Mr & Mrs S Hayes

Longworth House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 08 and 10 May 2018.

Longworth House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided. Both were looked at during this inspection. The care home accommodates 28 people. At the time of the inspection, there were 18 people who received support with personal care as nursing care is not provided at this home.

The service was managed by a registered manager who is also one of the service providers. 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.

At the last inspection in January 2016, the service was rated 'Good'.

At this inspection we found that the quality and safety of the service had deteriorated. We found shortfalls in relation to the management of risks associated to receiving care. This was because staff had not always sought medical advice when people had suffered falls and had failed to report serious injuries to safeguarding authorities; people's medicines were not safely managed and people had not been adequately supported to manage risks associated with unintentional weight loss and risks associated with choking. We also found consent to receive care had not been sought and Deprivation of Liberties authorisations had not been sought where people's care involved restrictions to their movement. There were shortfalls in training provided at the service. The quality assurance systems were not effective in identifying shortfalls or areas where the service was not meeting regulations and driving improvements. There was also a failure to notify the Care Quality Commission of serious incidents in the service.

We found there were seven breaches of the Regulations. These were breaches of Regulations 9, 11, 12, 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009. You can see what action we told the registered provider to take at the back of the full version of the 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of

inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The systems and processes for monitoring and assessing quality in the home to ensure people's safety and compliance with regulations were inadequate. There were no formal medicine audits and care plan audits. Internal audit and quality assurance systems had not been effectively implemented to assess and improve the quality of the service and to proactively identify areas of improvement. Policies in the home were outdated and not in line with current legislation, best practice and national guidance. There was a lack of managerial oversight on staff and the care that people received.

We found significant concerns with the care that people received after suffering head injuries and there was a significant number of unwitnessed falls and falls from bed. Risk assessments had not been effectively developed to minimise the potential risk of harm to people who lived at the home. They were not reviewed in line with people's changing needs. In addition there was a lack of appropriate risk assessments and risk management processes relating to the people who are at risk of falling, choking, risks related to unintentional weight loss and risks of scalding from hot water. There were no call bells for people to use if they needed to summon for help in the communal areas. There was no falls policy or written guidance to guide staff on the management of falls.

Staff had received safeguarding training however, local authority and national safeguarding reporting guidelines had not been followed. Significant incidents had not been reported to the local authority and the Care Quality Commission. Accident and incidents had been recorded. However, on a significant number of occasions, staff had not sought medical advice where this was required. We found this to be the case especially with incidents involving unwitnessed falls which involved head injuries. Improvements were required to demonstrate what support people had received following incidents such as repeated falls.

Although some of the staff had been trained in the safe management of medicines, people had not always received their medicines as prescribed. There were shortfalls in medicine management practices in the home.

People's consent to various aspects of their care was not always considered and where required Deprivation of Liberty Safeguards (DoLS) authorisations had not been sought from the local authority. People's capacity to make their own decisions was not assessed.
Recruitment checks were carried out to ensure suitable people were employed to work at the home.

Care plans were in place detailing how people wished to be supported. People and their relatives were involved in care planning. However, this had not always been recorded. People's independence was promoted.

Feedback from people and their relatives regarding the care quality was positive. People who lived at the home told us that they felt safe. Visitors and people who lived at the home spoke highly of the registered manager and the owner who is also the provider.

Risks of the spread of infections were not adequately managed. Risk associated with fire had been managed and fire prevention equipment serviced in line with related regulations. However, some doors were wedged open which could expose people to risk in the event of a fire.

The environment was clean. However, adaptations and decorations had not been adequately adapted to suit the needs of people living with dementia.

The provider had sought people's opinions on the quality of care provided.

We observed snacks and drinks were provided between meals to ensure people received adequate nutrition and hydration. Comments from people who lived at the home were all positive about the quality of meals provided. However, we found people were not adequately supported to manage the risk of unintentional weight loss.

We observed people being encouraged to participate in activities of their choice. People who lived at Longworth House and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

Staff had received induction and training. There was a policy on staff supervision and appraisals and staff had received regular supervision. However, systems for recording supervision required improvements and some training that we deemed necessary to ensure safe care for people living at Longworth House had not been provided.

Staff told us there was a positive culture within the service. Staff we spoke with told us they enjoyed their work and wanted to do their best to enhance the experience of people who lived at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People were not adequately protected from risks of falling, weight loss, choking and scalding from hot water. People's medicines were not always managed in accordance with safe procedures.

Improvements were required to the management of the risk of fire.

