Selborne Care Limited

Selborne House

Inspection report

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Date of inspection visit:
08 January 2019
09 January 2019

Date of publication:
13 March 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 08, 09 and 21 January 2019 and was unannounced. We completed a final unannounced inspection day on 21 January 2019 to check the provider had taken steps to safely manage risks we had identified during the first two days of our inspection. At the last inspection completed in January 2018 we rated this location as 'requires improvement'. We also identified two breaches of regulation around the provision of safe care and treatment and the overall governance and management of the service. At this inspection we found the quality of care had further deteriorated and this service was now rated as 'inadequate'. We found the provider remained in breach of the regulations identified at the prior inspection. Two further breaches were identified around safeguarding people and the need for consent.

Selborne House is a 'care home'. People in care homes receive accommodation and 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. Selborne House accommodates up to 15 people with learning disabilities in one building that contains two separate units. Many of the people living at the service were also diagnosed with mental health conditions and had complex support needs.

The care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was in post. A 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.

People were exposed to the risk of serious harm due to the provider's failure to identify key risks and to take appropriate action to mitigate against these risks. Where safeguarding concerns had arisen these were also not always identified, reported and appropriate action taken to protect people. Care staff were not always deployed effectively or as outlined in their people's plans. People were not always protected by robust infection control practices.

The provider had failed to ensure that robust governance and quality assurance systems were in place. The provider's own systems had not identified the level of risk we found people were exposed to. Where people's care and support did not meet their individual needs this had not been identified and corrective action had not been taken.

People's rights were not upheld by the effective applicaton of the Mental Capacity Act 2005. Where people did not have capacity to provide consent, decisions had not always been made in their best interests in line with the Act.

People were supported by a committed staff team although they had not always been equipped with the skills needed to manage risk effectively. People's health needs were not always monitored in line with their needs. Concerns were not always proactively identified to enable the appropriate intervention from healthcare professionals.

People enjoyed the food they ate and were encouraged to prepare meals independently wherever possible. People received their medicines as prescribed.

People were not consistently supported in a kind, caring and compassionate way. People's independence was promoted and their privacy and dignity respected.

People's care and support did not always meet their needs. People's care plans were not updated on a regular basis with the full involvement of the person.

People were supported to access a range of leisure opportunities and community activities. People and external professionals did not always feel they could raise concerns and complaints directly with the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The provider was in breach of the regulations surrounding safe care and treatment, safeguarding people, the need for consent and good governance. You can see what action we told the provider to take at the back of the full version of the report. 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.

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.

People were exposed to the risk of serious harm due to ineffective risk management. Safeguarding concerns were not always identified and reported.

Care staff were not always deployed effectively or safely. People were not always protected by robust infection control practices.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not upheld by the effective application of the Mental Capacity Act 2005.

People's health needs were not always monitored and appropriate intervention sought.

People enjoyed the food they ate and were encouraged to prepare meals independently wherever possible.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently supported in a kind, caring and compassionate way. People's independence was promoted and their privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and support did not always meet their needs. People's care plans were not updated on a regular basis with the full involvement of the person.

People were supported to access a range of leisure opportunities

and community activities. People and external professionals did not always feel they could raise concerns and complaints directly with the service.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to ensure that robust governance and quality assurance systems were in place. The provider's own systems had not identified the level of risk we found people were exposed to.

People were not always given a voice and had not been fully involved in the development of the service.

Selborne House

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.

This inspection took place on 08 and 09 January 2019 and was unannounced. We returned on 21 January 2019 for a final unannounced inspection day to check the provider had taken steps to safely manage risks we had identified. The inspection team consisted of one inspector and an assistant inspector.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. Prior to the inspection a number of concerns had been raised by healthcare professionals about the quality of care provided by the service. We used this information to help us plan our inspection.

During the inspection we spoke with three people who used the service. We spoke with the registered manager, an interim manager, the two deputy managers and six care staff. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We reviewed records relating to people's medicines, five people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2018, we rated the provider as 'requires improvement' for this key question. We also found they were not meeting the regulation around safe care and treatment. At this inspection we found the provider had failed to make the required improvements and was now rated as 'inadequate'. We found they were still not meeting the requirements of the law around safeguarding people.

