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 responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Huntingdon Court is a care home providing accommodation and personal care for up to 43 people aged 65 and over who may also be living with dementia. At the time of the inspection people were using the service. Accommodation is provided over the ground and first floor with communal lounges and dining areas.

People's experience of using this service and what we found
People were not always safe because risk was not managed effectively. Risk management plans were not robust. Systems and processes to manage risks of malnutrition and dehydration were haphazard and risked delays in identifying when people did not have enough to eat and drink and therefore delays in taking action and seeking medical attention. Some people identified at risk of falling continued to fall and sustain injuries.

Some people had complex needs and required supervision to keep them safe and to provide reassurance. Staff did not always have time provide this support and reassurance. Staff did not always have time to ensure people had a shower or bath at their preferred time.

Care and support did not always meet people's needs and preferences.

Leadership and governance was not effective and did not identify risk, drive improvement or seek and act on feedback from people.

The service was clean and fresh, and staff followed infection prevention and control and government guidance about the control of COVID-19.

Staff were recruited in a safe way because pre employment checks were carried out.

Staff had training and managed people's medicines in a safe way.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was requires improvement (published 27 July 2021) The service remains rated requires improvement. This service has been rated requires improvement or inadequate for the last five consecutive inspections.

Why we inspected

We received concerns in relation to the care and support provided to people and the leadership and management of the service. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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 full report.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to safety, the management of risk and oversight and leadership.

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.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led 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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Huntingdon Court is a 'care home'. People in care homes receive accommodation and nursing and or personal care as a single package under one contractual agreement dependent on their registration with us. Huntingdon Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. Since the inspection, a registered manager application has been received.

Notice of inspection
This inspection was unannounced.

What we did before 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with six members of staff including two area managers, two care team leaders and three care workers.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating ahs changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risk was not managed effectively. Two people were known to be at risk of falling, measures in place to reduce the risk were not effective because they had further falls resulting in injuries. One person fell from their bed during the night and was not discovered until the following morning, records did not support the checks staff were supposed to carry out had taken place. Another person with advanced dementia was at high risk of falling when mobilising yet continued to have unwitnessed falls.
- Three people identified at risk of malnutrition and dehydration did not have their food and fluid intakes recorded or checked each day. Systems were reliant on staff reporting each time a person did not eat or drink enough. This system was not robust and risked delay in identifying insufficient food and fluid intakes or opportunities to intervene and offer alternatives or additional food and drink.
- People's personal evacuation requirements in the event of a fire or emergency were not up to date. This was addressed on the first day or our inspection. However, managers had not identified this risk until we pointed it out.
- We saw an entry in the daily records of a person being found on the floor in their room by night staff having fallen, however there was no corresponding accident record and therefore no record of this risk being assessed or managed.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staffing numbers were calculated using a dependency tool based on people's needs. However, some people had complex needs and required staff supervision and support to keep them safe. It was not clear how the staffing numbers determined could provide this monitoring and supervision when more than one person became distressed or required support with mobility.
- Staff were very busy. Some staff told us there were not always enough staff on duty to meet people's needs. This resulted in them not always being able to offer people a bath or shower because they did not have time.

Staffing numbers were not sufficient to meet people's needs or keep people safe. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited in a safe way because pre employment checks were carried out to ensure as far as possible only staff with the right skills and experience were employed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Staff had training and understood their responsibility to report abuse. However, we were told about an allegation of abuse which had not been reported to the local authority or to the Care Quality Commission (CQC).
● Another incident occurred where a person sustained bruising caused by staff fingernails. This incident was not reported to the CQC. Systems and processes to protect people from abuse had not identified this risk to people during moving and handling.

People were not always protected from the risk of abuse. This was a breach of regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider had a history of non-compliance with our regulations since 2019. The breaches of regulation we identified at this inspection were continuing breaches or where improvements had been made, they had not been embedded or sustained.
● The local authority identified breaches to their contract, and this included staff not being aware of people's decisions regarding resuscitation. This concern had previously been identified but had not been addressed by the provider.

Using medicines safely
● People received their medicines in a safe way. Staff had training and had their competency assessed.
● Medicines were stored securely and correctly. Staff checked room and fridge temperatures daily to make sure they were correct.
● Records were accurate and up to date.
● Protocols were in place for medicines prescribed on as required basis. This meant staff knew when these medicines should be given. However, staff were not clear about when insulin should not be given if a person with type one diabetes blood sugar was low.

