Longridge Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 8 May 2017 and was unannounced. At our previous inspection we found that the service required improvement as it was not safe or well led. At this inspection we found that no improvements had been made and there were further concerns. We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not safe, effective, caring, responsive or well led. The overall rating for this service is Inadequate which means it will be placed into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Longridge Care Home is registered to provide accommodation and personal care for up to 32 people. At the time of the inspection 24 people were using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not receiving care that was safe as staff had not been trained to support people to mobilise safely. There were insufficient suitably trained staff to keep people safe.

Staff did not always follow people's individual risk assessments to reduce the risk of harm and people's prescribed external creams were not managed safely.

People were not always safeguarded from abuse as potential safeguarding incidents were not being reported to the local authority. Investigations into incidents and accidents did not always take place to

prevent the incident occurring again.

People were not always treated with dignity and respect and people's right to privacy was compromised. People's right to relationships were not always respected.

People were not offered opportunities to engage in hobbies and activities of their liking and there were routines and restrictions in place which meant people did not receive personalised care.

The principles of The MCA 2005 were not being consistently followed to support people who lacked capacity to consent to their care at the service. Consent was not always gained prior to people receiving support with their daily living needs.

The systems in place to monitor and improve the quality of care were ineffective. There was a lack of clear leadership and organisation in relation to staff performance and receiving the training they required to fulfil their roles effectively. People's views on the service were not being routinely sought to ensure they were happy with their care

People received health care support and advice when they became unwell or their needs changed and they were supported to eat and drink sufficient amounts to remain healthy.

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.

People's risk assessments were not being followed to ensure that their risk of harm was minimised.

People were not being safeguarded from the risk of abuse.

People's medicines were not being managed safely.

There were insufficient suitably trained staff to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not being cared for by staff who were trained and supported to fulfil their roles.

The principles of The MCA were not being followed effectively.

People were supported to eat and drink sufficient amounts and health care advice was sought when people became unwell or their needs changed.

Is the service caring?

Inadequate

The service was not caring

People were not always treated with dignity and respect.

People's right to privacy was not always upheld.

People were not able to be as independent as they were able to be.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not receiving care that met their individual needs and preferences.

People were not offered hobbies and interests to stimulate and meet their emotional needs.

There was a complaints procedure and people knew who to speak to if they had a concern.

Is the service well-led?

Inadequate

The service was not well led.

The systems the provider had in place to monitor and improve the service were ineffective.

People who used the service were not at the centre of the service and were not being asked for their feedback on the service they received.

The registered manager and provider were not meeting the requirements of their registration with us.

Longridge Care Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 May 2017 and was unannounced. It was undertaken by one inspector 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.

We looked at the information we held on the service including the last inspection report. We did this to inform the inspection.

We spoke with eight people who used the service and observed their care throughout the day. We spoke with four visitors. We spoke with the registered manager, senior carer and two care staff.

We looked at the care records for three people who used the service, two staff recruitment files, people's medication records and the systems the provider had in place to monitor the quality of service such as complaints and audits.

Inadequate

Is the service safe?

Our findings

At our previous two inspections we found that the service was not consistently safe. At our last inspection we had concerns that people were not being supported to mobilise safely by suitably trained staff. At this inspection we found that no improvements had been made since our last inspection and people were not receiving safe care and treatment.

We found that staff were still not always trained to care for people safely and they were undertaking tasks they were not trained to do. For example, several people required support with their mobility and needed staff to support them with the use of specialist equipment such as hoists and handling belts. We found that two of the four staff on duty had not received training in the safe moving and handling of people. We observed one trained and one untrained staff support people to move on several occasions. On one occasion, one person complained that the handling belt was hurting them and on another occasion we saw that one person almost fell from the stand aid and a member of staff had to grab them by their cardigan to stop them from falling. We discussed this with the registered manager who told us these staff would only be working with a trained member of staff. However, the trained member of staff was not qualified to train the untrained staff members and this meant there was a risk that people were not supported to transfer/mobilise safely. This meant that the provider and registered manager were not ensuring that staff were trained to provide safe care and treatment to people.

