Leicestershire County Care Limited

Lenthall House

Inspection report

Lenthall Square
Market Harborough
Leicestershire
LE16 9LQ

Tel: 01858463204

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09 December 2021

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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
Lenthall House is a residential care home providing accommodation and personal care to 35 people aged 65 and over at the time of the inspection. The service can support up to 40 people accommodated over two floors.

People's experience of using this service and what we found
Risk was not always safely managed. As a result, people were left at increased risk of not receiving the care and support they required in a safe way.

Environmental safety concerns were found in people's bedrooms and communal areas. Alcohol based hand sanitiser and paraffin based topical creams had been left in people's bedrooms and communal areas. This increased the risk of harm to people.

Accidents, incidents and falls were dealt with appropriately. However, themes and trends were not always identified, and lessons were not always learnt when things went wrong.

Medicines were not always safely managed. People were not always receiving their medicines as prescribed. Medicines were not always being stored appropriately or administrated safely. This placed people at increased risk of harm.

There were not always enough staff to meet people's needs and to ensure care records were accurate and up-to-date. The provider was unable to evidence appropriate recording of up-to-date information within care records, care plans and risk assessments to ensure people's care was person-centred and achieved good outcomes for people.

Effective systems and processes were not always in place to maintain oversight of the service, or effective in identifying areas of concern. Achievable action plans were not always developed, and when action plans were developed there were not always clearly set priorities, timescales and ownership of each issue.

There was a distinct lack of lessons learnt at provider level. Several of the issues identified had previously been raised at other locations under the provider's registration and the same issues were found at Lenthall House.

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

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

People were supported by staff who had been recruited safely and who 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.

Effective infection prevention and control (IPC) policies and procedures were in place and the service was following best practice and Government guidance in relation to the management of COVID-19 and other infections.

The provider and management team had good links with the local communities within which people lived.

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 14 June 2018).

Why we inspected
We received concerns in relation to staffing levels, staff training, recurrent falls and a lack of management oversight. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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.

The overall rating for the service has changed from good to inadequate. 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lenthall 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 risk management, staffing, medicines, the environment and management oversight at this inspection.

We issued a Warning Notice requiring the provider to be compliant by 31 March 2022.

Please see the action we have told the provider to take at the end of this report.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

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

The service did not have a manager registered with the Care Quality Commission. An interim manager had been appointed on a temporary basis and did not intend to register with the Care Quality Commission. A peripatetic manager was supporting the interim manager. The peripatetic manager's role was to monitor and improve quality across the provider's services. This meant the provider was legally responsible for how the service was 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 two people who used the service and 14 relatives of people who used the service about their experiences of the care provided. We spoke with nine members of staff including the operations director, the peripatetic manager, the interim manager, one care team leader, two care assistants, the head cook, the maintenance person and the administrative assistant. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and 10 people's medication records. We looked at three 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.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People had access to items that increased the risk of harm to them. We saw six bottles of hand sanitiser containing a hazardous substance were accessible to people. Two of these were found in the dementia unit. We saw eight containers of moist alcohol wipes containing a hazardous substance were accessible to people. Four of these were found in the dementia unit. There were no risk assessments in place relating to these items. There was a risk people may ingest the contents of the bottles or be exposed to harmful fumes emitted by the alcohol wipes, which would be hazardous to their health.
- The provider had not acted upon a recommendation following a Fire Risk Assessment (FRA) on 19 August 2021. The FRA recommended improvements to the compartmentation to the kitchen area by linking the existing roller shutter into the fire detection and warning system. It was recommended this action be completed by 17 November 2021. A staff member told us this had not been completed as the risk assessment deemed this low risk and the provider had assigned no budget for this task. This put people and staff at increased risk.
- Food safety checks and procedures were not always completed. We saw no fridge temperature checks had been recorded between 10 November 2021 and 8 December 2021. We saw no labels had been attached to several food items to show when they were opened and when they needed to be disposed of by. This meant people were at risk of consuming foods that had potentially not been stored at the correct temperatures or disposed of within the correct timescales, which could lead to illness.
- Care plans and associated risk assessments were not always reviewed and updated in line with the provider's policies and best practice guidelines. We saw a report showing 24 people's care plans and associated risk assessments had not been reviewed since August 2021. This meant staff did not have access to up-to-date information relating to people's risks and how their care and support needs should be met. This put people at risk of not receiving the support they required.
- Lessons were not always learnt when things went wrong. Staff told us they reported accidents and action was taken. However, there were no records to support this. Safeguarding and accidents and incidents logs were missing and there was no evidence of lessons learnt. The management team were unable to provide specific information regarding prior accidents and incidents that had been reported to the CQC. The provider failed to ensure lessons were learnt and changes were made to improve the safety of people living at the service.

