Shankar Leicester Limited

Longcliffe Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Longcliffe Care Home is a residential care home providing personal care to up to 42 older people and people with physical disabillities. At the time of our inspection there were 18 people using the service. The accommodation is over two floors of a large period property with bedrooms on the first floor serviced by a lift. The lift was out of use at the time of our inspection.

People's experience of using this service and what we found
People's medicines were not managed or administered safely. We found a number of medicine errors which had not been identified through the provider audits and which indicated people had not received their medicines as prescribed.

People were not protected from the risk of abuse or improper treatment. People who had made allegations of abuse, or actually experienced abuse, did not receive the support they needed in a timely way. The provider had not taken timely preventative action, including escalating safeguarding concerns to relevant external agencies. This placed people at significant and prolonged increased risk of harm. The provider did not consistently ensure all staff were suitably qualified, competent, skilled and experienced to be able to meet people's needs. People had confidence in most staff but felt other staff were not as willing or able to meet their needs.

The provider had quality assurance processes in place, but these were not used effectively to assess, monitor and improve the service. Audits and checks had failed to make sustainable improvements and we were concerned that full oversight had not been established. Concerns we identified at this inspection had not been identified by the provider's own systems. This is the sixth consecutive rated inspection where the provider has failed to meet regulations and achieve a good rating as a minimum standard.

People were protected from the risk of infections. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We observed people being offered choice during both days of inspection, and people told us they were offered choice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 14 January 2023) and there was a breach of Regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of safeguarding people from abuse and improper treatment. This inspection examined those risks.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for this service has changed from requires improvement to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse and improper treatment, staffing and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 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.
Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.
Details are in our well-led findings below.

Longcliffe Care 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act.

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 1 Inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Longcliffe Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Longcliffe Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there were 2 registered managers in post undertaking a job share role.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service and spoke with commissioners, responsible for funding some of the care for people using the service. We used the information the provider sent us in their latest provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 2 relatives. We observed interactions between people and staff in communal areas. We met with 6 staff including the registered manager, the compliance manager, the provider and 3 care staff. We reviewed care plans and records for 3 people and sampled medicine records. We reviewed training and recruitment records for staff. We also reviewed other records, including policies and procedures, relating to the safety and quality of the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection, we found medicines were not managed or administered safely. This was a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found medicine management and administration remained unsafe. The provider was still in breach of regulation 12.

- Medicines processes were not safe and people did not receive their medicines as prescribed.
- We found incorrect medicine stock counts for two people and missing signatures on people's medicine administration records. We could not be assured people had received these medicines safely.
- MARs for a third person showed they had not received their food supplement for three days during the month of April 2023. Staff were unable to provide an explanation as to why these medicines had not been signed for or administered. This meant this person had not received this medicine as prescribed to protect them from this risk of poor nutrition.
- A person was dependent on staff support for administration of their medicines and monitoring of their health condition, including twice daily blood sugar tests. Staff completed this monitoring, but administration records failed to guide staff on the normal safe range of blood sugar readings for the person. This information was included in the person's care plan but did not provide guidance for staff in the event the person's blood sugar readings were not within normal range for them. We saw several recordings where the person's blood sugar levels were much higher than their normal range. Staff had failed to take any action or additional monitoring in response to this. This poor monitoring put the person at risk of harm.
- Transdermal (medicines applied directly to the skin through an adhesive patch) patch records were not completed consistently. Staff did not consistently record the application of a patch and include the specific location it was put on a person's body, for example front, right, chest. This is important so other staff can check that the patch is still in place, correctly applied and rotated to avoid over absorption and potential overdose and checked every day.
- Following our last inspection, the provider had developed an action plan and introduced more regular medicine audits. We found audits were not effective in ensuring improvement had been made or sustained. People remained at risk from unsafe medicine management and administration.

The provider had failed to ensure all medicine processes were completed to maintain people's safety. This was a continued breach of regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People were not adequately safeguarded from abuse and improper treatment.

