London and Manchester Healthcare Ltd

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Inspection report

Gainsborough House Nursing Home
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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
London and Manchester Healthcare Limited, Gainsborough House is a residential care home providing personal and nursing care to 62 people requiring nursing and personal care. The service can support up to 72 people across three separate units, each of which has separate adapted facilities. Two of the units specialise in providing care to people living with dementia who have additional nursing needs, the third unit provides care to people only needing nursing support.

People's experience of using this service and what we found
At this inspection, we found concerns with the management of risk, medicines, record keeping, infection control and governance.

Staff did not have sufficient guidance to provide safe and appropriate care. Medication management was unsafe and placed people at risk of avoidable harm. Infection control standards were not being followed to protect people from the risk of infection such as COVID-19.

We identified that a lack of cohesive working and poor communication within the home had led to risks not being recognised and acted on. Some audits of the service were ineffective and, in some cases, not carried out.

Record keeping in relation to people's ongoing care needs were not always properly maintained. However, accidents and incidents were kept in order and there was evidence of monthly scrutiny of incidents and falls looking for patterns.

There were enough staff on duty to support people, and staff were recruited safely. Care staff were friendly, and treated people kindly. People's relatives confirmed this and felt their loved ones were well looked after.

Rating at last inspection
The last rating for this service was good (published 01 March 2018).

Why we inspected
We received concerns in relation to injury sustained through moving and handling, infection control, care delivery and governance. As a result, 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.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for London and Manchester Healthcare Limited, Gainsborough House on our website at www.cqc.org.uk.

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 breaches in relation to medicines, safe care and treatment, infection control and governance at this inspection.

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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority 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 overall rating for this service is 'Inadequate' and the service is therefore 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 timeframe. 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.

London and Manchester Healthcare Limited

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. We looked at the overall quality of the service and provided 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
This inspection was carried out by two inspectors, an inspection manager, a medicines 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
London and Manchester Healthcare Limited, Gainsborough House 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.

The service did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been newly recruited and was going through the registration process with CQC.

Notice of inspection

We telephoned the service from the car park on the day of the inspection and announced our arrival to the provider. The purpose of this was to obtain information about COVID-19 in advance of inspectors entering the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We liaised with the Local Authority to gain information on the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with the manager and the area manager whilst on site and spoke to 14 staff on the telephone. We reviewed a range of records. This included six people's care records, a sample of medication records, three staff recruitment files and records relating to the management of the service.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site, and were unable to speak with family members on the day, due to visiting restrictions. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit. We contacted 10 relatives by telephone about their experiences of the care provided and one person living in the home.

We continued to seek clarification from the provider to validate evidence found.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely.
- Thickening medication prescribed to thicken people's fluids to prevent them from choking were not managed safely. This increased the risk of a choking incident occurring.
- Staff did not always have enough information to ensure that as and when required (PRN) medicines were administered appropriately or, at the right dose. This meant there was a risk people would not receive the right medication when they needed it.
- Medicines were always not stored safely. For example; the key to the medicines fridge was taped to a cupboard and the fridge was unlocked; fridge temperatures on the day of inspection were out of a safe temperature range; oxygen was unchained and the sign indicating it was in use was on an A4 piece of paper; waste medicines were not stored safely prior to disposal.
- Records did not always support the safe management of medicines. For example, handwritten entries were not always signed, and we found poor recording of units of insulin, written as "iu" which is recognised as dangerous. Medicines in stock were not always on the medication administration records(MARs); the information on the MARs conflicted with the care plan and there were discrepancies between the records and the stock levels.
- Medicines prescribed to be given covertly were not safe as there was no advice available from the pharmacy to follow. This was because the pharmacy had declined to give such advice and no other advice had been sought. This meant that medicines were secreted in full bowls of cereal or full drinks; no monitoring had been put in place to ensure the full dose was given or that it was not taken by another person.
- Medicines competency assessments designed to assess a staff member's ability to administer medication safely and audits had been carried out. However, these did not reflect the findings of the inspection.

