Hunters Moor Residential Services Limited

Hunters Moor Neurorehabilitation Centre

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
Hunters Moor Neurorehabilitation Centre for the West Midlands – The Janet Barnes Unit provides personal and nursing care to up to 42 people. The service provides support to people with neurological conditions, brain injuries and complex physical rehabilitation needs. At the time of our inspection there were 27 people using the service.

People's experience of using this service and what we found
The provider failed to ensure systems to monitor the quality and safety of the service were sufficient to identify the failures found at this inspection.

People told us they felt safe in the home however, medicines were not always administered as prescribed and risks had not been sufficiently assessed. Observations to maintain people's safety were not always carried out and maintenance was required in some areas of the building. Trends and patterns were not identified following incidents to learn lessons and inform practice. Staff were employed safely, they understood safeguarding and whistle blowing procedures and maintained infection control in line with government guidance

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 03 July 2019).

Why we inspected
We received concerns in relation to insufficient numbers of staff, people's fluid intake and weight loss, staff response to call buzzers, observation intervals not being maintained and lack of management support. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

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

You can see what action we have asked the provider to take at the end of this full report.

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. This included checking the

provider was meeting COVID-19 vaccination requirements.

Enforcement and Recommendations
We have identified breaches in relation to the safe care of people and poor performance of management in the absence of a registered manager at this inspection.

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 request action plans from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led.

Details are in our well-Led findings below.

Hunters Moor Neurorehabilitation Centre

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Hunters Moor Neurorehabilitation Centre for the West Midlands – The Janet Barnes Unit is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means they and 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 inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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. We used all this information to plan our inspection.

During the inspection
We spoke with five people that lived in the service. We spoke with nine relatives about their experience of the care provided to their family members. We spoke with four members of staff, two therapy leads, the interim manager, the head of nursing, and the operations director. We also spoke with one healthcare professional involved in peoples care.

We reviewed a range of records. This included three people's care records, restraint records and medication records. We looked at one staff file in relation to recruitment. We also looked at records that related to the management and quality assurance of the service.

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

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management

- The provider failed to ensure service users' medication was safely managed. Medicines were not always administered as prescribed. We saw prescribed medication had been recorded as administered when it had not been consumed which resulted in a person being admitted to hospital.
- Risks to people had not been sufficiently assessed. We saw a 'risk assessment summary' had been completed for each service user which identified known areas of risk, such as risk of falls or setting fires and gave these a risk rating. For example, the 'risk assessment summary' for one service user rated them as a high risk of setting fires. However, risk assessments had not been completed in relation to these known risks and consequently there were no recorded plans for managing these.
- Care plans were not always followed, and observations were often not completed as required.
- We saw people had care plans which required staff to carry out observations at various intervals for their safety, however these were not consistently completed each day. For example, one person required observations to be completed every 15 minutes and we found no observations had been completed for nine days in a 12-day period.
- The provider failed to assess and mitigate risks to service users associated with the safety and maintenance of the premises. We found maintenance was required to flooring in multiple places in the home where temporary repairs had been made with tape which were potential trip hazards. No maintenance issues had been reported in the home's maintenance log since 27 July 2021.
- We found no evidence of daily or monthly health and safety checks on the premises and equipment, such as emergency lighting and window restrictors checks had been carried out. This meant the provider could not be certain the premises were safe for people.

This was a breach of regulation 12 (Safe are and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We raised the above concerns to the provider who took action to mitigate immediate risks and developed an action plan to address these areas.

- People's records detailed how they preferred to take their medicines including clear protocols for medicines as and when needed.
- People told us they knew which medicines they take with one person telling us, "I have a list of my medicines on my board and they bring them when I need them."
- We found people's fluid intake was monitored daily and was within the expected range to maintain their health.
- Some people had experienced weight loss however this was being regularly monitored and discussed at

weekly meetings with consultants.
● We found when people used their call buzzers to alert staff to their needs staff responded timely.

Learning lessons when things go wrong
● The provider failed to ensure incidents that occurred were sufficiently assessed for trends and patterns. Poor analysis meant learning from incidents had not been identified.