Staff were safely recruited

Staff were not always aware of their duty and responsibility around safeguarding. Concerns were not reported to the local authority and the Care Quality Commission.

People and their relatives told us they felt safe.

Is the service effective?

Requires Improvement

This service was not consistently effective.

The rights of people who did not have capacity to consent to their care were not supported. Mental capacity assessments were not carried out.

Staff received an induction and supervision. However, we identified some shortfalls in relation to the training provided to staff.

People's health needs were not always met. Specialist professionals were not consistently involved when risks increased.

The environment required improvements to ensure it was dementia friendly.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive timely medical attention when they needed it.

People and their relatives spoke highly of care staff and felt they were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.

Staff knew people and spoke respectfully of people they supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always reviewed following significant incident such as falls and hospital admissions.

People had plans of care which included essential details about their needs and the outcomes they wanted to achieve.

People had been provided with appropriate meaningful day time activities and stimulation to keep them occupied.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their care and treatment.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of clear and systematic approach to monitor the overall quality of the service and compliance with regulation. Governance systems for assessing the quality of records relating to care delivery were inadequate.

Policies were out of date and the systems and processes were not robust enough to identify concerns relating to care.

The provider had failed to send notifications regarding events in the service including death notifications.

There was a registered manager in post and people gave positive feedback about both the registered manager and the provider.

Longworth House

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 08 and 10 May 2018. The first day was unannounced.

The inspection team consisted of one adult social care inspector.

Before our inspection visit we reviewed the information we held on Longworth House.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service.

Before the inspection, we were aware that the registered provider had not submitted statutory notifications about incidents and events that had occurred at the service. A notification is information about important events, which the provider is required to send us by law. We contacted health and social care professionals who worked alongside the service for information. We also reviewed the information we held about the service and the provider. We spoke to community health care workers.

We spoke with a range of people about the home including five people who lived at the home, two visitors and four care staff. In addition, we also spoke with the registered manager who is also the owner. We were unable to speak to some of the people in the home due to their communication needs.

We looked at the care records of seven people who lived at the home, staff training records, three recruitment records of staff members and records relating to the management of the service. We observed the environment and people's interactions with staff.

Inadequate

Is the service safe?

Our findings

We looked at how accidents, falls and near misses were managed. There were significant concerns about the quality and level of support provided to people when they suffered a fall. We found eight people who were at significant risk of falls. There had been a significant number of falls in the home. Some of the falls were unwitnessed and some had been witnessed by staff.

Records we saw showed that eight people in the home had suffered falls which involved head injuries. Staff had not sought medical advice even when people showed visible signs of head injuries such as 'bumps on their head'. For example we observed one person fell on two consecutive days incurring head injuries on both days. Staff recorded the person had 'a lump above her left eye' and on another day, 'found on the floor with a mark to the right hand side of her head'. In another example, one person had fallen 11 times in nine months. In two of the falls they were reported to have 'banged their head' and observed to have 'cut on the back of head. We noted another person had fallen and informed staff that they were in pain however, no medical advice was sought. Two days later the person was admitted into hospital and found to have a fractured leg. This meant that staff had failed to ensure the person received timely medical intervention to prevent prolonged pain and a deterioration of their condition.

In addition staff and the provider did not report the injury to the local safeguarding authority or the Care Quality Commission in line with local guidance and regulations. This meant that authorities could not undertake independent investigations and determine whether the person had received the right care.

We found the registered manager and staff did not seek specialist support to ensure people were assessed when they suffered frequent falls. For example we found one person had experienced 22 falls in 11 months. Some of the falls had resulted in injuries to their face and head however, there was no evidence to show whether the registered provider had referred the person to services such as falls clinic or their doctor to investigate the cause of the falls. We spoke to the registered manager and staff to check whether there was guidance on how to support people when they suffered falls. We found there was no falls policy or protocol for staff to follow. In addition, after the incidents there were no post falls observations undertaken by staff in order to monitor their condition. This meant that people who experienced falls were at risk of not receiving safe care and treatment.

The provider informed us that staff were supposed to contact medical professionals after falls which involved head injuries. This was confirmed by staff we spoke with. However, in 22 cases of unwitnessed falls that we reviewed, staff had not sought medical attention even in cases where the person had complained of pain or had visible injuries. This meant that people could not be assured they would receive timely and appropriate intervention following a fall.

