Leicestershire County Care Limited

Curtis Weston House

Inspection report

Aylestone Lane
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11 November 2020
17 November 2020
23 November 2020

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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
Curtis Weston House is a residential care home registered to provide personal care and accommodation for up to 44 younger and older adults. People using the service had a physical disability, sensory impairment, dementia, mental health needs and a learning disability or autistic spectrum disorder. At the time of our inspection there were 27 people using the service.

Accommodation is split across two floors accessed by a lift. Communal areas include lounges, bathrooms and toilets.

People's experience of using this service and what we found
At the time of our inspection there was an outbreak of COVID-19 at the service. We found multiple failings in the service's infection prevention systems and processes which increased the risk of the transmission of COVID-19, and placed people at increased risk of harm.

Concerns relating to safe care and treatment and protecting people from harm and abuse had not been resolved since the last two inspections. Whilst care plans were more person centred, they were not always reflective of people's needs, and staff did not always follow them. Only senior staff had access to the most up to date electronic care records for people.

People were at risk of not receiving medicines as prescribed and at the time they needed them during the night as there were not always staff working at night that could give medicines.

There was no registered manager at the service, a new management team had been recruited and had recently commenced their roles. Initial feedback from staff about the new management team was positive.

Quality assurance systems and processes had not identified the concerns we found during this inspection. Care records were often undated or not timed. Information relating to the care that people received was stored in multiple locations and at time misfiled. This impacted on the management teams' ability to maintain oversight of the service. Opportunities to improve care had been missed as audits of care records had not always been undertaken.

Staff were committed to their role. We observed kind and caring interactions throughout our inspection.

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 11 August 2020) and there were multiple breaches of regulation.

Following our inspection (supplementary report published 16 April 2020) the service was placed in special measures. We imposed conditions on the provider's registration in March 2020 as they were in breach of the regulations. The provider completed an action plan after this last inspection to show us how they would meet these conditions. A monthly report was sent to CQC detailing progress. At this inspection and the inspection in (published 11 August 2020) not enough improvement had been made or sustained by the provider, therefore the service was still in breach of regulations. The service retains an Inadequate rating.

Why we inspected
We received concerns in relation to infection prevention, accidents and incidents, staffing, documentation, moving and handling and the leadership at the service. 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 remains 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 see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Curtis Weston 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 safeguarding, safe care and treatment and good governance at this inspection.

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 remains 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 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 well-led findings below.

Curtis Weston 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 carried out by three 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
Curtis Weston 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. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been recently appointed, they told us they intended to register with the CQC.

Notice of inspection
This inspection was unannounced.

Phone calls to relatives and staff were undertaken on 11 November 2020. Inspectors visited the service on 11, 17 and 23 November 2020.

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 used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and nine relatives about their experience of the care provided. We spoke with fifteen members of staff including the manager, compliance and care standards officer, care, laundry and domestic staff. We also spoke with an independent consultant employed by the provider.

We reviewed a range of records. This included eleven people's care records and a sample of medicines 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. We looked at training data, policies, quality assurance records, risk assessments and care records.

Inadequate

Is the service safe?

Our findings

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

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

At our last inspection the provider had not ensured that all the relevant information was in place to protect people from harm and that potential risks to people had been identified. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment and Regulation 13 safeguarding service users from abuse and improper treatment.

We imposed conditions on the provider's registration in March 2020 to ensure all care plans and risk assessments for people were updated and disseminated to staff, and for all staff supporting people with personal care to receive training in safe breakaway, sexuality and relationships, positive behaviour support and safeguarding adults.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 and regulation 13. Whilst the provider had made some changes to risk management, not enough action had been taken to manage the risk and keep people safe.

Preventing and controlling infection

- There were multiple failings in the provider's infection prevention systems and processes, including but not limited to; using incorrect cleaning products; no deep cleaning of bedrooms of COVID-19 positive people; no enhanced or more frequent cleaning to include high touch areas such as door handles and light switches; bedroom door of a person with confirmed COVID-19 left open; fans were being used; hoists not cleaned between use; bathrooms cleaned a minimum of once daily and some days not at all. These factors all increased the risk of transmission of COVID-19.
- Hoists slings used to support people with their mobility, were not always named, were not washed regularly and were stored together. This increased the risk of cross infection because hoist slings may have been shared rather than allocated individually.
- Staff did not always have ready access to the Personal Protective Equipment (PPE) the service had assessed as being required for people with COVID-19. For example, visors were not readily available on PPE stations outside the bedrooms of people with COVID-19. We also observed alcohol free hand sanitiser on a PPE station. This would have been ineffective in eliminating bacteria as the recommended minimum alcohol content for hand sanitiser is 60%.
- Whilst visitors temperatures were checked on arrival to the service, there was no screening of COVID-19 symptoms or a requirement for visitors to register their contact details for track and trace.
- Staff did not always change their face masks regularly during their shift, we observed staff return from breaks and continue to wear the same face mask. One staff member told us they didn't change their mask on their shift and did not know they needed to.
- The risk of transmission of COVID-19 was exacerbated as there was an outbreak of COVID-19 at the service

during our inspection. This placed people at risk of harm. A relative told us they were concerned about COVID-19 and that the service, "Have got it again".

