

Dwell Limited

Long Lea Residential Home

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 Lea Residential Home is a care home providing personal care and accommodation for up to 35 adults living with dementia or mental health needs, physical disabilities and sensory loss. The care home is a two-storey building with en-suite bedrooms and communal facilities. At the time of our inspection visit there were 28 people receiving care.

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

Risks associated with people's care were not always managed well and governance systems to monitor the quality and safety of the service required improvement. The provider had failed to maintain sufficient oversight of the service, to identify that risk management was ineffective. Audits were in place, but they were not robust enough to ensure areas for improvement were identified and action taken in a timely way.

Risk of harm or injury were not always identified, assessed and well-managed. Care plans and risk assessments were not regularly reviewed or updated. Risk management plans did not contain sufficient detail to provide staff with the necessary guidance to support people safely.

An 'infection prevention control' audit was carried out by CQC during the inspection. We found the provider was not always following government guidelines. Improvements had been made to infection prevention and control practices following support from the local authority (LA) and the local clinical commissioning group (CCG). However, further improvements were still required to keep people as safe as possible and minimise infection control risks associated with COVID-19

There were enough staff on duty to meet people's physical needs, but staff told us there were occasions when staffing levels needed to be increased to allow them to support people in a more dignified way.

Some aspects of medicines management were not in accordance with best practice.

People spoke positively about the staff and the care they provided. Staff had supported people to maintain contact with relatives via telephone or video calls.

The registered manager was open and explained they had struggled to maintain the managerial aspects of their role because they spent significant periods of time supporting staff and being with people. They were committed to making changes to improve the service and took action straight away to address some immediate concerns we identified to them.

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. (Report published 11 January 2020).

Why we inspected

The inspection was prompted in part due to concerns received about infection prevention control management and reduced staffing levels. Concerns were shared with us by the local Clinical Commissioning Group (CCG) and the local authority (LA). A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of 'Safe' and 'Well-led' only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Long lea Residential Home on our website at www.cqc.org.uk.

The overall rating for the service has deteriorated to requires improvement. This is based on the findings at this inspection.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches of the regulations in relation to the safety of people's care and the management of the service.

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

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, the local CCG and the LA to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

The 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 Lea Residential Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. 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

The inspection was carried out by six inspectors. Two inspectors visited the home. One inspector gathered information from the manager via email and spoke with staff over the telephone and the other three inspectors spoke with staff and relatives over the telephone.

Service and service type

Long Lea Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care. 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. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

Our inspection was announced. We gave the service 24 hours' notice of our visit because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of the home's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection

We reviewed the information we had received about the service since the last inspection and recurrent

themes of concerns. We sought feedback from the LA and health professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with one person who lived at the home about their experiences of the care provided. We spoke with the registered manager and the deputy manager in person and spoke with eight staff members via the telephone.

We did limited observations of the care people received in communal areas. We reviewed two people's care plans in detail, looked at specific aspects of another five people's care plans and looked at four people's medicine records. We looked at a sample of records relating to the management of the service including training data, improvement action plans, health and safety checks, policies and procedures and a sample of completed audits and checks.

After the inspection

We spoke with ten people's relatives and reviewed the additional documentation we had requested from the registered manager during the site visit. We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated 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.

