

Leicestershire County Care Limited

Harvey House

Inspection report

Church Lane
Barwell
Leicester
Leicestershire
LE9 8DG

Tel: 01455843575

Date of inspection visit:
09 August 2021
01 September 2021

Date of publication:
06 October 2021

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

Harvey House is a residential care home providing accommodation and personal care to 40 people aged 65 and over at the time of the inspection. The service can support up to 44 people accommodated over two floors.

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

The provider had quality control systems in place, however these were not robust enough to ensure the quality and safety of the service was maintained.

Risk was not always safely managed. As a result, people were left at increased risk of contracting and transmitting COVID-19 due to poor practice around safe entry to the service for visitors and staff.

Environmental safety concerns were found in people's bedrooms. Wardrobes were not fixed to walls and topical creams had been left in people's bedrooms. This increased the risk of harm to people.

There were not always enough skilled and experienced staff to meet people's needs, particularly at night-time and at weekends. Permanent staff were adequately trained and had regular competency checks, however assurances were not provided agency staff had undertaken all relevant training to carry out their roles safely.

The provider did not always learn lessons when things went wrong. Audits had identified issues but effective action plans were not always developed and did not always result in improvements being made.

People's relatives were not always involved in developing and reviewing their family member's care.

People's relatives and staff provided mixed feedback about the support provided by the management team and the quality of communication.

People were supported by staff who had been recruited safely and who were caring, respectful and knew people well. Staff demonstrated a good understanding of safeguarding and the signs of abuse and were able to describe how and who to report concerns to.

People were supported to receive their medicines when they needed them by staff who had received appropriate training in administering medicines.

Accidents and incidents were documented and reported on appropriately, with trends and themes being identified to prevent risk of re-occurrence.

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.

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 (published 5 April 2018).

Why we inspected

We received concerns in relation to how incidents between service users were managed, recurrent falls, allegations of neglect and lack of COVID-19 testing for visitors. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 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 requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. 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 Harvey 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 infection prevention and control, the environment and governance at this inspection. We issued the provider with warning notices relating to the safety of the service and the governance arrangements in place. Please see the actions we have told the provider to take at the end of the report.

Follow up

We will request an action plan from the provider to understand what they will do to improve 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 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 ●

Harvey House

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

The inspection was undertaken by two inspectors 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

Harvey 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 had a manager registered with the Care Quality Commission. This means that they 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

This inspection was unannounced.

What we did before the inspection

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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the

service. 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 seven relatives of people who use the service about their experience of the care provided. We spoke with seventeen members of staff including the registered manager, deputy manager, area manager, trainee manager, chef, activities co-ordinator, three care team leaders, five carers and three housekeepers. We also spoke with a visiting health professional.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

After the inspection

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 now 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.

Preventing and controlling infection; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff failed to follow Government guidance around visitors to the service. Visiting relatives and professionals were not always asked to complete a lateral flow test (LFT) and did not always have their temperature taken prior to entering the service. This placed people and staff at increased risk of contracting and transmitting COVID-19.
- Infection prevention and control (IPC) practices were not effective. We saw staff members failing to wear appropriate personal protective equipment (PPE) in line with Government guidance. We saw staff failed to sanitise or wash their hands between support tasks for different people. This placed people at increased risk of contracting and transmitting COVID-19.
- Risk assessments for people having visits away from the service were not in place. People were leaving the service with their relatives, but it could not be evidenced the service had considered risks associated with this. Relatives were not being asked to complete a LFT prior to taking people out of the service. This did not meet Government guidance and placed people at increased risk of contracting and transmitting COVID-19.
- Lessons were not always learnt when things went wrong. An IPC audit dated July 2021 identified visitors and staff had not completed an LFT or had their temperatures taken. The registered manager failed to ensure changes were made to improve safety of people living at the service.
- Agency staff were not always being tested for COVID-19. An agency staff member told us they had not completed an LFT at the start of their shift, neither had they completed a Polymerase Chain Reaction (PCR) test for over a month. This meant people and staff were being unnecessarily exposed to the risk of contracting and transmitting COVID-19.
- The environment was not always safe and concerns were not always identified. We saw wardrobes in four people's bedrooms were not fixed to the walls. We also found topical creams were left out and accessible to people in four people's bedrooms. This placed people at risk of harm.

The provider had failed to ensure people were protected from the 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.

- Accidents and incidents were recorded. Information was collated and analysed to inform measures to prevent incidents reoccurring.

Staffing and recruitment

- Agency staff were not always safely working at the service. We found some agency staff did not have up to

date training in place. One agency staff member had not undertaken IPC or COVID-19 training and had not completed refresher training for Basic Life Support, Hoist Awareness and Manual Handling. This meant the provider could not be assured this agency staff member could safely meet people's needs. However, permanent staff training was up to date and refresher training had been completed regularly.

- There were not always enough staff, especially at night. One staff member told us, "There are not enough night staff. It is hard. Dependency is high and most residents wake in the night." One relative said, "I think they are short staffed at night. If they had more staff they could spend more time with [name]". An oversight visit by the Area Manager in July 2021 identified the resident to staff ratio is higher than the service would like and over half of all falls in June 2021 occurred at night. This meant people were at increased risk of harm.
- Staff did not always feel supported during the nights or at weekends. One staff member told us, "There is not always enough out of hours support. Staff who are on-call are not always very good at answering their phones". The registered manager and deputy manager were responsible for being on-call. This meant when dealing with incidents care staff did not always have access to advice from senior members of the management team.
- Staff were recruited safely. Pre-employment checks were carried out when appointing staff. For example, a Disclosure and Barring Service (DBS) check and previous employer references were obtained. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions.

