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 23 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
People did not always feel safe because staff did not always support or respect their freedom to make choices. Risk was not always identified or managed. Staff did not always follow people's care plans and risk assessments.

Staffing numbers were not sufficient to meet people's needs or keep them safe. Staff did not always have time to spend with people to meet their needs and keep them safe. Opportunities for people to follow their hobbies and interests were very limited and some people were bored and unoccupied for the majority of the time.

People were not protected from the risk of avoidable harm. There were a number of unwitnessed falls and opportunities to learn from accidents and incidents were missed.

Some people told us they not like the meals provided and no action had been taken to address this feedback.

Infection prevention and control procedures were not following expected government guidance and requirements. Staff did not routinely clean hoists between use for different people and shared hoist slings without cleaning in-between use. This meant people were put at increased risk of infection, this was of particular concern during the COVID 19 pandemic.

There was not a registered manager in post. There had been frequent changes of manager since our last inspection. There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high quality care. Quality assurance systems and processes failed to identify concerns relating to safe care. The provider was in breach of our regulations for the last two inspection and had failed to make the necessary improvements.

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 inadequate (Published 24 January 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.

We received concerns in relation to the management of the service and peoples care needs. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led.

We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. We also checked whether the Warning Notice we previously served in relation to breaches of regulation had been met. The overall rating for the service has remained the same following this focused inspection and is inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about care and support provided to people at Huntingdon Court. A decision was made for us to inspect and examine those risks.

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 see what action we have asked the provider to take at the end of this report.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, staffing and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 the 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 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. This inspection checked whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment), Regulation 17 (Good Governance) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by two inspectors.

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.

Notice of inspection
This inspection was announced. We gave the provider five minutes notice by telephone because we needed to check the current COVID 19 status for people and staff in the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection on 11 November 2019. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care

provided. We spoke with seven members of staff including the interim manager, team leaders, care workers and catering staff. We reviewed a range of records. This included care records of five people at the service and multiple medication records. 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. This included, but was not limited to staff rota's, dependency tools and audits.

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 inspection 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. We issued a warning notice requiring the provider to become compliant with this regulation.

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. One person was known to become disorientated and unsafe when walking on a daily basis and could become aggressive and distressed during personal care. The risk assessment and care plan did not sufficiently detail how to manage these risks. We saw this person was asleep in the lounge for the majority of the day and then became restless and agitated in the late afternoon. The staff member attempted to keep them safe by asking them to sit back down. Staff recorded in daily records this person was frequently restless, unsteady and unsettled, and had been found on the floor having fallen in the communal lounge. These concerns had been identified at our last two inspections in April and November 2019. The required improvements to ensure people were safe had not been made.
- Another person was resistant to personal care and at times became distressed when staff were supporting them. The care plan and risk assessment did not inform staff about what to do should this person refuse personal care and this had resulted in distress and did not support the persons freedom to make choices or to feel safe. This person told us they were upset when they had their hair washed due to how staff supported them.
- Risk assessments had identified risk of malnutrition and instructed staff to record complete food and fluid charts and to check these at every shift. However staff were not recording food or fluid intake for this person. This meant staff were not monitoring food and fluid intake so could not take action when they did not have enough to eat or drink.
- The care plan for skin integrity had identified risk of developing pressure sores and stated the person should sit on a pressure cushion. We saw they did not have a pressure cushion in their chair. The risk of developing a pressure sore was not being managed.
- The care plan for one person instructed staff to support at mealtimes by making sure their food was cut up into smaller pieces. We saw this person struggling to eat their lunch which had not been cut up. Records showed this person was at risk of malnutrition and had a low body weight.
- Records of accidents and incidents showed there had been 11 accidents in August 2020, eight of these were unwitnessed falls. There was very limited evidence of action taken to prevent further accidents and this section of the accident record was left blank. There was no audit or analysis of accidents and incidents or

any consideration of what action could be taken to reduce the risks.
● Three people's personal evacuation plans had not been updated since 2019 and did not reflect their current needs. The evacuation plans recorded people could walk with assistance but they could not and were reliant on staff using a hoist for all transfers. This meant information to be used in the event of an emergency was not accurate.
● A hoist sling label was ripped and illegible, staff were continuing to use the sling when they had no way of knowing if it was safe to use because they could not read the label.

Preventing and controlling infection
● We observed staff sharing hoist slings between people and not cleaning the hoist before use with another person. This put people at risk of infections and was of particular concern during Covid 19.
● A commode in a person's room was stained and damaged making it impossible to clean effectively.
● There was no recent infection prevention and control audit carried out and these issues had not been identified.