We found incidents which had resulted in injuries and hospital admissions that had not always been reported to the Local Authority safeguarding team and the Care Quality Commission. For example one person suffered injuries on two occasions while being hoisted by staff. However, the service had failed to notify the local safeguarding authority or CQC. This lack of reporting meant people could not be assured the

registered provider and the staff would raise safeguarding concerns to allow independent investigations by relevant authorities. This meant that people could not be assured they would always receive appropriate support to reduce risks around them.

We found eight people had incidents of falling out of their beds. Staff had put some protective measures such motion sensors and crash mats in place. However, there was no evidence to demonstrate whether they had considered if other preventative measures such as bedrails or bed wedges were safe to use and reduce risks of falling out of bed. This meant that the registered provider had failed to consider all options available to them to reduce risks of falling from a bed which resulted in people experiencing further falls. In addition, we noted bed rails were in use for one person.. However, assessments had not been undertaken to check if they were safe to use the bed rails. This meant people could be exposed to risks such as entrapment or using equipment not suitable for their needs.

Health and safety checks had been carried out to inspect the safety of the premises; however, these were not robust. For example, we noted that hot water temperature checks carried out in April 2018 showed that the lowest water temperature in the six of the bedrooms checked was 50 degrees and with one bedroom recorded as 59 degrees. The recommended safe water temperature is 43 degrees. The registered manager was not aware of the temperature levels. The shortfalls meant that people were not adequately protected from the risk of scalding from hot water, especially where people lived with dementia. In addition, the health and safety audits were not robust in identifying faults and ensuring they were rectified in a timely manner. We discussed the risks and shortfalls with the registered manager. Following the inspection they sent us records to show that water temperatures in all bedrooms had been resolved and regular checks were being carried out.

Risk assessments had been undertaken in keys areas of people's care such as nutrition, skin integrity and moving and handling as well as behaviours that could pose a risk to self and others. However, this was not consistent. For example, we found one person had an experienced a choking episode. Care staff had ensured this person was safe at the time of the incident. However, there were no written care plans or risk assessments to provide guidance to care staff on how to support the person in future to minimise the risks or any measures that were required to minimise the risks to this person's personal safety. In addition, staff had not considered referring the person for an assessment by a specialist professional such as a Speech and Language Therapist to determine if the episode was a one off incident or an indication of ongoing risk. When we spoke to the registered manager they informed us that there was no one at risk of choking. This meant that there was a lack of awareness of risks around people which meant that people could not be assured they would receive safe care.

People at risk of unintentional weight loss and malnutrition were not adequately supported. We found one person living at the home had lost 5.7 kilograms in weight in three months and another person had lost 4.4 kilograms. There was no recorded evidence in the care records of what staff were doing about this. Care records were reviewed and staff recorded 'Reviewed no change' change to indicate there was no change in their condition when clearly this was not the case. We saw no evidence to demonstrate that the registered manager had considered referring the two people to specialist professionals or their doctors. This meant that the provider had not acted on the identified risk and taken appropriate action to reduce any further deterioration. We reported all concerns highlighted above to the local authority safeguarding team immediately after the inspection.

There was a safeguarding policy at the service and some staff had completed training in safeguarding adult's awareness. However, as noted above staff did not report serious incidents to the local safeguarding authority. This meant that the systems for ensuring that lessons were learned were not robust. The

registered provider had failed to ensure that staff followed the local safeguarding protocols and guidance and national guidance on the management of safeguarding incidents.

There were failings in the assessment of the risks to the health and safety of service users and measures to mitigate any such risks were not robust. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider ensured the proper and safe use of medicines in the home. We found policies and procedures for the safe management of medicines had not always been followed to ensure people received their medicines safely.

We observed the staff on duty administering medicines during lunch time. Staff were patient and respectful with people. However, we noted that people were not asked if they wanted their 'when required' medicines also known as PRNs. This meant that staff could not ascertain whether people wanted the medicines or not. We found there were no specific protocols for the administration of medicines prescribed as 'when required' and 'variable dose' medicines (PRN). The protocols are important to ensure staff are aware of the individual circumstances when this type of medicine may need to be administered or offered. The organisation's policy required that all people with PRN medicines should have PRN protocols. This meant that the provider had failed to follow their own policy to ensure the safe management of medicines.

We checked the arrangements in place for the management and storage of controlled drugs which are medicines which may be at risk of misuse. We found appropriate secure storage was provided. There were appropriate security arrangements to monitor the medicines cupboard. The fridge and the temperature of where overflow medicines were stored was being recorded on a daily basis to ensure those medicines were stored correctly and safely. However, the room temperatures where the medicines trolley was kept were not being monitored. Some medicines in use in the trolleys with shorter expiry dates once opened did not have the date of opening recorded on the containers. This meant there was no way of knowing when they would be out of date.