● The provider had systems and processes in place to record accidents, incidents and near misses. However, these had not been used effectively to ensure people were kept safe from harm. The provider had failed to escalate serious incidents to all relevant external agencies in a timely manner to ensure immediate action was take to keep people safe. This placed people at significant and prolonged risk of harm.
● People who had made allegations of abuse, or actually experienced abuse, did not receive the support they needed in a timely way.The provider, and their staff, failed to report allegations of abuse without delay. These concerns were not responded to appropriately to ensure people were protected and had access to the support they needed.
● The provider had failed to ensure all staff employed at the service had received relevant safeguarding training. The provider had engaged some agency staff without requesting assurances from the agency provider that staff had received all relevant training. The provider had failed to ensure they had robust processes to ensure all staff understood their safeguarding role to protect people from harm. This exposed people to the risk of harm from unsafe or unsuitable staff.

The provider had failed to take timely action to protect people from abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Staff completed accident forms for people, including body maps where injuries had occurred. The provider reviewed accidents each month to identify trends or patterns. However, they had failed to ensure timely, preventative action had been taken to keep people safe from known risks. We found some accidents had not been escalated to external agencies.
● For example, one person had broken a limb. Incident records showed staff had taken immediate action in calling emergency medical services to support the person at the time of the incident. However, the provider had failed to take action post incident to identify what, if any, remedial measures could be put in place to reduce further risk of harm for the person. Their mobility risk assessments had not been reviewed to reflect this increase in risk.
● A second person had experienced repeated falls in a short space of time. Staff had responded to ensure the person received immediate medical assistance following the first fall. The provider failed to ensure appropriate review and analysis had been taken post accident to reduce the risk of harm for the person. They experienced a further two falls which resulted in high levels of distress for the person. The provider had failed to take timely action to prevent further risk of harm for the person. This meant people were exposed to increased risk of harm.
● The provider had failed to review incidents and accidents to ensure lessons were learnt and known risks mitigated to keep people safe from harm.

The provider had failed to take timely action to mitigate the risk of harm for people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing
● Staff were not always safely recruited. The provider undertook pre-employment checks for permanent staff they recruited, including right to work status checks with the Disclosure and Barring Service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, they failed to check that agency staff had relevant DBS and employment checks. We also found the provider had failed to obtain a copy of a DBS check for a newly recruited member of staff.
● We reviewed staffing rotas between 6 February 2023 to 26 April 2023 and found several agency staff had

been employed to work in the service without an agency profile in place. An agency profile is essential to establish identity and ensure staff are safe and suitable to work in the service. The profile includes training, employment checks and skills. This meant some staff were working in the service who had not been assessed by the provider as safe and competent to work with people.

● People told us they usually felt safe with staff but some people had experienced staff who did not fully meet their needs. One person told us, "Most staff are very good. There is one who doesn't seem quite bothered. They are supposed to watch me get back to my room safely and they were behind me but I turned around and they were gone without saying anything." A second person told us, "I feel safe with most staff. The odd one is not so great. I had one who upset me as they told me I pressed the buzzer too much. Another one comes in, helps with personal care, then leaves. They never really talk to me."

The provider had failed to have robust processes to ensure all staff were safely recruited and suitably competent to be able to meet people's needs. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider took immediate action to ensure all staff were assessed, vetted and provided evidence of training and pre-employment checks prior to working in the service.

Preventing and controlling infection

● Hygiene and cleanliness of the service supported effective infection prevention and control. One relative told us, "I think it's clean and tidy, and they (provider) seem to be on a refurbishment plan. They are doing refurbishment regularly."

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using personal protective equipment (PPE) effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Relatives visited their family members, in line with current government guidance. Relatives and friends visited the service during our inspection.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● Monitoring systems were being implemented at this service, however, these were not effective as they were not undertaken regularly or consistently. This had placed people at risk of harm.

