Leicestershire County Care Limited

Huntingdon Court

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
Huntingdon Court is a residential care home providing care to up to 40 people with a range of support needs. There were 19 people living at the service at the time of our inspection. The service provides support to older people some of whom are living with dementia.

Huntingdon Court is purpose built. It is split over two floors with communal areas on each floor.

People's experience of using this service and what we found
Risk was not always managed to ensure people were safe and protected from harm. Staff did not always follow people's care plans and risk assessments. Infection prevention and control procedures did not fully protect people, staff and visitors from the risk of infection. Staff were not always recruited in a safe way. We have made a recommendation about safe staff recruitment.

There was not a registered manager in post. There had been frequent changes of manager. While some improvements had been made, continued significant shortfalls and breaches to regulations remained. Quality assurance systems and processes failed to identify concerns relating to safe care. Leadership and governance were not effective and had not taken sufficient action to make the improvements required.

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.

Rating at last inspection
The last rating for this service was inadequate (Published 20 November 2020) and there were multiple breaches of regulation. The rating for the service has remained inadequate. This is based on the findings at this inspection. This service has been rated inadequate for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about people's care and support and infection control. A decision was made for us to inspect and examine those risks.

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 coronavirus 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.

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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Huntingdon Court 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 repeated breaches in relation to safe care and treatment, infection prevention and control and governance and quality monitoring. 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.

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 safe findings below.

Huntingdon Court

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 carried out by one inspector and one assistant inspector. In addition to this, a second inspector and assistant inspector made telephone calls to people's relative's and to staff to seek their feedback.

Service and service type
Huntingdon Court 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. There had not been a registered manager employed at the service since April 2019. The current manager had been in post since November 2020 and told us they were in the process of applying to become registered.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
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. This information helps support our

inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and six relatives about their experience of the care provided. We spoke with seven members of staff including the nominated individual, acting manager, two senior care staff and three care assistants.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two 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. We looked at training data and quality assurance records.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last three inspections the provider failed to ensure that care and treatment was always provided in a safe way. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Assessing risk, safety monitoring and management

- Risk was not always identified or managed in a safe way. One person was known to become disorientated; they had a history of becoming distressed. Records showed they had become distressed and displayed risky behaviour on a regular and frequent basis.
- Care plans and risk assessments did not provide sufficient direction for staff about how to manage this risk. Staff had recorded the action they had taken in response to each incident of recorded distress. Actions taken did not follow the care plan for this risk and demonstrated a lack of understanding by staff. Action taken by staff in response to distress such as physical and verbal aggression, did not include intervention in line with best practice guidance for the management of behaviour that challenges and did not always follow the care plan and risk assessments.
- There was very little evidence of staff providing comfort and reassurance. This person had a known condition which could cause pain but there was no evidence this had been considered as a trigger or any prescribed medicines for pain offered.
- This person also had a history of pressure sores and had been assessed as 'at risk' of developing pressure sores. Despite this, staff were not carrying out regular positional changes as instructed in the care plan for skin integrity. Records showed the person was in the same position for several hours at a time. This increased their risk of developing a pressure sore.
- Information about this person's dietary needs was contradictory. They had been assessed by the speech and language therapy service as requiring thickened fluids due to swallowing difficulties and risk of choking. The electronic care plan for nutrition made no reference to this nor did the weight audit analyses for January and February 2021, both of these documents recorded 'normal diet and fluids' were required. This presented a risk of harm.
- Another person had been assessed by a speech and language therapist as requiring a special diet due to swallowing difficulties. The care plan stated they must not be given bread, yet records showed they had been given bread. This put them the person at risk of avoidable harm.

Preventing and controlling infection

● There were ongoing issues in the premises and environment which put people and staff at risk of acquiring infectious disease. Flooring, walls and unpainted surfaces in communal bathrooms and toilets were not sealed adequately that would allow proper cleaning or disinfection.

● Some staff told us they changed into their uniform at the start of each shift in the staff toilet. There was limited space in the staff toilet and this area was not an appropriate clean and hygienic area for staff to get changed and put on personal protective equipment (PPE).

● The infection control audit was not detailed enough to ensure areas were cleaned or disinfected properly. Cleaning schedules were not detailed to ensure staff had clear instruction and ensure the premises were disinfected and cleaned in line with infection control guidance.

The provider failed to ensure that care and treatment was always provided in a safe way. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) 2014.

Staffing and recruitment

At our last inspection the provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. This was a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some improvement had been made at this inspection and the provider was no longer in breach of regulation 18. However, improvements were still required because the skill mix of staff did not always meet people's needs and staff were not always recruited in as safe way.

● Recruitment practices were not safe because the required checks and references were not in place for two members of staff. These checks are required to ensure staff employed have the right skills and experience and have not been prohibited from working with vulnerable people. We recommend the provider carries out checks with the Disclosure and Barring Service and obtains appropriate references on all new staff before employment is offered.