We found topical medicines, such as creams were not well managed. Records showed that medicines administration records (MARs) for topical creams had not been robustly completed to demonstrate that staff had provided people with these medicines as prescribed. Topical creams were signed by staff who had not applied the cream. We also noted topical creams were not safely stored in people bedrooms. The lack of effective record keeping meant that it was not possible to determine if the prescribed creams had been given as prescribed. We discussed this matter with the manager, who took action to rectify this matter during inspection.

The registered manager had not established formal medicines audits. We saw an audit had been carried out by an external pharmacist. The internal medicine audit was carried out monthly however it was informal and there was no documented evidence of what the registered manager had looked at. This meant that the medicines audit had not identified the issues and concerns we found during the inspection. This may expose people to risks of medicines mismanagement.

There were shortfalls in the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have an emergency or contingency plan in place. This meant that staff did not have guidance on what to do in the event of an emergency which may involve evacuating the premises for more than 24hrs. There was an overall fire risk assessment for the service, however it had not been reviewed since

2016. We saw there were clear notices within the premises for fire procedures. However, during the inspection we noticed the fire doors were wedged open. We spoke to the registered manager and they informed us they would fit door stoppers that are recommended by fire safety authorities. They also informed us they would be devising a contingency plan.

People who lived at the home and their relatives told us they felt safe living at Longworth House and with the way staff supported them. Comments from people who lived at the home included, "Absolutely safe, I would rather be here, I couldn't manage at home", and, "I do feel safe here, as long as my family are happy." A relative told us, "Yes I think people are safe here, I don't have concerns about my relative." Another relative told us, "[My relative] is definitely safe nothing to worry about."

We found fire safety equipment had been serviced in line with related regulations. Fire alarms had been tested regularly. Fire evacuation drills were undertaken regularly to ensure staff and people were familiar with what to do in the event of a fire. All people had personal emergency evacuation plans (PEEPS). These are records that provide guidance to care staff should people who lived at the home ever need to be moved to a safer area in the event of an emergency.

The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. During our inspection visit, staffing levels were observed to be sufficient to meet the needs of people who lived at the home. However, we noted that there were a significant of incident of unwitnessed falls that had been recorded in communal areas. This demonstrated that staff deployment in the home was not always effective and some areas of the home had been left without adequate supervision. We spoke to the registered manager who informed us that staff would be deployed in the lounge areas to supervise and assist people. There were three care staff in the day and two care staff for the night shift. Comments from staff included, "There are enough of us and we help each other. If we are struggling the manager helps."

We looked at staff recruitment processes. We reviewed the recruitment records of three staff members and found that safe recruitment procedures had been followed. We saw the required reference and character checks had been completed before staff worked at the service and these were recorded. Disclosure and Barring Service (DBS) checks had been carried out before staff started their employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The home was clean with hand sanitising gel and hand washing facilities available around the premises. We found some issues around infection prevention such as the use of washable hand towels in shared toilets and bins were not foot pedal controlled. We discussed this with the registered manager who took immediate action and rectified the shortfalls.

We found equipment had been serviced and maintained as required. For example records confirmed gas appliances and electrical equipment complied with statutory requirements and were safe for use.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the inspection we looked at people's records and saw that the registered manager had applied to the relevant supervisory authorities for deprivation of liberty authorisations for one person. This authorisation had been requested when it had been necessary to restrict the person for their own safety and the measures in place were as least restrictive as possible. However, we found shortfalls in the manager's and care staff understanding of their responsibilities under the MCA 2005 legislation. There were eight other people living in the home who could not agree to their care and treatment and were not free to leave the premises unaccompanied. Another person had restrictions in the form of bedrails. However, the provider had not sought relevant DoLS authorisations from the local authority in line with the MCA/DoLS principles. This meant that people were at risk of being unlawfully restricted.

Although staff said they always asked for people's consent before providing care, we found the records to demonstrate whether people's consent was sought, were inconsistently completed. For example, people's consent to have their photographs taken and shared had not been considered. For one person their consent had not been considered for the use of bed rails. The principles of MCA require that consideration must be given to whether people can consent to their care, and if they are assessed as unable to do so, decisions should be considered using best interest procedures.

We found in six people's care records relatives had been recorded as giving consent. However, there was no documented evidence to demonstrate why these people could not consent for themselves. There were no mental capacity assessments completed in relation to the people's ability to make a decision about receiving care and treatment. Relatives cannot make decisions on behalf of people unless they have legal authority such as Lasting Power of Attorney for finance and property or health and welfare and the people involved had been assessed as unable to make the decision for themselves.

