Haresbrook Park Limited

Haresbrook Park Care Home

Inspection report

Haresbrook Lane
Tenbury Wells
Worcestershire
WR15 8FD

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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
Haresbrook Park Care Home, is a 'care home' providing personal and nursing care for up to 57 people across two units on the ground floor in one large adapted building. Haresbrook Park Care Home specialises in the care of people living with dementia and older people. At the time of our inspection, there were 41 people living at the home.

People's experience of using this service and what we found:

The quality of care had deteriorated since the last inspection. People were at risk because safeguarding policies and procedures were not being followed. The provider and manager had not assessed and managed risk, which placed people at risk of harm.

People did not consistently receive their medicines as prescribed.

There were concerns with staff practices regarding infection prevention and control and lack of knowledge regarding supporting people to safely eat and drink. The provider and manager failed to ensure that the nutrition and hydration needs of people were regularly reviewed during the course of their care. People were at risk of choking due to staff not being fully aware of their eating and drinking needs.

There continued to be insufficient staff with the correct skill mix to meet people's needs. Some people's relatives, professionals and staff continued to raise concerns about the limited insight staff had into people's needs, due to high staff turnover and high levels of agency staffing.

The provider failed to ensure people were not at risk of harm. The risks to people's health, safety and welfare were not always assessed, recorded and kept under review. Incident and accident records had not always been completed or signed off by the manager to confirm all necessary actions had been taken.

The provider's quality assurance systems and processes failed to address issues with documentation not being completed appropriately. We found unexplained gaps in recording on people's medicines application records and repositioning records. Professionals continued to express mixed views about and varying confidence in the management team. The majority of staff did not speak positively about the support they received from the management team.

The service was not well led. The provider failed to have sufficient oversight of the home and five breaches of regulations were identified.

Rating at last inspection
The last rating for this service was Inadequate (report published 15 July 2019).

Why we inspected
We received concerns in relation to moving and handling practices, staffing, risk management and medicines. 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. 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 remained the same.

We have found evidence that the provider needs to make urgent improvement. Please see Safe and Well-led sections of this full report.

Enforcement
The service met the characteristics of Inadequate in two key questions of safe and well-led. At this inspection, we identified breaches of regulation 9, 12, 14, 17 and 18. Full information about CQC's regulatory response to any breaches of regulation found during inspections is added to reports after any representations and appeals by the provider have been concluded.

Following the inspection we referred our concerns to the local authority. In addition, we requested an action plan from the provider, and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

Follow up
We will continue to monitor the service closely and discuss ongoing concerns with the local authority. 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.

Special Measures
The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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. We will have contact with the

provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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.

Haresbrook Park 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 was carried out by two inspectors.

Service and service type
Haresbrook Park 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 manager of the service was not yet registered with the Care Quality Commission and was going through the process of registration. The registered manager with the provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This was an unannounced inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This information included the previous inspection report and any information or concerns that CQC had received from the public and professionals since our last inspection. We sought feedback from the local authority and professionals who work with the service. We used all 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 also spoke with the provider, manager, operations director, deputy manager, office manager, three care staff and two domestic staff. In addition, we also spoke to a visiting health professional. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records, medicines records and staffing rotas. We also reviewed incident and accident records, and records relating to the safety of the premises and management of the service.

After the inspection
We spoke with a community health and social care professional about their experiences of people's care. We also contacted the Local Authority for further information. We reviewed additional information from the provider.

