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HM Coroner Emma Brown
HM Coroner's Court,
Coroner's Court
50 Newton Street
Birmingham
B4 6NE

13 September 2017

**By Email to:** coroner@birmingham.gov.uk

Our Reference: ENQ1-4103996990

Dear HM Coroner Emma Brown

**Ref: James Albert Harris**
**Re: Regulation 28 Report - Inquest touching on the death of James Albert Harris**

Thank you for sending the Care Quality Commission (CQC) a copy of the Regulation 28 Report issued following the Inquest touching on the death of Mr James Harris ('Mr Harris'). We are writing to you with our response to the matters of concern raised in relation to Cherry Lodge Care Home ('Cherry Lodge').

*Brief Background*

Cherry Lodge is a care home without nursing operated by Care First Class (UK) Limited, and is registered to provide the regulated activity of accommodation for persons who require nursing or personal care at the location of Cherry Lodge Care Home from 26 August 2014.

The first comprehensive ratings inspection at Cherry Lodge was conducted on 17 and 18 September 2015 where the service was rated as *'requires improvement'* with a breach under Regulation 13(5) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, (Safeguarding service users from abuse and improper treatment). A follow up inspection was carried out on 30 and 31 August 2016 where the provider remained as *'requires improvement'* but had met the legal requirements of the breach and there had been some improvement to the service.

On 28 January 2017 CQC received a statutory notification from the then deputy manager of Cherry Lodge advising that a service user (Mr Harris) had fallen on 26 January 2017 and had sustained a fracture to his hip as a result. The notification advised that Mr Harris had slipped in the toilet and at the time of the fall appeared not to have sustained any injury. The notification continued to explain that on 27 January 2017 Mr Harris complained to care staff of pain in his leg and the paramedics were called. Mr Harris was then taken to hospital and it was established he had a broken hip.

On receiving this notification the CQC requested additional information from the deputy manager of Cherry Lodge on 1 February 2017. We received a response on 6 February 2017 advising that this was the first time Mr Harris had fallen since his admission to Cherry Lodge on 10 January 2017. However it was noted that there had been a history of falls prior to his arrival to Cherry Lodge. On request CQC received copies of the accident report, the daily records for Mr Harris from 26 January 2017 and the night report for 26 January 2017. However, not all the requested information had been sent to the CQC and as part of our assessment of risk, further requests for information were made to the deputy manager on 9 February 2017 and 16 February 2017. On 17 February 2017 the CQC received the additional information requested which included copies of Mr Harris' risk assessment, initial support needs assessment and a daily notes.

In accordance with CQC processes, we considered the information we had available to us at that time (February 2017) to determine whether the service was meeting the The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("The Regulations"). Based on the information available to us at this time it was decided that no further action would be taken.

On 2 March 2017 CQC received a further statutory notification from Cherry Lodge, advising that during the Registered Provider's internal investigation into the events leading up to Mr Harris' fall there had been allegations made by a member of the care staff, that some statements provided by care staff around the time of the fall were not a true reflection of the incident. These allegations were reported to the Registered Provider who then made a safeguarding referral to the Local Authority and a police investigation ensued. It was during the course of the police investigation that the Registered Provider made CQC aware that Mr Harris had passed away in hospital on 3 April 2017 and his death had been referred to the Coroner's Court. In light of the police investigation and additional information

the CQC had received, we revisited our assessment process. As part of CQC's assessment of risk the decision was made to wait for the outcome of the Coroner and police investigations' before deciding if we needed to take civil or criminal action.

Further, in light of the additional information above and as part of the CQC assessment of risk, a decision was made that the date of the next scheduled inspection of Cherry Lodge would be brought forward. A comprehensive inspection ('the inspection') took place on the 15, 17 and 22 August 2017. In line with the CQC's inspection processes, the findings of this inspection will be published on the CQC website. The official rating of this inspection cannot be publicly reported on until the CQC have completed the entire inspection process. This includes the Registered Provider being given the opportunity to respond and challenge any factual inaccuracies they deem to be in the report.'

**CQC's response to the specific concerns you have raised in the Regulation 28 Report are taken in turn and set out below:**

1. **At the time of Mr James Harris' fall one of the carer's, [redacted], had not read his care plan or risk assessments:**

   The Registered Provider is responsible for ensuring care staff are competent, skilled and experienced and that they are appropriately trained as is necessary to enable them to carry out their duties, (Regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).The Registered Provider has the responsibility to ensure care staff follow service users care plans, and to make staff aware of the importance of knowing how to effectively and safely support service users and the appropriate actions to take by following a service users care plan. If care staff fail to read care plans there is a risk that they will not provide the care that is appropriate to a specific service user and thus putting that service user's safety at risk.

