Lutterworth Country House Care Home Limited

Lutterworth Country House Care Home

Inspection report

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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
Lutterworth Country House Care home is a residential care home providing personal care to 35 people aged 65 and over at the time of the inspection. The service can support up to 66 people. The care home accommodates people on two floors, each of which has separate facilities.

People's experience of using this service and what we found
The provider had deployed a senior manager to oversee the service and bring about the improvements required that were identified during our previous inspection. Not all of the improvements needed had been made at this inspection.

The audit system in place to monitor the safety and quality of the service was still not always effective in ensuring shortfalls would be identified and addressed.

People could not always be assured they would receive their medicines when they needed them. Procedures relating to the administration of medicines were not robust enough to ensure they were always safely managed.

People's care records were not always updated when their needs changed and risks to people's health were not always updated following an incident.

People remained at risk from their care needs not being met in a timely way because of the amount or deployment of staff at the service. Some staff, people and relatives shared their concerns of how the staffing arrangements continued to affect them.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 6 September 2019) and there were multiple breaches of regulation. The provider completed an action plan to show what they would do and by when to improve. At this inspection some improvement had been made however, the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 26 and 27 June 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve staffing and governance at the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions 'Safe' and 'Well-

led' which contain those requirements.

The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection.

The overall rating for the service has remained the same, requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lutterworth Country House on our website at www.cqc.org.uk.

Enforcement
Following the last inspection, we issued a Warning Notice against the provider in relation to the leadership and management of the service and staffing. The Warning Notice has been partially met but there is still a continued breach of regulation in relation to the leadership and management of the service.

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
We will continue to monitor information we receive about the service until we 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.

Lutterworth Country House Care Home

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.

Inspection team
The inspection team consisted of two 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
Lutterworth Country House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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. A registered manager 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 the inspection the provider's regional manager was managing the service. A new manager had been recruited. On the day of our inspection this was their first day in post.

Notice of inspection
This inspection was unannounced.
We inspected the service on 27 and 28 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 took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection and sought feedback from the local authority. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with the regional manager, deputy manager, and five care workers.

We reviewed a range of records. This included three people's care records and four people's medication records. A variety of records relating to the management of the service, including policies and procedures, were also reviewed.

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same.

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.

Staffing and recruitment

At our last inspection the provider had failed to demonstrate staffing levels were effectively managed to meet people's needs in a timely manner. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● We found improvements had been made to the levels and deployment of staff in the service. However, our observations and feedback from relatives, people and staff demonstrated some further improvements were needed.
● Relatives we spoke with said there were not enough staff. One told us, "Often there is not enough staff to meet the resident's needs." Another said, "Residents are often waiting for attention." A further relative said, "Sometimes I think there is not enough staff."
● There were numerous periods of time when people were left unattended in communal areas. We noted on one occasion two members of staff who were in the lounge area completing paperwork were facing the wall and unable to observe people.
● Staff held mixed views of staffing levels. One staff member said, "Staffing levels are ok." Another said, "We would benefit from an extra person in the mornings as it's difficult to get everything done."
● Most people thought there were usually enough staff on duty. One person told us, "There is always someone around if you need them." Another person told us, "I have a buzzer. I press it if I need to. I don't have to wait too long for attention." However, one person told us, "There is not enough staff."
● We discussed our findings with the regional manager. They told us they were happy with the current staffing level and were continually reviewing the deployment of staff, and call bell response times monthly; which did show a reduction in response times following our previous inspection.

Using medicines safely; Assessing risk, safety monitoring and management

At our last inspection, a breach of regulation 12 (Safe care and treatment) had been identified. Although this inspection was not intended to follow up on this breach, additional areas of concern were identified.