Assessing risk, safety monitoring and management

- Risk was not always identified, assessed and well-managed.
- Three people had urinary catheters in place. Their catheter care plans contained very limited information about the management of the catheter and there was no guidance for staff about monitoring for early signs of infection, to help prevent ill-health. Some staff had not received training in catheter care.
- One person was independently mobile and was seen walking around wearing ill-fitting shoes. This risk had not been identified so action could be taken to mitigate the risk of them falling. The person's falls risk assessment had not been reviewed since April 2019.
- Some known risks had not been assessed. There was no diabetes risk management plan for a person whose diabetes was controlled by medication. Not all staff had received training in diabetes care and there was no guidance to alert staff to the signs of any changes in blood sugar levels or what action to take in such circumstances.
- One person had moved into the home 14 days prior to our inspection visit. Not all their care plans had been completed in line with the provider's admission policy. For example, the person required equipment when moving and transferring. There was no information about the equipment the person required, or information to guide staff in transferring the person safely.
- The same person had some information in their care records that informed staff they had previously experienced choking episodes. There was no formal healthcare assessment to assess the level of risk or to guide staff as to what action they needed to take if the person started to choke.
- Some risk management plans did not contain the detail staff needed to provide safe care. One person lived with dementia and on occasions displayed behaviours that could cause themselves harm. Their positive behaviour support plan had not been reviewed for 11 months and contained no guidance to help staff manage the person's behaviours or reduce the person's levels of anxiety. The registered manager confirmed care plans should be reviewed monthly.
- Care records were not updated when people's needs changed. One person had been wearing specialist boots to prevent the skin on their feet being damaged, since 1 January 2021. Care records had not been updated to reflect this change. Another person's prescribed medicine had been discontinued by their GP on 9 December 2020. Care records had not been amended to reflect this change.
- Equipment in place to reduce risks of damage to people's skin was not routinely checked by staff. For example, there was no procedure in place to check people's pressure relieving mattresses to maintain people's safety. We looked at two people's weight record and found their pressure relieving mattresses were on settings that were too high for their individual weight. This meant risks of people's skin becoming sore or damaged were not effectively managed.

We found no evidence that people had been harmed as a result of failings, however systems and processes were not sufficient to demonstrate risk associated with people's care was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- An infection control audit was completed in November 2020 by the local authority (LA) and a further audit was carried out by the local Clinical Commissioning Group (CCG) in December 2020. Both audits identified infection prevention and control measures required significant improvement. In response to the findings the registered manager told us, "We were doing our best, but it wasn't until we got support and they (LA and CCG) did audits, we realised our shortfalls. We want to be doing things right. We lost our way."
- At the time of our visit some action had been taken and further action was planned to drive forward improvement. For example, new chairs that could easily be cleaned had been purchased.
- The provider was accessing testing for people and staff. However, government guidance had not been followed when one person had recently moved into the home, which posed potential risks of cross infection.
- Whilst the management team demonstrated commitment to preventing and controlling infection, we saw a rusty toilet frame that could not be cleaned effectively, was in use. Also, the process to ensure peoples' toiletries were not mixed up or shared was ineffective, because toiletries were found in a communal bathroom.
- Staff told us detailed infection prevention control training including information about COVID-19 had not been provided until the CCG facilitated training in December 2020. However, some staff told us they had not received this training.
- Enhanced cleaning schedules had been in place since December 2020, following support from the CCG. However, there was only one part-time member of cleaning staff to ensure hygiene levels were maintained throughout the service. Care staff were responsible for any additional cleaning, including high-touch surfaces.
- Guidance for effective hand-washing techniques and the correct use of personal protective equipment (PPE) were on display. Staff were observed wearing PPE correctly.
- Visitors were screened for symptoms of acute respiratory infection before entering the home and furniture in communal areas had been rearranged to encourage people to social distance to keep themselves and other safe.
- People were assessed twice daily to check for the development of symptoms associated with COVID-19. Current guidance on self-isolation within care homes was being followed.

Systems and processes to safeguard people from the risk of abuse

- Staff had received training about the different types of abuse. However, some staff training had not been kept up to date. Some staff had gaps in their knowledge about how concerns may be escalated to the local authority to investigate.
- The registered manager understood their obligation to report their concerns to the relevant authorities.

Staffing and recruitment

- Concerns were raised at the end of November 2020 when several permanent members of staff left the service at short notice. This meant remaining care staff were asked to work longer hours and there was an increased reliance on agency staff to fulfil the staff rota.
- We observed there were enough staff to provide support when it was needed on the day of our visit. However, call bells rang for long periods of time before being answered.
- Staff had mixed opinion if there were sufficient numbers of staff on shift. Some staff told us there were insufficient staffing levels in the early morning to support people to get up and ready when they wished to

do so.

- It was not clear how staffing levels were worked out to ensure people's needs were met. We asked the registered manager to provide information following the visit to explain how levels were calculated, but we did not receive this information.