People's risk assessments were not always followed to minimise their assessed risks. For example one person's risk assessment stated that a member of staff should walk behind them with their wheelchair as they tired easily and were at risk of falls. We observed that a member of staff did not follow these instructions by ensuring they walked behind them with their wheelchair when supporting the person to mobilise safely. The person became tired and asked for their chair and the staff member had to leave them standing alone while they went to fetch the wheelchair from another area of the service. We saw another person was assessed as being at risk of sore skin due to sitting for long periods of time and required the use of a pressure cushion. We saw that the person did not have their pressure cushion as required. The person's visiting friend told us: "[Person's name] often hasn't got their pressure cushion or a call bell they can use". This meant that people were put at risk of harm as their assessed needs were not being met to keep them safe.

We saw that some people were prescribed external creams to reduce the risk of sore skin. The creams were kept in people's bedrooms and applied by the care staff. There were no instructions available to staff as to where and when the cream should be applied. Two members of staff we spoke with told us they only applied creams to people's legs, however each cream was prescribed based on individual people's needs and not just to be applied to people's legs. The senior care staff signed to say that the creams had been applied without having observed this being completed. This meant that the registered manager could not be sure that people had their prescribed medicines as they needed it and this put people at risk of sore skin.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Staff we spoke with told us that they would report any suspected abuse to a senior or manager. However the registered manager had not reported or investigated all incidents of potential abuse. We saw that one person had recently been injured and had bruising. The incident record for this person stated; unknown bruising, possible fall. No further investigation had been undertaken or a referral to the local safeguarding authority been made. On the day of the inspection we saw this person was visibly upset and complaining about a member of staff, stating they frightened them. Although staff reassured the person there was no evidence that this person's concerns were taken seriously and acted upon. The registered manager told us that this person had complained about staff before and this had been referred to the local safeguarding team however the unexplained bruising had not been referred.

A further safeguarding incident was being investigated by the local authority which had involved staff moving a person with a hoist when they were not assessed as requiring it. The registered manager told us that they had not investigated this incident themselves internally to ascertain why this had taken place and to address the issue with the staff involved. This meant that the provider was not ensuring that people were being protected from potential abuse and people were at risk of further harm.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us mixed views as to whether they felt there were sufficient numbers of staff to meet their needs. One person told us: "I feel safe as you just press your button and there is somebody with you, that's what you need". Another person said: "It's ok in the day but at night there are only two of them". Another person said: "The staff come pretty quickly when I ring the call bell, two or three minutes as I'm not the only one here". We observed that people had to wait following meal times to leave the table if they required support. One person was left at the dining table for up to an hour after they had finished both breakfast and lunch with no explanation as to when staff would be coming to support them. This was because the person required two staff and the use of a stand aid to mobilise safely. We observed staff supported people who were more mobile to leave the dining room first which meant this person had to wait. The registered manager told us that they used a staffing tool to determine the staffing levels based on the needs of people who used the service. However consideration to the suitably of the staff in relation to their skills and ability had not been made and we found that there were untrained trained staff supporting people in an unsafe way. This meant that people's needs were not being consistently met in a timely manner by sufficient numbers of suitably trained staff.

New staff were employed using safe recruitment procedures to ensure that they were of good character and fit to work with people. Pre-employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that staff were of good character and fit to work with people.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found no concerns in the effectiveness of the service. At this inspection we found that not all staff had received training to be effective in their roles. The registered manager confirmed that some staff training was out of date and required refreshing. Records we looked at confirmed what the registered manager told us. Several staff had not completed training in the safe moving and handling of people. One member of staff had been in post for almost 12 months and had not received this or other training such as training in recognising and reporting abuse. This was putting people at risk as staff caring for them did not have the skills and knowledge to care for people safely and effectively.

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 Act 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. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We checked to see if the provider was appropriately applying the MCA and found they were not. For example, we could not see that people's mental capacity had been assessed prior to DoLS applications being made. This meant that the provider could not be sure that people actually lacked the capacity to agree to their care at the service and any restrictions that were in place.

