Harborne Lane Specialist Care Centre Ltd

Harborne Lane Specialist Centre

Inspection report

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25 June 2018
27 June 2018

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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

This focused inspection took place on 25 and 27 June 2018 and was unannounced. At the last inspection on 20 and 26 February 2018, the provider had not met some of the legal requirements. The service required improvement in all of the key questions: is the service safe, effective, caring, responsive and well-led and conditions were then imposed on the provider's registration. This inspection was in response to continued concerns about the service

We carried out a responsive, comprehensive, unannounced inspection of this service on 20 and 26 February 2018. Breaches of legal requirements were found. After the comprehensive inspection, we received further concerns in relation to:-

- Unsafe medicines management
- Protecting people from avoidable risk of harm ie falls
- Allegations of neglect
- Staff shortages and high use of agency staff

As a result, we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Harborne Lane Specialist Centre on our website at www.cqc.org.uk

Harborne Lane Specialist Centre 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.

Harborne Lane Specialist Centre is registered to accommodate 68 people in one adapted, four storey building. There are three independent units. The ground floor, known as Oak, contained 18 bedrooms to provide a service to people with complex nursing needs. The first floor, known as Willow and the second floor, known as Birch both with 25 bedrooms on each and provided a service to people primarily living with dementia. The home has a range of communal spaces including lounges, dining areas, quiet areas and a large landscaped garden. All the bedrooms are single occupancy with en-suite facilities. There were 49 people living at the home at the time of our inspection. The home provides care and support to people from a range of ages, gender, ethnicity and physical abilities, including those living with dementia, learning disability and mental health difficulties.

Since the last inspection, the registered manager had left their employment. There was a new manager in post who told us they intended to apply to become the new registered manager. The registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is

run.

Systems in place to monitor and improve the quality of the service were not always effective in ensuring people received a good quality of service. Where there were audits, they had not identified the issues we found and had not always been consistently applied to ensure where shortfalls had been identified, they were investigated thoroughly and appropriate action plans put into place to reduce risk of reoccurrences.

Full information about CQC's regulatory response to issues and concerns found during inspections are added to this report after any representations and appeals have been concluded.

Improvement was required with the monitoring and recording of incidents to ensure people were protected from risk of avoidable harm. Where risks were identified, we found that staff were not always following the guidance to minimise that risk. Staff understanding and training on how to support people whose behaviours may be challenging required improvement.

People told us they felt safe and staff understood their roles in safeguarding people from abuse. There were sufficient numbers of staff present to meet people's needs. Checks had been undertaken on new staff as well as agency staff to ensure they were suitable for their roles. There were improved processes in place to ensure medicines were safely stored and administered to people. People were protected from the risk of infection.

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 consistently safe

Although people told us they felt safe, improvement was required in the action taken, monitoring and recording of specific incidents to ensure people remained safe from the risk of avoidable harm.

People were not always supported by staff with a consistent approach because some staff did not always follow guidance on risk assessments.

People were supported by sufficient numbers of staff and they received their medication. People were protected from the risk of infection and cross contamination.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

Although there were some systems in place to monitor the quality of the service, they were not effective. There was no evidence of provider oversight of the service.

Some statutory notifications about notifiable incidents had not been submitted.

People and relatives told us the provision of service had improved since the last inspection.

Harborne Lane Specialist Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced, focused inspection of Harborne Lane Specialist Centre on 25 and 27 June 2018. This inspection was done in response to ongoing concerns about the service and to check that improvements to meet legal requirements had been made. The team inspected the service against two of the five questions we ask about services: is the service well led, is the service safe. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

On day one of the inspection, the team consisted of two inspectors, a specialist advisor and two experts by experience. The specialist advisor was a nursing practitioner with experience of working within a dementia setting. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of dementia care service. On day two of the inspection, the team consisted of one inspector.

As part of the inspection process we looked at information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority commissioners have concerns about the service they purchase on behalf of people. We also

contacted the Clinical Commissioning Group (CCG) for information they held about the service. At the time of this inspection, the local authority and the CCG had suspended the provider from admitting new people until the service had improved. This helped us to plan the inspection.