Using medicines safely

- We looked at four people's medicine administration records (MARs) and found these had been completed accurately to show people had received their medicines as prescribed.
- However, some of the processes to support safe medicines practice needed to be improved.
- One person was prescribed 'as required' medicine to control symptoms of anxiety. Guidance was not available to inform staff when they should give this medicine in line with national guidance for 'as required' medicines. Guidance is important to ensure these medicines are administered as prescribed.
- Handwritten amendments to Medicine Administration Records (MARs) were not always signed by the member of staff making them and/or countersigned by a second member of staff to confirm their accuracy.
- Medicines which had shortened expiry dates when opened, such as topical creams, did not have the date of opening recorded on them. This meant we could not be assured of the continued effectiveness of some medicines.
- Care staff were given limited guidance as to the application of topical creams and gaps in application charts meant the provider could not be assured creams were always being applied as directed.
- Some staff had gaps in their understanding of safe medicine management. Records did not clearly demonstrate when staff's medicine training had been completed.

Learning lessons when things go wrong

- Accidents and incidents were recorded and indicated what immediate action had been taken to ensure people's safety and any further action required to minimise the risk of future re-occurrence. However, the level of detail in the records was inconsistent.
- Staff were not aware of specific learning from accidents and incidents. However, they understood the importance of recording and notifying the registered manager of any events.
- The provider required accidents and incidents to be analysed at the end of every month. Records showed the monthly analysis had not consistently been completed, which meant any trends or patterns at service level might not be identified.
- The registered manager displayed a commitment to learning where things had gone wrong. They took action straight away following our visit to make improvements to the service.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated 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; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Risks associated with people's care were not always managed well and governance systems to monitor the quality and safety of the service, required improvement. Audits to monitor care plans had failed to identify risks associated with people's care had not always been identified or managed well.
- Audits in place to monitor the health, safety and welfare of people and the environment in which they were supported were not always effective. For example, in November and December 2020 the local authority (LA) and local Clinical Commissioning Group (CCG) carried out infection control audits of the home. These audits identified significant infection control concerns which required immediate action.
- Medication audits had not identified the concerns we identified in relation to the management of medicines. Medicines audits had not always been fully completed.
- Where audits had identified areas for improvement, there was no information about who was responsible for implementing any required actions and by what date they should be completed. This meant there was no ownership of actions to drive improvement in the home and no process to ensure they had been completed.
- The registered manager was open and honest that they struggled with some of the managerial aspects of their role because they spent significant periods of time supporting staff and being with people.
- The provider had failed to maintain sufficient and accurate oversight of the service and to identify risk management was ineffective. For example, the provider's quality audit in October 2020 had failed to identify that infection control, environmental and medication audits completed within the service were not effective and that regulations were not being met. Therefore, people were not in always in receipt of safe care.

We found no evidence that people had been harmed. However, the above issues demonstrate a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives were satisfied with the service provided and spoke positively about the registered manager and deputy manager. Relatives told us, "I cannot praise them enough" and "They keep us informed. We have confidence in raising anything with them. It is like one big happy family there."
- Staff felt supported by their management team. One carer told us the management team in the home was, "Caring and supportive." However, some staff told us they did not feel valued by the provider because they

felt their work was not recognised.

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 management team understood their responsibility to be open and honest when things had gone wrong. They took some immediate action following our inspection visit, to make improvements where significant shortfalls had been identified.
- Following our inspection visit, new monitoring tools were implemented to help the registered manager and provider increase their managerial oversight of the service.
- The registered manager understood their obligations for reporting important events or incidents to relevant agencies, including the CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Arrangements were in place to ensure relatives could maintain contact with family members via telephone or video calls. One relative told us, "Sometimes the home call us to speak with (Name) and do a video call, usually when they are awake properly and alert."
- Relatives told us staff kept in touch with them about their family member. A relative told us, "They ring us with any updates or when they feel it would be a good time to speak with (Name)."
- Staff told us they had supervision meetings with their manager, however this did not include discussion of training needs. There was no evidence of staff meetings. Staff explained they shared important information about people's changing needs via electronic group chat and at handover.

Working in partnership with others

- Staff worked with other agencies to improve people's experience of care. These included health and social care professionals.

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 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider did not adequately assess and protect people against risks by doing all that was practicable to identify and mitigate such risks.</p> <p>Regulation 12 (1) (2) (a)(b)</p>
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 had not ensured that systems or processes operated effectively to assess, monitor and improve the quality of the service and mitigate the risks relating to health, safety and welfare of service users. The provider had not maintained accurate and complete records in respect of each service user.</p> <p>17 (1) (2) (a)(b)(c)</p>