LJ Care Homes Ltd

York House

Inspection report

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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
York House is a residential care home and domiciliary homecare service providing accommodation and personal care primarily for older aged adults including those living with dementia. The service provides accommodation for up to 16 people across two floors. The service also provides homecare for people in Lincolnshire. This inspection focussed only on the residential care home service being provided. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

At the time of our inspection there were 16 people using the service for accommodation.

People's experience of using this service and what we found

People were not always protected from the risk of abuse. Risks associated with people's care and support were not always planned for. Medicines were not stored or managed safely. People did not always receive medicines as prescribed. People were at risk of harm due to widespread poor infection control practices.

People were at risk due to staffing levels and staff competence. Arrangements for staff recruitment, training and deployment did not support people's safety. Most staff were not evidenced to have received training and staff did not always have complete recruitment information. Despite these concerns, people and relatives were mostly positive about the safety of the service.

York House was not well led. Governance systems were not effective in adequately supporting people. Audits failed to identify and act upon issues and to ensure person-centred care. Care plans and risk assessments were not always put in place in a timely manner. The service did not create a comfortable environment for staff to raise concerns and put people at risk of harm.
The service worked in partnership with other organisations.

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 2 August 2018).

Why we inspected
We undertook a targeted infection prevention and control inspection (IPC) to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about visiting practices going against government guidelines during the COVID-19 pandemic. A decision was made for us to inspect and examine those risks.

We inspected and found there were other concerns, so we widened the scope of the inspection to become a

focused inspection which included the key questions of safe and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at IPC 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. This included checking the provider was meeting COVID-19 vaccination requirements

We have found evidence that the provider needs to make improvements. 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 York House 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safety, infection control, staffing, management and leadership 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
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 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 out safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in out well-led findings below.

York House

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 included checking the provider was meeting COVID-19 vaccination requirements. 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 an inspector and an inspection manager.

Service and service type
York House 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.

This service is also a domiciliary care agency. It provides personal care to people living in their own homes. This inspection focussed only on the care home service being provided.

The service did not have a manager registered with the Care Quality Commission. This means that only the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager in place who had submitted an ongoing application to be registered with CQC.

Notice of inspection
This inspection was unannounced. Inspection activity started on 13 January 2021 and ended on 02 February 2021. We visited the location on 13 and 31 January 2021. We made calls to staff and relatives throughout this

period.

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. 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 used all this information to plan our inspection.

During the inspection
As part of the inspection we spoke with the provider, the manager, eight members of care staff, one administrator and a member of the housekeeping team. We also spoke with one person who used the service and the relatives of four people. The local authority also visited the service and sought feedback from several people using the service and shared that with us during the inspection.

We reviewed a range of written records including six people's care plans, staff handover documents, staff recruitment and training records and information relating to the auditing and monitoring of service provision.

Inadequate

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

Systems and processes to safeguard people from the risk of abuse

- People were not protected from abuse. Several allegations of abuse were made to us by staff and relatives. Staff told us that people had become distressed due to alleged abuse at the service. Staff had not reported these concerns to the local authority and they were consequently not investigated at the time.
- Some staff members did not feel comfortable raising safeguarding concerns to the management team due to potential repercussions. One staff member told us, "Some staff are not keen to talk as they are scared."
- Most staff did not have a record of receiving safeguarding training. Some staff told us they had not received any safeguarding training. Following inspection, the manager provided us with evidence displaying that safeguarding training had been completed. We will assess the impact of this on competency at the next inspection.

Systems were not in place to protect people from the risk of abuse. This was a breach of regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people 's health, safety and welfare were not always identified or managed effectively. For example, care plans and risk assessments were not always in place. One person admitted for respite care, had no record of their current care and support needs. The risk assessments in place for this person were dated from 2019 when the person was not residing at the service and were not up to date with current needs.
- One person was assessed as being at "very high" risk of pressure ulcers and needed support for repositioning. The risk assessment stated that adults at high risk should be repositioned "at least every four hours". There was no record of routine repositioning in place for this person.