We found significant failings in the provider's management of risk within the service. We found people had known risks that were not being managed effectively and were not fully understood by care staff who were supporting them. For example, one person caused harm to themselves and had made threats of more serious harm. The provider, despite being aware of these risks, had not ensured effective risk assessments were in place and that care staff knew how to protect the person from ongoing harm. We found healthcare professionals involved in the management of this person's care had not been kept fully informed about incidents that had occurred. As a result, appropriate intervention and support had not been provided and risks had not been addressed. We found some incidents had been escalations of earlier incidents or had followed a similar pattern. The provider's lack of intervention around assessing incidents as they arose and taking appropriate action, are likely to have contributed to the ongoing incidents. We found the provider had also failed to effectively manage risks associated with behaviours that could challenge others. We found behaviours were not monitored and incidents that resulted were not addressed appropriately. As a result people were being exposed to the risk of ongoing harm.

We found risks within the environment in the service had not been managed effectively. We found the building was poorly maintained and risks relating to individuals had not been considered. For example, items that people could harm themselves with had not been removed from areas in which they spent time alone. The management team we spoke with had not considered these risks and appropriate risk assessments had not been completed.

The provider was also not managing risks associated with people's health effectively. We found one person had lost approximately 4kg from March 2018 to the present day. Some steps had been taken in December 2018 to seek medical advice due to health concerns having been identified. The provider had not ensured the concerns around the person's weight loss had been identified. Action had not been taken to monitor this and manage the risks to the person. We also found an example of a person whose care plan outlined the need for blood pressure monitoring. This had not been done therefore any potential risk was not identified and managed to protect the person from harm.

At the last inspection we found the provider had not ensured that staff members were supporting people 'within the line of sight' where required on a one to one basis to minimise risks to both them and others. At this inspection we found the provider had not made improvements in this area and people remained at risk of harm. During the inspection, it was at times challenging to identify who had one to one support. On one occasion we saw a person who required one to one support at all times distressed, alone and without their support staff in the nearby area.

Following our initial two inspection days the provider gave assurances the issues we had found would be addressed immediately. When we returned for our final day of inspection we saw improvements were being made. Steps had been taken to address the immediate risk to people although further improvement was still required.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Care staff we spoke with were able to describe signs of potential abuse and how they would report concerns. We found while care staff were able to describe the theory around the actions they should take to safeguard people, this was not happening in practice. We found the provider had not developed effective systems to ensure safeguarding incidents were known to the management team and reported to the local safeguarding authority. As a result we identified multiple incidents where appropriate investigations had not been completed and people were not protected from the ongoing risk of harm. Examples of this included incidents of where people had caused or threatened to cause serious harm to themselves. No action had been taken to mitigate the risk of these incidents reoccurring in the future.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding people who use services from abuse.

People were not protected by effective infection prevention and control practices. We found areas in the service were unclean and heavily stained. We saw in one person's bedroom there was heavy soiling of what appeared to be blood that had remained following an incident from several days prior. This had not been identified by the provider, the management or staff team and corrective action had not been taken.

We found sufficient numbers of care staff were in post to manage risks to people. However, these staff were not always deployed effectively. We found there were times people were left alone when their care plans stated they should always be supported by at least one member of care staff. We found care staff were recruited safely and appropriate pre-employment checks were completed.

People received their medicines as prescribed. We saw medicines were stored safely and securely. People's medicines administration records (MAR) were completed accurately. The amount of medicines outlined on people's MAR matched the quantities we found in stock within the service.

Requires Improvement

Is the service effective?

Our findings

At the last inspection completed in January 2018 the provider was rated as 'requires improvement' for this key question. At this inspection we found the provider had failed to make the required improvements. They were now also not meeting the regulation around the need for consent.

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 Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Where people had the capacity to provide consent we saw this was sought. We found discussions were held with the person which supported them to make decisions and choices. However, where people lacked capacity to make decisions or provide consent the principles of the MCA were not being followed. Care staff we spoke with did not have sufficient knowledge around the application of the law. The provider was making decisions on the person's behalf without ensuring these were taken in the person's best interests in line with the law. For example; sensor mats and decisions about medicines and health were taken without the principles of the law being adhered to.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

People who were able to share their views told us they enjoyed the food and drink they ate. We saw people were encouraged to be independent and complete their own food shopping and cooking wherever possible. Where people lacked capacity they were supported by care staff to prepare meals. We found food intake was recorded although this was not monitored effectively therefore not all concerns were identified proactively. This resulted in a failure to provide additional support or seek appropriate advice from healthcare professionals in a timely way.

Healthcare professionals we spoke with told us about concerns around the proactivity of identifying concerns about people and ensuring these were shared with the appropriate agencies and professionals. This reflected what we found during our inspection. We found healthcare professionals were involved in people's care but this was not always done proactively and in a timely way. Strong working partnerships had not been formed with external agencies and professionals to ensure the best possible outcomes could be achieved for people in terms of their health and wellbeing.