Some staff had not had received training in the MCA 2005 or the DoLS legislation. We observed that staff did not always seek consent from people before carrying out a task. For example. some people were taken away from the dining table without staff asking them if they wanted to leave. We saw some staff put aprons on people without asking them if they wanted to wear one and we saw people were restricted from leaving the dining table when they wished to. This meant that people were not always being consulted with and were being restricted without explanation.

People told us they enjoyed the meals and had sufficient to eat and drink. One person told us: "The food is beautiful, can't get better anywhere". Another person told us: "The cook comes round and gives us a choice; everything we have is usually nice". We saw when people lost weight that action was taken to ensure this was addressed with referrals being made to their GP and the Speech and language therapist. We saw that people who were prescribed food supplements to encourage weight gain had these when they required them.

People told us that when they became ill or their needs changed they were supported to see a health professional. One person told us: "Yes, they contact the doctor if I'm poorly, I see them quite often". A relative told us: "My relative has their feet done by the chiropodist and has recently had an eye test and new glasses". This meant that the appropriate health care support and advice was sought when people's needs changed.

Inadequate

Is the service caring?

Our findings

At our previous inspection we found no concerns in how staff interacted and cared for people. At this inspection people told us they were not always treated with dignity and respect. One person told us: "Sometimes the staff are bit snappy but sometimes I'm a bit snappy". A relative told us: "One of the girls when I came last time was really sharp with my relative". A visiting friend told us: "I've seen one or two staff that are a little bit curt. I don't call that respectful. There are people who want to be carer and those who don't". This meant that people were not always being treated with dignity and respect.

Although we saw some positive interactions, we observed that not all interactions between staff and people demonstrated respect for the person. We saw one person asked to leave the table following their meal. A senior member of staff said: "She has to stay there until she has had her medication". A member of staff then said to the person: "You have to stay there until you have had your medication". This person was not asked to stay, rather they were told to stay. However we observed that a staff member allowed another person to leave the dining room saying: "I will bring your medicine to you in the lounge". It was not made clear why one person was able to leave the table whilst another person was being stopped. Later we heard a member of staff ask a senior member of staff: "Can they [people who used the service] leave the table now?" To which the senior staff member responded 'yes'. This meant that people were not being treated with dignity and respect. People were not able to be independent and did not have the freedom to come and go as they wished.

Staff did not always respect people's relationships or choices. Two people were in a relationship and we observed one person say: "Come on lets go now we have finished", at which point the other person got up to leave with them". A member of staff abruptly told the person not to request the person to leave by saying: "Stop telling [person's name] what to do". This did not demonstrate respect for the couple's relationship and allow for people to make their own decisions and choices.

We observed several occasions when staff did not explain to people or ask people before moving them. We saw staff pull people's chairs away from the dining table in order to move them onto a wheelchair or to give them their walking frame without first asking them or explaining what they were going to do. We saw that people were supported with the use of a hoist and stand aid without staff talking through with them what they were going to do.

We heard one person who was living with dementia telling a senior member of staff they didn't like another member of staff and that they frightened them. The member of staff being complained about overheard the person and responded by saying: "What have I done now? It's the same everyday". The staff member's attitude was not addressed as being inappropriate.This did not demonstrate a caring attitude and an understanding of this person's needs.

People's right to privacy was not always upheld. We heard a member of staff talking about a person who used the service in the dining room where there were other people who used the service and some visitors. The staff member said: "[Person's name can pull herself up from the toilet". This did not protect this

person's right to privacy and demonstrate respect for the person.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives and friends told us they could visit at any time and we observed visitors throughout the day. A relative told us: "We can visit any time, they don't put any restriction on that".

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had no concerns about the responsiveness of the service. At this inspection we found that people were not receiving care that met their individual needs and preferences. For example staff were not always following people's individual risk assessments to keep people safe. Other interactions observed from staff to people did not allow people to meet their own preferences in relation to when they left the dining room and the daily routines of the home. A visitor told us: "My friend likes to sit and chat with the ladies in the other lounge but the staff say they can't keep an eye on her down there, that's not choice is it". This meant that people's individual preferences were not always being met.