We found there was significant risk that people could be harmed. This failure to ensure people were protected from the risk of harm was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always managed safely. We saw some people required time-specific medicines and staff were not recording the specific times these were administered. These medicines were required to be taken on an empty stomach. There was no regimented schedule to ensure the effectiveness of these medicines and it was unclear based on care records exactly when people were being given medicines and food. This meant people were at risk of their medicines not being as effective as they should be and potentially experiencing worsening symptoms of their medical conditions.
● Medicines were not always stored safely. We found topical creams were left out and accessible in 13 people's bedrooms, including bedrooms in the dementia unit. In 10 of these people's bedrooms the creams were paraffin based. There were no risk assessments in place relating to these creams being stored in people's bedrooms. This meant people were at risk due to the flammable nature of some of these creams and the possibility of ingesting these creams, which would be hazardous to their health.
● Thickening powders were not stored appropriately. We saw thickening powders in the kitchen in the dementia unit which were accessible to people and no staff were present. Thickening powders are added to foods and liquids to bring them to the right consistency so they can be safely swallowed. The failure to store thickening powders appropriately put people at risk of harm of choking.
● Medicines were not always administrated safely. One person was prescribed a liquid medicine. We saw there was a significant shortfall in the amount of liquid medicine in stock when compared to the stock records. A staff member told us they could recall another staff member spilling a person's liquid medicine a few weeks prior. However, this was not reflected in the stock records and an incident of this nature had not been recorded anywhere else. The provider had not identified the shortage during audits. This meant the service could not evidence where this medicine had gone nor have oversight to ensure there was sufficient medicine available for the person.

We found there was significant risk that people could be harmed. This failure to manage medicines safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although we found some poor medicines practice, staff had received training and we did observe staff administering medicines in a safe way, treating people with dignity and respect. Staff demonstrated knowledge of each individual and were able to describe how each preferred to take their medicines.

Staffing and recruitment
● There were not always enough staff deployed to ensure people were cared for safely. Over a 24 day period consisting of 72 shifts we saw staffing numbers did not meet the requirements of the provider's dependency tool on 44 occasions. One relative told us, "[Name] is happy there but is worried about the staff shortages, all the changes and use of agency staff". Another relative said, "A lot of the staff have left and there are not enough staff". This put people at risk of not receiving the care and support they required at the times they required it.
● There were significant gaps in care records. The peripatetic manager told us staff had been instructed to focus on care tasks and only record the most important information due to staff shortages. This resulted in missing information, including whether personal care had been offered and accepted, whether people were being repositioned regularly and whether people were engaged in meaningful activities. This meant the service could not evidence people received the care and support they required. This put people at risk of deterioration in their physical and mental health.
● In addition, we found inaccuracies in recording due to staff shortages. Care records stated the same care staff were providing support to different people at the same times. Records showed on one day at 20:00 a staff member was supporting a person with continence care and checking their skin integrity at the same time they were supporting another person with repositioning, personal care and continence care. Other care

records demonstrated this was common practice. These inaccurate and false records meant we could not be assured people were receiving safe care and treatment.

We found there was significant risk that people could be harmed. This failure to provide sufficient staffing levels to ensure people were protected from the risk of harm was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. For example, Disclosure and Barring Service (DBS) checks 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.

Systems and processes to safeguard people from the risk of abuse
● People were being cared for by staff who had undertaken training in safeguarding procedures. Staff demonstrated awareness of safeguarding and whistle-blowing procedures and were able to describe how to safeguard vulnerable people. One staff member told us, "I have had training in safeguarding and know how to protect people from abuse and neglect. Safeguarding policies are kept in the office and we have access to them".
● People and their relatives told us they felt people who used to service were safe. One person told us, "I feel safe here". One relative said, "We feel [name] is safe and is well looked after". Another relative told us, "[Name] is safe at Lenthall House and it is a nice environment".

Preventing and controlling infection
● We were somewhat assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was no registered manager in place at the time of inspection. An interim manager had been appointed on a temporary basis but did not intend to register with the CQC. A peripatetic manager was supporting the interim manager. The management team were unable to describe in any detail the needs of people using the service and most care plans and risks assessments they had access to had not been reviewed and updated since August 2021. This meant the management structure was not always effective and made it difficult for people, relatives and staff to establish clear lines of communication.
- Systems and processes to allow the provider to maintain appropriate oversight and identify issues were not always completed. The peripatetic manager told us no audits were completed between April 2021 and September 2021. The peripatetic manager confirmed no trend analysis of falls, accidents and incidents had been completed since April 2021. This meant the provider could not demonstrate they had oversight of the quality of the service during this time and were not actively or sufficiently promoting a safe service.
- Audits were not always effective. We saw only three audits had been completed since September 2021 and did not independently identify areas of concern. Two of these audits were completed as a result of the Local Authority visiting in October 2021 and raising issues. We found during inspection several issues found by the Local Authority had still not been addressed. This failure to maintain oversight and identify issues demonstrated a lack of good governance.