   A failure of staff to read care plans and risk assessments is an ongoing risk, as a Registered Provider cannot guarantee that even if care staff are given appropriate time to read risk assessments and care plans, that they will then provide care in line with these documents. However, the level of risk can be reduced if the Registered Provider has sufficient monitoring processes in place, such as regular spot checks, supervision and training.

   During the inspection, CQC inspectors spoke with seven members of care staff and noted that all seven possessed the requisite skills to perform their roles. All

care staff we spoke with confirmed they had read service users care plans and risk assessments and that there were given ample opportunities to read them

Following the inquest, CQC asked the Registered Provider what action they had taken. The Registered Provider informed CQC that there are now systems in place to ensure care staff read care plans and risk assessments of service users. The Registered Provider ensures that staff are given adequate time to read service users documents and care staff are required to sign the signature sheets on each of the care plans and risk assessments to confirm they have read and understood these documents. CQC checked during the inspection visit and found these processes had been put in place to document when staff had read care plans and risk assessments . Staff spoken with at the inspection, confirmed to us, they did read care plans and risk assessments and were given the opportunity to read them.

2. **His care plan stipulated that he was at medium risk of falls and should be accompanied when mobilising yet he mobilised to the bathroom from the lounge without assistance because the only member of staff present in the lounge was assigned to a resident requiring one to one observation and therefore could not accompany Mr Harris.**

The Registered Provider is responsible for ensuring sufficient numbers of suitably qualified, competent, skilled and experienced care staff are employed in order to minimise and reduce the risk of harm to service users, (Regulation 18 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). If there is a lack of care staff there is a risk that service users will not receive the level of support required to keep them safe from risk of harm.

At the inspection CQC saw that there were sufficient numbers of staff during the day to support service users. We discussed with the Registered Provider how they would continue to ensure this, whereby CQC were advised they used an agency with regular agency staff when required. We were also provided with evidence that the Registered Provider had an ongoing recruitment drive in progress to obtain more care staff.

Following the inquest CQC asked the Registered Provider what action they had taken following the incident. The Registered Provider advised that an additional shift had been created from 16.00hrs and 22.00hrs to provide additional support evening and night care workers. At the inspection, we saw this was the case. In addition, the Registered Provider also informed CQC that following the inquest, they had reviewed their initial assessment process for service users

moving into the home on a short or long term basis. Part of this initial assessment process included a more selective approach to ensure Cherry Lodge had appropriate staffing levels and staff skill mix to meet service users' needs safely and effectively. The responsibility to ensure that there are sufficient numbers of care workers available at all times to support service user's remains with the Registered Provider.

3. **Having fallen Mr Harris complained of pain in his groin. The homes 'Protocol for all Falls' included that if the resident complains of pain in any part of the body following a fall they ought not to be moved and medical attention should be sought. Medical attention was not sought and Mr Harris was returned to his room. The three carers who gave evidence at the inquest [redacted], [redacted] and [redacted] all gave evidence that they have not seen the document entitled 'Protocol for all Falls' prior to Mr Harris' fall on the 26 January 2017, although [redacted] and [redacted] were not found to be credible witnesses, [redacted] was credible. Evidence of police investigations identified that the Protocol ought to have been clearly available for staff around the home as a result of issues raised by the CQC prior to this incident.**

   The Registered Provider has the responsibility to ensure care staff are familiar with their internal policies, processes and procedures. If care staff fail to read the Registered Provider's policies and procedures, for example the falls policy, the risk of harm to service users is increased because care staff may not be aware of what to do in the event of a fall and who they should contact.

   This is an ongoing risk as a Registered Provider cannot guarantee that care staff do read and understand their policies, even if care staff sign to say they have read and understood the policies. This level of risk can be reduced if the Registered Provider has sufficient support mechanisms in place, such as regular supervision and training to ensure care staff knowledge is up to date and care staff have a clear understanding about the actions they are expected to take in the event of an emergency. It is important to note that care staff also have an individual responsibility to make sure that if they do not understand a policy this is brought to the attention of the Registered Provider so the policy can be explained to them.

