Leicestershire County Care Limited

Thurn Court

Inspection report

Thurncourt Road
Thurnby Lodge
Leicester
Leicestershire
LE5 2NG

Tel: 01162413126

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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

Thurn Court is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Thurn Court is registered to accommodate 44 people including those living with dementia. This includes six interim assessment beds for people being discharged from hospital to determine their ongoing care and support needs. At this time of this inspection visit there were 32 people in residence.

At the last comprehensive inspection on 27 February 2017 the service was rated overall as Requires Improvement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Thurn Court on our website at www.cqc.org.uk

At this inspection we found the service remained Requires Improvement.

We undertook an unannounced focused inspection of Thurn Court on 8 November 2017. The team inspected the service against two of the five questions we ask about services: is the service safe? And is the service well led?

We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework these topic areas are included under the key question of is the service Safe? And is the service Well Led. The ratings from the previous inspection for these key questions were included in calculating the overall rating in this inspection.

Thurn Court had a registered manager. 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.

The registered manager provided leadership. However, improvements had not been consistently sustained to meet the legal requirement to display the latest CQC rating and ensure the inspection reports available.

The provider had a quality assurance system in place but it was not reliable. Audits we looked at were not always fully completed, fragmented and where plans were put in place improvements had not been sustained. We found the culture of the service did not always involve or empower people and the staff, to influence the service. There were limited opportunities for people to share their views about the service and to influence how the service was managed.

Staff were supervised and receive appropriate training for their role. Staff felt supported by the registered manager. The lack of formal staff meetings meant that staff were not kept up to date with changes within the service, received feedback from audits and plans to address shortfalls to improve the quality of service

provided.

People told us they felt safe at the service and with the staff team. Staff understood risks and signs of potential abuse and were aware of the safeguarding procedure to follow. To maintain people's safety, the service does not always ensure risks had been managed appropriately. We found no evidence that lessons had been learned or changes implemented to reduce further risk.

People's safety was promoted as potential risks were assessed, managed and regularly reviewed. Staff were able to demonstrate a good understanding and knowledge of people's specific needs to ensure their safety. Assistive technology was used to maintain people's safety without restricting their freedom.

People's and staff comments found staffing levels were not always sufficient to consistently meet the needs of people who used the service. Care staff had to help in the kitchen to cover unplanned staff absences which further impacted people's care and their safety.

The management of medicines, recording and stock levels were not always managed in a safe way. Although the service is due to change to a new medicine administration system regular checks should be carried out until the transfer has happened. There was no system in place to trigger a review of medicines at appropriate intervals by the prescribing doctor to ensure they continued to be effective.

People lived in an environment that was maintained. Staff had followed infection control procedures to manage a recent outbreak of an infectious illness.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People mostly received their prescribed medicines at the right time. Staff were not confident with the current medicines management system and discrepancies were found with the medicine in stock and the records. There were no systems in place to trigger a review at appropriate intervals to ensure medicines continued to be effective.

Staff were recruited safely. Staff were trained to recognise abuse and respond to allegations or incidents. Incidents reporting procedures were followed, but lessons were not learned or changes implemented to reduce further risk.

People's views found staff were not able to consistently provide support in a timely manner. We have made recommendations as to how calculating staffing levels for the service and system to trigger review of medicines within the report. Risks associated to people's needs were managed and monitored effectively. The home was well maintained and mostly clean.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager understood their role and responsibilities to ensure the service as managed but legal obligations were not always met Whilst procedures were mostly followed, management did not evidence that lessons were not learned to manage risks or changes implemented.

The quality assurance system was fragmented and not used effectively. Improvements were not sustained and little evidence of any lessons learned that resulted in changes to improve the service. This included limited opportunities for people and staff to share their views about the service and to influence how the service was managed. A system was in place to train staff. Staff felt supported by the registered manager.

Thurn Court

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 checked 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.

The inspection was prompted in part by notification of an incident that indicated potential concerns about the management of risk and reporting procedures. The Police, the local authority and Care Quality Commission (CQC) were aware of a recent death of a person at the location. This inspection examined those risks as we wanted to be assured that the provider has mitigated them appropriately.