The provider had not ensured they had effective systems and processes in place to assess, monitor and mitigate the risks to the health, safety and welfare of people using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- There was a distinct lack of lessons learnt at provider level. Several of the issues raised around environmental risks and medicines had been raised at other services under the provider's registration. The provider had not learnt lessons from this or communicated effectively with other services under their registration to ensure these risks were not present at Lenthall House. This failure to act on feedback for the purposes of continually evaluating and improving services demonstrates a lack of lessons learnt by the provider.
- Action plans were not always effective. We saw an Action and Development Plan was developed on 1 October 2021 and updated on 12 October 2021. The only progress had been with medicines following an

audit in November 2021. Whilst the action plan identified some issues raised on inspection and contained actions to be taken and by who, there was not always a priority rating given to each task, nor timescales for completion. There was no area for updates during reviews to demonstrate progress. This failure to develop effective action plans and progress them appropriately demonstrates a lack of good governance.
● The paper-based record keeping system was not effective when considering the number of people being supported, their level of need, the amount of information required to meet fundamental standards and the number of staff available to the provider. We saw care records were difficult to audit due to the level of cross-referencing required. The record keeping system did not allow staff to accurately record the time of care delivery, as records were routinely completed in bulk.

The provider had not ensured they had effective systems and processes in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● This service did not always promote a person-centred culture. The peripatetic manager told us staff had been instructed to focus on care tasks and only record the most important information. We saw significant gaps in care records and care recording was task-based rather than personalised to each person. We saw care plans and risk assessments were not reviewed and updated in line with best practice guidelines and the provider's policies. This meant the provider was unable to evidence appropriate recording of up-to-date information to ensure people's care was person-centred and achieved good outcomes for people.

The provider had not ensured they maintained accurate, complete and contemporaneous records in relation to people's care and treatment. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed feedback from staff and relatives regarding how supportive the management team were. Staff told us the regular changes to the management team had been unsettling. One staff member told us, "I do feel supported in my role in terms of my day-to-day responsibilities, but staff are expected to work long hours and this is not very supportive". One relative told us, "It is not well run or organised. The owners don't seem to care enough". Another relative said, "It is well run and organised. They are doing a superb job".
● Staff were knowledgeable about people who used the service and were able to describe people's likes and dislikes, as well as how they preferred their care to be delivered. One staff member told us, "I know people really well and we always make sure people get the care they need, but their care plans are not up to date and we don't always get time to read them".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Several people's relatives told us they did not feel involved in decisions about Lenthall House or their relative's care. One relative told us, "There are no options for relatives to join in meetings, not even video call meetings. Nobody communicates with you". Another relative said, "They have never discussed [name]'s care plan with me. I've only ever had a phone call to ask whether [name] can have a vaccination. Communication could be better".
● The management team worked with staff to identify improvements and address any issues they may have. One staff member told us, "Team meetings are being held every month and we are able to contribute to them. I do find them useful and I do think things change as a result." Another staff member said, "We are

asked our opinions around any improvements and can make suggestions or raise issues".
● People's equality characteristics were considered when sharing information, accessing care and activities. The peripatetic manager was able to demonstrate understanding of the importance of meeting people's equality characteristics and told us, "We can translate policies into different languages if necessary. We can also provide large print and braille copies. People's cultural needs and religious needs are met and we make changes to the menu for anyone who has dietary needs relating to their religion or personal beliefs".

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 was aware of their responsibilities under the duty of candour, which is a regulation all providers must adhere to. Under the duty of candour, providers must be open and transparent, and it sets out specific guidelines providers must follow if things go wrong with care and treatment.
● The provider had implemented a complaints policy and had provided information relating to this to all people, relatives and staff. There were posters in the communal areas advising people of who to contact if they had concerns. We saw complaints had been dealt with appropriately and responses had been provided to complainants in a timely manner.

Working in partnership with others
● The provider had established and maintained good links with local partners that would be of benefit to people who use the service, such as GP practices, community nurses and social work teams.

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 risk management, medicines and staffing were safely managed.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant by 31 March 2022.

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 and improve the quality and safety of the service.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant by 31 March 2022.