The Royal Masonic Benevolent Institution Care Company

Lord Harris Court

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Lord Harris Court is a care home providing personal and nursing care to 52 adults at the time of the inspection. Some people at the service have a diagnosis dementia. The service can support up to 76 people.

People's experience of using this service and what we found
This was a targeted inspection that considered the risks of people falling and safe moving and handling practices. Based on our inspection, we are satisfied that the service is proactively preventing people from risk of falls and related injuries. Appropriate measures were in place to assess risks and lessen them. Staff were appropriately trained in moving and handling techniques. Incidents and accidents were recorded, investigated and used to learn when things went wrong.

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 21 November 2017).

Why we inspected
We undertook this targeted inspection to check on specific concerns we had about people's falls, and the safety of moving and handling practices. The overall rating for the service has not changed following this targeted inspection and remains good.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Lord Harris Court

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on specific concerns we had about people's falls and moving and handling practices.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carries out by an inspector, a specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Lord Harris Court 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 had a manager registered with the Care Quality Commission. This means that 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 the inspection
We reviewed information we held and had received about the service since the last inspection. We sought feedback from the local authority, safeguarding team and other professionals who work with the service. We checked information held by Companies House and the Information Commissioner's Office. We looked at the content of the provider's website. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about

their service, what they do well, and improvements they plan to make. This information helps support our inspections. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people and a relative about their experience of the care and support provided. We spoke with registered manager and assistant director of quality and governance. We also spoke with the clinical lead, a registered nurse, the facilities manager and a care worker. We received written feedback from the local authority and commissioning teams. We reviewed a range of records. This included three people's care records and medicines administration records. A variety of records relating to the safety of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and received quality assurance and other governance records. We held a telephone conference with the registered manager and assistant director of quality and governance to discuss accidents and incidents.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from avoidable harm.

We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if people were protected from the risks of falls and associated harm.

We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

- People told us they felt safe with the care and support provided. They said they had access to the equipment they needed for mobilising or moving. People said staff responded promptly when they asked for assistance.
- The risk of falling and injuries was effectively mitigated by robust systems the service had in place. This meant people could be assured they received safe support when mobilising or being moved.
- There was a satisfactory policy and procedure in place for moving and handling. This highlighted risks for falling and methods that could be used to reduce risk to people.
- Staff received appropriate training on moving and handling on a regular basis. Training consisted of both theoretical components and practical exercises. Training was offered by a staff member who was appropriately qualified. Staff were required to complete an annual competency to ensure they were following safe processes, especially with equipment such as hoists and slings.
- People had comprehensive pre-admission assessments in place which identified any aspect that might place them at risk of falls. The assessment also recorded how independent a person was, any mobility aids in use and how many staff were required to safely support them.
- People's risk assessments and care plans were thorough and appropriate. They included information about any risks with people's moving and handling. For example, a person's assessment said, "Requires full body sling, assistance by [two] carers with care during transfer, for turns and rolls in bed. Importance of using slide sheets. Ensure [the person] uses her specialist chair when sitting out."
- The service had considered factors contributing to falls, such as poor vision or hearing, appropriate footwear usage, medicines that might affect a person's balance and medical conditions. Regular reviews of the risk assessments and care plans were completed by staff.
- If a person fell, staff knew what procedures to follow to ensure the person's safety.
- Where a person experienced multiple falls, staff examined the reasons that might be contributing to this. Appropriate referrals were made to other healthcare professionals. For example, a GP was contacted if medicines needed reviews and falls risk clinics were used for more detailed assessments. For example, one person's notes stated, "[The person] had a fall today; please be aware of new mobility advice." At shift handover, this was highlighted on the information sheet for discussion.
- Mobility equipment was properly serviced and checked on a regular basis. The service ensured they

complied with the requirements set out in the relevant regulations for equipment. Any repairs required were promptly detected and repaired.
● Regular environmental risk assessments were completed. Observations were made weekly and monthly and recorded in health and safety audits. These contained key details such as whether the corridors and flooring were clear, whether there was sufficient lighting and if there were any slip, trip or fall hazards identified.

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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● There was a robust system in place for identifying accidents and incidents, recording them, investigating causes and providing feedback or outcomes.
● Falls diaries were used to record when people experienced an accident or incident with their mobility. Information in the document was used to help inform staff of risks and ways of reducing the recurrence of the person sustaining further falls.
● The management team used a falls tracker. Information was collated from all falls within the service. The data was used to identify, where possible, why people sustained a fall. The tracker listed information such as time of day, what the person was doing at the time, the location, whether the call bell was used. This helped information the management about patterns or trends.
● Information about falls was shared with staff in a variety of ways, to aid learning and share good practice. Falls and changes to a person's care were mentioned at staff shift handovers. Safe moving and handling was also discussed in team meetings. This ensured staff had the latest information about people who were at risk of falls or had sustained any harm.
● Where a person who fell sustained harm, appropriate reporting took place. This included to the local authority, GP and the Care Quality Commission. The management team also reported all falls to the provider's quality team.
● Accident forms recorded details of all falls. Formal investigations were launched and completed for falls where there was any concern about the underlying cause or event.
● The registered manager, clinical lead and senior care workers were proactive about preventing, investigating and managing falls. They had a good knowledge of the people who used the service, the risks of falls for individuals and best practice in falls management.
● Although the service was transparent in their approach with people and others when falls and injuries occurred, some improvement in following duty of candour requirements was required. The registered manager and assistant director of quality and governance acknowledged our findings about this.
● We discussed this with them at the site visit and again after the inspection. They accepted changes were required to the underlying policy, and provided an explanation of how this and other changes would be put

into practice. We were reassured that the management team and provider would take appropriate action to ensure this occurred.

- We have signposted the provider to relevant resources to develop their approach.