People were not offered any hobbies or activities to stimulate them. We observed people sat in the one of the two lounges with the television on. In one of the lounges two televisions were on but one was so quiet people couldn't hear it. One person told us: "I keep falling asleep because there is nothing else to do". Another person told us: "There is not much going on, maybe things will get better in the summer. I would join in". A visitor told us: "I don't think there's enough going on. [Person's name] is not stimulated, there's nothing going on, no exercises or anything, they just sit in a chair. I don't think their emotional welfare needs are being met". We looked at people's daily records and saw that no activities were recorded as having taken place.

There was a conservatory that overlooked the gardens however this was not useable as it had not been maintained. This had been noted and discussed at our previous inspections however, no action had been taken to make this a usable space as the lounges were observed to be crowded. A relative told us: "The garden could be better, better for the residents to go outside. Just to put their hats on and take a cup of tea outside".

We saw that there were residents meetings held approximately every three months. However as part of these meetings we could not see that people were asked if they were satisfied with their care and what they may like to improve the experience of residing at the service.

There was a complaints procedure which was visible on the wall of the corridor. The registered manager told us there had been no recent complaints. A relative told us: "I complained once and it got sorted pretty quickly". Another relative told us: "I would speak to the senior if I had any concerns and they would sort it". However several people complained to us on the day of the inspection and they had not previously complained to a member of staff or the registered manager. This showed that people did not feel able to complain about their care and support at the service.

Inadequate

Is the service well-led?

Our findings

At our previous two inspections we had found areas that required improvement. At the last inspection we had found some improvement had been made however at this inspection we identified further areas of concern and several breaches of the regulations.

The systems the provider had in place to monitor and improve the quality of the service were ineffective as people were receiving care that was not safe, effective, caring, responsive or well led. We saw records that confirmed that the registered manager conducted observations of staff practise. However these observations had not identified the issues of poor staff practice we observed on the day of the inspection in relation to staff treating people with dignity and respect and the moving and handling of people. There appeared to be a culture of staff telling people who used the service what they could and couldn't do. People were seen to be complying with staff by sitting and waiting for instructions rather than being free to come and go.

The provider was not ensuring that staff delivering care to people who used the service were trained and effective in their roles. We saw people's moving and handling risk assessments stated that staff should be trained, however we saw that staff were not always trained. We saw several members of staff whose training was out of date and needed refreshing. This meant that the provider was not following their own procedures by ensuring staff were trained to safely deliver care. We discussed this with the registered manager who had a matrix of staff's training needs and was aware that the training was due but this had not been planned or arranged.

The registered manager was not able to tell us which training the agency staff they were using had received as they had not asked the agency for this information. Permanent staff employed by the provider were not receiving the training they required to provide good quality care. For example, one member of staff who had worked at the service for almost 12 months had not been trained to support people to move safely or in how to recognise and report the signs of abuse.

The registered manager had not conducted an investigation into a recent safeguarding incident which involved potential poor staff practice. They were not aware of whether the staff had been trained or were untrained to undertake the activity they had been involved in during the incident. No action had been taken to minimise the risk of this incident occurring again.This meant that lessons were not being learned and risks of further incidents reduced.

During the inspection we brought it to the registered manager's attention that staff were supporting people to mobilise with the use of equipment they had not been trained to use. We observed that later staff were still seen to be moving people when they had not been trained to do so. This meant that the registered manager had not taken action to stop this practise after we had brought it to their attention.

People's views on the service were not being routinely sought and people told us they were not always happy with their care. There had not been a recent quality survey undertaken with people and they were not

regularly asked their views in reviews or meetings. The provider had no effective systems in place to gain people's feedback and use this information to improve people's experiences.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not appropriately notified us of a safeguarding incident as they are required to do so by law. This meant that they were not following their legal requirements as a registered manager with us (CQC).

This was a breach of Registration Regulations 2009 (Regulation 18)

The provider is required to display their quality rating from our previous inspection to ensure people are aware of the rating and to be open and transparent. We found that the rating was not on display.

This was a breach of Regulation 20A of The Health and Social Care Regulations (Regulated Activities) Regulations 2014.