● Whilst some improvements had been made the systems in place for medicine administration and mitigating risks to people's health were still not robust enough or managed effectively.
● The morning medicine round was not completed until 11.15am. The following medicine round then began at 12.00pm. We spoke to the staff member administering medicines who told us, "It's taken so long because I have to support the other carers with care duties they can't get done themselves. We really need an additional carer."
● We noted despite wearing a 'do not disturb' tabard the staff member administering medicines was continually interrupted by other carers to help support people with their care needs. In these instances, the staff member paused the medicine round to support other carers, resuming on their return. This meant there was a risk people may not receive their medicines or personal care in a timely way due to the staff resource at that time.
● One daytime member of staff told us they had left a person's medicines pre-potted for a night agency member of staff to administer, but the medication was refused by the person, left loose in the medicine trolley and not recorded on the medicine administration record (MAR). This is not safe as the night staff member could not be assured that the correct medicines had been left out.
● There were discrepancies in stock levels of some medicines. The MAR for one person stated there should be 26 tablets left but the stock level was 25. This meant the person may have been given an extra tablet or one dose administered was not recorded. Another medicine record showed there should have been nine tablets in stock, but we found there were 12.
● The process for carrying over medicine stock was not followed properly. This meant it was difficult to calculate the actual number of some medicines that should be in stock at any one time. The regional manager agreed immediately to audit the entire medicine stock.
● Procedures for the disposal of medicines were not followed. A medicine that had been dropped on the floor was left in a pot in the medicines room and with no records to show why it was there and what was to be done with it.
● During our previous inspection a chart was introduced to ensure people were not at risk of having a transdermal patch continually applied to the same part of the body, which can affect the rate the medicine is absorbed into the blood stream and damage the skin. Whilst the chart was in use during this inspection recordings were unclear and confusing. This meant there was a continued risk people may have patches applied to the same part of their body.
● People told us they received their medicines when they needed them. One person told us, "I have medication and they do not forget to give it to me."
● Risks to people's health were not always reviewed or followed. A relative said their family member was at risk of falling. They told us, "Staff have put a pressure mat next to [family member's] bed, and they have a call bell. I have never seen either of them plugged in." We visited the person's room and found both pieces of equipment were not plugged in. This meant staff would not know when the person got up, and the person would be unable to summon staff's assistance when they needed them.
● Risk assessments were not always updated following an incident. For example, one person who had fallen had not had their risk assessment reviewed to assess whether any changes to their support were needed to reduce the risk of falls occurring in the future. We discussed this with the manager who informed us they would immediately review the risk assessments and care plan for this person.
● We found some care plans had not been regularly reviewed or reviewed when people's needs changed. One relative told us, "I think there is a care plan, but I don't remember it ever being reviewed." The manager acknowledged that not all care plans had been reviewed when they should have. They said they would carry out a full review of all care plans to ensure they fully reflected people's current needs.
● One relative told us, "The keyworkers always keep us informed of any changes with [family member]."
● Where staff were required to support people at specific times records confirmed they did this.
● Following the inspection, the provider submitted an action plan to remedy all the concerns identified in

managing medicines and mitigating risks to people's health within four weeks.

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 requires improvement. At this inspection this key question has remained the same.

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 our last inspection systems were either not in place or robust enough to demonstrate that effective systems and processes were in place to monitor and improve the quality and safety of the services provided. This was a breach of regulation 17(1) (Good governance) of the Health and Social Care Act 2008.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There remained shortfalls in the systems and processes to monitor and improve the quality and safety of the service. Audits carried out did not identify all the shortcomings found during our inspection. These included audits for medicines, care plans and risks to people's health. Some people's records were not routinely reviewed when people's needs changed or following an incident. This meant staff may not know people's current care needs well enough to support them safely.
● A daily 'walk around' the service by a manager was still in place, however, concerns we found during this inspection had not been identified, and staff had not reported the issues they raised with us to managers.
● The provider acknowledged our concerns and told us they would review their auditing system and make the necessary changes within four weeks to bring about the improvements required. To reduce the risk of future medicine errors and to aid effective auditing the provider also informed us they were considering moving to an electronic based medicines administration process.
● The amount and deployment of staff was regularly reviewed, however, the concerns we identified during this inspection did not assure us this was a fully effective tool to accurately calculate the staff resources needed to meet people's needs in a timely way. We found communal areas were not routinely staffed and a member of staff tasked solely for administering medicines was unable to carry out the role effectively as other staff required them to support people with their care needs.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they had met the regional manager and they made themselves available if needed. One

person told us, "I have been introduced to the new manager. I'm getting good vibes." Another told us, "I know who the manager is, and they seem good."

● Staff told us the regional manager was supportive and the service was better organised in recent months.

● The regional manager told us they had made themselves more visible in the service since the previous inspection and comments from people and staff confirmed this.

Continuous learning and improving care; Working in partnership with others

● The regional manager told us they were committed to improving the service. A new manager was being supported into the service on the day of our inspection. The regional manager told us progress had been made since our previous inspection but recognised there were further improvements needed.

● The manager was working with the local authority's quality improvement team. Falls training and best practice guidelines were being provided to reduce the risk of any incidents and how to respond appropriately when they occurred.