Longridge Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 2 June 2015 and was unannounced. Our previous inspection took place in May 2013.

The service provides accommodation and personal care to up to 32 people, some of which may have dementia and physical disabilities. At the time of the inspection 23 people were using the service.

There was a registered manager. 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.

Summary of findings

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. The Deprivation of Liberty Safeguards are for people who cannot make a decision about the way they are being treated or cared for and where other people are having to make this decision for them. People were being unlawfully restricted of their liberty within the service and no applications for a DoLS authorisation had been made.

Allegations of suspected abuse were not reported to and investigated by the local authority. Staff knew what constituted abuse however some staff did not feel confident in the providers whistle blowing procedure.

People had not been involved and consented to their care, treatment and support. Some people told us they did not receive care that reflected their needs and preferences and they didn't feel they could complain about it.

Staff received training to fulfil their roles, however not all staff had the same opportunities to develop their skills and career.

Medicines were safely stored and administered. People received their prescribed medicines at the time they needed them.

There were sufficient trained staff who had been recruited through safe recruitment measures to meet the needs of people and keep them safe.

People had access to a range of health care professionals and were supported to attend appointments when required.

People's nutritional needs were met, when people required extra support to eat and drink or a special diet they received it.

We found three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe. Suspected abuse was not always recognised and responded to.

People were protected from harm through the effective use of risk assessments. There was sufficient suitably trained staff to meet people's needs in a safe way. People's medicines were stored and administered safely.

Requires Improvement

Is the service effective?

The service was not consistently effective. The principles of the MCA were not consistently followed to ensure that people were not being unlawfully deprived of their liberty and that people had consented to their care.

Access to health care was provided in a timely manner when people required it. People had enough to eat and drink to maintain a healthy diet.

Requires Improvement

Is the service caring?

The service was not consistently caring. People were not involved in the planning of their care and their preferences were not always respected. People did not always feel listened to.

We observed staff spoke to people kindly.

Requires Improvement

Is the service responsive?

The service was not responsive. People's preferences were not always met and they were not involved in how the service was run.

People told us they did not have enough to do and that they didn't feel they could complain.

Requires Improvement

Is the service well-led?

The service was not well-led. Effective systems were not in place to assess, monitor and improve the quality of care. Some staff did not feel supported and felt unable to whistle blow if they suspected abuse.

Requires Improvement

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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 2 June 2015 and was unannounced.

The inspection team consisted of two inspectors.

We looked at the information we held about the service. This included notifications of significant events that the manager had sent us, safeguarding concerns and previous inspection reports.

We spoke with seven people who used the service and observed people's care. We spoke with three visiting relatives, six members of staff, the registered manager and provider.

We looked at four people's care records to see if they were accurate and up to date.

We looked at the providers systems to monitor the quality of the service, staff rosters, training records and other documents to help us to see how care was being delivered, monitored and maintained.

Requires Improvement

Is the service safe?

Our findings

We had received information of concern about the systems the provider had in place to protect people who used the service from abuse or the risk of abuse. We were informed that several members of staff had reported serious allegations of abuse towards three people who used the service. The manager told us that an internal investigation had been conducted by the provider however safeguarding referrals to the local safeguarding team had not been made to ensure that the investigations had been completed impartially and within the guidance of the Safeguarding of Vulnerable Adults policy (SOVA). This meant that the provider was not protecting people from abuse and improper treatment by ensuring the due process was followed in investigating allegations of abuse.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most care staff we spoke with knew what constituted abuse and who they should report it too. Safeguarding training had been provided and we saw that everyone had attended and were scheduled to attend refresher courses. One staff member told us: "I would report abuse to my manager, or area manager or CQC". Another staff member told us: "I have already reported abuse, I know who to report to". Staff told us that they had all been recruited following safety checks and clearances to work with people. This meant that safe recruitment systems were in place to ensure that staff were fit and of good character prior to being employed at the service.

People were kept safe through the effective use of specialist equipment and individual risk assessments. We observed that people were supported with their mobility safely when they required support, for example one person was supported by two staff members with the use of a hoist. The person was verbally reassured throughout the process and was transferred safely and respectfully. Another person was trying to be independent and walk small distances with the use of their walking frame. We saw a member of staff walked slowly behind them with the person's wheelchair so they were able to sit down safely when they were tired. This meant that these people's agreed risk assessments were being followed to encourage their independence and keep them safe.

People told us they felt there were enough staff to keep people safe. One person said: "There are enough of them; they just can't be in two places at once can they?" Another person said: "I don't have to wait long; they are always popping in on me." A relative told us: "There always seems plenty of staff about and they are all nice". From our observations people did not have to wait too long to have their care needs met, call bells were answered in a timely manner and when people required support they received it.

