HC-One Limited

County Homes

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
County Homes provides accommodation for up to 90 people who need help with nursing or personal care. At the time of the inspection 68 people lived in the home. Most people living in the home required nursing care and most people lived with dementia.

People's experience of using this service
At this inspection we identified concerns with the management of risk, care planning, the delivery of care, the management of medicines and governance.

People's care plans did not contain adequate details of their medical conditions and the clinical care they required, to keep them safe and well. Some people had mental health needs or high-risk medicines that had not been properly risk assessed or care planned to ensure staff knew how to mitigate risks and support them appropriately. We also found that people's medical and health needs were not sufficiently monitored by nursing staff to ensure their health and wellbeing was being maintained or to identify possible early signs of ill-health. This placed people at risk of avoidable harm.

Record keeping overall, in respect of people's care was poorly maintained and at times this made it difficult to keep track of people's progress and well-being.

Medicines were not managed safely. Information about some people's medicines was not accurate or up to date. This resulted in some people not receiving the medicines they needed. Some people did not always receive the correct dose of their medicine, or missed doses of their medicines without explanation. Medicines that needed to be given at specific times were not always given correctly and staff did not have adequate information them on how to administer covert medicines (medicines hidden in food or drink), safely. We had service wide concerns about the safety of medication management so we referred our concerns to the Local Authority Safeguarding Team to investigate. After the inspection, the provider submitted an action plan to CQC outlining the immediate improvements they intended to take with regards to medicines.

Accident and incidents and safeguarding allegations were not recorded accurately to enable the provider to be assured that people's safety was being maintained and the risk of injury or abuse mitigated.

The provider had a range of audits in place to monitor the quality and safety of the service. These audits had identified similar concerns with care planning, medicines and the environment, yet there was little evidence that any action had been taken to address these concerns. This resulted in the same concerns being identified at this inspection.

There was a staff and resident COVID-19 testing programme in place and appropriate safety measures in place for visitors and new admissions to the service. There were also arrangements in place to ensure that

infection control standards were maintained. However, on the day of the inspection, parts of the environment were malodorous and unpleasant to live in.

The provider had a system in place to determine safe staffing levels. People and their relatives told us staff were kind, caring and respectful. The majority of people we spoke with felt there were enough staff on duty to support people's needs.

People received support from a range of health and social care professionals including dieticians; mental health teams; speech and language therapy and their local GP.

The culture of the service was open and transparent. The manager and regional manager engaged with the inspection positively and were committed to making any 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 good (published 01 December 2021).

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding.

During this inspection, the provider was found to be in breach of regulations 12 (Safe care and treatment) and 17 (Good Governance). This resulted in a change to the provider's overall rating which is now rated as 'Requires improvement'.

During 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 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.

For more details, please see the full report which is on the CQC 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.

At this inspection we found breaches of regulations 12 and 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to the failure to ensure people received safe care and treatment and a failure to ensure the service was always governed and managed adequately.

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

Follow up

We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will work with the local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe

Details are in our Safe findings below.

Inadequate

Is the service well-led?

The service was not always Well Led.

Details are in our Well Led findings below.

Requires Improvement

County Homes

Detailed findings

Background to this inspection

The inspection
We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act under the domains of safe and well-led, to look at the overall quality of the service, and to provide 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
This inspection was undertaken by four 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 service.

Service and service type
County Homes is a care home. People in care homes receive accommodation with personal or nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 a registered manager in post.

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 who work with the service.We used all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with the manager, the regional manager, seven staff from the nursing and care team and the activities co-ordinator. We reviewed a range of records. This included six people's care records, a sample of medication records, four staff recruitment files and records relating to the management of the service.

We spoke seven people living in the home and four relatives to gain their feedback on the service and the care they received.

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 good. At this inspection, this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes

Using medicines safely
- The home had started to use a new electronic medication administration recording system (eMAR) on the day of the inspection. Staff told us that the system was slow and that the wi-fi signal required to use the system did not work in some parts of the home.
- Information about some people's medicines had not been entered onto the eMAR system correctly. This resulted in some people not receiving the medicines they needed.
- Some medicines were not always given correctly. Some people had been given an incorrect dose of their medicine or missed a dose of their medicine without explanation. Time specific medicines were also not always given at the correct time to ensure they were effective.
- The home did not have a safe process in place to check what medicines a person was prescribed on discharge from hospital. This was poor practice and meant some people did not receive their medicine when they were admitted or returned to the home.
- Care plans for medicines prescribed as and when required and covert administration plans (when a medicine is hidden in food or drink) did not always contain adequate guidance on how to administer these medicines safely.
- Some people had swallowing difficulties and required a thickening agent to be added to their drinks to prevent choking. It was not always possible to tell if people's drinks were thickened appropriately because accurate records had not been made.

The management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to service wide safety concerns with medicines being identified, we made a referral to the Local Authority Safeguarding Team for further investigation.