People whose records we looked at had been diagnosed dementia; two had end stage dementia and had significant cognitive impairment which has an impact on their ability to make certain decisions about their care. In addition, we found not all staff had been offered MCA training. The provider told us that their policy was that only the registered manager and senior care staff received MCA training. However, this was not in line with best practice and regulations. Regulations require providers to ensure that staff who obtain the consent of people who use the service are familiar with the principles and codes of conduct associated with

the Mental Capacity Act 2005. It also requires that staff are able to apply those when appropriate, for any of the people they are caring for. We asked the provider to take immediate action to ensure authorisations were sought and staff received training, they informed us that had started to do this.

The provider had failed to comply with requirements of the Mental Capacity Act 2005 in respect of obtaining consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff completed an induction when they joined the service. They had received supervision and appraisals. Staff had also received national vocational qualifications levels two and three. Staff told us they could request training if they felt they wanted it and this would be arranged. However, we found shortfalls in the training provided in the home. For example MCA training was offered to senior care staff only; there was no ongoing dementia care training when the service was registered to care for people living with dementia. There was no ongoing equality and diversity training and no ongoing or refresher for infection prevention and control. We found the competence of staff was not checked in areas such as moving and handling and medicines management. Competence checks are used to check if care staff are competent in these areas following completion of their training.

There was a failure to ensure that all staff had received such appropriate support, training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home and their relatives told us they felt their needs were met. Comments included, "The staff are nice, they are very busy but will do anything for you", "We are well fed here if you don't want what's on the menu you can choose something else", "I'm happy here but I'm not exactly home but it's okay" and, " They seem to know when I'm not well before I even tell them."

All staff we spoke with told us they knew people well because they had worked at the care home for a long time and because the home was small.

People told us they could get up anytime they wanted and chose to spend time in their bedrooms if they wanted to. We saw three people who preferred to stay in their own bedrooms.

Improvements were required to ensure staff were skilled in relation to the processes for protecting people against discrimination, including in relation to characteristics such as culture, gender, religion, race or age. For example, the majority of the staff had not received training in equality and diversity which would assist in their understanding of human rights principles. There was a policy to protect people against discrimination and harassment; however this was not up to date which meant it was not reflecting the current best practice and regulatory requirements.

We reviewed how people's individual needs were met by the adaptation, design and decoration of premises. We saw people who lived at the home had access to the back garden which was enclosed and safe for people to use. In addition, there were two lounges in which people could sit. We observed people moved around the building freely. We saw some people had brought their own furniture which helped personalise their bedrooms and made it homely for them. We noted that improvements were required to ensure the environment was dementia friendly. For example there were heavily patterned carpets in some parts of the home which can affect people living with dementia and with visual impairment.

We recommend the registered provider considers best practice and research in creating a dementia friendly

environment.

We observed staff supported people to eat their meals. The atmosphere was calm and caring and people were not rushed with their meals. All people appeared to have enjoyed their meal and had eaten very well. Staff offered a choice of drinks. They encouraged individuals with their meals and checked they had enough to eat. We observed staff gave people an alternative choice if they did not like the meals on offer. People could choose to sit where they wanted. Comments about the food were positive. One person who lived at the home said, "The food is good and its home made."

The care records we reviewed had a section which noted any special dietary requirements people had such as the need for a soft diet. Staff recorded in care records each person's food and fluid likes and dislikes. This was good practice to provide preferred meals in order to increase their nutritional intake.

Care records we looked at contained information about other healthcare services that people who lived at the home had access to. Staff had documented when individuals were supported to attend appointments or received visits from for example, GPs and district nurses. Documentation was updated to reflect the outcomes of professional health visits and appointments. However, we found eight people who had suffered frequent falls had not been referred to specialist professionals despite having suffered frequent falls and injuries. This meant that people could not be assured they would always have access to specialist professionals in a timely manner if they needed them.

Requires Improvement

Is the service caring?

Our findings

During our inspection visit we observed people were relaxed, happy, smiling and comfortable. We confirmed this by talking with people. For example, comments people made to us included, "It's very peaceful here, we are allowed to go out in the garden", "Basically we are fine here", and "The staff have time for me." Comments from relatives included, "[My relative] is definitely fine I have no worries has been looked after very well here" and "The care my relatives gets is brilliant."