This inspection took place on 8 November 2017 by two inspectors and was unannounced.

We checked the information we held about this service, the previous inspection report and notifications. A notification is information about important events and the provider is required to send us this by law. We contacted Leicester City Council who fund the care for some people. This was used to inform our inspection judgements.

We used a variety of methods to gain people's views and experiences of the service. We spoke with seven people who used the service. We spoke with the area manager, registered manager, three senior care staff, eight care staff, the activity co-ordinator and a member of the house-keeping staff. We also used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who used the service.

We looked at care records of five people, which included their risk assessments, care plans and records relating to their daily care needs. We looked at a sample of people's medicines and six people's electronic medication administration records. We also looked at records as to how the provider monitored the quality of service. This included three staff recruitment and training records, meeting minutes, policies and procedures, and a range of quality audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person told us they would speak to staff if they had any concerns and felt sure they would listen and take action. A person said, "I'm not harmed or hurt in anyway. If anyone did, I'd tell them to get out of my room and I'd speak to [staff] and let them know what's happened."

Staff were trained in safeguarding and knew how to recognise the signs of abuse. Staff were able to describe how and who to report suspected abuse to. However, there had been some delay in staff taking action regarding a recent safeguarding incident. While this had not resulted in any harm, the risk had not been managed appropriately and neither was there any evidence that lessons had been learned or changes implemented to reduce further risk.

Risks were assessed and management plans were put in place to reduce risks and avoidable harm. For example, people had their risk of developing pressure sores, malnutrition and falling assessed. We saw that action had been taken where risk was identified. One person had been referred to a 'falls clinic'; this resulted in changes to the person's prescribed medicines and had reduced the number of falls.

Care plans were in place to manage behaviour that was challenging such as verbal and physical aggression. We saw that these behaviours were recorded along with the action taken to reduce risk and distress. A member of staff explained how they used a range of distraction techniques to diffuse the situation for one person. They spoke with the person about their family and the place they used to live and this was effective.

People's freedom to take risks was respected and their human rights upheld. For example, one person had chosen not to follow the advice of a healthcare professional. The risks had been clearly explained to the person and their decision was respected by staff. People told us that staff checked on them and asked them if they had any concerns. People said, "They check on me a lot [for their safety and wellbeing] it was every hour when I was unwell" and "I'm not stopped from having a cigarette" and pointed to the secure area used.

The service had sent notifications about important events that affected people who used the service such as incidents and deaths. These were detailed and where appropriate actions taken to prevent further risks. Staff knew what to do in the event of an accident. They knew the criteria for seeking medical attention and records showed that this had been followed. All accidents were recorded along with the action taken by staff in response. For example, accident records showed that staff had considered environmental factors following a person falling. They checked that call bells and mobility aids were accessible and appropriate and they increased observations for a 24 hour period following the fall. Some people used assistive technology such as pressure mats so that staff were alerted as soon as the person stood up and was at risk of falling.

Some people told us there were not enough staff to meet their needs and at times they had to wait for staff to attend to them. Some staff also felt there were not enough staff on duty. In particular, when staff called in sick at the last minute they were not replaced. There were staff shortages in the kitchen and care staff had to cover these duties. The duty rota for the week commencing 30 October 2017 showed that there were no

catering staff for five days out of seven because of staff sickness. There was supposed to be five care staff in the morning and four in the afternoon but this was not always achieved because of staff sickness, as a consequence of care staff had to work in the kitchen.

We were told that staffing numbers were calculated using a staffing ratio rather than on the needs of people who used the service but that a new dependency tool was being implemented. Eight people who used the service required two staff to assist them with their mobility needs; four people were completely dependent on staff for all their needs. One of these people required three members of staff to help them use the hoist. We did not feel there always sufficient numbers of staff on duty to meet people's needs and keep them safe.

We recommended that the service re-evaluated the needs of the people who used the service to determine the appropriate level of staffing numbers. This would ensure there were consistently sufficient numbers of staff available, to safely meet people's needs and to respond to requests in a timely manner to keep people safe.