Using medicines safely

● Protocols were in place to administer medicines as required. However, we found there were not always competent staff working at night to administer these medicines. This put people at risk of not receiving their medicines as prescribed and when needed. For example, medicines to help people to sleep, for distress and to manage people's pain.

● Audits of Medicines Administration Records (MAR) were undertaken, which recorded actions taken to address some areas for improvement. For example, recording the reason for declining medicines on the MAR in addition to people's care records. However, for outstanding actions it was not clear who the tasks had been assigned to.

Assessing risk, safety monitoring and management

● Risk assessments for people with COVID-19 did not specify an end date for their isolation and staff we spoke with told us different dates for people's isolation ending. At our inspection in June 2020 we identified a person with COVID-19 had accessed communal areas. At this inspection we found this had not been resolved. Care records evidenced two people with COVID-19 had accessed communal areas in a two-week period prior to the inspection. There was no risk assessment in place, to instruct staff of the actions they needed to support these people to isolate effectively.

● 20 people at the service had lost weight between October to November 2020. Four of these people's Body Mass Index (BMI) meant they were underweight. Records showed these people had not always been offered snacks during the morning, afternoon and evening. Where people had declined meals, they had not always been offered alternatives, or re-offered a meal later. This put them at risk of weight loss and malnutrition.

● Risks had not always been assessed. For example, we observed one person using a mobility scooter indoors, another person at the service became visibly anxious as the scooter reversed towards them. A risk assessment had not been undertaken for the use of the scooter indoors. This meant control measures had not been put in place to reduce risks to people.

● Care plans and risk assessments were not always followed. One person's care plan stated a 'crash mat' should be in place, instead we found a sensor mat in place. This would not have reduced the risk of injury should the person have fallen from their bed. Another person was at risk of falling, we observed them trying to stand from their bed. Their walking aid was out of reach, there were no sensors in place to alert staff to their movements as detailed in their care plan and the call bell was wall mounted, meaning should they fall they would be unable to alert staff.

● Two people had locking mechanisms installed on the outside of their bedroom doors. Staff confirmed one person's lock had been used in the past at night, and one persons was in use at night to prevent other people entering their bedroom. This meant people were not free to leave their bedrooms at night and there was an increased risk of a delayed evacuation in the event of a fire. Least restrictive options had not been explored.

Learning lessons when things go wrong

● Accidents and incidents were recorded and reported. However, we found some accident and incident records were misfiled. Accident and incident reports reviewed showed there was rarely an analysis concluded to determine the cause of the incident or any actions taken to reduce further risk.

● There had been no audit of records where staff recorded distressed behaviours for people for four months. This meant opportunities to identify themes, trends and causes of distressed behaviours had been missed. Therefore, no changes had been made to people's care plans.

Systems were either not in place or robust enough to demonstrate infection prevention was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service accessed COVID-19 testing for staff and people living at the service and encouraged people to socially distance within the service.
● Damaged flooring identified during previous inspections as being an infection risk had been replaced and new furniture had been purchased.
● MARs contained people's details including a photograph ensuring the correct person was administered the medicines.

Systems and processes to safeguard people from the risk of abuse
● One person's care notes detailed episodes of distress and declining personal care and meals. They had lost 5kg in a month. Despite, a condition of their Deprivation of Liberty Standards (DoLS) authorisation being to update their care plan as their needs changed, the person's care plan and risk assessment did not fully reflect the change in their care needs.
● Staff told us one person often tried to leave the service. Despite this known risk, on both days of inspection we observed this person to be unsupervised, with access to fire doors that opened externally.

Systems were either not in place or robust enough to protect people from abuse and improper treatment. 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.

Staffing and recruitment
● Staff told us there were enough staff to meet people's needs. However, we observed staff had very little time to spend with people undertaking activities. We observed and staff told us, people were spending longer periods of time in bed. No action had been taken to address this.
● One relative told us at night, "[Name] has to wait a long time for someone to help them to the toilet. It can take an hour."