   During the inspection we asked the Registered Provider what action they had taken in relation to Cherry Lodge's falls policy and ensuring staff reviewed and understood this. The two care staff members ([redacted]) had been disciplined following the provider's internal investigation into their

failure to follow protocol and were both subsequently dismissed for gross misconduct.

*Further at the inspection, each member of care staff that CQC spoke with was able to explain, in detail the protocol in the event of a service user having a fall. We saw evidence of the falls protocol being displayed in the staff room, the main office, a copy appeared in each staff members personnel file and each staff member had signed their own copies to confirm that they had read and understood their responsibilities in relation to this protocol. As mentioned above, during the inspection CQC inspectors noted that staff had received training in relation the falls policy and in moving and transferring people. In addition risk assessments for service users at high risk of falls had been reviewed and updated to reflect the falls protocol.*

4. **Mr Harris was not offered any analgesia despite his reports of pain.**

Under Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 the provider must ensure that service users medicines are available in the necessary quantities and at all times to ensure that the risk associated with medicines not been administered as prescribed, this would include medicines available for pain relief.

The Registered Provider had a system to ensure that service users received their prescribed medication, including medicines prescribed on an as required basis. However, individual care staff had not followed the provider's protocol when Mr Harris complained of pain. The policy of the Cherry Lodge was not to offer or keep homely remedies on the premises. This means, if a service user required pain relief not already prescribed by a GP, a care worker cannot administer the medicine. In such an event, the Registered Provider's protocol is to call for assistance either through 111 or 999. Cherry Lodge is not a nursing home and as such care staff do not have the necessary clinical skills to make judgements about people's health, or the risk associated with administering medication that had not been prescribed.

At the inspection CQC found that following the inquest the Registered Provider had taken steps to reinforce this protocol with all care staff and that a number of care workers had completed their basic life skills/first aid training. Following the Registered Provider's internal investigation into the incident, the two care workers on duty at the time of Mr Harris' fall were disciplined and dismissed for gross misconduct. The care staff we spoke with at the inspection all explained the correct process to follow should a person, not prescribed pain relief, start to experience pain.

5. **Records of routine checks on residents are not made. Therefore whilst it was asserted that Mr Harris was checked hourly throughout following the fall there is no evidence that the checks were carried out, by whom and what was found.**

   The Registered Provider has a duty to ensure processes are followed to protect service users from the risk of harm, which includes monitoring the checks made on service users were conducted and reviewing the records of these checks. The care staff at Cherry Lodge were aware that they should have recorded when checks were made on Mr Harris. However, the Registered Provider has the overall responsibility to ensure there are appropriate processes in place which should ensure regular monitoring checks are made on people and accurately recorded.

   At the inspection we asked the Registered Provider what action they had taken following the incident. The internal investigation had found the care workers had not followed the processes that were in place at the time, and had been later dismissed for gross misconduct. Since the incident the Registered Manager has re-introduced night spot checks which will take effect from September 2017. The spot checks will be unannounced and will be conducted by the manager and deputy manager, and will include checking to ensure care staff are accurately recording when service users are monitored, including the time and details of the check. The responsibility to ensure that the service has the appropriate checks and processes in place remains with the Registered Provider.

   At the inspection all of the care workers informed CQC that they did conduct checks on service users regularly to ensure they remained safe and that appropriate records of these checks were kept.

6. **The home is currently without a registered manager and has been for sometime.**

   A Registered Manager is essential in providing staff with leadership, guidance and support; hence it is a condition of the registered provider's registration that they have a Registered Manager in post.

   The previous Registered Manager commenced employment at Cherry Lodge in July 2016; suffered a period of sickness in December 2016 and returned to work in January 2017. However, the Registered Manager later resigned in May 2017.

The Registered Provider made attempts to recruit a Registered Manager and an offer was made to one applicant to start in June 2017 but they then later declined. At the inspection it was confirmed that a new manager had been in post at Cherry Lodge since 14 July 2017, and CQC were advised that they were in the process of applying for registration. CQC will monitor this application and the provider has been made aware that failure to have a registered manager places them in breach of their registration and could result in criminal enforcement action.

Should you require any further information please do not hesitate to contact me on Tel: [redacted]

Yours sincerely

M Hamerly

[redacted]
Head of Inspection
Adult Social Care Directorate

"Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3) (as amended)
Care Quality Commission (Registration) Regulations 2009) (Part 4) (as amended)"

This document sets out our guidance to providers on meeting all of the HSCA regulated activity regulations.

Enforcement Policy