● Required staffing numbers were decided by looking at people's dependency needs and calculating the staffing hours required. Staffing rotas showed staffing numbers determined by the provider were met. However, some staff and one relative felt there were not always enough staff on duty.

● We continued to be concerned about staffing numbers in relation to one person who had complex and high dependency needs. Records showed this person got up during the night and displayed risky behaviour and often required staff to provide close supervision to keep them safe, during the day and night. It was not clear how staff could meet people's needs while also providing one to one support for this person, especially during the night when there were only three staff on duty.

Learning lessons when things go wrong

● People's health, safety and welfare were compromised. We identified breaches of regulations at our inspection of April 2019, our inspection 11 and 12 November 2019 and at our inspection 8 September 2020. While some improvements had been made, the provider was still in breach of these regulations at this inspection. This meant the provider had not taken enough action to improve.

● Improvements had been made regarding the management of falls for some people and the incidence of these had decreased since our last inspection.

● Improvements had also been made regarding assessing people's capacity to make decisions and

upholding their human rights.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider failed to ensure people were safeguarded 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) 2014.

● Some improvement had been made at this inspection, the provider was no longer in breach of regulation 13. However, improvements were still required because some relatives we spoke with lacked confidence in the managers and did not always receive a response when they raised concerns.

Using medicines safely
● People told us staff managed their medicines in the right way and they got their prescribed medicines at the right time. One person said, "Yes staff give me my medicines every day, they are pretty good".
● Staff had received training about managing people's medicines and had their competency assessed.
● Peoples medicines were stored securely and in line with manufacturers requirements.
● Medicine records were accurate and up to date.

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 inadequate. At this inspection this key question remains 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.

At our last inspection the provider failed to ensure they had effective systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people. This was a continued breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There had not been a registered manager at the service since April 2019. There had been frequent changes of manager. Relatives we spoke with expressed their frustration about this at our last inspection and again expressed these concerns at this inspection. The current manager was in the process of applying to become registered as the manager with the Care Quality Commission.
- At our inspection it was evident the managers knowledge of people's day to day care and support needs was limited.
- Systems for identifying, capturing and managing risks and issues were ineffective. Audits had not fully identified the deficiencies we found at this inspection.
- People's care plans and risk assessments were not always followed, and this put people at risk of harm. There were inconsistencies in some people's care plans and risk assessments. This meant there was a risk care and support provided may be unsafe.
- Changes had been made to improve staff access to care plans and risk assessments and other important information which may be required by medical professionals. It was too early to assess if these new systems were effective as they had not been fully embedded.
- Care plans and risk assessments had recently been updated and electronic systems for record keeping had changed. New care plans were person centred but not all staff had, had time to review the new care plans at the time of our visit.
- Despite having an outbreak of Covid 19 in November 2020, deficiencies were identified in the prevention of infection and infection control at this inspection.
- Staff were not always recruited in a safe way.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- While recently reviewed care plans contained comprehensive information about people's needs, people

and where appropriate their relatives, had not always been consulted.
● A relative told us about ongoing issues regarding their relatives' support and communication needs which had not resolved and this had an impact on their day to day quality of life.
● Activities such as games, arts and crafts were taking place. However, there was no evidence of people being able to follow their hobbies or interests or of any activities being provided in response to people's unique life and social histories.
● People had limited opportunities to keep in touch with their relatives during visiting restrictions during the Covid 19 pandemic. Relatives told us there were some opportunities for video calls and window visits, but these were infrequent and not always suitable for people or their relatives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Two people's relatives told us communication was poor and they had not been informed about important changes affecting their relative's health and wellbeing.
● Two people's relatives told us they had a poor experience contacting the manager and had still not received a response to their queries.
● The majority of staff we spoke with felt they were supported by their managers.
● Systems for obtaining feedback from people about the service they received were not robust. Minutes of 'residents meeting' had very limited feedback or participation by people who used the service recorded. There were no systems in place to obtain feedback for people with communication difficulties. People's relatives told us they had not been consulted or involved in developing care plans or asked for their feedback.

Continuous learning and improving 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
● The provider failed to use the findings from our last three inspections to drive enough improvements. At this inspection we found the provider was still in breach of legal requirements.

The provider failed to ensure they had effective systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people. This was a continued breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had been consulted about the meals provided since our last inspection and improvements had been made to the quality of meals and choices available. People had the adaptive equipment they required to facilitate independence with mealtimes such as plate guards.

Working in partnership with others
● Staff had worked with the local authority infection control team and staff had completed external training about infection prevention and control.
● People had access to healthcare and other professionals such as GP's, community nurses and local authority workers.