Greenleaf Healthcare Limited

Livesey Lodge Care Home

Inspection report

Livesey Drive
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Livesey Lodge is a residential care home providing accommodation and personal care to 13 people aged 65 and over at the time of the inspection. The service can support up to 24 people.

People's experience of using this service and what we found
At the time of our inspection there was an outbreak of COVID-19 at the service. We found multiple failings in the provider's infection prevention systems and processes which increased the risk of the transmission of COVID-19, and placed people at significant risk of harm.

The service was not well managed following the COVID-19 outbreak. The registered manager and deputy manager were both absent from the service but had not ensured appropriate cover had been arranged. It was not clear who had responsibility for managing the service.

Quality assurance systems and processes had lapsed despite our previous recommendations to embed them. This prevented the concerns we found during the inspection being identified.

People's care plans and risk assessments had not been reviewed. The impact of people being required to self-isolate had not been fully considered.

Staff were working consistently long hours and whilst caring and respectful the time they could afford to support people was limited as they were assigned multiple roles in absence of regular staff.

People's medicines were managed safely.

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 17 March 2020).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we received about the service. The inspection was prompted in part due to concerns received about infection prevention and control and staffing at the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with infection control and staffing arrangements therefore, we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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.

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

We have found evidence that the provider needs to make improvement. 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 Livesey 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 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, safe care and treatment and the governance arrangements at this inspection.

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
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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Livesey 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
The inspection was carried out by two inspectors.

Service and service type
Livesey Lodge 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We could not meet with people to discuss their views of the service due to the risks associated with an outbreak of COVID-19 at the time of our inspection. We spoke with five members of staff who were all undertaking multiple roles in the service including care, laundry, cooking and housekeeping. The registered manager did not make themselves available for the inspection.

We reviewed a range of records. This included people's care records and a sample of medicines 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 to validate evidence found.

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 good. 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

- People using the service, staff and visitors were not protected from the risk of being exposed to infectious diseases. Government guidance in relation to the safe disposal of Personal Protective Equipment (PPE) was not followed.
- The training matrix confirmed not all staff had received infection control training. During the inspection we identified one member of staff undertaking cleaning duties without this training.
- The service had an outbreak of COVID-19 at the time of our inspection visit. The shortfalls identified meant robust action had not been taken to ensure the risk of the further spread of infection had been minimised.
- There was a significant risk of cross contamination because used PPE and incontinence wear was not disposed of or kept safe in line with government guidelines. PPE was found disposed of in open bags in communal toilets and bathrooms, with one hanging from a bath hoist in, and in three people's ensuite bedrooms. A bin in a communal toilet had no liner, was not pedal operated, and contained used PPE and continence wear.
- The service's COVID-19 risk assessment dated 28 November 2020 stated that 'all main bathrooms have gloves, aprons and masks'. We found two bathrooms did not have this PPE within them.
- Cleaning schedules identified bedrooms had not been cleaned since 5 December 2020. Nightly cleaning schedules did not evidence that hoists and slings were cleaned. This coincided with the regular housekeeper not being present at the service. The registered manager did not make suitable arrangements to ensure robust cleaning of the service continued in the absence of the regular housekeeper.
- The communal shower room had no adequate ventilation. This room was windowless, and the air-circulation fan was not working.

The provider failed to ensure people were protected from the risk of infection and systems were either not in place or robust enough to ensure infection prevention measures were effectively managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider told us improvements had been made to infection prevention and control at the service. Staff had been 'encouraged' to update their training and instructed to follow government guidelines regarding COVID-19 and the use and disposal of PPE. An electrician had been contacted to repair the air-circulation fan in the communal shower room.

Assessing risk, safety monitoring and management

- Some people had signage on their bedroom doors stating they were COVID-19 positive. Staff said this information wasn't always accurate as some people tested as positive had completed their isolation period.

This meant it was difficult to accurately assess COVID-19 risk levels at the service.
● Some people were isolating in their rooms. There was no clear information in the service as to when each person's period of isolation began and ended. The staff on duty were unable to give us this information. This meant we were not assured that people were being supported to follow the recommended programme of isolation.
● People who were isolating had no risk assessments or care plans to instruct staff how to support them during the time they were in isolation.
● One person isolating in their room was distressed and tearful. They told us they were 'lonely', 'bored' and 'frightened'. Staff said the person was 'constantly anxious' and 'really needs someone with them all the time.' The care plan and risk assessment had not been updated to reflect the impact upon their well-being despite staff being aware of how this could be managed. This meant the person was at risk of further and continuing distress.
● The nurse call system did not accurately display the bedroom people were accommodated in. It included people who no longer lived at the service. This meant people who called for assistance may not always be responded to in a timely manner.

