road
Weston Super Mare
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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
Longton Court is a residential care home for up to 7 adults who have a learning disability, autism and/or mental health needs. At the time of our inspection there were 5 people living at the service. Three people were living in self-contained flats and 2 people lived in the main house.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
The service did not always give people care and support in a clean environment. Staff did not always support people with their medicines in a way that achieved the best possible health outcome. People had plans in place to guide staff on how to support them if they became anxious or upset. The service worked with people to plan for when they experienced periods of distress so that their freedoms were restricted only if there was no alternative. 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.

Right Care
Staff protected and respected people's privacy and dignity. They understood and responded to their individual needs. Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had enough appropriately skilled staff to meet people's needs and keep them safe. Staff and people cooperated to assess risks people might face.

Right Culture
The systems to monitor the quality of the service were not fully effective in ensuring shortfalls were actioned. Staff understood people well and were responsive to their needs. People's quality of life was enhanced by the service's culture of improvement and inclusivity. Staff valued and acted upon people's views.

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 27 March 2020).

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 changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

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

Enforcement
We have identified breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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.

Longton Court

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 2 inspectors and an Expert by Experience made telephone calls to people's relatives. 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
Longton Court 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. Longton Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The providers compliance manager was overseeing the management of the service. The provider had appointed a new manager and they started working for the service on the second day of our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed information we had received about the service. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people and 4 relatives about the care and support provided. We spoke with 8 staff including the interim manager. We reviewed a range of records. This included 3 people's care and medicine records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 good. At this inspection the rating has changed 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.

Using medicines safely

- Medicines were not always managed safely. People had medicine administration records (MAR) that staff completed once medicine had been administered. We found gaps in people's MARs which meant we were unable to determine if medicines had been given.
- The list of people's prescribed medicines in their medicine folder did not always correlate with their MAR.
- We found a discrepancy with 1 person's medicines stock. Another person's medicines had been counted in with their stock count, which meant it was incorrect.
- Some people were prescribed medicines on an 'as required' (PRN) basis. There was not always detailed guidance for staff on when or how these medicines should be given. Some of the PRN protocols that were in place had not been reviewed since 2020.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines were stored securely. Temperatures were taken of the storage areas to ensure they remained in an optimal range for medicines storage.
- Where people were prescribed creams and ointments, these were dated when opened to ensure they were disposed of at the appropriate time after being opened.
- Staff received medicines training and had their competency assessed. Medicines errors were investigated and action was taken following errors such as retraining staff.

Preventing and controlling infection

- Infection prevention and control measures were not fully effective in minimising risks to people.
- We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the service were not clean. Areas of the service were showing signs of deterioration which meant they could not be effectively cleaned. This included a toilet in the main house, areas of the kitchen and in people's flats.
- Cleaning records showed gaps in cleaning. This meant we could not be fully assured areas of the home had been regularly cleaned.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed this with the manager who told us they had plans to address these areas of the environment, new cleaning forms were about to be used which included more detailed records of cleaning. The manager confirmed there would be oversight of the cleaning and associated records.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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
● The service was facilitating visits in line with current government guidance.

Assessing risk, safety monitoring and management
● Risks relating to the safety of the environment were not all being safely managed.
● A fire risk assessment was completed by an external contractor in August 2022. Action points had been identified as part of the risk assessment to be completed within 1 month of the report. During the inspection we found 2 of the identified action points had not been completed.
● Following our inspection, the maintenance manager confirmed the fire action points were being addressed.
● There were several uncovered radiators throughout the service. Although there was a generic risk assessment in place, individual risk assessments had not been completed, which was one of the control measures in the generic risk assessment. The manager told us there were plans to complete individual risk assessments relating to the uncovered radiators and cover the radiators in communal areas as required.
● A range of health and safety checks within the service were completed, such as weekly fire tests, fire drills, water temperature checks and checks on the fire system.
● People had individual personal emergency evacuation plans (PEEPs) in place that detailed the support they required in the event of an emergency evacuation.
● Risks to people were assessed and control measures were implemented to reduce the risk. For example, health conditions, self-neglect and accessing the community. Risks to people were escalated to relevant professionals where additional support was required.
● Some people could become anxious leading to incidents that could cause harm to themselves, others and the environment. There were detailed plans in place describing how staff should support people at these times. Staff told us they felt confident to support people and they received the right training and support.
● Restraint was not used within the service. Staff were trained in the use of de-escalation techniques. Staff told us they knew people well and were usually able to distract people and withdraw from a situation safely.
● The training staff received on restraint was certified as complying with the Restraint Reduction Network Training standards.

Staffing and recruitment
● We received some mixed feedback from people's relatives relating to the staffing at the service. One relative told us, "There are staff shortages." Other comments from relatives included, "Yes I do think there's enough staff" and "There has been quite a few staff changes." One person told us, "Yes mostly" when we asked them if there were enough staff.

