Scope

Harbour Close

Inspection report

8-11 Harbour Close
Murdishaw
Runcorn
Cheshire
WA7 6EH

Tel: 01928712973
Website: www.scope.org.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook a focused inspection of Harbour Close on 26 and 28 July 2016.

At the comprehensive inspection of this service in November 2015 we found the provider was meeting all the regulations we looked at and was rated as a GOOD service.

This focused inspection was carried out to look at concerns raised by Halton Council with regard to staffing levels and leadership of the service.

This report only covers our findings in relation to the Safe, Responsive and Well-Led domains.

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

8 -11 Harbour Close is a purpose-built care facility providing personal care and accommodation for 12 people who have physical disabilities. The service consists of four bungalows each accommodating three people. The bungalows are owned by Liverpool Housing Trust and the service is managed by Scope. The home is located in the Murdishaw area of Runcorn and is within easy access of local amenities including shops, social and educational facilities. There is also a small office located adjacent to bungalow 10 which is used by staff to store and access information.

There was no registered manager at Harbour Close. 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.

We found that since our last inspection the registered manager had left the service and the staffing levels were now a cause for concern. We were aware that concerns had been raised by Halton Council regarding the staffing and overall governance of the service.

We identified breaches of the relevant regulations in respect of person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, good governance and notifications to the Commission.

Care plans were not person centred and did not provide enough information to direct staff in the care they needed to deliver. We found that a number of agency staff were employed that had difficulties in understanding the needs of people living at the home and staff told us that they did not have time to read the care plan and risk assessments. People did not receive care that met their individual needs and preferences.

Risk assessments were out of date and did not include full details of any action taken to minimise avoidable harm. We saw some examples of unsafe practice that put people living at the home at risk of harm. We identified a number of incidents and issues that should have been referred to the local authority's safeguarding team. These had not been referred and we had not been notified about them.

There were insufficient staff employed to safely meet the needs of people living at the home.

The registered provider was aware of many of the shortfalls in practice because the local authority had previously carried out quality monitoring visits and implemented an action plan. However, leadership and management of the home had failed to address many of the issues.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the Commission. 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.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

The health and well-being of the people who lived at the home was at risk because the service were failing to provide care in accordance with each person's assessed needs.

Managers and staff were not doing all that was reasonably practicable to identify, control and mitigate risks and ensure that people were protected from unsafe and ineffective care.

There was an insufficient numbers of suitably, experienced qualified and competent staff to ensure the well-being of the people who lived at the home.

Is the service responsive?

Inadequate

The service was not responsive.

The registered provider failed to ensure that care and treatment was provided which meet people's individual needs.

People were not provided with social activities which resulted in their social isolation.

Risk assessments and care plans did not accurately reflect any identified risk to people's health and wellbeing.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager of the service and staff were unsure of who was leading the service on a day to day basis.

The registered provider had not taken effective action to address care practice failings identified by health and social care professionals so vulnerable people had remained at risk of receiving unsafe care.

The registered provider had failed to ensure that systems and processes were established and operated effectively to assess,

monitor and improve the quality and safety of the service.

Harbour Close

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 was 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 a focused inspection of Harbour Close on 26 and 28 July 2016.The inspection was unannounced. We carried out this inspection in response to concerns raised by a representative of Halton Borough Council about the standards of care provided at the home and the lack of governance.

We inspected the service against three of the five questions we ask about services: is the service safe, is the care provided responsive to individual need and is the service well led.

The inspection was undertaken by one adult social care inspector on the first day and one adult social care inspector and an inspection manager on the second day.

Before the inspection we checked with the local authority safeguarding and commissioning teams for any information they held about the service. We considered this together with any information held by the Care Quality Commission (CQC) such as notifications of important incidents or changes to registration. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we met with eight of the people who used the service. People were not always able to communicate verbally with us but expressed themselves in other ways such as by gesture or expression. Due to the nature of people's complex needs, we did not always ask direct questions. We did however chat with people and observed them as they engaged with staff during their day to day activities. We spoke with six staff members as well as the area manager and the team leader.

We received information from Halton Borough Council about the outcome of their recent contracts monitoring visits. The information they shared with us indicated that they had found evidence that vulnerable people were being placed at serious risk to their health and wellbeing. In response we instigated

this focused inspection in which we looked at records including six care files, two staff files, staffing rotas, the training matrix, complaints and audit reports.

We also looked around the buildings and facilities and, by invitation, observed people during their lunch time meal and looked in six people's bedrooms.

Inadequate

Is the service safe?