Risks to people's health and well-being were not safely managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff rotas did not always identify who was the person in charge of the service each day in the absence of the registered and deputy managers, so it was not clear who had responsibility for the service at those times. The staff rota for the week ending 13/12/2020 showed the registered manager being on duty for three of these days. However, staff told us they were not present in the service at these times. The registered manager told us they were available by telephone.
● The rota did not show staff roles, so it was unclear which staff member did what. There were no designated cleaners or cooks on the rota.
● Staff said and rotas confirmed they were consistently working long hours undertaking multiple roles on top of their caring duties due to regular staff being absent from the service. For example, a senior carer on duty during the inspection was working a 16-hour shift which included cleaning and laundry duties. One staff member told us they were 'exhausted.'
● Following our inspection visit, the registered manager told us staff had been allocated set roles at the service, and the rota updated to show the various roles staff were undertaking following regular staff returning from self-isolation.
● When new staff were recruited the provider carried out checks to ensure they were suitable to work in a care service. Agency staff sent profiles to the provider to demonstrate their suitability.

Systems and processes to safeguard people from the risk of abuse
● The service's safeguarding policy was last reviewed in 2017. It stated that safeguarding investigations should take place within the service and the outcome shared with the local authority. This was incorrect as the local authority take the lead in safeguarding investigations and determines how they are carried out.
● The staff on duty understood safeguarding and what to do if they had concerns about a person's well-being. They said they would tell the registered manager and, if the situation wasn't addressed, refer the person to the local authority or CQC.
● The service's whistleblowing policy was due to be reviewed in August 2019, but this had not been done. One staff member told us, "Some of us [staff] see no point in going to the registered manager with concerns as they wouldn't do anything about them."

Learning lessons when things go wrong

● At our last inspection we found that staff cleaning practice did not always reflect best practice guidance. We recommended the provider develop and embed cleaning schedules to improve this. At this inspection, although cleaning schedules were in place, records showed these had not always been completed or followed. This meant the provider had not learnt from our last inspection.

Using medicines safely

● Medicines were managed safely. We saw medicine administration record (MAR) charts were in place, these showed people received their medicines as prescribed.

● When people were prescribed medicines 'as and when required' (PRN), the correct protocols were in place to inform staff when to administer these medicines. Records confirmed when and why they had administered PRN medicines.

● Staff told us they had received training and their competence regularly checked by managers.

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 good. 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; Continuous learning and improving care

- The service was not well-led. There were multiple failings in the provider's response and managing the COVID-19 outbreak. The registered manager had not ensured government guidance for 'working safely in care homes' was followed; for example, the safe disposal of used PPE and staff resource to ensure the service was cleaned effectively. This meant people and staff were continually exposed to the risk of infection.
- Previous recommendations made to the service to improve and embed quality monitoring systems had either not been implemented or sustained. These included, but were not limited to, infection control, the environment and care plans and risk assessments. This meant the registered manager had not identified the concerns found during the inspection.
- The provider had not arranged effective management cover when both the registered manager and deputy were absent from the service following the COVID-19 outbreak. The registered manager told us they offered 'telephone support' to the service due to the risks they presented of entering the service themselves. Shortfalls identified during the inspection confirmed this arrangement was not robust enough to ensure the safe management at the service continued in their absence.
- The service did not always follow its own risk assessments and policies; for example, the COVID-19 risk assessment. This had not been updated following the onset of the pandemic in March 2020 where there had been multiple changes to the guidance and advice to care settings.
- Staff were required to undertake multiple roles including cleaning and cooking. Staff commented they were tired and exhausted. This was in direct conflict with the registered managers view who told us staff were happy to work longer hours.
- Some policies had not been reviewed for a significant amount of time and contained guidance that was either outdated or incorrect; for example, safeguarding and whistleblowing policies.

Systems and processes were either not in place or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was no evidence people's wishes had been gathered on how they would like to be supported when

required to isolate. Shortfalls in staffing arrangements led to people's isolation in their bedrooms being compounded causing them undue stress and anxiety.

Working in partnership with others

● The registered manager had missed opportunities to seek support and guidance from the local authority following the COVID-19 outbreak. Following the inspection, the registered manager told us they would contact the local authority to support them Infection Control training.

● The service did consult and refer people to other agencies, such as GP's to ensure people had the right access to support their health needs when they needed it.

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 The provider failed to ensure people were protected from the risk of infection and systems were either not in place or robust enough to ensure infection prevention measures were effectively managed and risks to people's health and well-being were not safely managed to ensure people were not exposed to avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People did not receive safe person-centred care. Systems and processes were either not in place or robust enough to demonstrate the service was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Urgent Notice of Decision