We used a number of different methods to help us understand the experiences of people who lived at the home. We spoke with four people, eight relatives, 12 staff members that included nursing, care and domestic staff. We also spoke with the home manager, home improvements manager and the clinical lead. We spent time observing the daily life in the home including the care and support being delivered. As there were a number of people living at the home who could not tell us about their experience, we undertook a Short Observational Framework for Inspection (SOFI) observation. (SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.)

We sampled five people's care records to see how their care and treatment was planned and delivered and seven medication records to see how their medicine was managed. Other records looked at included two recruitment files to check suitable staff members were recruited. We also looked at records relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

We carried out an unannounced, responsive comprehensive inspection of this service on 20 and 26 February 2018. After that inspection we received concerns in relation to allegations of neglect, people not protected from the risk of avoidable harm, high turnover of staff and use of agency staff and unsafe medicine management. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic.

At the last inspection the provider had not met all the legal requirements regarding the safe administration and storage of medicines and was a breach of Regulation 12 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Following the February inspection, we had continued to receive concerns about medicine practice at the home. We sampled records for seven people and looked at how medicines were managed, which included checking the medicine administration record (MAR) charts and associated records. We spoke with people, relatives and nursing staff and reviewed how medicines were stored. All those spoken with reported there had been improvements. One person told us, "They [staff] bring them [medicine] and I get them on time. I also have to have morphine for my back but they [staff] always come to do it."

We found improvements had been made against all the issues we had identified at the February inspection. For example, staff were monitoring the counted doses for inhalers, medicines refrigerator temperatures were being measured correctly, medicines prescribed on a 'when required' basis had written information to support staff on when and how these medicines should be administered. Although some further information around what could trigger the need for the person to require their medicine could be improved. We found where people needed to have their medicines administered directly into their stomach through a tube; nursing staff followed a set protocol. We looked at how Controlled Drugs were managed. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found that the Controlled Drugs were being stored securely and were being regularly audited. There were no broken ampoules and nursing staff were recording the location of where pain relief patches were being applied to people's bodies in keeping with safe practice. We observed nursing staff administer medicines to people and found their practice was safe. The provider had improved sufficiently to meet the breach of Regulation 12.

Shortly prior to this inspection visit, there had been a serious incident and issues reported to us concerning allegations of neglect. We discussed the incidents with the home manager and asked what improvements had been made to protect people from risk of harm. We found the home manager had conducted thorough investigations and had implemented some changes to reduce the risk of reoccurrence. For example, staff members were now continually present on the corridors of each floor and in communal lounge areas. This meant they had a clear view of people walking up and down the corridors and seen entering and leaving bedrooms where staff members were on hand to support people if and when required. Additional 1 to 1 support had also been introduced for some people whose identified needs had increased.

However, further improvement was required around the management of falls. One relative shared with us

their family member fell out of bed that had side guards on it. Although, on this occasion, they had not sustained any injury, the relative remained worried. We also noted one person had a number of falls within a short period of time. There was no analysis completed to identify why they had fallen, no action plan in place to mitigate future risks and we could not see if a referral had been made to health care professionals. We spoke with the home manager and on the day of the inspection a referral was made to the appropriate professionals. We also found risk assessments required improvement. The improvement manager and the home manager explained their intention to introduce an electronic system that would be clearer and more consistent for staff to use. Our observations also showed that staff required more support and training around identifying and managing risks. For example, at lunchtime on the first day of the inspection, one person refused their lunch and was not offered an alternative. A staff member explained this could have caused the person's behaviour to change but this had not been taken into account by the staff supporting the person on the day of inspection, because no alternative choice was offered. We saw one person's risk assessment stated they could eat unsupported but in their care plan and our observations, showed the person required 1 to1 support to eat. During the first day of our inspection, two staff members had refused to support a person because they had become violent towards them. Although the person did receive support from staff, we discussed the need for urgent training for staff in management of behaviours that challenge with the home manager. A number of relatives we spoke with felt there was a training requirement for some staff when supporting people living with dementia.

