Leicestershire County Care Limited

Huntingdon Court

Inspection report

Regent Street
Loughborough
Leicestershire
LE11 5BA

Tel: 01509217474

Date of inspection visit:
30 April 2019
01 May 2019

Date of publication:
17 June 2019

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
Huntingdon Court is a care home and offers care and support for up 41 older people, some of whom are living with dementia. There were 39 people using the service at the time of our visit. We inspected the service on 30 April and 1 May 2019. The inspection was unannounced and was carried out in response to information of concern we received.

People's experience of using this service
Risk was assessed but management plans were not always sufficient to protect people from harm or were not always followed. Some risks in the environment had not been identified, the registered manager took action on the day of our inspection to address these environmental risks.

Staffing numbers and skill mix were not always sufficient to meet the needs of people who used the service or keep them safe. Many people were up during the night or getting up very early in the morning and there were only three staff on duty. This number of staff was not sufficient to monitor people at risk of falling or to attend to people's needs.

People mostly had their medicines managed in a safe way. Records were accurate and up to date and staff made sure people had their medicines at the right time and in the right way. However, one person's cream was past its expiry date and staff had some difficulty maintaining the room temperature of the medicine storage area at 25 degrees centigrade or below as per manufacturers guidance.

Slings for use with hoists to support people with mobility needs were used communally and this posed a risk of cross infection. Action was taken in response to an accident or incident such as providing assistive equipment such as pressure mats to alert staff when people were up and walking when they were at risk of falling. However, lessons had not been sufficiently learned in response to the high number of falls that occurred in March 2019.

People, staff and relatives were engaged and involved. However, people and staff views were not always acted on. The registered manager had not been aware that people's meals were not hot enough until we pointed this out. Staff were disappointed about the changes made to the medicine management and care planning systems and felt the new systems were less efficient and user friendly.

Staff were recruited in a safe way and checks were carried out to make sure as far as possible that only staff with the right character and skills were employed.

Staff understood their responsibilities to protect people from abuse and knew how to report their concerns.

The service was clean and fresh. Housekeeping staff followed cleaning schedules and staff had access to the protective equipment such as gloves and aprons.

The registered manager and area manager carried out regular audits to check that staff were working in the right way to meet people's needs and keep them safe. These checks were not always effective because they had not identified the risks and concerns we found during our inspection.
People and staff felt supported by the registered manager. They told us they were open, accessible and would listen to them.

The registered manager and staff worked in partnership with other authorities and healthcare providers to ensure that people benefited from joined up care.

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

Rating at last inspection
At the last inspection we rated this service Good (report published on 20 June 2018).

Why we inspected
This was a focused inspection based in response to information of concern. We received information about low staffing numbers and staff getting people up very early in the morning. We were also concerned about four specific incidents resulting in serious injuries which the provider had notified us about.

We have found evidence that the provider needs to make improvements. Please see the safe and well led domains in this report. You can see what action we have asked the provider to take at the end of this report.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received 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?

Requires Improvement

The service was not consistently safe.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

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 planned this inspection to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector and one assistant inspector.

Service and service type
Huntingdon Court is a care home. People in care homes receive accommodation and nursing or 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. The service is registered to accommodate 41 people. On the day of our inspection thirty-nine people were using the service.

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 focused inspection took place on 30 April and 1 May 2019 and was unannounced. The inspection was carried out as a result of information of concern we received.

What we did
Prior to this inspection, we reviewed information we held about the service such as notifications. These are events which happen in the service that the provider is required to tell us about. We also considered the last inspection report and information that had been sent to us by other agencies. We also contacted commissioners who had a contract with the service.

During the inspection, we spoke with six people who used the service and two relatives for their views about the service they received. We spoke with the registered manager, the area manager, the activities organizer,

four care staff, a trainee manager, two housekeepers and the senior care worker. We looked at the care records of five people who used the service. The management of medicines, staff training records, as well as a range of records relating to the running of the service. This included audits and checks and the management of fire risks, policies and procedures, complaints and meeting records.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: 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. Regulations may or may not have been met.

Assessing risk, safety monitoring and management
• Risks to people were assessed but their safety was not always monitored and managed. During the month of March 2019 there had been a high number of falls. There had been 11 falls at the service, four of which had resulted in a serious injury.
• The care plan and risk assessment for one person who had fallen had identified a falls risk. The care plan instructed staff to assist the person when they were mobilising with their frame and to use a pressure mat at night to alert staff when they were out of bed so staff could assist them with their mobility. This person fell and sustained a serious injury during the early morning when they had been in the communal lounge unaccompanied by staff. The person was found in the corridor having fallen.
• Some staff were also not clear about how to respond to a person when they became physically and verbally aggressive. On the day of our visit staff had not followed the person's care plan. This put the person and staff at risk of harm and did not align with best practice.
• A cupboard on the first floor containing an electrical fuse board was not locked and was accessible to people some of whom were living with dementia. The signage on the cupboard door instructed staff to keep it locked because of a danger of 240 vaults but there was no lock on the cupboard. Action was taken on the day of our inspection and a lock was fitted to the cupboard door.
• There was an electrical extension lead on the floor in an upstairs lounge with trailing wires and electrical trunking form the TV lead had come away from the wall. This was not risk assessed and was a potential trip and electrical hazard.
• One person had their blood sugar levels checked up to four times a day. The guidance for staff about what action to take if the blood sugar was found to be out of normal limits was not clear. On one occasion the person's blood sugar was below a safe limit but staff had not sought medical advice. There was no guidance for staff to take about how high the blood sugar could be before medical attention should be sought. Action was taken on the day of our inspection and clear guidance for staff to follow was put in place.
• One person had sustained a skin tear on their hand. Staff had applied a dressing but there had been no questioning or investigation as to how the skin tear had occurred or when the wound should be reviewed.