Staff were recruited in a safe way. Staff we spoke with told us they provided two references before being offered employment and underwent checks for their suitability to work at the service. We looked at staff records for three members of staff and saw that all necessary checks had been carried out.

People told us they had their prescribed medicines at the right time and in the right way. Staff had received training about the safe management of people's medicines and had their competency assessed. We observed staff administering people's medicines in a safe and sensitive way. Staff followed safe administration procedures and completed the electronic system of recording the medicines administered. We were told that this system was being replaced because it had led to difficulties with the ordering of new medicines. Staff told they did not have confidence in the electronic system. We checked stock levels against records for six prescribed medicines. Five out of the six medicines and records did not tally with the actual amount of tablets in stock. This meant that staff could not be sure that people had received their medicines as prescribed by the doctor.

Medicines were ordered, stored, and disposed of safely and securely in ways that met the relevant legislation and guidance. Records were maintained for all medicines received into the service and these returned to pharmacy. These were up to date, accurate and tallied with the actual amounts in stock.

There was one person managing some of their medicines. They had a secure place to store the medicine and staff checked they were managing them in a safe way. Where medicines were given covertly this was only done following a best interest decision and proper authorisation. We asked staff how they ensured that people had their medicines reviewed by the prescribing doctor to ensure they continued to be effective. There were no systems in place to trigger review of medicines at appropriate intervals. We recommended that they develop a system to address this.

People told us they were happy with the cleanliness of their rooms and of the communal areas and that their rooms were cleaned most days. We saw that most of the communal areas and people's private rooms appeared clean and fresh. We saw that in one of the communal lounges there was a fish tank that was extremely dirty and had an unpleasant odour. Staff took action and cleaned the fish tank during our inspection, however there continued to be a very unpleasant odour in this lounge even after they had done this. This was reported to the registered manager to be addressed as it impacted on people's wellbeing.

There had been a recent outbreak of an infectious illness that had affected many of the people who used the service and staff. Staff told us about the action they had taken and this was in line with current guidance.

Protective equipment such as gloves and aprons and hand washing facilities were available to staff. Staff confirmed that this was always the case. Some staff felt that there were not always enough domestic staff on duty and records showed that at times there were no domestic staff on duty after 2 pm. Cleaning schedules were in place but these did not provide enough detail about what should be cleaned and disinfected when and how. We could not be assured that the service was following the department of health's code of practice on the prevention and control of infections (2008). We recommended that the provider re-evaluated all aspects of the service when planning the number of staff required.

People told us they lived in a safe environment. The premises were maintained and records showed that regular safety checks were carried out. The provider had an extensive business continuity plan covering potential situations and events, such as a power failure, flood or fire. This, if activated, would mean the registered manager and staff would follow the emergency procedures that would enable them to provide support and care to people to keep them safe. For instance, the management of an infectious illness procedure had been followed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found one area was in need of improvement where the CQC rating had not been displayed and a copy of the latest inspection report was not available at the service. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This was rectified on the day by the registered manager when it was raised with them.

At this inspection we found the same issue existed. The current CQC rating was not displayed and a copy of the latest inspection report was not available. When we raised this with the registered manager they took action. The CQC rating was displayed and a copy of the inspection report was made available. We will continue to monitor this.

The registered manager understood their responsibilities to manage the service. They had followed procedures to protect people who used the service and staff from potential risks. For example, they had liaised with the health protection agency to manage an infectious illness and protect people and staff from further risk. With regards to another reported incident at the service the registered manager had worked the Police and the local authority. We found the registered manager and the provider had no evidence to demonstrate whether any lessons had been learnt from incidents or changes implemented should a similar incident occur. This showed the service does not continuously learn from events to drive improvements

The provider had system in place to support the registered manager. Despite this, developments in social care sector, changes in legislation and new guidance about best practice were not always shared in a timely manner. We discussed this with the area manager. They told us they were due to meet with the registered managers within the provider group, to discuss the new changes with regards to how CQC inspect services, which came into force on 1 November 2017. This was an example of the management team being reactive as opposed to being pro-active to change.