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 has remained the same. 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 we found people had been harmed or were at risk of harm as systems and processes were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We imposed conditions on the provider's registration in March 2020 to ensure all care plans and risk assessments for people were updated and disseminated to staff; for all staff supporting people with personal care to receive training in safe breakaway, sexuality and relationships, positive behaviour support and safeguarding adults; for an adequate risk assessment and safeguarding children's training to be in place should nursery children visit; and to ensure people were not admitted to the service without prior written agreement of the CQC.

Not enough improvement had been made at this inspection and the provider was still in breach of regulations 12,13 and 17.

This is the third inspection since March 2020 rated Inadequate. There had been a failure to make the necessary improvements, therefore the provider remained in breach of regulation 17. Quality assurance systems and processes had not identified the concerns found during the inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was no registered manager in post. A manager and deputy manager commenced employment during our inspection. The manager told us they intended to register with the Care Quality Commission, initial feedback from staff about the new manager was positive.
- Inconsistent leadership contributed to the failings identified during this inspection. The service failed to make the necessary improvements following inspections in March and June 2020.
- Quality assurance systems and processes did not identify the concerns we found during the inspection and were not always effective in driving improvements. For example, care plans had been reviewed but did not always reflect people's current needs. Records relating to people's distressed behaviours had not been audited for four months meaning opportunities had been missed to review care plans and risk assessments to reduce distressed behaviours. Medicines audits had not identified occasions when night staff were unable to administered medicines because they had not been trained to do so.
- The service did not always follow its own risk assessments and policies. For example, the COVID-19 risk assessment required cleaning of high touch and communal areas a minimum of three times a day using a chlorine based cleaner, this did not happen. We found communal areas were cleaned once daily and there

were days bathrooms had not been cleaned at all. The risk assessment also stated 'gloves, masks, visors and aprons are readily available'. We found whilst aprons and gloves were readily available, visors and facemasks were not distributed through the service for staff to access promptly.

● Staff recorded the delivery of people's care in multiple records and locations, some information was misfiled, and records were not always timed and dated. This impacted on the manager's ability to identify areas for improvement and meant health and social care professionals could not easily access records they may require.

● Staff were required to undertake an 'e-competency' assessment after they had undertaken an online training course. We found compliance with this was poor. For example, only 15 out of 38 staff had undertaken the infection control e-competency and 13 out of 38 moving and handling. Furthermore, 20 staff had not undertaken their basic life support training that was required annually. A new member of staff had not received any training prior to them delivering care.

● There was no reliable on-call system in place for staff to contact managers outside their usual working hours. One staff member said, "There is not always a person on call." Staff relied upon calling each other for advice and support, with two staff telling us they would attend out of hours if needed to give medicines.

● A room containing confidential data was not secured. This information had not been processed in line with the General Data Protection Regulation (GDPR).

● The service had not always submitted legal required notifications to the CQC.

● Staff had not received regular supervision. This meant they were not given this opportunity to discuss their learning and development needs or discuss any concerns they may have.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us they had not had the opportunity to provide feedback on care. Staff meetings had not been undertaken during the pandemic. The new manager told us, they planned to undertake these.

Systems and processes were either not in place or robust enough to demonstrate the regulatory activity was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the second day of inspection, the provider submitted an action plan detailing how they intended to address concerns identified. On the third day of inspection, we found action had been taken to address the most urgent concerns. However, newly implemented systems and processes needed to be embedded and sustained in practice.

● We received positive feedback from staff that had attended safe breakaway training in October 2020.

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

● Improvements had been made to people's care plans and risk assessments to personalise them and staff knew people well. However, staff did not always have access to the electronic care plans and risk assessments or time to read them.

● Relatives told us they had not always been involved in care plan reviews.

● People had limited opportunities to engage in activities of interest. This had been further impacted by the need for people to isolate in their rooms during an outbreak of COVID-19 at the service.

● Staff we spoke with, were committed to their role and willingly worked additional hours to ensure people received care from familiar staff. A staff member told us, "I lived here during COVID-19(early pandemic) and spend more time here than home." Staff spoke positively about the people they cared for and we observed

kind and caring interactions with people during our inspection.
● Relatives told us, they had enjoyed socially distanced visits in line with government guidance.

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 management team were aware of the duty of candour, which sets out how providers should explain and apologise when things have gone wrong with people's care.
● Without exception all relatives told us the service informed them if their relative had an accident or fall. One relative said, "[Name] has had some falls, no injuries. Staff ring me up each time."

Working in partnership with others
● The service worked closely with other health professionals such as community nurses and the GP. District Nurses had trained care staff to undertake dressings. Referrals had been made via the GP to dietitians at the services request.