We recommend the provider reviews staffing levels to ensure appropriate numbers of staff are available at night, as per the recommendation within the oversight visit completed by the Area Manager in July 2021.

Systems and processes to safeguard people from the risk of abuse

- Staff had undertaken training in safeguarding procedures. One staff member told us, "I have had safeguarding training which is refreshed every year. We learn what safeguarding is, how to safeguard people, how to report safeguarding concerns and how to whistle blow." Another staff member said, "Anything that might be considered abuse I would report to a manager. If it wasn't dealt with properly, I would speak to the Local Authority or the CQC".
- The registered manager understood their role and responsibilities in relation to safeguarding. We saw safeguarding referrals had been made to the Local Authority appropriately and promptly and, where necessary, information had been shared with partner agencies and CQC.
- Relatives thought their family members were safe. One relative said, "[Name] is safe, absolutely. They (staff) are diligent in looking after [name]". Another relative told us, "I have no concerns at all about the safety of [name]. [Name] seems happy".

Using medicines safely

- Medicines were managed safely. Medicine administration record (MAR) charts were in place and had been completed accurately. Medicine stock was checked in to the service, stored and disposed of appropriately.
- As and when required (PRN) medicine protocols were in place. Staff recorded clear evidence about when and why they had administered PRN medicines. One staff member told us, "If people have PRN medication we have information to show when this might be needed, such as when a person is in pain. There are protocols in place for each resident who is on PRN medication".
- Staff were trained to administer medicines safely. Competency tests were regularly completed and specific training for administering insulin to people with diabetes had been provided by relevant health professionals.
- Regular audits were carried out to ensure correct procedures were followed by staff regarding medicines and any action required was identified promptly.

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 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; Continuous learning and improving care

- The registered manager and provider did not always maintain oversight of the service. Systems and processes did not always identify failings or areas requiring improvement. There was no effective system in place for the registered manager to monitor and evidence staff compliance with Government guidance around wearing PPE, or to allow visitors to enter the service safely. This failure to maintain oversight of IPC issues meant people and staff were unnecessarily exposed to the risk of harm.
- Audits were completed but, when issues were identified, effective action plans were not always developed. For example, audits identified actions needed to be taken, but nobody was accountable for completing the tasks. Audits did not always document the name of the person investigating the incident, the outcome and any lessons learnt or actions taken. Failure to implement action plans meant opportunities to improve the service were missed.
- Risks to people using the service were not always identified or managed effectively. Risk assessments were not always completed in line with best practice. There was no effective procedure in place to identify when risk assessments had not been completed or were not detailed enough. This failure to recognise risk and complete appropriate risk assessments put people at increased risk of harm.
- There was no effective procedure to assure the registered manager agency staff were safe and suitably trained to work at the service.

The failure to ensure good oversight of the service and to ensure systems and processes were effective is 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

- We received mixed feedback from staff and relatives regarding how supportive the management team were. Staff told us the changes to management whilst the registered manager was on extended leave had been unsettling. One staff member told us, "The registered manager and area manager are very supportive. I don't feel that senior management and the owner are supportive at all". One relative told us, "It seems that only if the management team are pushed or have to do something, they do it". Another relative said, "The management team is good when you need to speak to them".
- Information within care plans was person-centred and included relevant information around people's

needs, their likes and dislikes, their life history and family relationships. One relative told us, "Staff know [name] well. They are always chatting".

- Staff were knowledgeable about people who used the service and demonstrated they took a person-centred approach to providing care. One staff member told us, "Care plans provide the information I need so I know people well".

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

- People's relatives were not always involved in reviewing their care. Four relatives told us they had not been involved in reviewing people's care plans, while two relatives had been. An oversight visit completed by the Area Manager in July 2021 identified care plans did not evidence resident or relative involvement.
- People's relatives were not always asked to feedback on the care their family member was receiving. The registered manager told us they sent out paper surveys by post. Three relatives told us they had received and completed a survey within the last year and three told us they had not received a survey.
- Staff felt involved in decisions about Harvey House. One staff member said, "We have team meetings and supervisions every other month. I feel the meetings are useful and things change if you raise any issues". Another staff member told us, "I find the meetings really useful as it gives us time to sit down and get everything out in the open. Management do listen to concerns and will make changes to improve things for residents".

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 provider had implemented a complaints policy and had provided complaints information to people, relatives and staff. There were posters in the communal areas advising people of who to contact if they had concerns.
- All relatives we spoke with confirmed they had not raised a complaint recently, but past complaints had been taken seriously and investigated. One relative told us, "When the registered manager was off I made a complaint which was sorted out as soon as she got back."
- People's relatives were informed when their family member was involved in an accident or incident at the service. One relative told us, "[Name] had a fall. Staff phoned me to let me know". Another relative said, "Staff always inform me if there is an accident or an incident involving [name]".

Working in partnership with others

- The management team had established and maintained good links with local partners that would be of benefit to people who use the service, such as GP practices, district nurses, physiotherapists, chiropodists, dentists, hairdressers and social work teams.
- The registered manager ensured health services were promptly involved when concerns for people's health developed. One relative told us, "They manage all [name]'s hospital appointments and arranged a follow-up appointment when [name]'s medical condition deteriorated."

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 registered persons did not ensure all aspects of infection control and environmental safety were safely managed.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant by 27 October 2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not ensure systems and processes were either in place or effective enough to monitor the quality and safety of the service.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant by 15 December 2021.