Due to poor management of medicines people were placed at risk of harm. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Part of the reason we visited was in response to the major incident of a person becoming injured during a moving and handling procedure. We looked at care plans and risk assessments to ensure staff had appropriate guidance when supporting people. We identified another person with a similar health condition. There were no specific instructions in the persons file describing how to safely move the person. This meant the risk to this person were significant.
- We identified that people with high risk health conditions such as diabetes, were not appropriately risk

assessed.
● We identified that one person's mental capacity information in regard to COVID-19 held information about another person. In addition, not all people had a risk assessment with regards to COVID-19.
● Systems in place to monitor people's needs were not adequate. There were significant gaps in relation to other people's monitoring information such as oxygen levels, diet and fluid intake.
● We identified that when a person with diabetes was having their blood sugars checked that these were consistently high but there was no evidence of anything being done about this. The manager acted on this following feedback.
● Risk assessments and care plan reviews were not sufficient. Comments such as 'reassurance given' and 'no change' were used. This was not meaningful as it did not give robust information

The provider had not ensured risks in relation to people's care were properly managed to prevent avoidable harm. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Accidents and incidents records were kept in order and there was evidence of monthly scrutiny of incidents and falls looking for patterns. There was evidence that issues were addressed in response to falls, for example referrals to falls teams.
● Environmental health and safety checks were regularly carried out to ensure it was safe for people living in the home.

Preventing and controlling infection
● Infection prevention control procedures (IPC) including those relating to COVID-19 were not being followed in accordance with government guidelines. For example, there was ineffective barrier nursing, staff were observed leaving a bedroom with 'barrier nurse' on the door and did not follow 'donning and doffing of PPE' protocols.
● PPE was not readily available in corridors for example, some corridors had none and in one case the upper floor had a box of masks in the reception area that was not close to the person being barrier nursed. No gloves were seen to be in the vicinity.
● Staff were observed wearing masks inappropriately, under their noses.
● Clinical waste bins were not readily available especially where barrier nursing was in place.
● Discussions with a staff member indicated that these practices were not followed. This meant that the staff training and knowledge in regard to IPC had not been checked to be effective.
● Government guidelines state that the temperatures of people living in the home should be checked twice a day. This was not happening regularly.
● Infection control and COVID-19 audits had been carried out however these did not reflect the findings of this inspection.

Infection control did not adhere to government guidelines to protect people from the risk of, or, spread 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.

Staffing and recruitment
● On the day we visited, there were enough staff on duty to meet people's needs.
● Staff were recruited safely with appropriate checks being undertaken before staff started employment.

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 good. At this inspection this key question has now deteriorated 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.

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

- Part of the reason we inspected was in response to the incident of a person becoming injured during a moving and handling procedure. We identified in discussion with the provider following the inspection that CQC were not notified until this was picked up by the area manager during a provider visit.
- We also found recommendations following a safeguarding investigation from the local authority were not acted on. This identified the provider did not have processes in place for appropriate oversight of the home when there was no manager at the service.
- The investigation into the above incident was not comprehensive. Care plans were not discussed and there was no evidence that the findings of the local authority were acted on. This means lessons were not identified to be learnt from.
- The audits we looked at did not reflect our findings. For example, the medicines audit scored very highly, there was no indication that the issues we found had been identified. This indicated the audits were not meaningful as it did not give robust information and so could not improve the quality of the service.
- Infection control processes did not comply with government guidelines on infection control and COVID-19. The provider's quality assurance checks had not identified this.
- Systems to monitor the governance of Gainsborough House in regard to staff practice was also ineffective. Staff training and competencies did not reflect the findings from the inspection.
- Additionally, the reporting of staff with regard to poor practice, for example to the National Midwifery Council (NMC), did not occur until this was highlighted by another agency. This meant that the provider did not recognise when staff needed to have accountability for their actions.

The provider failed to operate effective systems to ensure the quality and safety of the service which placed people at risk of harm. They also failed to maintain accurate and up to date records. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had employed a new manager who had been in post for a short time and who was starting to improve systems and processes. There had been a significant lack of leadership within Gainsborough House and a lack of understanding about roles and responsibilities.
● The findings of the inspection identified a lack of cohesive working within the home as we identified that there was some disconnect between the three units in the home. This impacted on how each of the units worked and staff knowledge.
● There was a concern that the culture within Gainsborough House was not conducive to the home being able to move forward and make the required improvements due to the lack of cohesive working, as there was a marked issue with management not working together. However, the nominated individual for the provider assured us that action was being taken to address this.
● Records in relation to people's care did not always contain adequate information and were not always completed properly. This meant it was difficult to tell if people received the care they needed and if this care promoted good outcomes for people.
● Care plans did not hold the appropriate information of professionals to be contacted. For example, diabetic nurse information.

The provider failed to operate effective systems to ensure the quality and safety of the service which placed people at risk of harm. They also failed to maintain accurate and up to date records. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to ensure the quality and safety of the service which placed people at risk of harm. They also failed to maintain accurate and up to date records.