Medication was stored safely and only administered by trained members of staff. However we were informed that there was not always a member of trained staff to administer people's prescribed medication during the night time hours. Some people required as and when required (PRN) medication such as pain relief and inhalers. The manager was not able to tell how these people would be able to have this medication if they required it. This meant that people were at risk of not being able to have their prescribed medication.

Requires Improvement

Is the service effective?

Our findings

Several people who used the service had dementia or mental health issues that at times meant that they required support to make decisions. We did not see that any capacity assessments had been completed to ascertain peoples' capacity to make informed decisions. We saw that the building was locked with a key pad and there were locked areas within the home. People were not able to leave the building without the support of staff. Stair gates prevented people from coming downstairs and doors were alarmed to alert the staff that people were mobilising upstairs. We discussed this with the manager who informed us that these things were in place in people's best interests and to keep people safe. No consideration to the Deprivation of Liberty Safeguards (DoLS) had been made and no referrals had been made to the local authority for authorisation. The DoLS are for people who cannot make a decision about the way they are being treated or cared for and where other people are having to make this decision for them. This meant that the provider was not working within the guidelines of the MCA and some people were being unlawfully restricted of the liberty.

This meant a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people had a Do Not Attempt Cardio Pulmonary Resuscitation order (DNACPR). This is a legal order which tells a medical team not to perform CPR on a person. We saw one person had been assessed as having capacity by their GP; however they had not been involved in the decision making about the DNACPR. It was recorded that discussions had taken place between the person's GP and a relative, the person themselves had not been included. Other people lacked capacity to be involved in the decisions about a DNACPR. In these situations a best interest's decision involving all the people involved in the person's life should be made ensuring that the decision is made in the person's best interest. We saw that these people's DNACPR orders had been signed by the person's GP with no evidence of consultation with relevant people. This meant that the provider was not ensuring that care and treatment for these people was being provided with the consent of the relevant person.

These issues meant a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People who used the service and their relatives told us they felt that the staff were effective in their role. One person told us: "I have a sore on my back; the staff are very good at looking after it. I have cream on and a special cushion to sit on and a special mattress that they have pump up every so often. It's very comfortable." A relative told us: "My [relative] had a choking episode they called the paramedics and they were taken to hospital as a precaution. They phoned us straight away and we went to meet them at the hospital". Staff we spoke to demonstrated a good knowledge of people's needs and what to do if they noticed a change in them. One staff member said: "We have an on call system if we are worried about anything". We saw that one person had recently had a fall and medical support was gained by the paramedics, this was then later followed up by the person's GP. We saw people had access to a range of health care professionals such as their GP, Speech and Language therapist's (SALT), dietician and physiotherapists. We saw a visiting optician and staff supported people to attend to have their eyes tested, explaining to them what was happening and staying with them if they required support.

People told us they liked the food. There were two choices available for the main meal and people could have what they liked for breakfast and tea time. The cook told us: "I always ask what people would like on the day because some people forget what they have asked for, if we ask before". One person told us: "The cook comes in every day and asks what I want to eat. They know I don't like to eat a lot these days so she always comes and talks to me. Like yesterday, I didn't like either of the choices so she made me an omelette and do you know, that was the first omelette I've had in years, I ate the lot, it was lovely." Food was cooked fresh and was homemade. When people had been identified as losing weight timely referrals were made to their GP and dietician. We saw that several people required their food pureed following the advice from the SALT team. The cook showed us that food although pureed to the correct consistency was still presented so it was visibly pleasing. This meant they were able to taste the distinct flavours of the food they were served.

Requires Improvement

Is the service caring?

Our findings

People we spoke with gave mixed views on the way they were treated. One person told us: "I get on with most of the staff; I can't say all of them". Another person said: "You pay to be looked after and staff don't always listen to you". Two people told us that they had asked for support in will writing and about what benefits they were entitled to but the staff member they had spoken to hadn't done anything about it. The manager told us that they were unaware that these people had made these requests as the information had not been passed on. This meant that these people did not always feel respected and listened to and the support they required had not been gained.

People's care plans were regularly reviewed by staff, however people and their relatives were not involved in the process. One person who used the service told us they had not seen their care plans and were not aware there were any. This person had the capacity to be fully involved in their own care planning. A relative told us: "I was involved in my [relatives] initial assessment but I don't know what is in the care plans now".

One person told us: "We don't have resident meetings, they run the service as a business, money talks". Another person said: "No they don't ask my views, I make myself content, I wouldn't say I'm happy but I'm content". The manager confirmed that apart from an annual survey they did not seek the views of people who used the service in how it was run. This meant that people were not involved in making decisions about their care treatment and support and care did not reflect their preferences.