Using medicines safely

- Medicines were not always managed and stored safely.
- The medicines room was accessible by an external door. We found this door to be unlocked with the key in the lock, making it accessible to the public. Medicines were stored in boxes on shelves with no secondary secure storage. We informed the manager, who locked the door and removed the key immediately.
- Medicines storage was disorganised and increased the risk of error. One person had their medicines stored in a plastic box which had another person's name, date of birth and photograph on it.
- People did not always receive medicines as prescribed. One person was prescribed a pain-relief patch to be changed every 72 hours. The medicine administration record showed the patch had not been changed between 23-31 December 2021 and no reason was recorded. This may have resulted in the person

experiencing avoidable pain.
● Medicine administration records were not always kept up to date with important information. We found several people did not have a photograph on their medicine records. One person was prescribed a medicine to be taken once daily but the administration record stated this was to be given 'as needed'. This medicine had not been recorded as administered since 19 December 2021. This meant the person was at risk of not receiving their medicines as prescribed.
● Staff did not always receive full training to administer medicines. Some staff told us they had not received full medicines training. Other staff told us that training had been completed with the manager. Online training records were incomplete and there was a lack of evidence of staff completing training. This meant people were at risk of not receiving their medicines safely.

Preventing and controlling infection
● People were at risk of harm due to widespread, poor IPC practices and a failure to implement effective measures in response to a COVID-19 outbreak.
● There were insufficient measures in place to reduce the risk of infection spreading. For example, people with COVID-19 did not have notices on their doors and were not being regularly identified on handovers. A staff member was observed entering the room of a person with COVID-19, wearing only a mask, to offer them a biscuit from a shared dish. The local authority IPC team intervened before this dish was shared with other people. The staff member told us they were not aware the person had tested positive for COVID-19.
● Staff did not always wear PPE safely. We saw staff not wearing masks in the kitchen and dining area of the service. We also saw a staff member wearing a mask under their chin during a COVID-19 outbreak.
● Staff did not always have the required knowledge to manage IPC. We reviewed the training matrix and found that only six staff were documented as completing IPC training. Staff told us conflicting information about where they would remove contaminated PPE. Some staff members told us they removed contaminated PPE in the downstairs bathroom whereas others stated they would do this in the people's rooms.
● People did not have COVID-19 care plans or risk assessments in place. This included people who were COVID-19 positive, living with dementia and who had specific respiratory needs.
● There was not a robust cleaning process in place. The service employed a housekeeper who worked three days a week. There was not a documented cleaning schedule for daytime cleaning outside of these days, including for a visiting area and high frequency touch points. We saw a night-time cleaning schedule was in place for staff but several records were missing. The manager told us they had removed these records as the cleaning had not been signed as completed by staff but had now ensured staff were completing this.

Systems were not in place to assess, monitor and mitigate risks related to people's care and support needs, medicines management and infection, prevention and control. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the management team began addressing the above concerns. For example, the service had since relocated the medicines room and now used locked cupboards to store medicines. In addition, they had ensured care plans and risk assessments were in place for people receiving respite care.
● Despite the above concerns, people and relatives were overall positive about the safety of the service. People told us they knew to speak to staff if they needed to raise concerns. One person said they have, "Never had to raise a complaint… but the manager would sort problems if needed." One relative said staff, "Ensured their relative was eating, taking medicines properly, ensuring they are warm and safe."

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an

emergency. We checked to make sure the service was meeting this requirement.
● We found the service did not initially have effective measures in place to make sure this requirement was being met. The service monitored the vaccination status of staff. However, they did not have evidence of the vaccination status of professional visitors. Following discussion with our inspectors, the manager put systems in place to ensure the vaccination status of professionals was checked. The government has announced its intention to change the legal requirement for vaccination in care homes.
● We found the service's approach to visiting did not always align with government guidance. People were not always enabled to have visitors and some restrictions were placed on relative's visits to the service. This is evidenced further in the Well-led section of this report.

Staffing and recruitment
● Staffing levels at the service put people's safety at risk. The service deployed two care staff on shift for days and nights. There were two people who required two staff to provide their care. This meant no staff were available to support other people during these times.
● Feedback on staffing levels was mixed. Some staff felt staffing levels were too low, especially at night when completing medicines rounds or supporting people who had a fall. One person told us staff, "Come when they press (the call bell)." The manager told us there was an informal process where staff were contacted to support the service at short notice in the event of an emergency, such as a person requiring medical treatment.
● Training records were incomplete, less than half of the care staff had complete training records. The manager told us that all training records had been deleted prior to the manager starting in post in October 2021. This put people at risk as staff members may not have the right knowledge and skills to provide safe care and support.

The provider had not ensured there were sufficient numbers of suitably trained staff employed to meet people's needs. This was a breach of regulation 18(1)(2), (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment arrangements were not always robust. The provider had not always sought adequate information about staff suitability and their conduct in previous roles. We reviewed two staff files and found one application form was blank and the other incomplete with no recent employment history. One staff member had no evidence of an interview taking place. Following the inspection, the manager stated that all staff files had been completed.
● Despite the above concerns, the provider had completed Disclosure and Barring (DBS) checks for staff. DBS checks provide information including details about criminal convictions and cautions which help employers make safer recruitment decisions.
● Issues identified with training records were addressed by the manager following the inspection. The manager had implemented a new online training system with the intention of all staff completing mandatory training.
● Staff members deployed were consistent and the service only used permanent staff. Relatives and people told us they knew the staff.