Systems and processes to safeguard people from the risk of abuse
● The provider had clear safeguarding and whistleblowing systems in place which staff had received training and knew how to effectively use. One staff member told us, "We have safeguarding and whistleblowing training yearly, we know it is to protect people and keep them safe from abuse. We know we can whistle blow if we need to."
● Relatives we spoke to told us they felt their loved ones were safe and happy in the home. A relative told us, "We know the [staff] will look after [person]. We know and get on with the majority of the [staff] who look after [person]. In that respect, I think [person] is safe."
● People told us they felt safe and had a good rapport with staff. One person told us, "Yes I do feel safe I get pretty well looked after here." Another person said, "I absolutely feel safe, I can speak to any of the staff."

Staffing and recruitment
● We reviewed rota records and found there were not always a sufficient number of staff on duty to meet the needs of people in the home. However, this was not planned and was as a result of sickness or Covid-19 positive results. A staff member told us, "Staffing has been horrendous, the new head of nursing has improved things and gives us much better staffing now than we had."
● People told us there was not always enough staff due to Covid-19, but the staff worked together to meet people's needs. One person told us, "There is not always but it's not their fault." Another person said, "Covid-19 had an impact, but they manage as best they can." A third person said, "I get help when I need it."
● The provider continued to recruit staff safely through the requirement of references and application to the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● There was a clear visiting procedure which facilitated people having visits from friends and family in their rooms. Visitors completed Lateral Flow Tests (LFT) and had their temperatures taken. Visitors were provided with PPE in line with government guidance before their visit began.

Care homes (Vaccinations as Condition of Deployment)
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The providers systems and processes to assess and monitor the quality and safety of the service had failed to identify known risks to service users' health, safety and wellbeing had not been assessed.
- A 'risk assessment summary' document had been produced for each service users, on which was recorded key areas of known risk. However, audits failed to identify that no risk assessments had been completed in relation to these known risks.
- The providers systems and processes had failed to identify reported incidents had not been consistently recorded in the providers overview system therefore reported incidents involving service users had not been consistently acted upon.
- The analysis of incidents had not been communicated to staff. A staff member told us, "We complete incident forms but don't know what happens to them, we never see any analysis."
- Systems and processes for the analysis of incidents involving service users were not robust and failed to identify trends and patterns or learning for staff.
- The providers systems and processes for monitoring the safety and quality of the service failed to identify staff were not consistently following service users' care plans. For example, we found observation checks, as required in people's care plans, were not consistently being completed and the providers systems failed to identify this.
- Effective systems and processes were not in place for addressing identified gaps in staff training. We found 'Training Compliance Matrix' dated December 2021 had identified only 42% of staff had completed fire safety training, 53% of staff manual handling training and 46% nutrition training. No action had been taken to improve the percentage of staff trained in these areas.
- The provider failed to actively encourage feedback about the quality of care from service users' relatives and friends. One relative told us, "I was really frustrated by the lack of feedback, not knowing what is happening." Another relative said, "I do not know the full name of the person in charge, I do not know who to contact."

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found the competency assessments and spot checks to monitor service delivery were not always carried out in the absence of a registered manager.

● The provider had recently employed new therapy leads and a head of nursing who had identified and actioned a number of areas for improvement such as the detail included in handover. The provider had also recruited a new manager to start in February 2022 to register with CQC.

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

● The provider did not always promote a positive culture that achieved good outcomes for people. For example, communication with staff was poor and the needs of staff were not always sought and acted upon.

● Staff we spoke to told us the morale in the staff team was low and this was due to the lack of management support they had had until recently. One staff member said. "We don't get supervisions or meetings we haven't had them, there is no support and don't feel we are listened to."

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 understood their legal obligation to submit statutory notifications relating to key events as and when they occurred at the service. We saw examples where the registered manager kept people informed about complaints and other actions taken. People and their relatives were kept informed in an honest and open way.

Working in partnership with others

● The Provider ensured the service worked with external professionals to promote healthcare Such as GP's and consultants. The provider had their own therapy teams to provide rehabilitation to people as part of their care.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the service delivery was always safe

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure oversight of the service provided

The enforcement action we took:

Warning Notice