We observed staff engaged with people in a caring and relaxed way. For example, they spoke to people at the same level and used appropriate touch and humour. We saw people were dressed appropriately in suitable clothing of their choice and they were well groomed.

Although people told us staff were caring and we observed some warm interactions, as reported in the in our question on safe people were not adequately supported following incidents and injuries. Medical advice had not been sought timely to prevent people from suffering prolonged pain.
Some staff had received training which included guidance in equality and diversity. Staff were able to described the importance of promoting each individual's uniqueness. However, ongoing training was required to ensure staff were familiar with issues around people's human rights.

We observed people being as independent as possible, in accordance with their needs, abilities and preferences. We observed people being encouraged to do as much as they could for themselves. For example, we observed people eating independently and walking independently around the premises. Staff explained how they promoted independence, by enabling people to do things for themselves.

Staff maintained people's privacy and dignity throughout our visit. For example, we saw staff knocked on people's bedroom doors before entering. Staff also addressed people in their preferred names. Care records that we saw had been written in a respectful manner. We also noted there was a policy which promoted people's confidentiality. Staff we spoke with informed us they would ensure information about people is kept confidential and not discussed with other residents or relatives.

Relatives told us the management team encouraged them to visit at any time. They said this gave them the freedom to access the home around their own busy schedules. We observed staff welcomed relatives with care and respect and they had a friendly approach. One relative said, "They always make you feel welcome."

We spoke with the registered manager about access to advocacy services should people require their guidance and support. The registered provider had information details that could be provided to people and their families if this was required. This ensured people's interests would be represented and they could access appropriate services outside of the home to act on their behalf if needed.

Requires Improvement

Is the service responsive?

Our findings

We checked how the provider ensured that people received personalised care that was responsive to their needs. We looked at care records of six people. The majority of the care plans we reviewed were detailed and well written. However, the care plans and risk assessments were not reviewed when people's needs and risks increased. For example, eight people had experienced multiple falls; in one instance this was over a period of more than nine months. However, their care records had been reviewed and staff had documented 'Reviewed, no change'. This was the case in all records we reviewed including in cases where people had suffered significant injuries and unintentional weight loss. In addition, risk assessment scores completed were inaccurate and did not reflect the levels of risk. This meant that people's changing needs had not been adequately reviewed to establish alternative way of reducing risks or to determine if they needed specialist support. People living at Longworth House could not be assured they would receive safe care and treatment.

We looked at how people were supported to ensure their personal care needs were met. We found there was a bath rota in the home. Each person was allocated a day one day per week to have bath. We checked to see if this was in line with people's preferences and choices. However, care records we reviewed did not state if this was people's choice. We spoke to staff who told us that this is how they have always operated; however, if a person asked for a bath any day they would get one. The practice operated in the home reflected an institutionalised approach to care.

The care records had been developed, where possible, with contributions from each person and their family. They identified what support they required. People and their relatives told us they had been consulted about support that was provided before using the service. However, we found no evidence to show that people and their relatives were involved in the review of their care records. This meant that people who used the service were not assured they could receive person centred care and treatment that was appropriate, met their needs and reflected their personal preferences. There was a key worker system which was meant to provide people with a familiar point of contact in the home to support good communication. However, we found the system was not being actively implemented. People we spoke with and their relatives did not know who their keyworkers were.

The provider had failed to ensure that each person received appropriate person-centred care and treatment that was based on an assessment of their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home made positive comments about the staff team and the care and support they received at the service. Their comments included, "They are good people (staff), they let us in the garden when the weather is good.", "We usually get trips, I'm looking forward to that.", "They are most attentive and do take me out now and again", and, "The staff have time for you but we know they are very busy."

A health professional we spoke with told us, "It's a quiet home this one, we don't have concerns. They will ask us to check people if they are worried about them and will follow recommendations we give."

The provider had considered the use of technology to support people. For example there was a call bell system which allowed people to summon for support from staff; however, this needed to be improved to cover communal areas. There was also working broadband and a telephone system that was accessible to staff and people who lived in the home.

People were supported to maintain local connections and important relationships. People were also actively encouraged and supported to maintain local community links. For example children from a local children's nursery visited the home regularly and people enjoyed the interactions and read stories for the children. Relatives visited and could take their family members for meals and to visit their family homes whenever they wanted.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We found there was information in people's care plans about their communication skills to ensure staff were aware of any specific needs. However, improvements were required to ensure all information displayed in the home was written in a way that people could easily read, for example the menu noticeboards. We would also expect the provider to incorporate the practices into their policies to ensure consistency.