Everyone we spoke with told us they felt the home was a safe environment. One person said, "I am quite safe here. The staff are always around to help me get about safely." A relative told us, "[Person] has been here since March. I have found it wonderful here. I know they are safe and well looked after as they have staff around and about all the time." Staff we spoke with recognised the signs of potential abuse and knew how and who to report any concerns to. One staff member said, "It is very challenging here. Residents threaten one another and can just do it without warning. You have to be tolerant when dealing with outbursts but sometimes you need to walk away and get someone else which works." We checked the incidents and accidents and although there had been some improvement with incidents being notified to the appropriate authorities, there had been person on person contact that had not been reported. We discussed these incidents with the home manager and found appropriate action had been taken. The home manager agreed there was room for improvement when recording action taken and measures put in place to mitigate future risk.

Everyone we spoke with told us there had been an improvement with staff numbers and consistency. One person said, "Oh yes, plenty [of staff] they are always around to support me." A relative we spoke with told us, "Staffing is better now. Before there was not enough staff but it's going in the right direction." Some relatives explained to us there was still room for improvement with staffing at nights and weekends. We saw the provider had started a recruitment programme and there were a number of care staff waiting for their pre-employment checks to be completed. One staff member said, "The manager and nurses ask if there are enough staff on [duty]. If not, they arrange for cover through an agency and try to ask for the same people." We found on the days we visited the home, there were sufficient staff numbers on duty. The home manager explained they were still using agency staff but they did try to request the same staff. They continued to tell us there had been some issues with night staff but this was being monitored and measures were being implemented to address the concerns.

We checked two staff members' recruitment records and found the provider's recruitment practices had improved. Pre-employment checks were completed, including a Disclosure and Barring check (DBS) before staff started to work for the provider. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people.

At the last inspection we identified some concerns around the safety of the home environment. The home manager explained a fire officer had visited the home since the last inspection and given them advice and guidance that the provider was in the process of implementing.

We looked at the cleanliness and hygiene of the home and found it to be satisfactory. One staff member had raised some concern about two sluice rooms being unlocked on the first and second floors. A domestic staff member we spoke with explained that whilst the doors were unlocked, there was nothing contained in any of the rooms that could pose a risk to people. They confirmed all cleaning materials were safely stored and locked away on the fourth floor and could only be accessed by staff. We checked and confirmed the doors were unlocked but there were no dangerous products kept in the rooms.

Requires Improvement

Is the service well-led?

Our findings

We carried out an unannounced, responsive inspection of this service on 20 and 26 February 2018. After that inspection we received concerns in relation to the management of the service. As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. At the last inspection in February, there were no effective quality assurance processes in place to monitor service delivery and we had not been informed of incidents the provider was required to do so by law. This was a breach of Regulation 17 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014 and Regulation 18(1) Notification of other incidents, Care Quality Commission (Registration) Regulations 2009. We took enforcement action against the provider and requested they submit to CQC monthly updates on the service to demonstrate action had been taken to address the issues we had found.

At this inspection although there had been some improvement, further improvement was still required. We found initial admission records, risk assessments and care plans had not been consistently and accurately completed. For example, we sampled the records for one person that had been involved in a number of altercations with other people. We found their pre-assessment stated the person would only demonstrate aggressive behaviours on 'rare occasions'. However, assessments conducted by professionals showed there had been a number of failed placements due to aggressive behaviour and physical violence. The home manager agreed the initial assessments were poor and had they been more effective at identifying certain behaviours, the service would have been better equipped to support the person.