The provider had a quality assurance system to monitor the service. However, it was not reliable or effective and risks were not always identified or managed. The registered manager carried out a range of quality audits and checks. These included checks on the premises and equipment, review of people's care records, medicines and the analysis of incidents, accidents and falls. These were not always fully completed, fragmented and where plans were put in place these were not monitored to ensure improvements were made in a timely manner.

The infection control audit failed to identify that the daily cleaning in kitchen had not been done consistently. There were a number of missing entries in the records from June 2017 to date. This included eight days in October 2017 and two days in November 2017. The area manager's quality monitoring audit for July and September 2017 in relation to the kitchen cleaning schedule stated that the records were 'fully up to date'. This demonstrated that the system was not robust.

Systems for monitoring the safe management of people's medicines were not effective. This had been identified in the provider's quality audit as an area the needed to be improved. The medicine audit was only

partly completed and not linked to the electronic medicine reports. It meant any gaps; administration errors or records to confirm medicines had were administered or refused could not be identified promptly or addressed. We found medicines in stock differed to the amount recorded. The registered manager said they would review the system generated report the following day which would identify any gaps or errors. That showed they could not be assured that people had sufficient stock of their medicines and had been administered as prescribed. It was evident from the provider's quality audits that there had been a number of issues with regards to the management of medicines. Regular stock checks had been implemented and further training was provided to staff but our findings showed that the improvements had not been sustained.

We found the culture of the service did not always involve or empower people and staff to influence and improve the service. The provider had a system to gather feedback through meetings and surveys. A schedule of the monthly residents and staff meetings for the year was displayed. However, the last resident's meetings took place in May 2017 and the last staff meeting was held in June 2017. Meeting minutes showed there were no updates on any issues raised from the previous meetings or how the people who used the service and the staff team were encouraged to share ideas about the way the service could be improved. We found little evidence to demonstrate how feedback from audits and observations were used to drive improvements, such as cleanliness and social opportunities for people to take part in. The registered manager told us they had limited links with the local community facilities and resources. They told us that people were invited to coffee mornings at the local community centre but had declined. However, people we spoke with were not aware of this. This indicated the service was not consistently well led.

Staff were aware of their responsibilities related to preserving people's personal information and their legal duty to protect personal information they encountered during the course of their work. However, the area manager and the registered manager was unable to evidence that they complied with the data protection act.

This was a breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider's quality assurance system had not been used effectively to sustain, learn from and drive improvements. There were limited opportunities for people who used the service and staff to share their views about the service to influence changes.

People and where appropriate their relatives, had been involved in the review of their care and were confident that their ongoing needs would be monitored; and met. People felt they could approach the registered manager to discuss any concerns or issues they may have had about their care.

The registered manager and staff we spoke with understood the expectations of the provider to deliver quality care. Staff spoke positively about the registered manager's leadership and felt they were approachable and supportive. Staff felt they were valued, and any issues raised were listened and acted on. They said, "She's a good manager, approachable, she listens and deals with issues," and "She helps with residents if we need a hand and has worked in the kitchen because [kitchen staff] called in sick."

The provider's equality policy and procedure was in place. Staff told gave examples that demonstrated equality and diversity was promoted and that they were treatment equitably and without discrimination. For example, an expectant staff member told us they had been supported in their role and risks related to their role had been managed without discrimination.

A system was in place to train and supervise staff. Training records we viewed confirmed this. Staff knew about the provider' 'whistle blowing policy', this policy supported staff to raise concerns should they need

to. Staff supervisions were planned in advance to ensure they had time to prepare and reflect on their work.

Following our inspection visit the registered manager wrote to us about the actions they had taken. Staff had been due to complete training in falls prevention awareness, and mental capacity act. Quality assurance questionnaires would be sent to people's relatives and professionals and given to people who used the service. In addition a residents meeting had been planned on 16 November 2017 and a staff meeting planned for 21November 2017.

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 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system had not been used effectively to sustain, learn from and drive improvements. There were limited opportunities for people who used the service and staff to share their views about the service to influence changes. Regulation 17