Friends and relatives were free to visit at any time. However one relative told us that they had once had to wait a long time for the doorbell to be answered. When they had complained about it, the staff member responded by saying: "It's not my job to answer the door". This meant that visitors were not always treated with respect and made to feel welcome.

We observed interactions between staff and people who used the service and saw they were kind and caring. Reassurance was offered when people became upset or distressed. At lunchtime one person had become anxious and was looking for their relative, a staff member reassured them and comforted them and the person became more relaxed and was able to enjoy their meal. One person told us: "I get on with most of the staff; I can't say all of them".

During lunch we saw that people were listening and singing along to some music. People were offered an apron to wear to save their clothes from spillages, some people refused and this was respected. People had been offered a choice of food and drinks, one person asked for water instead of juice and a staff member got this for them.

Requires Improvement

Is the service responsive?

Our findings

Some people told us they did not feel that the staff responded to their individual needs. Three people who used the service told us that they were supported to get up and come downstairs very early in the morning and then had to wait for their breakfast. One person told us: "They get me up at 4.30am and I am in the lounge by 5.00am, they say you can go to bed when you like but they keep mithering you from 6pm, so I give in and watch TV in my room". Another person said: "They [the staff] ought to listen to us". However staff told us that there were no routines and people could chose to do what they liked when they liked. One staff member told us: "Some people like to go to bed at 6pm but they are still asked each day and if they want to stay up or watch TV in bed, that's fine. Night staff get people up if they are awake and want to get up. Some people get up very early, it's safer for them to come downstairs and get up if they are awake because some of them 'wander'".

Another person told us: "I think I could do a better job. I looked after my mum and I would sit with her and chat to her, they don't do that here, they don't have time. When I first came, a girl used to sit with me and say 'let's have a chat' but she got told off for it so she left. I do appreciate all that they do for me though."

Some people told us they did not have enough to do. One person told us: "I have never seen so many TV programmes since I've been here, but there is nothing else to do". Another person said: "I stay in my room because I can't talk to anyone in the lounge and I can't see the TV because of the way the chairs have been set out". A member of staff told us: "We have Bingo once in a blue moon. It's getting them to actually do it that's the problem. Some play cards, we tried to play dominoes but they get bored too quickly. We have board games but some people say they are babyish. There's colouring books. We try and encourage them to do things".

A relative told us: "There is no stimulation for people, there are games but people can't reach them. I come two or three times a week and the TV is always on, when they do arrange something people come alive".This meant that people were not offered hobbies and activities that reflected their preferences.

Some people who used the service told us they didn't feel they could complain. One person told us: "I don't think we would have our complaints listened to". Another person said: "If you complain they will get you another way". We saw a guide to the complaints procedure was in the hallway and there was a service user guide and visitor surveys available. The manager showed us that a recent service user questionnaire has been completed by staff with people and most of the comments received back had been positive. A relative told us: "There always seems plenty of staff about and they are all nice, you can talk to any of them. My relative had an issue we told [staff member] and she sorted it out, she's good like that". "I don't have any complaints; I'd go to [staff member] if there was a problem". Another relative told us: "I don't know who the manager is, so I don't really know who to complain to". This meant that the complaints procedure was not effective and would not ensure that improvements were made in line with people's concerns.

Requires Improvement

Is the service well-led?

Our findings

Some staff told us they did not feel supported by the management to whistle blow if they suspected abuse following a recent incident. These staff members felt that there had been repercussions from whistle blowing which meant they would be reluctant to do it again. This meant that there was a risk that incidents of abuse would go unreported. The manager confirmed that appropriate steps to protect the identity of whistle blowers had not been followed.

When people who used the service had been involved in an incident of suspected abuse it had not been referred to the local authority for investigation. The MCA and DoLS guidance had not been followed to ensure that people were safe and not being unlawfully restricted. This meant that the provider and manager were not working with other agencies to ensure a continuous improvement in the standard of care being delivered.

Not all staff were given the same personal development opportunities. A post had become available which the manager and provider had identified one staff member as being suitable to fulfil. This staff member was being given the opportunity to gain the knowledge and train to complete the role. Other staff members told us they wanted to progress within the service and had aspirations to fulfil the vacant role, however the opportunity had not been given to them. This meant that staff did not have equal opportunities to be able to progress and develop their career.

Some people were reluctant to complain and a relative didn't know who the manager was. This meant that the complaints procedure was not effective and would not ensure that improvements would be made in line with people's concerns and complaints.

There were a number of quality audits completed and accidents and incidents analysed. However there were no action plans formulated to ensure that the information within them was used effectively to improve the service.

The above evidence shows that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing.

The manager and provider had not notified us of all significant events which had occurred in line with their legal responsibilities.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 1. Care and treatment of service users must only be provided with the consent of the relevant person.

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 1. Service users must be protected from abuse and improper treatment in accordance with this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.