Preventing and controlling infection
● 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 that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Visits were mostly managed in a safe way, however, two visitors in the communal lounge were not wearing face masks and there was no evidence this risk had been considered or any risk assessment in place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care and support was not always planned and delivered to meet people's needs and preferences. People's recorded personal care needs were not always followed. One person's care plan instructed staff to monitor for signs of dehydration but did not instruct staff about ensuring they had enough to eat and drink each day. Another person had complex mental health needs but their care plan did not sufficiently identify the risks associated or what staff should do when they became upset or distressed.
- At the time of our inspection care plans and risk assessments were changing over to an electronic system. We were told this system would be more efficient and easier for staff to access and use. As well as this, a system was being developed to ensure staff could quickly identify people's decisions about resuscitation and other important information.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The service was not meeting this standard. This was identified at our inspection in June 2021. The previous manager told us they were in the process of developing their policies and procedures to ensure people using the service had information in formats accessible to them. There was no accessible information policy available at the time of this inspection or any evidence to show this standard was being met.

Improving care quality in response to complaints or concerns

- The provider had a complaints procedure but there were no recorded complaints at the time of our inspection.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to maintain relationships with their friends and family.
- There were a range of activities available to people including visits to shops and facilities in the town of Loughborough.
- Some people had complex mental health needs and staff used sensory activities such as music and singing and we observed people enjoying this activity.

End of life care and support

- People's advanced end of life preferences were recorded.
- Staff consulted with healthcare professionals such as GP's and community nurses about pain relief and symptom control.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- A new acting manager commenced employment at the service on the second day of our inspection. The service was being managed by area managers; however, they did not have a detailed knowledge of people's needs and risks and were reliant on care team leaders for this information.
- The last acting manager left their employment suddenly on 5 May 2002. There had been several managers at the service since 2019 and this created a lack of consistency for people and staff. There was a lack of leadership and oversight and a failure to make or sustain improvements.
- Ineffective risk management was identified at our inspection in November 2019 and the provider had not made the required improvements or had not successfully sustained improvements to an acceptable standard in this time.
- Risk management was not effective. Identified risks such as risk of malnutrition, dehydration and risk of falling were not managed. This was despite known risks such as two people regularly going for long periods of time without food or fluids because of their mental health.
- Systems and processes to ensure people had enough to eat and drink were haphazard and did not manage the risk. There was a lack of oversight and accountability, food and fluid intakes were either not recorded or where they were recorded, no one was checking if daily amounts consumed were sufficient for each person.
- Several people had complex mental health needs and required close supervision to make sure they were safe and not distressed. If this additional support was required at the same time, there would not be enough staff to manage their needs or the needs of other people using the service. In particular at night when there were only three staff on duty.
- Daily care records were poorly completed and unsigned. This issue had been identified and raised at a staff meeting in April 2022, but this issue had not been resolved. Systems for documenting care and support and risks were being changed from paper records to an electronic system. We were told this system would improve record keeping.
- The culture of the service did not always achieve good outcomes for people. People did not have access to regular baths or showers. Records showed baths and showers were not always being offered. Some staff felt they did not have time to offer baths and showers when they were busy meeting people's needs and keeping them safe. The provider's own policies and procedures required people to be offered at least one bath or shower per week, but this was not taking place. This issue had also been raised at a staff meeting in

February 2022 but still had not been addressed or resolved.

● There were very limited mechanisms in place to engage and involve people who use the service or to gain feedback about their experience of care and support provided. The provider used a form known as a 'listening form' to gather people's feedback and views. There were no recent examples of this form being used.

The provider failed to provide consistent and effective leadership to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); This was a breach of Regulation 17(1) Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others

● Leicestershire County Council carried out a contract monitoring visit on 28 April 2022. They found the service was not compliant with the core contract in those areas monitored at the visit.

● Staff consulted with healthcare professionals such as community nurses and GP's and followed their guidance and advice

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

● We were given an example of when the provider was open and honest with the appropriate family members following an incident resulting in a serious injury.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers were not sufficient to meet people's needs or keep them safe.