Learning lessons when things go wrong
● We did not find evidence of lessons being learnt following accidents and incidents. There were a small number of falls recorded in an accidents and incidents audit. We did not find any adjustments made to reduce future risk of further incidents.
● One staff member told us about a person falling out of bed and lessons had not been learnt. They stated, "Nothing was done to minimise the risk of them falling again... There is a huge risk they will fall out of bed

again."

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems to ensure the safety and quality of the service were not effective. There were insufficient audits and governance systems in place.
- Governance systems were not effective. As noted in the safe section of this report, audits had failed to identify and mitigate risks we found during inspection. For example, medicines management, IPC, staff recruitment files and people's risk assessments.
- Systems were not in place to ensure visits to the service were in line with government guidance. Prior to the inspection, we were made aware that the service was limiting visitors to people to one at a time. The manager also confirmed that the family of a staff member had visited the service for a meal on Christmas Day. This presented an inequality of approach to visiting. The manager stated restrictions on visitors were no longer in place, however, one relative told us their relation waited outside while they visited as they had not been informed of this change.
- The management team failed to ensure systems and processes were in place for staff to provide a person-centred approach for people. We found that one person admitted from hospital was isolating in their room following admission to the service, due to covid-19. There were no care plans or risk assessments in place to ensure social support from family and staff for this resident during this period of isolation.
- Effective action had not been taken to address known issues. We observed in the September 2021 review of incidents and accidents, the provider had identified that staff required practical moving and handling training. It was documented that the training had been booked. In subsequent months the same action had been identified. At the time of the inspection, there was still no evidence that staff had received practical moving and handling training. This failure to take timely action posed a risk that staff may not be competent to safely support people who required assistance to move and transfer.

The provider failed to ensure that effective governance systems were in place. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the management team ensured they had a system in place for people receiving respite care to have care plans and risk assessments in a timely manner.

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; Engaging and involving people using the service, the

public and staff, fully considering their equality characteristics

● The provider had not ensured relatives of people were informed about an outbreak of COVID-19 in a timely manner. One person told us their relative had not been contacted about the outbreak and they turned up at the service expecting to visit but were told they could not enter the premises.

● One family member told us they had been informed when their relative had a fall at the service.

● The provider did not always create a comfortable environment for staff to raise concerns. Some staff members told us they did not feel comfortable raising certain issues to the manager due to fear of consequences or that nothing would be done. One staff member said, "I feel like if a complaint was made about another worker then not much would happen… other people have raised concerns and not much has happened."

● The provider has not established a system to seek feedback from the public, staff and relatives since a change in management at the service in October 2021. At the time of inspection there were records of three staff meetings. There was evidence of one survey taking place for all people using the service. The manager told us they intended to issue surveys quarterly for families, staff and people using the service.

● Staff were not always engaged in the running of the service. One staff member said, "I've never been part of or seen the outcome of a team meeting."

● There was mixed feedback from relatives on the responsiveness of the service. One relative told us the service was "very responsive" to their requests. Another relative told us, "I suggested a foot stool to carers… but they (their relative) have not been given one."

Working in partnership with others

● The service worked closely with the local GP surgery. The manager told us they had a good working relationship with the doctors and manager of the surgery. One relative told us the GP surgery had been contacted for a nurse to visit when their family member needed support.

● We saw evidence of contact with external agencies, such as district nurses, when reviewing people's care plans.

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 risks associated with fire safety, medicines management, infection prevention and control and pressure area care were robustly assessed, mitigated and monitored to ensure people were supported safely.

The enforcement action we took:

We issued a warning notice to drive improvements in the safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes were in place to protect service users from abuse.

The enforcement action we took:

We issued a warning notice to drive improvements in the service to protect people from the risk of abuse.

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 provide safe and effective care, and person centred care. The provider failed to keep accurate records, take effective action to address known issues and ensure safe recruitment processes were in place.

The enforcement action we took:

We issued a warning notice to drive improvements in the management of the service.

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 enough

staff to run the service safely and that staff were competent. The provider had not ensured staff had received the appropriate training necessary to enable them to carry out their duties.

The enforcement action we took:

We issued a warning notice to drive improvements in safe staffing practices at the service