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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Longridge Care Home Limited is a care home providing accommodation and personal care to 21 people aged 65 and over at the time of the inspection. The service can support up to 32 people.

People's experience of using this service and what we found
People did not consistently receive safe care. The identified risks to people's safety had not been effectively mitigated. Areas of increased or new risk were not assessed and planned for. Staff were not aware of how to keep people safe and manage risks to safety. Medicines were not managed safely. People were not kept safe from incidents of abuse as incidents were not reported to allow investigation by outside bodies. There were insufficient suitably skilled and trained staff available to support people to meet their needs safely.

The provider had not acted to address the concerns identified in the last inspection. There were no plans in place to address the short falls and people remained at risk. The systems to monitor the quality of care were not effective in identifying concerns. Actions were not taken to make improvements where issues had been identified. There were failings in leadership and the provider was not ensuring people were kept safe and people continued to be exposed to poor care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection and update
The last rating for this service was Inadequate (published 19 June 2019). At this focussed inspection improvements had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of risks, staffing and support with people's medicines administration. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.
We reviewed the information we held about the service. Ratings from the previous comprehensive inspection for other Key Questions were used in calculating the overall rating at this inspection.
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 Longridge Care Home Limited on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, staffing and governance 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 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 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.

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.

Longridge Care Home Limited

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.

Inspection team
The inspection took place on three days. On day one there were two inspectors, day two there was one inspector and day three there were three inspectors.

Service and service type
Longridge is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 in post, but they were not yet registered with the Care Quality Commission. The registered manager 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 sought feedback from the local authority and professionals who worked with the service. We used this information to plan our 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.

During the inspection-
We spoke with three people about their experience of using the care service. We spoke with five staff members including care staff, senior care staff, the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with five visiting professionals including nurses, occupational therapists and social workers. We observed care delivery to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records and multiple medication records. A variety of records relating to the management of the service, including incident records, staff rotas, handover reports and quality audits carried out to check the quality of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at additional care records for eight people and quality assurance records.

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 Inadequate. At this inspection this key question has remained the same.

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

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they did not always have their needs met. For example, one person told us they had asked for a light bulb in their room on many occasions, but this had not been provided and left them feeling unsafe. The person was at risk of falls and the poor visibility increased the risk of the person falling.
● The provider had failed to ensure risks to people were adequately assessed, and plans were in place to mitigate them. One person was admitted with a skin tear. The person's care plan did not include a risk assessment or plan to mitigate further risk to the service user's skin. The person sustained a further two skin tears since admission and despite advice and changes of equipment from a visiting health professional staff were not made aware and there was no care plan and risk assessment in place.
● In another example, one person was diagnosed with having seizures. The provider had not put in place a risk assessment, care plan or information to inform staff about how to keep the person safe. Staff confirmed they were unaware of the diagnosis or what action to take. This meant the person was at risk of harm as staff would not know how to respond if the person had a seizure.
● The provider had failed to reduce risks to people from concerns with the hot water system. We found several water outlets where the temperature was too hot and posed a risk to people of scalds. The provider was prompted during the inspection to take action to keep people safe.

Using medicines safely

At our last inspection the provider had failed to ensure safe administration of medicines for people. 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 not administered safely. We found there were medicine records without clear instructions for staff on how and when to administer medicines. This meant people were at risk of not receiving their medicines as prescribed.
● Medicines records were not accurately completed in line with the law. We found stock balances had not been currently recorded for some medicines which required accurate record keeping. The issue had not

been identified by staff and the matter had not been reported to the appropriate bodies.
● The providers systems had failed to identify these concerns prior to the inspection. The provider informed us they had begun an investigation and would report these matters to the appropriate bodies.

Learning lessons when things go wrong

At our last inspection the provider had failed to implement a system which enabled them to learn when things went wrong. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not have a system in place to learn when things went wrong. A recent incident had activated the fire alarms. The automatic door closures had not worked as effectively as they should, and some staff lacked the knowledge to use the fire evacuation equipment. The provider had not taken any action to address these concerns and was prompted to take action at the time of the inspection.
● In another example, incidents were not reviewed to reduce the risk of reoccurrence. One person had sustained an injury in May 2019, there had been no review of their risk assessment and care plan and no action to prevent incidents. The person sustained a similar injury in June 2019 as a result. This meant the person had been exposed to harm.

At this inspection the above failings placed people at continued risk of harm and the provider remained in breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from potential abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not protected from potential abuse. Some staff had not received up to date information and training about how to recognise abuse and report any concerns.
● We found there was no clear process in place to review where incidents had occurred and report these to the safeguarding authority.
● One person had sustained two skin tears whilst being supported to use equipment for transfers. There was no consideration of whether there were acts of omission or neglect which led to the person sustaining these injuries. The provider acted to review these incidents only when prompted through the inspection process.

At this inspection the above failings to protect people from abuse meant the provider remained in breach of improvements had not been made and the provider was still in breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider did not have enough staff to meet people's needs on a consistent basis but were meeting the regulations.

