

Roseberry Care Centres GB Limited

Long Meadow

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Long Meadow is a residential care home providing personal and nursing care to up to 41 people. The service provides support to older people including those who are living with dementia. At the time of our inspection there were 25 people using the service. The care home accommodates people across two floors, each of which has separate adapted facilities and communal areas.

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

There was not always enough staff deployed at the service to meet the needs of people safely and ensure cleaning tasks within the home were carried out.

Guidance relating to risk management was not always in place or detailed enough to support people safely. Systems and processes in place to monitor the quality of the service were not effective in driving improvement.

The culture within the home was not always positive and staff did not always feel listened to. People and their relatives told us they had opportunities to feedback in the running of the home.

People and their relatives felt the service was safe and there were systems in place to protect people from abuse.

Medicines were managed and administered in accordance with best practice. People received their medicines as prescribed and the home consulted regularly with the pharmacy for people who had medicine administered covertly.

The home worked in partnership with a range of different professionals and ensured timely referrals when appropriate.

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 10 April 2019). The service was inspected but not rated on 8 February 2021. The service has deteriorated and is now rated Requires Improvement.

Why we inspected

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

We inspected and found there was a concern with staffing, so we widened the scope of the inspection to

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

Enforcement and Recommendations

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 staffing and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Long Meadow

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 one inspector.

Service and service type

Long Meadow 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.

Inspection activity started on 11 January and ended on 24 January. We visited the location's office/service on 11 January.

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 who work with the service. 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-

We spoke with one person who used the service. We spoke with 15 staff members including the registered manager, regional operations manager, deputy manager, senior care workers, care workers, domestic assistants, kitchen assistant, maintenance and administrator. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed.

After the inspection –

We spoke with four relatives of people who used the service. We continued to seek clarification from the provider to validate evidence found. We looked at training data and further quality assurance records. We requested policies and additional information from the provider.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- Staffing levels were not sufficient to meet the needs of people using the service. Whilst the provider had a dependency tool in place to calculate the number of staff required to meet people's needs, rota's showed staffing levels were not always in line with the required numbers.
- There were not always enough staff during night shifts. Rota's showed that on occasions three staff were on shift to support 25 people over two floors when it had been identified by the provider's dependency tool that four were required.
- Staff told us they had worked night shifts alone on the ground floor due to short staffing and staff from upstairs were not always available to support. One staff member said, "There's not enough staff [at night] I can be quite often on the floor on my own with nine residents." Some people on this floor required support from two members of staff with moving and handling and personal care needs. This meant staff were not always available to provide support to people, placing them at risk of harm.
- Ancillary staff were used to cover other shifts, taking them away from their original duties. For example, domestic assistants were sometimes required to cover laundry or care shifts. This meant some days there were no domestic assistants on duty and cleaning schedules showed no cleaning tasks completed on these days. This placed people at increased risk of infection.
- Staff told us they did not feel there was enough staff, and this had an impact on both them and people using the service. One member of staff told us, "To be honest, the people don't get the care they are supposed to in the mornings, we can't always meet their needs properly it's not fair on them." Another staff member said, "They need to sort their staffing levels out. It puts so much pressure on everyone and we get worn out."
- Relatives told us it was sometimes difficult to locate a member of staff. One relative told us, "When you go in the weekend you can't get anyone's attention, can't seem to find anyone. I don't go in too often, but when I do go in to get someone's attention to get back out it's a challenge."

The provider failed to ensure staffing levels were sufficient to meet the needs of the people using the service, placing them at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following inspection, the provider responded and told us they had reviewed their budget and were able to advertise for an additional domestic assistant.

- Staff were recruited safely. The provider ensured the appropriate recruitment checks were in place before staff started working at the service.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People's risks were not always managed effectively. Following increased falls, a person's risk assessment had identified the need for a specific falls care plan, we found this had not been implemented. This meant lessons had not been learned and staff had limited guidance on how to support people who were identified as high risk of falls, placing them at risk of further falls.
- Care plans did not always provide enough information about people's identified care needs and the support they required. For example, a person's catheter care plan gave limited information or guidance on how staff should support them, including what signs of infection to look out for. One staff member told us, "[Care plans] could do with being a little more detailed, you get the idea, some things could be more detailed."
- Some care plans were too generic and not always relevant to people's specific needs. For example, an epilepsy care plan had lots of information about different types of seizures but did not identify which seizure the person experienced and their specific signs and symptoms.
- There were measures in place to monitor weight loss and malnutrition risks. People were weighed regularly and when identified as at risk of malnutrition, prompt action was taken. For example, additional weighing, implementing dietary intake charts, referrals to dietitians and changes to diets when appropriate.
- Regular health and safety checks were completed on the environment and equipment.