● Staffing at the service had improved. There were enough staff available to meet people's needs. People had individual hours commissioned, rotas were arranged flexibly to meet people's needs. We reviewed the rotas and people's hours were being met.
● Staff told us staffing was improving and they used regular agency to cover any shortfalls. One staff member told us, "It is on the rise, a lot of staff left after lock down, we do use some agency who have worked here for a while, they know people well and routines."
● The service operated recruitment processes to check staff's suitability for the role. This included requesting references from previous employers and completing a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held.

Learning lessons when things go wrong
● There were systems in place to monitor, record and learn from incidents.
● Incidents and accidents were reported. These were recorded and reviewed by the manager and the providers positive behaviour support practitioner. Incidents were reviewed for themes and trends to determine any learning or actions for staff. Staff told us incidents were manageable and they received a debrief following incidents.
● People's relatives were kept up to date with incidents where people consented to this information being shared. One relative told us, "They will call me if there's been an incident and after an investigation they will call to update me."

Systems and processes to safeguard people from the risk of abuse
● One person told us they didn't feel safe at night. This was due to incidents that occurred in the service. Staff had supported the person to find ways of making them feel safer. We discussed this with the manager who told us they would look into the concerns.
● Another person told us they were happy living at the service and with the staff supporting them.
● Relatives told us their family members were safe. One relative told us, "[Name of person] is as safe as they can be anywhere." Another relative commented, "I feel [Name of person] is safe."
● There were systems in place to protect people from abuse. Staff were aware of the systems to report concerns internally and externally, they told us they would report any concerns and they were confident these would be responded to. Staff received safeguarding training.
● The service had reported safeguarding concerns to the local authority and the Care Quality Commission (CQC) as required.

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. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. 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. Any conditions related to DoLS authorisations were being met.

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

- There were systems in place to monitor and improve the quality and safety of care provision. However, these systems were not fully effective in ensuring shortfalls were addressed.
- The medicines audits had not ensured people's MARs were consistently completed, people's medicine stock was correct and relevant protocols were in place for all 'as required' medicines.
- The systems to oversee infection prevention control measures had not ensured the service was consistently clean and cleaning records were fully completed.
- Although action plans had identified uncovered radiators required covering or an individual risk assessment, this had not yet been completed.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager and provider had a range of quality assurance checks and action plans in place. These included walk around the service checks identifying any actions required. There was also a quality improvement plan covering areas such as medicines, incidents and accidents, and health and safety.
- There was a management structure in place. The manager was supporting staff to understand their roles and responsibilities within the team.
- Statutory notifications were submitted as required. Statutory notifications are important because they inform us about notifiable events and help us to monitor the services we regulate.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a person centred and positive culture. Staff commented positively about the service, the teamwork, and the people they supported. One staff member told us, "It's good here, we are a really good team, willing to help each other and support each other."
- Relatives told us their family members were well supported by the staff and they got on well with them. One relative told us, "I have an excellent rapport with the staff. We are all very honest. I think [Name of person] is happy there." Other comments included, "The staff are very caring" and "Longton have been brilliant with [Name of person]. It's the longest placement they have had, they [Staff] go over and above."
- There had been changes in the management of the service, relatives were aware of the changes. One relative told us, "I know the manager at the moment, I am very happy with the service, if I had any concerns, I

let them know. They get back to me very quickly. They listen and they act."
● Staff commented positively about the manager and support from the senior managers and the provider. One staff member told us, "I feel very supported by [Name of manager]." Another staff member commented, "I feel supported, when there are serious incidents the director and clinical lead are always here to support."

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
● The provider was aware of their responsibility to act openly and honestly when things went wrong.
● The manager was aware where concerns had been identified, appropriate notifications should be sent to the CQC as required by law, and to the local authority.
● Staff knew they had to report concerns to the manager and were confident that these would be acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were systems in place to receive feedback from people using the service and their relatives via a survey. The results of the most recent survey were in the process of being collated. A relative told us, "They did recently send a questionnaire about 2 months ago. It's on my to-do list which has reminded me to fill it in."
● One person told us how they met with their keyworker who helped them to plan what they wanted to do.
● Staff meetings were held for staff to discuss any current concerns and share information. Staff felt listened to and able to raise their views.
● Daily briefings were also held for the staff team on duty each day to enable them to discuss any incidents, day to day matters, receive updates and plan each day.

Continuous learning and improving care; Working in partnership with others
● The manager and provider had systems in place to review and learn from any incidents.
● The manager was aware there were areas for improvement in the service and they were committed to ensuring the improvements were made.
● The service worked in partnership with other organisations to support care provision. For example, a range of professionals such as GPs, social workers, advocates, the mental health team, and a range of other professionals.

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 ensure medicines were managed safely and infection control procedures were followed. Regulation 12 (1) (2) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always operate effective systems and processes to assess and monitor the quality and safety of the service. Regulation 17 (1) (2) (a)