People who were able to share their views told us they thought care staff supported them well. Healthcare

professionals told us there was a 'striking' difference in the competency of different staff members within the service. We found care staff did have the appropriate skills to support some people living in the service and their needs were met effectively. However, where people had complex needs and mental health conditions care staff did not have the skills and knowledge to minimise risk and provide effective support. We saw care staff did have access to a range of training. However, despite the service accommodating high numbers of people with complex mental health conditions, the provider had not ensured care staff had the appropriate training and supervision. The provider was not monitoring the skills of care staff in these areas to ensure that any gaps in their competency were identified and addressed to ensure people received effective support. The provider gave assurances they would address this concern immediately. When we returned for our final inspection day we found a training session had been held which was of good quality and received positive feedback from care staff.

The provider had not ensured the design and adaptation of the building consistently met the needs of the people living in the service. While we found positive examples; such as the use of a room that mimicked the living environment of a flat to help support a person's independence, we also found poor examples. For example; one person's room had not been adapted to accommodate the use of their wheelchair. This caused them challenges when trying to use their bathroom independently. The registered manager told us there were plans for work to be completed to address this issue but this had not been done proactively and there was no immediate plan for this work to begin. We found the decoration of the service in some areas could trigger issues for those living with mental health conditions. This had been raised by people living in the service and healthcare professionals. The registered manager told us they would be redecorating to address this issue but again, this had not been done proactively and there was no immediate plan for the work to begin.

Requires Improvement

Is the service caring?

Our findings

At the last inspection completed in January 2018 we rated the provider as 'good' for this key question. At this inspection we found the provider had failed to maintain those standards and was now rated as 'requires improvement'.

People who were able to share their views told us they were happy with the support they received from care staff. We saw some good examples of kind and caring interactions between staff and people but we also saw some poor examples. We saw while some care staff were proactive in supporting and working with people, others were not. Some care staff did not engage or interact with people in a productive and positive way. For example; we saw sat sitting in communal areas not interacting when this could have been of benefit to people. We found the provider did not have systems in place to ensure the culture that was developed in the service was caring towards people. The lack of proactivity around managing incidents where people had displayed distressed or self-harming behaviour meant people were not given appropriate support to ensure their distress was minimised as far as possible. We found the lack of leadership and organisation amongst the staff team resulted in people sometimes being caused avoidable distress or confusion. For example; we observed a situation where one person was going out for a hair cut. There was confusion around which staff member would go to support them. For people were learning disabilities or mental health conditions this sort of confusion could cause unnecessary distress. The person appeared to be stressed and unsettled during this confusion.

Care staff protected people's privacy and dignity while completing tasks such as personal care and while they were out in the community. People had their own rooms which we saw were personalised and contained their own personal possessions. Their room was their own space and we saw staff sought consent before they entered these rooms.

We saw positive examples of where people's independence was promoted. People were encouraged to take control of their lives as much as they were able to. We saw people, with the support of care staff, going out to complete their own weekly shopping, cooking, completing household tasks and to engage in their own choice of leisure opportunities. We saw people were able to move around the service without any unnecessary restrictions. We saw a really positive example of one person who had made strides forward in terms of what they were now doing independently since moving into the service recently. They were living in a room with it's own kitchen and living area and were being supported to develop their own independent living skills. We found the registered manager was keen for people to develop skills which would enable them to potentially live in more independent settings in the future.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection completed in January 2018 we rated the provider as 'good' for this key question. At this inspection we found the provider had failed to maintain those standards and was now rated as 'requires improvement'.

People did not always receive care in line with the requirements of their care plans. For example; where one person's care plan stated they required specific health monitoring to be in place, we found this was not being carried out. We found people's care plans were initially developed in detail, however they were not updated to reflect people's changing needs. We also found there was no monitoring system to ensure care plans were accurate and that people's needs were being met.

People were involved in the creation of their care plan although were not always proactively involved in updating their plans on an ongoing basis and being encouraged to own this process. One person told us, "I don't remember it [the care plan] but I have seen it". We saw care plans were initially developed with people's input. However, they were not created in an accessible format that gave people the best opportunity to be fully involved. Care plans were not used as a tool for people to outline what they wanted to achieve and to monitor their progress in achieving these goals and outcomes.

People were encouraged to access a range of leisure opportunities. We saw, where people had the capacity, they were engaged in conversations about where they wanted to go and how they wanted to spend their time. For example; we saw one person expressed a desire to go trampolining and they were supported to do this on the same day. We saw people supported to access the community on a daily basis and were encouraged to complete everyday activities such as shopping and domestic tasks. People were able to spend time completing activities in the service of their choice. For example, one person enjoyed doing drawing and colouring and we saw them being enabled to do this. We found people were supported to celebrate special occasions such as their birthdays and were able to maintain relationships with people who were important to them.