A number of health and safety audits had not been reviewed since April 2018. For example, we reviewed audits for Birch unit and found they had not been fully completed and there had been no review. For Willow and Oak, there was no health and safety audit completed with all the forms blank and undated. We noted an environmental audit completed on Birch during March and April 2018 had not followed the provider's own policies to ensure 50% of the bedrooms were checked. Where issues had been identified, for example 'heating too hot, temperatures to be checked', we could not see what action had been taken to mitigate any potential risk. Audits had not identified themes and trends following incidents, for example when people had a high number of falls or when there were confrontations between people. It was not always clear what action was taken in response to these incidents and what measures had been put in place to mitigate the future risk of any reoccurrence.

We discussed at length with the improvement manager, the need for a greater input from the provider. It was apparent from the number of issues identified at this and previous inspections; there was no oversight from the provider. We were told the then registered manager was responsible for the management of the service. However; there had been no supervision of the registered manager and the provider had not been kept informed of the concerns and issues that were being identified. The registered manager was no longer employed at Harborne Lane and the deputy manager had been promoted to home manager. The improvement manager confirmed there were going to be changes to the service that included more support from the provider. We were shown details of plans in place to introduce improved record keeping systems that would make it easier to monitor that people living at the home were all receiving planned care and support. The improvement manager had identified the need to involve staff in introducing the new system

to ensure that all staff would be able to use it after appropriate training.

We recognised the provider had become more involved in the management of this service in the last month. However, there had not been sufficient improvement from the last inspection in February 2018 to the governance processes on a permanent or interim basis and this was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). Good governance.

At the last inspection the provider had failed to inform us of a number of safeguarding incidents they were required to by law. We reviewed the provider's incidents and accidents and found although there had been an improvement, there were still a number of incidents the provider had a legal responsibility to notify CQC about and they had not. This was a continued breach of Regulation 18(1) Notification of other incidents, Care Quality Commission (Registration) Regulations 2009.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The home manager was able to tell us their understanding of this regulation and we saw evidence of how they reflected this within their practice. Both the home manager and improvement manager were open with us where there was a need to improve. They made themselves available to the inspection team and remained on site for the duration of the site visit.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and there was a whistle-blowing policy in place. They explained the new management team were approachable and if they had concerns regarding the service and they would speak with them. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, a person's safety), wrongdoing or illegality. The whistle-blowing policy supports people to raise their concern(s) within the organisation without fear of reprisal or to external agencies, such as CQC if they do not feel confident that the management structure within their organisation will deal with their concern properly.

Everyone, without exception, spoke positively about the management of the home and how much it had improved since the last inspection. A relative we spoke with said, "I was unhappy with the previous manager but much happier with current management arrangements. I feel I can knock on the [manager's] door and be heard and that is an improvement. [Improvement manager] is receptive and I'm happy to go speak to them." Staff also shared with us their views on how the service had improved since the last inspection. One staff member told us, "The managers are often in at 7.00am and some of us [staff] are visiting other services to look at different ideas for improvements." Another staff member explained, "There have been lots of improvements since [home manager's name] came and more staff have been interviewed to take on. [Home manager and improvement manager's names] are very supportive always around and very approachable. I love it here and love the residents."

The provider had introduced relative/resident meetings since the last inspection and this had been received with positive feedback from the people and relatives we spoke with. However, some relatives felt more could be done to ensure they were kept informed of changes to their family member or when an incident occurred. For example, one relative shared with us it had been two hours after their family member had fallen that they were contacted and notified.

The service had significant input from the Clinical Commissioning Group (CCG) and we saw evidence to support the service had worked in partnership with them and other organisations, stakeholders and healthcare professionals. The CCG and the Local Authority shared with us their feedback that the service

had made some improvements since the last inspection.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents At the last inspection the provider had failed to inform us of a number of safeguarding incidents they were required to by law. We reviewed the provider's incidents and accidents and found although there had been an improvement, there were still a number of incidents the provider had a legal responsibility to notify CQC about and they had not. This was a continued breach of Regulation 18(1) Notification of other incidents, Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

The conditions imposed from the February 2018 inspection will remain in place until the provider has sufficiently improved.

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Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There had not been sufficient improvement from the last inspection in February 2018 to the governance processes on a permanent or interim basis and this was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). Good governance.

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