Our findings

When we visited Harbour Close we saw that the arrangements to ensure people received safe care and treatment were inadequate. People told us that they did not receive adequate care as there were few staff around to assist them. Families of people who lived at the home told us that staffing levels were poor and that agency staff were used at the time. People said that the agency staff did not understand their needs and were not able to effectively communicate. One person said, "I don't like it here- I don't feel safe – there is another service user who shouts at me all the time – and staff have said that it's just their mood".

Our observations during the inspection indicated that at times there were not enough staff on duty. The rota showed that on 26 July five staff were on duty from 7am until 3pm across the four bungalows. However at the time of our visit only four staff were on the premises as one staff member had escorted a person who lived at Harbour Close to an appointment within the community. Twelve people were accommodated in the properties, the majority of whom have severe physical disabilities and many of whom also have significant challenges with communication. Two of the staff on duty were agency workers and one staff member told us they were very new to the job. Records and discussions showed that the agency staff had not received induction and had very little awareness of the individual needs of the people living at Harbour Close. Staff told us that they did not have time to read people's care plans and we saw that at times they offered inappropriate and unsafe care.

We observed that staff were not readily available to assist people when they needed help. We saw that a person who was in need of assistance needed to wait ten minutes before a staff member became available as they had been assisting another person who lived at the home. Many of the service users living at Harbour Close rely on staff that know them well and are able to meet their preferences and routines. It was apparent that staff did not understand what people using the service were trying to communicate. For example one person was exhibiting signs of distress and the inspector saw in their care file that they suffered from pain and analgesia needed to be administered when required. The care worker when asked by the CQC inspector, as to what she should be doing, failed to recognize that the service user was in pain. When advised by the inspector that the service user appeared to be in pain the staff member told the inspector she was unable to administer medication as she had not yet been assessed as competent to do so. The staff member called for assistance but was told that none of the people in that bungalow required lunch time medication. There was no recognition that even if people in the bungalow did not require regular medication at that time, they may need medicines to ease pain.

We were given a list of the people living at Harbour Close and brief details of the dependency and care needs. It was not clear from the information provided, why some people required two staff for most tasks whilst other people only required one staff member for tasks. All the people using the service are wheelchair bound and require hoisting. We could see that staff constantly had to request help from other staff in other bungalows to assist in moving people or attending to personal care which led to delays in care delivery. During our visit we noted that people who lived at Harbour Close were left alone locked in their bungalow whilst staff went to assist in other properties. Staff told us that they had to double up in order to assist with people who needed two staff to transfer them or to attend to personal care needs.

On the second day of the inspection, although there were more staff on duty that were permanent members of staff, and therefore knew people living at the home better, staffing levels remained inadequate. We found that there were five carers on duty but one carer had to escort someone to a hospital appointment, so again we saw that people were left waiting to be attended to and that for a short period the two people remaining in one bungalow, where one person had gone for the hospital appointment, were left unattended until a carer from the next door bungalow had finished bathing someone.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people living at the home.

We looked at a sample of risk assessments and found that they were generic and did not provide specific information to staff about how to reduce risks for the individual. We saw that many of the risk assessments had not been reviewed for over a year. We had concerns that some staff were not following even the minimal guidance provided on the risk assessments.

We saw that two vulnerable people who had been assessed at risk of choking by their speech and language therapist had been put at risk. We saw that staff were providing one person with a totally unsuitable diet. When questioned about this they said they had not had time to read the care plan or the person's dietary needs. We needed to stop the staff member from providing the meal as the person would have been at risk of choking. Another person whose care plan stated they must be supervised during mealtimes was left alone to feed themselves and was seen to be in distress with food all over their hair and face. We informed the acting manager during the inspection that these incidents should be referred to the safeguarding team at Halton Borough Council.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that care and treatment was provided in a safe way for service users.

We spoke with a person living at the home who told us they did not feel safe and did not consider themselves to be "at home". They told us that the atmosphere was "bad" in the bungalow because another person living in the bungalow shouted at them and made them feel upset and frightened. They told us they hadn't brought it up with staff because "they won't do anything – they just say that's their mood."

We looked at a number of care files for people using the service and had concerns about several incidents where people's personal or health care needs had been neglected. One incident could have led to serious consequences for the individual. We asked if the matter had been referred to the safeguarding team at Halton Borough Council and the acting manager said it had been reported as a care concern. We checked with Halton Borough Council but they had no knowledge of this incident. The matter had been referred to Scope's own internal safeguarding team but the correct safeguarding procedures had not been followed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that service users were protected from abuse and improper treatment.

Inadequate

Is the service responsive?

Our findings

People told us that they were not provided with person centred care to meet their individual needs. They told us that they were not able to participate in many activities and felt lonely and isolated in the home. People spoken with said they had not been out for a long time due to staff shortages.

