Healthcare Homes Group Limited

St Leonards Court

Inspection report

6 St Leonards Street
Mundford
Norfolk
IP26 5HG

Tel: 01842878225
Website: www.healthcarehomes.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Leonards Court provides accommodation and personal care for up to 25 older people some of whom may be living with dementia. At the time of our visit there were 22 people using the service. The home is situated in the village of Mundford in Norfolk.

People's experience of using this service and what we found
People were not always receiving safe care and treatment. Allegations of abuse or harm had not always been reported to the local safeguarding team or the Care Quality Commission (CQC). We could not be sure that these allegations had been dealt with appropriately or that action had been taken to prevent a reoccurrence. During the inspection we made safeguarding referrals to the local authority safeguarding team. There was not always effective oversight or management of incidents which had occurred. As a result, staff were placing themselves and others at risk. Incidents recurred and people were harmed. The manager took immediate action to ensure safeguarding procedures were followed to keep people safe.

Infection, prevention and control measures were not always being followed to prevent the spread of infections. Staff had received training and regular information updates throughout the pandemic. Infection control and cleaning audits were being undertaken to identify any issues quickly so that action could be taken to make any improvements.

Risk assessments had been completed to reduce risks to people's health and safety when possible.

Staffing levels were sufficient to meet people's needs in a timely manner. Vacant roles had recently been recruited to. Recruitment procedures were followed to ensure that staff suitable to work with vulnerable people were recruited.

Safe management of medicines procedures were being followed to ensure people received their medicines as prescribed. When errors in the administration of medication occurred, these had been identified and action taken to prevent a reoccurrence.

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 (report published August 2018).

Why we inspected
We received concerns in relation to staffing levels, the cleanliness of the home, and people not receiving adequate personal care. 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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings 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.

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.

Since the inspection the provider has taken steps to mitigate the risks. Processes have been put in place to ensure that all safeguarding concerns are reported to the local authority and the Care Quality Commission. The allocation of staff now ensure that there is a member of staff present in the communal areas during the daytime to support and monitor people.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Leonards Court 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 keeping people safe from harm. Please see the action we have told the provider to take at the end of this report.

We also identified that not all notifications had been sent to the Care Quality Commission as required. We are continuing to investigate this.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St Leonards 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.

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
Two inspectors carried out this inspection.

Service and service type
St Leonards 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 had a new manager who was applying to be registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before the 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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with three people who used the service about their experience of the care provided. We spoke with four members of staff including the regional operations manager, manager, and care workers. We observed the care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records and multiple 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Our findings - Is the service safe? = Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
- The systems to protect people from the risk of abuse were not always being followed.
- Not all allegations of abuse by a person living at the home were reported to the local authority safeguarding team. We saw nine records of person on person harm that had not been reported to the local safeguarding team. This meant that opportunities to prevent further harm may have been missed.
- The providers incident and accident forms included a section for the manager to complete an analysis of the incident to try to mitigate further risks. However, these investigations had not always been completed so that lessons could be learnt.
- One person's care plan stated that due to previous incidents they should not be left without staff members present when they were with other people who lived at St Leonards Court. This was to ensure their safety and the safety of the other people. However, during the inspection, we found the person to be with other people in the dining area of the home without any staff supervision. This placed people at risk from harm.

The provider had failed to safeguard people 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) Regulations 2014.

The manager responded to our concerns immediately by arranging for a named member of staff to be in the communal area. They also arranged refresher safeguarding training for all staff to ensure they were following the correct procedures if they thought anyone had been harmed.

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 somewhat assured that the provider was using PPE effectively and safely. Staff were seen to pull their masks down for short periods of time when working with people. Staff did not always ensure that they cleaned equipment or changed their gloves when supporting people with cutting their nails.
- 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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We fedback our finding to the manager who took immediate action to ensure all staff complied with the providers Covid-19 Policies. We have also signposted the provider to resources to develop their approach.

Assessing risk, safety monitoring and management
● People had risk assessments and guidance in place to support staff to reduce the risk of harm occurring. Staff used the information from risk assessments to help keep people safe. For example, people had risk assessments with information about their health conditions which gave staff clear guidelines to follow.
● People had risk assessments in place for different behaviours which people may exhibit. Staff were able to explain how these behaviours may present, triggers to be aware of, and how to support the individual.

Staffing and recruitment
● There were enough staff on duty to support people safely and we saw they had the skills to meet people's needs. One person told us, "Staff keep me nice and clean. I have clean clothes every day." Another person told us, "Staff come quickly when I ask them for help".
● Pre-employment checks were carried out before staff started work. This kept people safe because it helped the provider make sure that only suitable staff were employed. Staff told us that they had not been able to start work until their employment checks had been completed.

Using medicines safely
● Medicines were administered appropriately. People we spoke with told us they got their medicines on time.
● There were good protocols in place when medicines were prescribed on a 'when required' [PRN] basis.
● Medicines were administered by trained staff who also underwent regular competency checks.
● The medicine audits carried out by the provider showed previous incidents of medication errors had been mitigated and reduced.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

●We identified concerns with the way the provider had dealt with statutory notifications to the Care Quality Commission. We will investigate this further.

●The manager had delegated the checking and processing of incident forms to a member of staff. However, they had not always had oversight of these to ensure that the correct actions were being taken. The providers reporting systems had not identified the issue with the incident reports either.

●The provider had a full audit process in place so that improvements could be identified, and action taken as necessary. The manager added to the ongoing action plan. For example, the manager was aware that the environment needed refreshing and was arranging for new flooring and refurbishments throughout the home.

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

● People and staff spoke very positively about the new manager and hoped that they would take the position permanently. One person told us, "[The manager] comes around most days. She asks me basically what you (CQC) are asking. Is everything alright, do you think we could do anything better."

● The manager promoted a culture of person-centred care by engaging with everyone using the service and their family members.

●Staff understood the service's vision and felt valued. One member of staff told us, "[The manager] and leadership team, are so good for the home."

●The manager stated in the PIR. We have daily meetings involving the manager, head of care, senior care lead, kitchen cook, site maintenance and domestic assistant. This identifies different topics making staff and management aware as to the issues and positives in the care home. With a focus on residents' welfare and health and safety. We also have a "lessons learnt discussions" with staff to reflect on practice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others;

● The manager was aware of the need to work closely with other agencies to ensure good outcomes for people. This included working with health and social care professionals as well as external agencies who

supported best practice.

● Satisfaction surveys had been sent to residents and relatives. There was a notice board that reflected the findings and what action the manager had taken in response. There were also regular residents and relatives' meetings. These provided people with an opportunity to identify areas for improvement.

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 How the regulation was not being met: Safeguarding procedures had not been followed to reduce the risk of harm to people. Regulation 13 (1) (2)