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

Staffing and recruitment
• We visited the service at 6 a.m. because part of the information we received was about people getting up very early in the morning. At 6.20 a.m. there were 14 people up and dressed for the day sitting in the main

lounge. Six people were asleep in their chairs. Nobody we spoke with said they had not wanted to get up so early, but two people told us staff had asked them to get up and they had not minded.
• There were three staff on duty and one of them was new to the service and was shadowing a senior member of staff until they improved their English language skills.
• Night staff told us all the people who were up and dressed had requested to get up early and that nobody had got up before 5 am. However, it was difficult to see how so many people had been supported to get up and dressed in one hour and 20 minutes with only three staff on duty.
• The registered manager told us staffing numbers and skill mix were calculated according to people's dependency needs.
• People we spoke with felt there were enough staff to meet their needs. One person said, "Staff walk with me, they won't let we go on my own."
• However, there were at least 10 people who required two staff when being supported with mobility and personal care needs, many people were living with dementia and some people were frequently getting up in the night and could be disorientated to time and place. If two staff were busy attending to people's needs then this left only one member of staff available for the remaining 38 people.
• A relative told us, "The only time we don't see them [staff] is when they're busy hoisting people before dinners."
• One person's care plan stated they were often up and walking about during the night. The care plan also stated they were 'unsteady on their feet' and 'needed encouragement to rest.'
• Another person's care plan stated they were frequently shouting and distressed during the night.
• There were not always enough staff to meet people's needs and keep them safe.

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 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• The provider followed a safe recruitment policy so they were as sure as possible only staff who were suitable to work at the service were employed. Checks were carried out such as a Disclosure and Barring Service (DBS) check and references. DBS checks made sure staff did not have a criminal record or had been barred from working with vulnerable people.

Using medicines safely
• Staff mostly managed medicines well. They had undertaken training and competency checks so they could give people their prescribed medicines safely. The provider had ensured a secure area for the safe storage of medicines and staff kept stock to a minimum.
• We found creams in one person's room had passed their used by date.
• Staff monitored the temperature of the medicine storage area and medicine fridge to ensure the temperature was maintained in accordance with manufacturers guidance. The medicine storage area was frequently at the top end of safe temperature (25 degrees centigrade), staff managed this by using a fan to bring the temperature down. However, in warmer weather the room temperature could not be maintained below 25 degrees centigrade. The registered manager told us they planned to buy an air conditioning unit when the weather became warmer.
• Staff had been given training to administer insulin and were then observed and signed off by the district nurse. Staff were not allowed to administer insulin until the home had received the certificate to confirm they were competent and safe to administer it.
• Where people were prescribed medicines only to be taken when needed, there were clear protocols in place so staff knew when to offer this medicine.
• There was no-one receiving their medicines covertly but staff knew this could only be done following a best interest decision involving appropriate healthcare professionals.

• Medicines were stored securely and records were accurate and up to date.
• There was recording of all medicines received into the home, administered and returned to the pharmacy. This meant there was a clear audit trail and staff could check that people had received all of their prescribed medicines.

Preventing and controlling infection
• The provider had systems in place to make sure staff practices controlled and prevented infection as far as possible. The majority of areas at the home were clean, fresh and tidy. However, one of the chairs in the upstairs lounge was heavily stained, the rotunda used for mobility was dirty and the floor in the medicine room was stained.
• Staff had undertaken training and were fully aware of their responsibilities to respond appropriately to protect people from the spread of infection. They followed good practice guidelines, including washing their hands thoroughly and wearing gloves and aprons appropriately. However, we observed one staff member carrying soiled bed linen and were holding it against their uniform and they were not wearing a protective apron.
• Hoist slings were used communally and this posed a risk of cross infection. People should have their own slings and they should not be used by other people, to prevent the spread of infection.

Learning lessons when things go wrong
• The registered manager had a system in place to check incidents and accidents.
They were fully aware of the increase in falls during March 2019 but had not identified any causal factors and action taken had not been effective to prevent further accidents.
• The majority of falls had been unwitnessed by staff.
• Care staff told us they should be in the communal lounges at all times to make sure people were safe. This was not always adhered to. We saw one person sitting alone in an upstairs lounge, the windows were open and they were cold, this person was living with dementia and was seeking comfort and support.
• While action had been taken for some people who had been identified as at risk of falling or had fallen such as providing pressure mats to alert staff when they were up and about, action taken had not always been effective.