People had access to various activities to occupy their time. There was no dedicated activities co-ordinator to assist with activities. However, we observed staff offering people activities and engaging with people in a positive and inclusive manner, taking consideration of their choices and abilities. We checked the activities records which also confirmed activities that had been offered. We also noted that outside trips had been arranged to Blackpool and other local areas.

People we spoke with knew how to make a complaint or raise concerns and felt comfortable to do so if needed. We saw people were encouraged to do so by information that had been posted in the home and was in the service user guide provided to them when they first arrived. People were confident to speak up. The service had a complaints' procedure that was made available to people on their admission to the service. Copies were on view in the service. The procedure was clear in explaining how a complaint should be made and reassured people they would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations. There had been no complaints received since our last inspection.

Records we saw demonstrated that staff had supported people towards the end of their life. We received positive feedback from a professional about the care that people received. However, staff did not always record where people wished to die, including their preferences in relation to their religious, spiritual and cultural needs. In addition, records we reviewed showed that people were not always offered the opportunity to discuss their end of life plans. We discussed this with the registered manager and they informed us that two staff had received training in caring for people towards the end of their life; they informed us they would arrange training for all other staff and ensure a policy was in place. This would ensure that people would be supported at the end of their life to have a comfortable, dignified and pain free death.

Inadequate

Is the service well-led?

Our findings

There was a registered manager employed at Longworth Care Home. 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.

We looked at how the registered manager demonstrated how they continuously learnt, improved, innovated and ensured sustainability in the service. The registered manager who is also one of the registered providers had established a mixture of formal and informal auditing system to assess quality assurance and the maintenance of people's wellbeing. We saw that audits had been undertaken in various areas such as medicines, infection prevention and health and safety. They had also kept a record of significant incidents in the home. However, the audits systems were inadequate and not robust to enable the registered manager to learn from shortfalls and to check whether they were complying with regulations. The medicines audits were informal and records we saw did not identify which areas of medicines management practice had been audited. The audit did not comply with best practice such as NICE guidance and regulations. We found shortfalls that could have been picked by formal audits.

The health and safety audits carried out were not accurate or reliable. The audit had failed to identify the faults that we identified around the premises. For example we found health and safety audits did not take into consideration checks required to ensure bedrails were regularly checked. In addition health and safety audit had failed to identify that water temperatures were higher than the expected safe temperature levels. We also found shortfalls in infection prevention and control audits and in the care records, and accidents and incident records which had not been identified by the audits. In addition we found accident and incidents analysis carried out in the home had failed to identify that staff were not consistently following the local safeguarding protocols which included failure to report serious incidents to CQC and safeguarding authority. The provider had failed to provide staff with policy and guidance on how to manage falls in the home. As a result people who experienced falls were not provided with appropriate and consistent safe care and treatment.

There were poor systems and processes for assessing risks for people who were at risk of falling. The registered manager and the provider had not taken into consideration, all that was possible to reduce or prevent the risk. There was limited skill and knowledge on how to support people by way of seeking medical advice following a serious fall, or skill to undertake robust risk assessments for considering alternative measures to reduce the risks such as the use of assistive technology. In addition the systems for reviewing the incidents of falls was inadequate and did not ensure lessons were learned from these incidents. This meant that people were at risk of experiencing repeat falls and injuries.

The organisation had maintained some links with other organisations. They worked with organisations such as local health care agencies and, local pharmacies, district nurses and local GPs. However, the provider had not established a robust a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at Longworth House. Evidence we saw

showed that that professional advice was not always sought to improve the quality of the care and practices in the home. For example, when one person suffered 22 falls and, no referral was submitted to specialist professionals. People at risk of weight loss had not been referred to their doctor or dieticians for specialist oversight.

We also noted that the staff and the registered manager had not effectively utilised local initiatives with the local authority and local clinical commissioning groups in areas such as of prevention of pressure ulcers, safeguarding champions and dignity champions. A safeguarding champion had been nominated however; they had not attended any locally organised workshops. These initiatives are promoted by the local authority and local clinical commissioning groups to share best practice and to improve the way services meet people's needs and introduce preventative measures. This meant that the registered provider and the registered manager were not always taking opportunities to learn from best practice designed to improve people's outcomes. Following the inspection they informed us that they would be contacting the Local Authority and join in the initiatives.

The registered manager had failed to demonstrate their skill, knowledge and understanding of the regulations to enable them to provide adequate oversight and governance on staff and monitor people's safety. We found all policies in the home were out of date and did not comply with current regulations and best practice. They had been written in 2010 and had received no update since that date to incorporate changes to legislation and best practice. We noted that there had been no update to the policies. This meant that the registered manager and the provider had failed to assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service.