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. We issued a warning notice requiring the provider to become compliant with this regulation.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Some staff felt staffing levels were too low to safely meet people's needs and keep them safe. A staff member told us they worked long hours without a break and some staff were working excessive hours every week. Staff rotas showed that a few staff were regularly exceeding 50 hours a week and one staff member had a worked a 75 hour week. This posed a risk that people could receive unsafe care and support.
● Required staffing numbers were decided by looking at people's dependency needs and calculating the staffing hours required. Staffing rotas showed staffing numbers frequently fell below those determined by the provider. Five of the unwitnessed falls recorded for August occurred in the afternoon/evening time when staffing numbers were below those determined by the provider.
● Six people required two staff to attend to them because of their mobility needs. Two people had complex mental health needs and were entirely dependent on staff for all their needs and to keep them safe. Staffing numbers fell below numbers determined by the provider's assessment and were not sufficient to meet people's needs or keep them safe.
● Two people told us they were bored and there was nothing to do, there was no separate staff to facilitate activities and care staff were expected to provide these in the afternoons. We saw people sitting in the communal lounge without occupation or stimulation for the majority of the day. Many people were asleep. Two relatives told us they were concerned about the lack of activities and stimulation.
● These concerns had been identified at our last two inspections in April and November 2019. The required improvements to ensure people were safe had not been made.

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 continued breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Appropriate checks were carried out and references were obtained before staff commenced employment. This meant so far as possible, only staff who were suitable to work at the service were employed.

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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Two people told us they didn't feel safe or have choices about their care. They told us they could not go to bed or get up at the time of their choosing. Staff told us these people's relatives had asked staff not to allow them to go to bed before a certain time of day. This was done without consideration of people's capacity to make decisions and without an agreed best interest decision. This did not uphold people's human rights or freedom to make choices.
● Some staff did not have confidence in the provider and did not feel supported because of a lack of consistency and frequent changes of manager. Staff did not receive supervision and therefore had limited opportunities to raise concerns they may have. Other staff told us their managers would listen to them and take action where required.

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.

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 and at our inspection 11 and 12 November 2019. The provider was still in breach of these regulations at this inspection. This meant the provider had not taken sufficient action when things went wrong and did not learn lessons in order to improve.
● There was very little information recorded about remedial action taken following falls and accidents, this meant the provider did not learn from accidents and incidents and did not use them as an opportunity to learn and improve.

Using medicines safely
● People told us staff managed their medicines in the right way and they got their prescribed medicines at the right time.
● 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. We issued a warning notice requiring the provider to become complaint with this regulation.

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 and some staff expressed their frustration about this. Relatives told us there were ongoing issues that were never sorted out because the managers kept moving on or leaving their employment.
- Systems for identifying, capturing and managing risks and issues were ineffective. Audits had not been carried out or had not 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. Care staff did not routinely access the comprehensive care plans stored electronically and therefore may not have all the information required to provide person centred, safe care
- Staff did not always clean equipment such as hoists and slings between use for different people. This did not always protect people from the risk of infection and this was particularly concerning during the Covid 19 pandemic. There was no recent infection control audit which may have identified this issue.
- There was no analyses and limited action taken in response to accidents or incidents in order to reduce further risk and reoccurrence.
- . Staffing numbers determined by the provider were frequently not met. This meant staff did not always have time to meet people's needs and keep them safe.

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

- The culture at the service was not person centred. Two people told us they were unhappy about the day to day routines as they were not always given choices. People said they were bored and did not have enough to do.
- Many people went to bed early and got up early in the morning. It was not clear if this was because there

were not enough staff, because there was a lack of activities or stimulation or if it was people's personal choice. People were unable to tell us this as many people were living with dementia.
● We received a mixed response from staff about the support they received from their managers. Some staff felt they were supported, but others felt they had raised concerns and no action had been taken.
● Staff had not received supervision with their managers and this was a missed opportunity for staff to discuss their learning and development needs or to discuss any concerns they may have.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems for obtaining feedback from people about the service they received were not effective. Staff used listening forms and had residents meetings but these had not been used for several months.
● People did not like the meals provided and had raised this with staff but no action had been taken.

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 two inspections to drive 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.
● A socially distanced meeting for peoples relatives had taken place to discuss the response and visiting arrangements during the Covid 19 pandemic.

Working in partnership with others
● Professionals expressed some concern regarding frequent changes of management and the negative affect this had on communication and the lack of progress to improve.
●People had access to healthcare and other professionals such as GP's, community nurses and local authority workers.