- Most of the Medicine Administration Records (MAR) had allergies recorded and photographs of residents to reduce the risk of a medicine being given to the wrong person.

Assessing risk, safety monitoring and management;
- Staff lacked adequate information on people's medical or mental health needs and the clinical care they required. Where people had medical needs that required clinical monitoring, there was little evidence this monitoring was undertaken to ensure their health and wellbeing was being maintained or to identify fpossible early signs of ill-health.
- Some people lived with diabetes. Records showed that some people had consistently high blood glucose readings which placed them at risk of a Hyperglycaemic attack, yet there was little evidence that any effective or consistent action was taken to mitigate this risk.

● Some people's needs had changed but their care plans had not been updated. This placed them at risk of unsafe and inappropriate care. For example, one person returned from hospital with a catheter in place. There was no catheter care plan in place for staff to follow, and the person's daily records incorrectly identified the person as able to manage their own catheter care.
● People's fluid intake and output were not always appropriately recorded to enable staff to be confident that people's fluid intake was sufficient to prevent them becoming dehydrated or constipated.
● The environment in which people lived was safe but malodorous in some areas which made for unpleasant living conditions. The regional manager told us parts of the home were due to be refurbished but at the time of the inspection, there was no firm plan in place with regards to this.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Staff did not always follow the provider's accident and incident reporting procedure to ensure all accidents and incidents were recorded. This meant that accident and incident information was not always accurate or up to date.
● Accurate records in respect of safeguarding incidents had also not been maintained. The systems in place to record and report safeguarding incidents had not always been followed or properly checked by the provider.

The provider had not ensured all the risks to people's health, safety and welfare including safety events were adequately recorded, assessed, and mitigated to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All of the people we spoke with who lived in the home, told us they felt safe with the staff team.
● Everyone living in the home had a personal emergency evacuation plan in place to advise staff and emergency personnel how to evacuate them safely in the event of a fire or other emergency.

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 overall within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection
● There were procedures in place to ensure that visitors and new admissions were safe to enter the home in accordance with government guidelines.
● The home's cleaning and decontamination regimes were satisfactory
● There was a COVID-19 testing programme for people living in the home, staff and visitors to identify and mitigate risks of the infection.
● Personal protective equipment (PPE) was in use and worn appropriately.

Staffing and recruitment

● Staff were recruited safely. Appropriate pre-employment checks were carried out to ensure staff employed were safe to work with vulnerable people.
● On the day we visited, staffing levels were satisfactory.
● The majority of people and relatives we spoke with, told us they felt there were enough staff on duty to meet people's needs.

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 good. At this inspection, this key question has 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- At this inspection, serious concerns with the management of the service and the safe delivery of care were found. As a result, the service failed to meet its regulatory requirements and failed to ensure risks to people's health, safety and welfare were mitigated.
- The governance systems in place to monitor the quality and safety had identified some of the same concerns we found during our inspection. For example, concerns had been identified with medicines, care planning and the environment. There was little evidence that any effective action had been action taken to address these concerns and at this inspection, these improvements still needed to be made.
- Care planning and risk management required improvement. People's medical and mental health needs were not properly assessed or monitored. This did not promote positive outcomes for people.
- The systems in place to record and monitor people's safety for example accidents and incidents, safeguarding and health monitoring were lax and not properly implemented to ensure that risks were mitigated and positive outcomes maximised.

The governance arrangements in place were not always robust. Not all identified risks or areas for improvement were effectively acted upon to protect people from avoidable harm. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care files contained important person centred, information about the person, their family and their preferences to help staff foster positive relationships with people. People and their relatives told us, they felt staff knew them well. Their comments included, "Yes they know me, and they know I like biscuits"; "Yes they listen and know us" and "I feel that the staff know me well".
- The culture of the service was open and transparent, and both the manager and the regional manager were supportive of the inspection process. It was clear they were committed to making any necessary improvements to the service.

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; Continuous learning and improving care

- The majority of notifiable incidents had been reported to CQC as required. However, record keeping in respect of accident, incident and potential safeguarding events required improvement.
- Staff meetings took place to share learning and areas for improvement within the service.

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

● Some of the people who lived in the home were not sure who the manager was but knew the staff team who were supporting them .

● Relatives told us they were kept informed of their loved one's progress and told us the manager was approachable if they had any concerns. One person said, "Any concerns they (the manager) lets me know. They (the manager) is very good to me, Friendly, they are friendly and nice. All the staff are. I know all the staff".

●People received support from a range of other health and social care professionals as and when required. For example, the Speech and Language Therapy Team, local GP's and dieticians.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medication was unsafe. The provider had not ensured all the risks to people's health, safety and welfare were adequately assessed, and mitigated to prevent avoidable harm

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The governance arrangements were not robust. Risks and areas for improvement had not always been effectively acted upon.