● People told us they did not have to wait too long for staff to support them. However, they commented the

staff did not have time to take them out or spend time doing things with them.
● There were insufficient suitably skilled staff to meet people's needs. The provider had not planned for the staff they needed to meet people's needs. For example, there were periods shown on the rota where there were no trained staff to administer medicines and the provider had to be prompted to arrange for staff to be available.
● The local authority had to provide additional staff to supplement the providers staffing and ensure there were suitably skilled staff available to provide safe care to people.
● We found the home was being staffed by agency staff who were not aware of people's needs. The agency staff had received no handover from staff at the start of their shift and were unable to tell us how they needed to support people.
● For example, one person rang the call bell to ask for help from staff. An agency worker responding was unable to offer support to the person as they were unaware of the persons mobility needs and the person could not describe these. The person had to wait whilst the agency staff member fetched a permanent member of staff to assist.
● Staff were not consistently knowledgeable about peoples changing needs. Staff were not receiving a handover at the start of their shift and communications about changes to people's needs had not been received.
The above evidence shows the provider had not planned for enough suitably skilled staff to be deployed to support people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Cleaning schedules were in place and completed daily in the records we checked. However, some areas of the home were found to have malodours. We saw there was one domestic staff member responsible for cleaning the home and carrying out laundry duties. This meant cleaning tasks were not carried out promptly and there was an increased risk of cross infection.
● Staff told us there had been a shortage of bags provided to transfer dirty linen to the laundry. This meant there was an increased risk of cross infection. The provider told us they had now provided additional bags to prevent this from reoccurring.
● We observed staff using protective clothing such as gloves and aprons when supporting people and staff could describe how they used hand washing procedures to reduce the risk of cross infection.

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 Inadequate. At this inspection this key question remained the same.

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

At our last inspection the provider had failed to have systems in place which checked the quality of the care people received. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a manager in post who was new to the home and not yet fully aware of people's needs and the homes processes. They had not yet made an application to register with the commission.
- The manager was not fully aware of their role and responsibilities and had not developed a strategy or addressing the failings in the home from the last inspection with the provider.
- The provider was being supported by the local authority to manage the home and provide leadership. For example, the local authority had acted to identify the lack of trained staff and seek a solution. They had to prompt the provider to seek input from health professionals to keep people safe and update risk assessment and care plans.
- The system to monitor medicines administration was not effective. The provider had an audit process in place, however this was not consistently completed and had failed to identify the concerns we found with stock control, a lack of guidance for administration which placed people at risk of harm.
- The system to monitor accidents and incidents was not effective. People were exposed to a continued risk of harm as action had not been taken to mitigate the risk of reoccurring incidents.
- The providers systems to monitor the water temperatures in the home had failed to identify and enable action to be taken when water outlets had temperatures which were too hot, and this placed people at risk of being scalded.
- The providers systems for monitoring the fire safety of the building were not effective. People were left at risk of harm as faults had not been identified and action taken to address these.
- The provider did not have a system in place for ensuring enough suitably skilled and knowledgeable staff were available to meet people's needs. This meant people were at risk of not receiving the care they needed.

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

At our last inspection the provider had failed to put in place systems which promoted a person-centred culture, meet legal responsibilities and act on their duty of candour. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider has continued to fail to implement systems which deliver person-centred, high-quality care.
● At our previous six inspections carried out in June 2015, June 2016, May 2017, October 2017 and April 2018 and May 2019 we found that improvements were required in aspects of people's care and that regulations had been breached.
● The provider continues to be rated inadequate. This means people have been exposed to poor care for an unacceptable amount of time.
● The provider had not consistently notified people when things went wrong. For example, there were issues we found which should have been reported to health professionals for advice.

At this inspection the above failings to make and sustain improvements to the governance of the home means there is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.was still in breach of regulation 17.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
● The provider did not consistently listen to feedback about the home. Staff told us they had raised concerns about some of the issues we found during the inspection, but no action had been taken. People and relatives told us they did raise concerns about some issues with the provider, but these had not been acted on.
● The provider did not have systems in place to continually learn. For example, where an incident had occurred which posed a risk to people's safety from fire no actions had been taken to address these concerns.
● The provider had not consistently followed and embedded the advice of health professionals. A range of health professionals had been visiting people making suggested changes to mitigate risks to people's safety. However, this had not been effectively communicated to staff and care plans and risk assessments had not been updated. This meant staff were not aware of changes to people's care.

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 had failed to ensure risks to people were assessed, planned for and mitigated. Medicines were not administered safely.

The enforcement action we took:

Imposed urgent conditions on the providers registration to restrict admissions.

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 had failed to ensure there were systems in place to report concerns to the appropriate body for investigation.

The enforcement action we took:

Imposed urgent conditions on the providers registration to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to identify concerns about medicines management, risk assessment and staffing levels. No action had been taken to address the concerns we found.

The enforcement action we took:

Imposed urgent conditions on the providers registration to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient suitably skilled staff available to meet peoples needs safely.

The enforcement action we took:

Imposed urgent conditions on the providers registration to restrict admissions.