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.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- The provider failed to ensure people were not at risk of harm. The risks to people's health, safety and welfare were not always assessed, recorded and kept under review. For example, one person required their medication to be crushed, however their care plan and medication chart lacked information on how to administer this medication or if the type of medication was safe to crush.
- Prior to this inspection, concerns were raised with us regarding the alleged use of unsafe moving and handling techniques and people being left sat in the same position for long periods of times in soiled clothing. Staff told us and we saw that two people in one communal area were not supported to mobilise regularly as their care plan had advised. This left them at potential risk of developing pressure wounds. We found one person slipping out of their chair in the lounge and had to alert staff.
- We discussed the concerns raised regarding staff moving and handling practices and the length of time people remained in the same position without support, with the management team and they responded staff have received appropriate moving and handling training.
- People's repositioning records contained unexplained gaps in recording. We saw one person who remained seated in a chair in their room during our inspection. Their bed had been stripped of bedding and they remained in their nightwear despite the locum manager asking staff to assist the person to wash and dress. The person's repositioning chart had not been completed.
- People were at risk of potential harm from inappropriate people accessing the building, without being challenged by staff.
- People who required thickened fluids for safety were at risk of choking as care plans were not current and staff had limited knowledge of the consistency each person required for their own safety. We spoke to three members of staff who gave us conflicting information regarding the consistency of fluid that two people required. Care records and prompt sheets for staff all gave different advice on what each person required. We saw one person who required thickened fluid had a cup of tea that was almost solid it was difficult to pour out of the spout, while the other juice had no thickener. We raised this with the locum manager immediately, so we could ensure the person was given safe drinks. The locum manager reviewed the person's care record and confirmed it was not clear how thick the person's drink should be. Therefore, the provider could not be assured people were consistently safe when drinking.

The provider failed to ensure people's nutritional needs were assessed and food provided to meet those needs. The provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 14: Meeting Nutritional & Hydration Needs.

Using medicines safely

● People were exposed to harm as the provider did not have robust procedures in place to ensure people had their medicines safely and as prescribed.

●People were placed at risk of ingesting medication that was not prescribed for them. For example, we found a pot of crushed medication left on the dining table, near to where three people were sat. We returned the medication to the deputy manager who was administering medication, who confirmed they were unsure who the medicine belonged too. This also meant that a person had not received their medicines as prescribed.

● People were at risk of harm from untrained staff administering medicines. We found a staff member had acted outside of their remit and had administered medicine to a person which should have been given by the person's doctor or advanced nurse practitioner. We reported our findings to the provider, so they could ensure the person received their medicine from the right healthcare professional.

● People were exposed to harm by not receiving their medicines as prescribed to ensure they were effective. For example, people who required time sensitive medicines did not receive these at the prescribed time. Records did not accurately reflect when the medicine was given.

● People did not receive their medicines as prescribed. For example, we found one person who was prescribed medication in patch form was placed at risk of deterioration in their mental health because of patches not being applied correctly and the location of the patch on the person's body not recorded appropriately in the medication administration records.

● People were at risk of over or under dosing of medicine. We noted on the day of inspection, the deputy manager told us the morning medicine round began at 9:30am, the morning medicine round finished at 11:30am, and the afternoon round began again at midday. The medication administration records (MAR charts) for people did not reflect the actual time of administration, therefore staff could not be assured there was sufficient time between people's medicines.

● We found medication records did not always demonstrate that people had received their medicines. For example, people who required patch-based medication, records contained multiple unexplained gaps in recording.

The failure to ensure the safe management of medicines was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection, we found the provider had failed to ensure there were sufficient competent staff on duty to meet people's needs. This was an ongoing breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18: Sufficient suitable qualified staff.

● Professionals and staff, we spoke with continued to raise concerns about the impact of staff turnover and high levels of agency staffing upon the service's ability to meet people's individual needs. This included agency staff's limited insight into people's individual care needs and their lack of familiarity with the provider's care recording system. A staff member said, "High turnover of staff creates instability and agency staff are not used to our systems. The service users need familiar [staff] faces." A community professional said, "I don't think the current staff know the residents well enough. There is a lack of cohesion, understanding of residents' behaviours and how to manage these effectively."

● The provider continued to fail to ensure there were sufficient staff available to support people with the right mix of skills, knowledge and experience to meet people's individual care needs.

● The provider failed to ensure people were supported by staff who knew how to meet their needs. On the day of our inspection, the majority of the staff on shift were agency staff. The rota stated for the day shift on 12 September 2019, there was one permanent senior and one permanent carer on shift. The other seven care staff on shift were agency staff, some of whom when we spoke to them had limited knowledge of people who used the service. We looked at rotas for the previous two months and confirmed there was a high reliance on agency staff.

Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 18.

Preventing and controlling infection

● People were put at risk of infection because the provider had not ensured staff followed safe practice. Staff failed to consistently follow infection control procedures and put service users at risk of potential harm.

