Lester Hall Apartments Limited

Lester Hall Apartments

Inspection report

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Date of inspection visit:
14 December 2020
21 December 2020

Date of publication:
04 February 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Lester Hall Apartments is a residential care home providing accommodation and personal care for people living with mental health needs, including those living with dementia. The service can support up to 33 people and there were 26 people living in the service at the time of inspection.

People's experience of using this service and what we found
Poor infection prevention and control processes and practice placed people at risk of harm. During a recent outbreak of COVID-19 government guidance on how to work safely in care homes was not always followed. The service did not always follow their policy on how to safely manage an outbreak of COVID-19. This included safe use and disposal of personal protective equipment (PPE) and not effectively using cohorting and zoning of people and staff to reduce the risk of infection spread. It also included not adhering to their policy in areas such as laundry and uniform processes.

Management oversight of infection prevention and control processes required urgent improvements. Quality assurance processes had not identified the widespread concerns in this area found during the inspection. There were not always enough domestic staff on shift to do all necessary cleaning tasks to help reduce the spread of infection. Improvements were required to the environment to support good infection prevention and control.

Rating at last inspection
The last rating for this service was requires improvement (published 19 October 2020).

After the last inspection the provider completed an action plan which outlined their planned improvements and timescales to achieve these. A t this inspection not enough improvement had been made and the provider was still in breach of regulations.
You can read the report from our last inspection, by selecting the 'all reports' link for Lester Hall Apartments on our website at www.cqc.org.uk.

Why we inspected
As part of CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure that the Infection Prevention and Control practice was safe and the service was compliant with IPC measures. This was a targeted inspection looking at the IPC practices the provider has in place.

This inspection took place on 14 December 2020 and was announced shortly before entering the building. A follow up unannounced visit took place on 21 December 2020.

We have found evidence the provider needs to make improvements. Please see further detail in the Safe section of this report.

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 a breach of regulations in relation to infection prevention and control which meant people's safety could not be assured.

Follow up
We will monitor information which the provider will send weekly to CQC updating us of the actions they are taking to make improvements. 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?

Inspected but not rated

Further information is in the detailed findings below.

Lester Hall Apartments

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check infection prevention and control measures in place. This was undertaken as part of CQC's response to care homes with outbreaks of coronavirus.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Lester Hall Apartments is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was announced shortly before we entered the building on the first visit, and unannounced on the second visit.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
On 14 December 2020 we used a CQC information gathering tool to look at various aspects of infection prevention and control. We spoke with the provider and seven members of staff including the deputy manager, health and safety manager, domestic and care staff. We also spoke with the compliance manager by telephone.

Following this visit we sent a letter to the provider outlining the concerns we found during the first day of

inspection. They submitted a response confirming the actions they intended to take to make improvements and ensure people's safety.

We carried out a second visit on 21 December 2020 to check progress against the action plan. We spoke with the provider and seven members of staff including the registered manager. We also spoke to care, domestic and administration staff. We spoke with the compliance manager by telephone.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and received information including data about COVID-19 test results for people and staff, training information, policy and audit documents, risk assessments for people and staff. We also sought additional feedback from the local authority.

Inspected but not rated

Is the service safe?

Our findings

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked the part of the key question relating to infection prevention and control.

S5 How well are people protected by the prevention and control of infection?

● People were at risk of harm due to national guidance on the safe use and disposal of PPE not always being followed. Not all staff wore the correct face masks or changed their PPE at the right times. For example, after going into a room where someone had tested positive for COVID-19. PPE was disposed of in non-clinical bins, even when clinical bins were available. This meant the risk of infection spread was high.
● Processes for cohorting and zoning were not well developed or effective. Cohorting and zoning means separating and grouping people and staff, which reduces the risk of the virus spreading.
● There was poor management knowledge and oversight about which people and staff had tested positive for COVID-19 and when their isolation period was due to end. There was no information on people's doors confirming their COVID-19 status to support staff safely manage their care. Some improvements were made by the end of the inspection.
● There were not consistently enough domestic staff on shift to ensure effective cleaning of all areas, including high touch areas, could be undertaken and sustained. Effective and enhanced cleaning during the pandemic period supports people stay safe.
● The provider's outbreak management policy was not followed in all areas. For example, not all staff wore or changed into uniform in the service or were bare below their elbows. Some staff did not socially distance during their break times when they had removed their masks. Spot checks which were introduced to check staff infection control practices were ineffective as they did not pick up on these issues.
● Laundry processes placed people at risk through cross contamination. Dirty laundry was not stored or sealed safely before being taken to the laundry room or moved off site for washing.
● Not all staff had received recent infection prevention and control training. The provider and registered manager were not clear about the content of the training which had taken place. This meant they could not be assured staff had up to date knowledge or skills in infection prevention and control processes.
● The quality assurance audit for infection prevention and control was not effective. The most recent audit in December 2020 had not identified the widespread issues found in this inspection. The audit had not been updated since the start of the pandemic to include enhanced infection control measures and practices needed to keep people safe.
● Areas of the service were in poor condition which impacted upon the effectiveness of cleaning. For example, some furniture was old and not wipeable, some flooring and painted areas were chipped and required renewal, and some areas were cluttered. This meant the risk of further infection spread was high.

Infection control procedures did not consistently protect people from the risk of infection. This was a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured that the provider was preventing visitors from catching and spreading infections.

Since the inspection the provider has sent weekly reports to CQC outlining the actions they have taken to make improvements.

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 Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of harm due to poor infection prevention and control practices. Government guidance on how to work safely in care homes was not followed. The service did not follow their policy on COVID-19 outbreak management. Management oversight of the COVID-19 outbreak required improvements.

The enforcement action we took:

We placed conditions upon the provider's certificate of registration