Preventing and controlling infection

- The provider's infection prevention and control policy stated the service would increase cleaning due to the COVID-19 pandemic and regular cleaning of frequently touched surfaces would be carried out. We found that this had not taken place due to domestic staff covering other roles. This placed people at risk of acquiring infections.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- The provider supported people to receive visits from relatives and friends. The provider's approach to visiting the home was in accordance with government guidance.

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 had effective measures in place to make sure this requirement was being met.

Using medicines safely

- Medicines were managed safely. People received their prescribed medicines when required and medicines were stored and administered safely.
- Some people required their medicines to be administered covertly. We saw the provider followed the principles of the Mental Capacity Act (2005) and ensured discussions were had with pharmacists to ensure covert medicines were safe to administer.
- People received their medication by trained staff who knew them well. Staff were able to demonstrate their understanding of how people expressed pain or discomfort. As required medicine protocols were in place and provided guidance to staff.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. The provider had a safeguarding policy and systems in place to help protect people from the risk of harm or abuse. Safeguarding information was visible around the home for people and staff to refer to.
- When people had accidents or incidents, appropriate referrals were made to relevant safeguarding and healthcare professionals. The registered manager had proactively arranged a meeting with the local authority to discuss recent safeguarding investigations.
- Staff had received safeguarding training and understood how to recognise different signs of abuse and what to do if people were at risk of harm.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider failed to ensure there was sufficient governance oversight to monitor, assess and manage risks and ongoing improvements.
- Audits were completed; however, they were not always used to drive improvement. For example, following a provider check it was noted that staff visibility was variable, and an increase in number of falls during the night-time had been identified. Despite these concerns being indicative of potential staffing issues, the provider had not considered increasing staffing numbers to address these concerns.
- The provider had also been made aware of concerns around staffing levels by staff, for example through staff meetings. A staff member said, "Management have been told several times it's physically and mentally draining." These concerns were not addressed, and staffing remained a concern during our inspection.
- Systems and processes to ensure oversight of cleanliness within the home were not effective. For example, the provider's audit identified gaps in cleaning records, but effective action had not been taken to address them as gaps were also found during inspection.
- The provider's audits failed to monitor peoples' risk assessments to ensure they reflected people's current needs and provided enough detailed guidance for staff to support people safely.
- Staff were not engaged or empowered to be involved in the running of the service. We were not assured staff meetings were a supportive and learning environment to discuss best practice. A night staff member told us night staff do not have team meetings.

The provider had failed to ensure that systems and processes were in place to drive quality and improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had opportunity to feedback into the running of the service at residents' meetings and relatives told us they had been invited to complete surveys in relation to their experience of the service or their views on how it could be improved. Relatives told us after they had completed a recent survey the provider began some re-decoration within the home.

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

- The provider did not always ensure a positive culture was promoted within the home. Staff told us they

did not feel supported by the provider and described staff morale as low. One member of staff told us, "It's not a nice work environment especially at the moment as staff are doing more than their contracted hours." Another staff member said "I wouldn't class it as a number one job. It's a shame really, everyone is just leaving."

- The provider did not always invest in ensuring a comfortable atmosphere. Staff and relatives said there was often delays in addressing maintenance issues. One relative said, "I just don't think it's very homely."
- Relatives told us they had good relationships with the care staff and spoke positively about them. One relative said, "I trust the care staff, they keep me informed." Another told us "Staff are very good; they do an incredibly difficult job."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood the responsibilities of their registration with us. They reported significant events to us, such as safety incidents, in accordance with the requirements of their registration.
- The registered manager was open and transparent with the inspection process and current challenges the home was facing with realistic expectations of improvements being made.

Working in partnership with others

- The provider worked in partnership with a range of professionals and made referrals when appropriate. For example, we saw communication with district nurses, podiatry, speech and language therapists and GP's in people's care files.
- The provider worked with the local environmental health team to ensure the home was meeting the necessary standards. We received a copy of their report which highlighted significant improvements.
- At the time of inspection, the provider was working in conjunction with the local authority on improving the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not ensure systems and processes in place were effective to drive quality and improvements. Actions identified in audits were not always completed. Feedback from staff was not used to improve the service.</p>

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 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet the needs of the people using the service, placing them at risk of harm.

The enforcement action we took:

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