At our previous inspection we rated the home 'good' in all domains and there were no breaches of the regulations. However, at this inspection we found six breaches of the regulations. We noted that there had been a significant deterioration people's care and safety. The provider had failed to continually evaluate and seek to improve their governance and auditing practice. This meant that the governance systems and processes in place did not enable the provider to identify where quality and/or safety was being compromised and to respond appropriately and without delay.

The provider had failed to maintain good governance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events related to people who lived at the home. We found that the registered manager and the registered provider had failed to notify CQC of the keys events that had occurred in the home. For example, the registered manager and the registered provider had failed to send notifications in relation to notifiable incidents and events in the home. We found on two occasions a person had been injured while being hoisted by care staff. On another occasion a person had fallen and fractured their hip and, no notification was submitted. The Regulations require registered providers to submit notifications of significant events to ensure that we can be assured they took the correct action to support people involved and to reduce re-occurrences. A notification is information about important events which the service is required to send us by law. The lack of notifications regarding these incidents meant that CQC could not effectively exercise its regulatory role by taking follow up action where required. We could not ascertain how incidents had happened and whether the provider had taken appropriate action to prevent or reduce occurrence in the future.

The failure to send notifications and to report safeguarding concerns meant that the provider had failed to demonstrate openness and transparency. In addition safeguarding issues had not been referred to the local

authority and had not been dealt with objectively in the service.

The service provider had failed to notify the Commission of a number of incidents at the home. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We checked how people who used the service, the public and staff were engaged and involved in the running of the home. Residents and relatives meetings were arranged and saw minutes of meetings that took place in the home. There was quality assurance surveys carried out to seek people's views on the care provided. In addition, there were staff meetings. We saw the registered manager and the provider shared the challenges and expectations with staff during the staff meetings.

Staff we spoke with told us they felt the registered manager worked with them and supported them to provide quality care. For example, we only received positive comments from staff and relatives and they included, "The registered manager is involved in the day to day running of the service. They will get involved if we are short of staff and if we need to take someone to hospital." Also, a relative said, "If we have anything to say we can approach staff or registered manager and we feel listened to."

Staff we spoke with demonstrated they had a good understanding of their roles and responsibilities. We found the service had clear lines of responsibility and accountability with a structured management team in place. Care staff had delegated roles including medicines management, catering and domestic duties. Each person took responsibility for their role. However, there was a lack of evidence on how the registered manager was monitoring staff to ensure that people were receiving appropriate care that met their identified needs.

We looked at how staff worked as a team and how effective communication between staff members was maintained. There was communication about people's needs among staff and the management team. We found handovers were used to keep staff informed of people's daily needs and any changes to people's care. However, these were verbal and not formal. We spoke to the registered manager regarding consideration for handovers to be formalised to ensure accountability and effective sharing of information about people's needs among the staff team. They informed us that they would consider this.

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 the safe management of people's medicines. The provider had failed to ensure that risks to receiving care and treatment were identified and managed robustly. The provider had failed to operate effective systems for the prevention and control of infections. -Regulation 12(2) (a) (b) (g) (h) HSCA RA Regulations 2014 safe care and treatment.

The enforcement action we took:

Enforcement action was taken by the Commission in light of the significant work needed within the home to improve the quality and safety of the service being provided. We added a condition to the service providers registration to prevent the Company admitting new people to the home whilst those changes took place.

We also added positive conditions which required the provider to undertake specific actions to improve the safety of the care provided.

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 ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance. Regulation 17 (1) (2)(a)(c) HSCA RA Regulations 2014 Good governance

The enforcement action we took:

Enforcement action was taken by the Commission in light of the significant work needed within the home to improve the quality and safety of the service being provided. We added a condition to the service providers registration to prevent the Company admitting new people to the home whilst those changes took place.

We also added positive conditions which required the provider to undertake specific actions to improve the safety of the care provided.

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 staff received such appropriate support, training, professional development, as is necessary to enable them to carry out the duties they are employed to perform. This was because essential training had not been provided in some areas. Regulation 18 HSCA RA Regulations 2014 - Staffing

The enforcement action we took:

Enforcement action was taken by the Commission in light of the significant work needed within the home to improve the quality and safety of the service being provided. We added a condition to the service providers registration to prevent the Company admitting new people to the home whilst those changes took place.

We also added positive conditions which required the provider to undertake specific actions to improve the safety of the care provided.