People did not always feel they were able to raise concerns and complaints. One person had raised a complaint directly with CQC prior to the inspection. We also received a number of complaints from healthcare professionals who did not feel able to raise complaints directly with the service. We saw one complaint had been received by the service in the 12 months leading up to the inspection. This complaint had been considered and an appropriate response had been sent. The registered manager told us they would take action to identify what the barriers were to people raising more concerns with them directly in order to make improvements.

We looked to see how the provider developed support plans to assist people at the end of their life. There was nobody within the service that required support with end of life care at the time of our inspection.

Inadequate

Is the service well-led?

Our findings

At the last inspection completed in January 2018 we rated the provider as 'requires improvement' for this key question. We also found they were not meeting the regulation around effective governance. At this inspection we found the provider had failed to make the required improvements and was now rated as 'inadequate'. The provider continues to be in breach of the regulation, and were also not sending CQC notifications of serious incidents which are required by law.

The provider had not ensured appropriate audits and governance systems were in place within the service. This meant the provider and registered manager were not aware of the issues we identified during our inspection. The provider took swift action to address the immediate risk within the service and to make improvements on being notified of the severity of our concerns. However, their own internal systems had neither identified this nor ensured appropriate action was taken. The provider has advised they will be conducting internal investigations to identify how their internal systems failed and they will be sharing their findings with CQC, in addition to ongoing action plans.

We identified multiple areas of significant risk within the service; including incidents involving behaviours that could result in harm to the person themselves, other people or staff members. Many of these incidents were unknown to the management team due to a failure in effective reporting systems. Where incidents were known, systems were not in place to review risk appropriately to ensure the likelihood of future events was mitigated against wherever possible. As a result of these failures in the provider's systems, people were exposed to the risk of ongoing harm. We found incidents had reoccurred, some of which may have been preventable had risk been reviewed earlier and action taken.

We found the provider did not have systems in place to review gaps in staff member's skills and knowledge in order to ensure people received the best possible care and support. We found the provider had not identified that care staff had not received appropriate training in mental health, despite the majority of people living in the service being diagnosed with at least one condition. We found appropriate competency checks were not being completed on an ongoing basis, as a result, issues had not been identified and further support, training or disciplinary action had not been taken. As a result, care staff did not always have the skills required to support people safely and effectively.

The provider had failed to ensure there were effective systems in place to ensure people's needs were met. They had not identified care plans and risk assessments were not being updated in line with people's changing needs. They had also not identified that where care plans stated certain aspects of someone's health and wellbeing required monitoring, that this was actually done. We identified issues where people's health needs were not being monitored to ensure they were not exposed to the risk of harm. We also found where some aspects of people's health were routinely recorded, this was not monitored and concerns identified to ensure that appropriate action was taken. We found for example that where people had lost weight, increased monitoring was not in place and healthcare professionals had not been involved proactively and in a timely way. As a result, people were exposed to the risk of avoidable, ongoing harm.

We found the provider did not have systems in place to ensure that processes were reviewed as things changed within the service. For example; we found the provider had accommodated people under the age of 18 years old without ensuring the appropriate barring lists had been checked on staff members Disclosure and Barring Service checks (DBS). DBS checks enable employers to review staff member's criminal history in order to ensure they are appropriate to work with vulnerable people. We also found the provider did not have systems in place to ensure clear plans were in place to address issues that were identified; for example, with concerns around the décor and accessibility of certain aspects of the service.

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

The provider had not sent statutory notifications to CQC regarding safeguarding incidents and serious injury. Statutory notifications are required by law to inform the commission of significant events.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notifications of other incidents.

People who had the capacity to share their views told us they felt they were able to speak with management and their views were heard. We saw the provider had not taken sufficient steps to enable those without capacity or those who were not able to verbally communicate to share their views. We found there was very limited support for people to access tools that may be able to assist with their communication.

Care staff told us they felt they had access to support from the management team. They told us they felt able to share their views and had regular one to one meetings to enable discussions with their managers.

We provided feedback to the registered manager at the end of the first two days of inspection. They acknowledged the feedback given in a constructive way and told us they were committed to making the required improvements. The provider also took immediate action to make improvements in the service and to address the concerns identified. When we returned for our final day of inspection we saw the provider had taken the action they had outlined to us. They had developed plans to ensure that ongoing improvements would be made and were ensuring a presence from senior management within the service.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not upheld with the effective application of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were sufficiently protected from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure safeguarding concerns were identified and reported. People were not protected from the risk of ongoing harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that effective systems were in place within the service. The provider had not identified that people were exposed to the risk of harm.