● Some audits, such as kitchen audits, had not been undertaken since August 2022. The provider's quality assurance processes had assessed these as requiring quarterly auditing. An infection prevention and control audit, assessed by the provider as needing monthly auditing, had not been undertaken since January 2022. Monthly fire extinguisher visual checks had not been undertaken since January 2023 and a fire drill had last been undertaken in November 2022. Fire evacuation information had not been updated as this included the names of people who no longer used the service. This demonstrated audits and checks had not been undertaken routinely in line with the provider's quality assurance processes.

● Where audits and checks had been completed, for example care planning and maintenance, action plans failed to record if improvements had been made and if these were within targeted timescales.

● We found failures and breaches of regulation in many areas, which included medicines management; appropriate risk identification and actions; safeguarding processes and staffing. The provider did not provide additional quality checks, and oversight, and had not identified or addressed the multiple issues we have
covered in this report. This meant procedures were not robust, and people had been placed at risk of receiving unsafe care.

● Medicine audits were undertaken but had failed to identify the issues of concern around the management of medicines that we found during our inspection. An audit undertaken on 19 April 2023 had failed to identify the errors we identified in MARs and medicine stock counts. This demonstrated audits were not effective in identifying and sustaining improvements.

● The provider and registered managers were not clear about their role in protecting people from abuse and improper treatment, including escalating and taking timely, preventative actions. For example, the provider had not escalated safeguarding concerns to all agencies to keep people safe but had waited to be told what to do by local authority safeguarding. This demonstrated the provider lacked understanding of safeguarding processes and their responsibility to protect people from abuse. This meant people had been exposed to the risk of or incurred actual harm.

● The provider had not been proactive in reviewing and analysing incidents and events in the service to ensure lessons were learnt and improvements made. For example, there was a lack of learning following accidents within the home to reduce the risk of reoccurrence.

● The provider had failed to make sustainable improvements following action plans from external agencies,

such as the local authority. These widespread failings did not demonstrate the provider had safe and effective oversight of the service provided to people, nor did it demonstrate to us an understanding of regulatory requirements for the safe care of people.
● This is the sixth consecutive rated inspection where the provider has failed to meet regulations and achieve a good rating as a minimum standard. The proivder had a history of failing to respond adequately to serious concerns raised by the Commission.

Quality assurance and monitoring systems were being implemented however these were not effective at identifying and addressing shortfalls. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered managers and registered provider were not always clear on their roles and responsibilities under the duty of candour. They had failed to make appropriate notifications or ensured effective and accurate referrals to relevant agencies.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider used informal processes to engage with people and their relatives. Most people felt able to share concerns and make suggestions directly to the registered managers or the provider. Other people preferred to speak with specific members of staff who they felt comfortable with.
● People were consulted and involved in decisions affecting the service. For example, people had been consulted following the change in government requirements around wearing of face masks for staff. One person told us, "If I have any concerns or need anything, I just speak with the manager. They are good at sorting things out."
● Records failed to show how and when people had been consulted about their care and support as individuals.
● Relatives felt consulted and involved in their family member's care. One relative told us, "Staff always phone me if [Name] is unwell or anything changes. If there are ever any small issues, I just speak to [provider] and it's sorted."

Working in partnership with others
● At this inspection, we found the provider had failed to work effectively with other agencies to ensure timely action was taken to keep people safe from harm.
● Staff worked with health and social care professionals to support people's day to day health and well-being. For example, staff supported people to access routine and specialised healthcare appointments. Guidance and information from professionals was included in people's care plans.

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	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to have robust processes to ensure all staff were safely recruited and suitably competent to be able to meet people's needs

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 all medicine processes were completed to maintain people's safety. The provider had failed to take timely action to mitigate the risk of harm for people.

The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to take timely action to protect people from abuse.

The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and monitoring systems were being implemented however these were not effective at identifying and addressing shortfalls. This placed people at risk of harm.

The enforcement action we took:

Notice of proposal to cancel registration