● Staff were provided with personal protective equipment (e.g. disposable gloves and aprons) to protect people from infections. However, staff did not make consistent use of this equipment when supporting people with their personal care. We observed a person being assisted to the bathroom and two members of staff were unable to locate the correct personal protective equipment as they didn't know where these were stored. Another staff member was unsure when they were expected to use disposable aprons.

● Flooring in bathrooms and some hallways were either damaged or not sealed correctly which left people at risk of cross contamination.

The failure to ensure staff followed infection prevention and control guidance was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The provider failed to complete timely reviews of incidents and accidents to ensure risk of harm was mitigated promptly.

The failure to evaluate all accidents and incidents was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The provider had procedures available designed to ensure the relevant external agencies were notified of any abuse concerns in order that these could be thoroughly investigated. However, the current management team were not always following these procedures and appropriately reporting all incidents. We found there had been several incidents of altercations between a few people within the home, however these incidents had continued to happen as the provider had failed to action recommendations.

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. Some regulations were not met.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; continuous learning and improving care:

At our last inspection we found the provider's quality assurance systems were inadequate. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider failed to carry out regular audits and checks, designed to enable them to monitor and improve the quality and safety of the service. The provider's quality assurance had not ensured records were accurate or complete. The systems were not robust or effective to ensure that the audits the manager reported they were doing were taking place and were effective. The provider was not aware that long term staff were leaving the home or that the manager had placed staff on gardening leave. The provider was also unaware that the shift pattern had been changed which meant that medication was not being administrated until 9:30am each day.
● The provider failed to ensure there was a system in place to review 'Incident and accident records' completed by staff to confirm all appropriate actions had been taken to mitigate risks. The manager told us they were focussed on reviewing audits of incidents for May and June however, we were told these documents were at their home address and therefore we could not evidence this. From the incidents we saw for July, August and September, they were not assessed, reviewed or risks mitigated.
● Staff told us that morale was low due to the high turnover of staff. Several experienced staff had left the service recently, resulting in more reliance on agency staffing.
● Staff told us that they felt unsupported by the manager. One staff member told us "[the manager] spends the majority of the day in the office and is difficult to approach, they [the manager] don't come out and see the problems we are having so nothing gets done about it".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
● Most staff raised concerns about a lack of clear leadership and direction on shift. One staff member told us, "It's a bit chaotic at the moment, it was better with a team leader on shift." Some of the professionals we

spoke to felt staff needed to be better organised, and our observations of people's lunchtime meal supported this view.

● We found that the daily handover sheets to share information between staff on each shift were not dated or completed. This left staff not knowing what had happened during the previous 12 hours or overnight for people. We discussed the issue of lack of direction for staff with the management team. They explained they were in the process of recruiting team leaders, following the recent departure of those previously employed at the service.

● Staff told us they have not had any one to one meetings (supervision) with the manager since the manager started with the service and regular team meetings had not been arranged. This left staff feeling isolated and unsupported.

● There were gaps in records such as care plans, risk assessments, monitoring charts and medication administration records. There was inaccurate recording in daily hand over forms. This meant the service did not have an accurate, complete and contemporaneous record in respect of each person. There were also gaps in other records such as audits and reporting documentation.

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

● There was a lack of evidence of promotion of equality and diversity within the home, and it was not clear if the service considered people's protected characteristics. Staff told us that everyone was given the same meal as cultural meals were not needed.

● Care plans did not show any evidence of involvement with people when making decisions that impacted upon their daily life. Monthly reviews were paper based exercises, with no evidence of people being asked their views or opinions.

● People's care plans lacked important information about how care staff delivered care and support to people in ways they preferred. We saw one person, who lacked capacity to make a decision about their nutritional intake, was asked once by a member of staff if they would like lunch. The person declined, and they were not offered an alternative or encouraged to try the meal. This person was at risk of self-neglect and was losing weight, but this was not recognised by staff.

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 provider failed to be open and honest with people, and relevant others, when things went wrong with the care provided. Safeguarding concerns were not always correctly escalated by the manager or reviewed by the provider.

Working in partnership with others:

● The provider failed to have effective systems to keep professionals up to date. Professionals told us that they were not confident that the service was keeping them updated with relevant information and had found it difficult to engage with the management team.

● The provider failed to notify the District Nursing Team of important issues, including the death of a person they were supporting, and dressings falling off people who had open wounds.