Systems and processes to safeguard people from the risk of abuse
• People and their relatives felt people were safe at Huntingdon Court. One person said, "You're not frightened to ask for anything, I'd get my family to tell them (if they had a concern), I think they'd come and see me."
• People liked the security of the locked doors, with codes needed to get in or out.
• The provider had systems in place to protect people from abuse.
• Staff had received training and knew how to recognise the signs of abuse and how to report it. They were confident their managers would listen and take action if they reported any concerns.

Requires Improvement

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.

Requires Improvement: 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 requirement

• The registered manager and area manager carried out regular audits to check staff were working in the right way to meet people's needs and keep them safe. We saw auditing was not always effective and had not identified the risks and concerns identified at our inspection.

• People's personal information was not kept secure to maintain confidentiality. We found files containing personal information dated from 2017 in cupboards which were accessible to visitors and people within the home. The registered manager agreed that it was in breach of the General Data Protection Regulation and took immediate action. Locks were fitted to the cupboards during our visit.

• Staff were not clear about the eating and drinking needs for one person. This person was given a liquidised diet when there was no assessed requirement for this. The local authority had identified this error at their recent visit but despite this, some staff had not been made aware and continued to unnecessarily restrict the type of food this person could have. This meant that staff were not following the person's care plan and the registered manager was not monitoring the care given to people.

• One person had a very poor intake of food and fluids. Staff had sought medical advice about this on more than one occasion and were supporting the person to have their prescribed food supplements but had failed to monitor the persons weight or accurately record the action taken when food and fluid records showed a very low intake.

• The infection control audit had not identified the communal use of hoist slings.

• The heating in one of the upstairs lounges could not be controlled and this room was often too warm for people to use comfortably. This had not been identified as part of the environmental audit yet this issue was known to the registered manager.

• People who had lunch in the upstairs dining room told us the food served was not hot enough. There was no heated food trolley and meals were getting cold by the time they were served to people. We discussed this with the registered manager who put in an order for a heated trolley on the day of our visit.

• The specialist pressure reliving mattress for one person was set for a person who weighed 140kg but this person's weight was last recorded at 78 kg. This meant the person's risk of developing a pressure sore was not being managed or monitored effectively. The person maybe placed at risk of developing a pressure ulcer due to increased pressure from the mattress.

• The registered manager had carried out an environmental audit and development plan in January 2019 and had identified shortfalls and informed the provider of these. The registered manager had carried out many of the actions they had identified but was not aware of any timescales for when the maintenance issues beyond their control would be addressed. This included replacing the flooring in the medicine room and other maintenance issues.

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 breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• The service had a registered manager and they were supported by an area manager and senior care workers. We received positive feedback about how they managed the service.
• People knew the registered manager. People were confident they could raise issues with their relatives, senior staff and the manager and they would be dealt with.
• Staff told us they felt supported and gave high praise to the registered manager. A care worker said, "The manager is brilliant." Another staff member told us, "The registered manager is always supportive, accessible and always listens."
• The registered manager understood their legal duties and sent notifications to CQC as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Meetings were held for residents. The minutes of the last meeting held in March 2019 showed that people had asked for changes such as meals to be added to the menu and this had been actioned. People had asked to go out for day trips and the registered manager told us a boat trip had been planned for some people.
• Staff used a document known as a 'listening form' where they asked people about the care and support they were receiving and if there was anything they would like to change. One person had asked to go out more and staff were supporting them to visit their local pub at least once a month.
• The registered manager told us that wheelchair accessible transport would soon be available as the provider was purchasing a vehicle for use within their group of services.
• Staff told us they attended meetings and had opportunities to share their views and ideas. Staff had asked for new towels and flannels and these had been provided.
• The provider sent out surveys to people's relatives. The results were analysed and discussed at a resident and relatives meeting in October 2018.
• A staff morale survey had been carried out. The results showed that staff had requested an additional staff member and this had been actioned. However, this had since been reduced following further discussion with staff.
• Recent changes had been made to the medicine management system. The electronic recording system had been replaced with a paper based recording system. Staff were disappointed about this change and felt the new system was less efficient. This meant staff were not always actively engaged in developing the service.
• The electronic care planning system had also been replaced and some staff were also disappointed with this change and felt the new system was not as accessible or user friendly.

Continuous learning and improving care
• The provider had an internal support network of area managers and other registered managers. The registered managers and area managers within the group shared best practice and communicated changes within the sector for continuous improvement.
• The service had achieved a silver dignity award from the local authority quality assessment framework. This demonstrated that the service had exceeded the local authority's standard quality of service for dignity. However, we did identify practice during this inspection that did not always promote people's dignity.

Working in partnership with others

• Staff and the management team worked in partnership with other professionals and agencies, such as the GP and the local authority to ensure that people received joined-up care.
• The registered manager and area manager took immediate action where this was possible during our visit.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that care and treatment was always provided in a safe way. Risk was not always identified or managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure quality assurance systems were always effective and had not identified the risks and concerns we found during our visit.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staffing numbers were always sufficient to meet people's needs or keep them safe.