People's relatives told us that they felt staffing levels were so poor that it was impossible for them to provide stimulation for the people who lived at Harbour Close. One person told us that staff did not even have time to take their relative for a much needed haircut. However they did say that the permanent staff were kind and considerate but just had to work too hard. Another relative told us that they visited three times a week. They advised the inspectors that agency staff were regularly used who did not understand the social and communication needs of the people who lived at the home. Other relatives told us that staff were kind and caring but just had too much to do.

One person told us they liked to go out but it did not happen often. They said that when it did sometimes the taxi drivers refused to take the wheelchair. They told us that they did not always get help to use the toilet when they needed to because there were not enough staff. This person told us they used incontinence products but "I wait all day until night to be changed." This person also said that on the limited occasions they left the home there were not enough staff to assist them to use the toilet and change their pad before they went out. On the day of the inspection this person was really looking forward to going out but when the taxi came they were unable to accommodate the wheelchair so the person was unable to go.

We saw that some people had risk assessments for when they travelled in Scope vehicles; however, these were out of date, because when we asked the acting manager she told us Scope did not have any transport that was used at the home.

We saw a care record which identified that a person wished to attend church each week but there were no staff available to assist.

We looked at the daily records of several other people who lived at the home and could see that one person had only been out of the home once during the month of July, another person had been out four times and a third person had been out of the home once during the month. The main activity recorded for this person was watching soaps and DVDs.

These issues were a breach of Regulation 9 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that care and treatment was provided that met their needs and preferences.

Staff also told inspectors that agency staff did not understand effective communication with the people who lived at Harbour close.

Care plans examined in detail showed that they had not been regularly updated. Risk assessments to

identify if people were at nutritional risk were in place however there was no information to show that any identified risks had been acted upon. We saw that staff were unaware of people's dietary needs therefore putting them at risk. We saw that one person had been weighed on 8/4/16 and had not been weighed again until 14/7/16 when they had lost 6.5kgs in weight. We asked why this person had not been weighed for over 3 months and were told that the scales had been broken. This person did not have a corresponding care plan to advise staff of actions they needed to take to address the weight loss. We saw that in this person's care file there was guidance dated 20/5/16 regarding their diet due to swallowing difficulties but it did not refer to any type of fortified diet to increase the person's calorie intake. Furthermore, we had concerns that staff were not following the guidance for this person regarding their soft diet and did not have an adequate care plan in place in respect of their oral hygiene. This had put the person at serious risk of harm.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that care and treatment was provided in a safe way for service users.

During the inspection we identified a number of incidents that should have been dealt with through safeguarding protocols, part of which would be notifying the Commission. We had not received notifications about these incidents.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.The registered provider had failed to notify the Commission without delay of all incidents that affect the health, safety and welfare of people who use the service.

Inadequate

Is the service well-led?

Our findings

There was no registered manager at Harbour Close. Management arrangements had been implemented as a consequence of Halton Borough Councils visits and the requirement for the home to have clear governance in place.

We saw that the provider had seconded a service manager from another SCOPE service to support the current team leader. The provider had also arranged for other senior staff to visit Harbour Close to offer support. However we saw that an action plan which had been submitted to Harbour Close from Halton Contracts department had not been completed.

The manager sent the Commission a copy of the action plan which showed what actions were necessary to address the practice failings identified. However evidence provided by health and social care professionals showed that the actions identified had not been addressed. As a result vulnerable people had remained at risk of receiving unsafe care and treatment.

We saw that risk assessments had not been updated, eating and drinking guidelines had not been followed and staff training had not been provided. We noted that care planning and reviews were out of date and daily records were not monitored or reviewed to assess the quality and quantity of recording.

Records showed that care concerns and safeguarding notifications which the provider is required to submit to the Care Quality Commission and Halton Borough Council had not been sent.

Despite the local authority being given assurances that effective action would be taken to protect vulnerable people we saw that inappropriate food had been prepared for a person who could have suffered serious consequences had the inspector not noted the error. We saw that a person who needed support with eating had been neglected and moving and handling requirements had not been addressed.

Staffing levels had not improved and the service depended on the use of agency staff. We noted that they had not been inducted, trained or given details of people's individual requirements. We spoke with two agency workers who told us that they were unable to identify the individual needs of people because they worked across all areas of the home and had been given no time to read people's care plans. When asked basic questions about individual care they were unable to answer but told us they 'just used common sense'.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided. The registered provider had also failed to ensure that systems and processes were established and operated effectively to assess, monitor and mitigate risks relating to the health, safety and welfare of service users.